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**Pain is what the patient says it is, but...:**

an ethnographic study of the factors which  
influence nurses when they make pain management  
decisions in a clinical setting

Petronella A van Raders

A thesis submitted in partial fulfilment of the  
requirements for the degree of

Doctor of Philosophy

University of Warwick,  
School of Health and Social Sciences

23 July 2012

## Table of contents

<b>Table of figures and tables</b>	<b>6</b>
<b>Acknowledgements</b>	<b>7</b>
<b>Declaration</b>	<b>9</b>
<b>Abstract</b>	<b>10</b>
<b>Abbreviations</b>	<b>11</b>
<b>Chapter 1 Introduction</b>	<b>12</b>
<b>Chapter 2 A review of pain management</b>	<b>21</b>
<b>2.1 Search strategies</b>	<b>21</b>
<b>2.2 What is pain?</b>	<b>23</b>
2.2.1 History of our knowledge of pain	25
<b>2.3 The prevalence of pain</b>	<b>29</b>
<b>2.4 Pain as an inpatient</b>	<b>31</b>
<b>2.5 The purpose of pain management</b>	<b>36</b>
2.5.1 Humanitarian	37
2.5.2 Physiological	38
2.5.3 Enhanced Recovery	40
<b>2.6 The role of the nurse in inpatient pain management</b>	<b>41</b>
<b>2.7 Pain assessment</b>	<b>42</b>
2.7.1 Pain assessment tools	43
2.7.2 Nurses' and pain assessment	45
<b>2.8 Pain management practices</b>	<b>52</b>
<b>2.9 Summary</b>	<b>58</b>
<b>Chapter 3 Influencing factors or barriers to effective pain management</b>	<b>61</b>
<b>3.1 Introduction</b>	<b>61</b>
<b>3.2 Institutional influences on pain management</b>	<b>62</b>
<b>3.3 Cultural influences on pain management</b>	<b>67</b>
3.3.1 Clinical leadership and culture	70
<b>3.4 Patient influences on pain management</b>	<b>73</b>
3.4.1 Public influences on pain management	73
3.4.2 The patient's role in pain management barriers	77
<b>3.5 Healthcare professionals influence on pain management</b>	<b>80</b>
3.5.1 Nurses' influence on pain management	80
3.5.2 Nurses knowledge and attitudes to pain management	83

<b>3.6</b>	<b>Decision-making</b>	<b>87</b>
3.6.1	Clinical decision-making skills	91
3.6.2	Nurses' pain management decision-making	97
<b>3.7</b>	<b>Summary</b>	<b>101</b>
<b>Chapter 4 – Section 1 Methodology</b>		<b>103</b>
<b>4.1</b>	<b>Research aims</b>	<b>103</b>
<b>4.2</b>	<b>Introduction</b>	<b>104</b>
<b>4.3</b>	<b>Philosophy</b>	<b>105</b>
4.3.1	Ontology	107
4.3.2	Epistemology	107
<b>4.4</b>	<b>Methodology</b>	<b>110</b>
4.4.1	Explication of study research methods	113
<b>4.5</b>	<b>Ethnography</b>	<b>114</b>
4.5.1	History of ethnography	116
4.5.2	Ethnography in nursing	117
4.5.3	Quality in ethnography	119
<b>Chapter 4 – Section 2 Research methods</b>		<b>123</b>
<b>4.6</b>	<b>Ethics in ethnography</b>	<b>123</b>
4.6.1	Confidentiality	124
4.6.1.1	Confidentiality in this study	125
4.6.2	Security of data	126
4.6.2.1	Security of data in this study	126
4.6.3	Informed consent	127
4.6.3.1	Informed consent in this study	128
4.6.4	Justice	129
4.6.5	Ethical committee review	130
4.6.6	Ethical issues which arose during the study	131
4.6.7	Ethics in ethnography summary	133
<b>4.7</b>	<b>The ethnographic field</b>	<b>134</b>
4.7.1	Gaining access to the field	134
4.7.1.1	Gaining access to the field in this study	135
4.7.2	Positioning within the field	135
4.7.2.1	Positioning within the field in this study	137
4.7.3	Sample	138
4.7.3.1	Sample in this study	139
4.7.4	Key informers	140
4.7.4.1	Key informers in this study	140
<b>4.8</b>	<b>Fieldwork</b>	<b>141</b>
4.8.1	Observations	142
4.8.1.1	Observations in this study	145
4.8.2	Field notes	147
4.8.2.1	Field notes in this study	149

4.8.3	Interviews _____	150
4.8.3.1	Interviews in this study _____	152
4.8.4	Document analysis _____	153
4.8.4.1	Document analysis in this study _____	154
4.8.5	Fieldwork summary _____	155
<b>4.9</b>	<b>Ethnographic data analysis _____</b>	<b>155</b>
4.9.1	Data analysis in this study _____	157
<b>4.10</b>	<b>Summary _____</b>	<b>160</b>
<b>Chapter 5</b>	<b>Findings _____</b>	<b>161</b>
<b>5.1</b>	<b>Introduction _____</b>	<b>161</b>
<b>5.2</b>	<b>Themes _____</b>	<b>163</b>
<b>5.3</b>	<b>Maintenance of pain management ward culture _____</b>	<b>165</b>
5.3.1	Newcastle Ward: the physical environment of pain management ____	165
5.3.1.1	The sisters' office _____	167
5.3.1.2	The nurses' station _____	167
5.3.1.3	The clinical room _____	168
5.3.1.4	The pain management team _____	169
5.3.1.5	Policies _____	171
5.3.1.6	Pain control leads _____	172
5.3.1.7	Dissemination of research _____	173
5.3.1.8	Nurses' view of pain management in this environment _____	174
5.3.1.9	Anticipation of busyness _____	178
5.3.2	Pain management communication _____	182
5.3.2.1	Handover twenty-one (HO21) _____	184
5.3.2.2	Handover twenty-four (HO24) _____	186
5.3.2.3	Other pain management communication opportunities _____	189
5.3.3	Pain management roles and tasks _____	194
5.3.3.1	Medication rounds _____	198
5.3.3.2	Clinical leadership _____	200
<b>5.4</b>	<b>Nurses' responses to pain management opportunities _____</b>	<b>203</b>
5.4.1	The culture of pain assessment _____	203
5.4.2	Nurses' knowledge of pain management _____	217
5.4.2.1	Pain management knowledge _____	217
5.4.2.2	Medications _____	218
5.4.2.3	The use of sophisticated pain management devices _____	226
5.4.3	Inattention to pain cues _____	230
5.4.4	A single action following pain management decisions _____	232
<b>5.5</b>	<b>Nurses' expectation of patient behaviour and knowledge _____</b>	<b>239</b>
5.5.1	How the patient should look _____	239
5.5.2	What the patient should say _____	241
5.5.3	What the patient should know _____	243
5.5.4	Patients who do not conform to expectations _____	246
<b>5.6</b>	<b>Summary _____</b>	<b>256</b>

<b>Chapter 6</b>	<b>Discussion and conclusions</b>	<b>259</b>
<b>6.1</b>	<b>Introduction</b>	<b>259</b>
<b>6.2</b>	<b>Pain management culture on Newcastle Ward</b>	<b>260</b>
6.2.1	Pain management within a ward environment	261
6.2.2	Local pain management policies and procedures	263
6.2.3	Pain management link nurses	264
6.2.4	How Newcastle Ward was defined by the staff	265
<b>6.3</b>	<b>Consequences of not prioritising pain management</b>	<b>267</b>
6.3.1	Pain management roles and tasks	268
6.3.2	Pain management communication	269
6.3.3	Clinical leadership	272
6.3.4	Summary	272
<b>6.4</b>	<b>Nurses' understanding of pain management responsibilities</b>	<b>273</b>
6.4.1	A single pain management action following a decision	274
6.4.2	Culturally shared pain management strategies	276
6.4.3	Inadequate pain assessment	277
6.4.4	Pain management behaviours arising from knowledge	280
6.4.5	Inattention to pain cues	282
<b>6.5</b>	<b>The patient's role in pain management</b>	<b>284</b>
6.5.1	Nurses' rules for patients regarding pain management	287
<b>6.6</b>	<b>Summary of findings</b>	<b>290</b>
<b>6.7</b>	<b>Social psychology and pain management culture</b>	<b>292</b>
6.7.1	Framework to summarise findings	298
<b>6.8</b>	<b>Trustworthiness</b>	<b>300</b>
<b>6.9</b>	<b>Limitations</b>	<b>300</b>
<b>6.10</b>	<b>Researcher reflection</b>	<b>303</b>
<b>6.11</b>	<b>Conclusion</b>	<b>303</b>
<b>6.12</b>	<b>Recommendations</b>	<b>312</b>
6.12.1	Recommendations for practice and education	312
6.12.2	Recommendations for further research	314
<b>6.13</b>	<b>Final words</b>	<b>315</b>
	<b>References</b>	<b>317</b>
	<b>Appendices</b>	<b>350</b>
<b>Appendix 1</b>	<b>Search strategies</b>	<b>350</b>
<b>Appendix 2</b>	<b>Research Ethics Committee first response</b>	<b>352</b>
<b>Appendix 3</b>	<b>Research Ethics Committee final approval</b>	<b>355</b>
<b>Appendix 4</b>	<b>Study code of conduct</b>	<b>359</b>
<b>Appendix 5</b>	<b>Interview schedule</b>	<b>360</b>
<b>Appendix 6</b>	<b>Pain control folder May 2009</b>	<b>362</b>
<b>Appendix 7</b>	<b>Handover sheet analysis</b>	<b>363</b>

## **Table of figures and tables**

Figure 1.	Nine dimensions of detailed observations _____	148
Figure 2.	Plan of Newcastle Ward (not to scale) _____	166
Figure 3.	Summary framework for findings _____	298
Table 1.	Pain management words on nursing handover sheets _____	363
Table 2.	Comparison of oral and written handovers _____	364

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## **Declaration**

This thesis is entirely my own work. I confirm the thesis and no part of it has been submitted for a degree at another university.

There has been no work from this thesis published yet.

## **Abstract**

Barriers to effective postoperative pain management mean many patients suffer needless pain. Few studies have observed nurses as they manage postoperative pain in a clinical setting; those who used observation have demonstrated the importance of context to pain management practice.

This ethnographic study aimed to examine what factors influenced nurses when they made pain management decisions, and how the culture of the clinical environment impacted on pain management practice. One hundred and fifty seven hours of participant and non-participant observation, semi-structured interviews with thirty-six members of staff, contemporaneous field notes, and document analysis were used to investigate the culture of pain management in one postoperative ward.

Analysis identified three themes with sub themes. First, the revealing of a pain management culture, which incorporated the ward environment and processes, and a new finding of the silence of routine pain management communication. Second, nurses' decision-making responses to pain management opportunities including a new finding of a single pain management action. The final theme is nurses' expectations of patient behaviours and knowledge, including how patients should look, what they should say and know, and nurses' responses to patients who do not conform to expectations.

The findings suggest culturally mediated pain management behaviours, linked to a ward culture where pain was not a priority, leading to inattention to pain management. Using Social identity theory these behaviours are presented as in-group pain management social norms; part of the culture of 'how pain management is done around here'.

These pain management in-group behaviours are presented as the critical factors influencing nurses' pain management decision-making in a clinical setting. They are not targeted through traditional education and their explication may indicate pain management education should be directed more towards cultural change.

## Abbreviations

#	Fracture
APS	Acute Pain Service
BPS	British Pain Society
BD	bis die (twice a day)
BQ	Barriers Questionnaire
CAQDAS	Computer Assisted Qualitative Data Analysis Systems
CSAG	Clinical Standards Advisory Group
DGH	District General Hospital
ED	Emergency Department
EMSA	Eliminating Mixed Sex Accommodation
GP	General Practitioner
HCA	Healthcare Assistant
HO	House Officer
IASP	International Association for the Study of Pain
IM	Intramuscular
IV	Intravenous
MST	Morphine Sulphate Tablets
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NMC	Nursing and Midwifery Council
NOF	Neck of femur
NRS	Numerical Rating Scale
NSAID	Non Steroidal Anti-inflammatory Drug
OD	Overdose
PARIHS	Promoting Action on Research Implementation in Health Services
PCA	Patient Controlled Analgesia
PR	per rectum
PRN	pro re nata (as required)
R&D	Research and Development
RCN	Royal College of Nursing
RCOA	Royal College of Anaesthetists
RCOS	Royal College of Surgeons
RN	Registered Nurse
RTA	Road Traffic Accident
SN	Staff Nurse
SR	Sister
UK	United Kingdom
USA	United States of America
VAS	Visual Analogue Scale
VRS	Verbal Rating Scale
WHO	World Health Organisation

## Chapter 1 Introduction

*“Pain is ubiquitous – it is an integral part of life.”*  
(Turk & Melzack 2011b p. xi)

When clinical nurses specialists in pain management gather they talk, as all people do, about the things they have in common. One of the most familiar topics of conversation is the perennial question of why pain management is still poor in their hospitals. They tell stories of patients left in pain, incorrect analgesic doses, indifferent pain assessment poorly documented.

Occasionally they will relate an account that speaks of a patient whose pain was well looked after, with a nurse who had the correct knowledge and gave excellent pain management care. After these stories the tone of the conversations is more buoyant for a while, before the stories of difficult discussions and poor pain management practice return. Clinical nurses specialists in pain management are passionate about the very best pain management nursing care for their patients, they have excellent evidenced-based knowledge, confirmed by the postgraduate qualifications many have, and they are engaging and lively speakers and educators. What they do not understand is why their passion, knowledge, energy, and enthusiasm for one element of nursing care, pain management, is not having more of an impact on how pain management for postoperative patients is undertaken. This study has its foundation in these very conversations; if ward nurses are not fully using the advice from the clinical nurses specialists, then what factors are influencing them when they make pain management decisions in the clinical setting?

Over thirty years ago it was said, “*the professional nurses administer the drugs and treatments and assess, observe, record, and communicate the patient’s pains and response to the various pain-relieving approaches*” (Fagerhaugh & Strauss 1977 p. 61). While the nursing role in pain management has evolved since then as nurses play a significant role in deciding the most appropriate of an ever increasing range of therapeutic pain management options (Polomano *et al.* 2008), this statement remains an accurate reflection of a nurse’s responsibility with regard to pain management (Dunwoody *et al.* 2008).

Postoperative pain management however has remained poor (Brennan 2011). There has been a significant increase in the knowledge of pain physiology and pain management over the last five decades. Over twenty five years ago (Sofaer 1985) claimed that it is questionable whether nursing practice has altered in the light of research findings, and this statement appears true today, because despite abundant literature that emphasises the importance of pain management to patients (Allcock 1996a, Camp 1988, Carlson 2010, Carr 1997, Carr & Thomas 1997, Chapman *et al.* 1985, Diekmann & Wasseem 1991, Hawthorn & Redmond 1998, Wadensten *et al.* 2011, Wall & Melzack 1999, Young *et al.* 2006), pain continues to be poorly managed by nurses (Hirsh *et al.* 2011). It is difficult to read a paper or book about pain or pain management that does not refer to the less than adequate pain management for hospital inpatients (Carr 2002, Subramanian *et al.* 2011).

There are barriers and enablers which influence effective pain management. Healthcare professionals' knowledge and attitude to pain management has been studied extensively for over the three decades. In 1972 it was said, "*Pain is what the experiencing person says it is, existing whenever he says it does*" (McCaffery 1972 p. 8). Ferrell and McCaffery (2008) devised a survey in 1987 (updated as required, last in 2008), to investigate knowledge and attitude to pain, using vignettes and closed questions. Since then they, and many other researchers have used this questionnaire extensively. It has been used in different countries (de Rond *et al.* 2000), with different healthcare professionals (Coulling 2004), for many graduate and post graduate degrees (van Raders 2003). Results from surveys using this questionnaire have been very similar, showing healthcare professionals believe vital signs are a suitable validation of a patient's verbal pain score, their knowledge is inadequate regarding analgesics, and they are more likely to give analgesics to someone who 'looked in pain' (McCaffery *et al.* 2000, McCaffery *et al.* 2007).

Other surveys developed to investigate and understand knowledge about and attitude towards, pain have again shown similar results. Many healthcare professionals wrongly fear addiction from the use of opioids (Bell & Salmon 2009), they believe patients are not truthful about the severity of their pain (Hirsh *et al.* 2010), and they believe that pain severity can be predicted from the operation or disease state (Manias *et al.* 2002). They place little value on the patient being pain free (Brockopp *et al.* 2004b), and they have a lack of knowledge about analgesics while believing their

knowledge is sufficient (Plaisance & Logan 2006). These attitudes and beliefs are demonstrated again and again and it seems that despite the many studies and many recommendations, change has been slow.

Many studies have advised more education, better communication and further research to address this problem, though the same advice had been given over twenty years ago (McCaffery *et al.* 1990, McCaffery & Ferrell 1992). There is little evidence which shows education has made significant difference to nurses decision-making skills (Thompson & Stapley 2011), with Bell and Duffy (2009) suggesting further research into postoperative pain assessment and management is futile as nursing audit is sufficient to effect practice change.

It seems important however to study pain management in more depth than is possible from the myriad of knowledge and attitude surveys, questionnaires and vignettes. Studies with observational and descriptive components have offered greater understanding of the complexity of performing pain management in a clinical setting. A team of researchers in Australia have been using these qualitative techniques to investigate pain assessment and management from a nurse, patient, and organisational perspective (Botti *et al.* 2004, Bucknall *et al.* 2007, Manias *et al.* 2002). This body of work has suggested context affects how pain management is undertaken in a ward.

This study is informed by all the aspects of pain management research published over many decades, but is particularly inspired by qualitative research with the ability to provide context. How the culture of an environment effects the context within which pain management is performed

has been little investigated. This study set out to discover the factors which influenced nurses when they made pain management decisions in a clinical setting, and how the culture of the clinical environment effects pain management practice.

This first chapter has set the scene for the study, explaining the interest in the subject of postoperative pain management and how the study questions developed.

The literature discussing pain is reviewed in Chapter 2. This chapter begins with an exploration of what is known about pain: how it is defined, and a brief history of how and what we know about pain. The prevalence of pain is reviewed, initially using community populations, and then focusing on how much pain is evident in postoperative patients. The literature discussing why is it important to manage pain is reviewed, looking at humanitarian and physiological reasons. The nurse in the surgical ward has a role to play in how pain is managed and this role is examined, following by a more focused examination of pain assessment and the nurse's role in this. An exploration of the pain management practices in postoperative wards concludes the first pain literature review chapter.

Chapter 3 continues the literature review but focuses on the barriers and influences which impact on pain management. Initially the influences that institutions, including public health organisations, have on the pain management practices are reviewed. Institutions and organisations create cultures, and influences and barriers that are formed by cultures in clinical

areas are discussed. Clinical leadership is an important component of the how the postoperative ward culture is developed and maintained; the literature focusing on this aspect of ward culture is examined, using the Promoting Action on Research Implementation in Health Services (PARIHS) framework to demonstrate the interrelationship between leadership and culture. The patient is thought to have an influence on how pain management is performed, so the literature discussing the public influence on pain management, and then the role the inpatient plays in the formation of pain management barriers is explored. Healthcare professionals are responsible for many of the influences and barriers to effective pain management; the literature discussing elements of this is examined, including knowledge and attitude studies. The way clinical decisions are made impacts on pain management, therefore clinical decision-making is examined, focusing initially on nursing, and then on pain management decision-making more broadly.

Chapter 4 is divided into two sections. Having reviewed the literature which explores pain and pain management, including barriers and decision-making, the study questions are first explicated. The choice of a methodology for a research project should to be underpinned by sound ontological, epistemological and methodological choices and these are clarified at the start of Section 1. Ethnography is described, beginning with a brief history of its use and then focusing on what contribution it has made within field of nursing. This section concludes with a discussion on how rigour in ethnography is ensured.

The second section of Chapter 4 examines the methods used in ethnography, beginning with the importance of ethics, which leads to a description of the formal ethical review process for this study, and a discussion about how the ethical components of this study were addressed. The ethnographic field, and the process of access to the field, is described, followed by a discussion of how to sample data within the field. Elements of ethnographic fieldwork and data collection are discussed with descriptions of how it was undertaken in this study. This chapter concludes with an exploration of ethnographic data analysis.

The findings of the study are presented in Chapter 5, beginning with the presentation of the themes and subthemes identified in the data analysis. Findings relating to the maintenance of the pain management culture on the observed ward (named Newcastle Ward), describe the processes within the ward, and how nurses felt about working there. The pain management communication on Newcastle Ward is described and two formal shift handovers examined in more detail, demonstrating a new finding of a silence of routine pain management communication. The pain management roles and tasks are described, and the role clinical leadership in maintaining the pain management culture is explored.

Findings relating to nurses' responses to pain management decision-making opportunities are presented, initially focusing on how nurses undertake pain assessment on Newcastle Ward, and how their pain management knowledge influences their decisions. Nurses are shown to be inattentive to pain cues, a conclusion presented in the literature previously, however a new

finding of nurses performing only a single pain management action is also demonstrated.

Nurses' expectations of patients' behaviour and knowledge are presented in the final section of Chapter 5. How nurses' felt patients should look, speak and know about pain management is demonstrated, as well as an exploration of what happened to those patients who failed to meet these expectations.

The findings are discussed in Chapter 6 within the wider literature regarding social psychology, national policy and clinical leadership. The pain management culture is discussed with a conclusion that pain was not a priority on Newcastle Ward. An exploration of the consequences of this position leads to a discussion of a new finding; the silence of routine pain management communication, and the role clinical leadership has in the maintenance of this culture. The next section explores another new finding; the performance of a single pain management action following a pain management decision. This finding is presented as part of the culturally shared pain management strategies on the ward. A set of nurses' rules for patients that emerged from the data is presented as an indication of the pain management culture.

The exploration of the findings in the context of social psychology theories leads to a explication of the in-group culture within Newcastle Ward, and the consequences of this are discussed with a summary framework of findings presented to facilitate understanding of the factors which influence nurses

when they make pain management decisions in a clinical setting. The limitations of the study are discussed. In conclusion the findings of the study are summarised and discussed and recommendations for practice and further research given.

## Chapter 2      A review of pain management

*“Pain is not just a sensation, but like hunger and thirst,  
it is an awareness of an action plan to be rid of it”.*  
(Wall 1999 p. 179)

### 2.1      Search strategies

The literature from 1958 to 2012 informing pain management has been reviewed using a number of search strategies. Databases (British Nursing Index, Medline, PubMed, OVID, Embase, AMED, CINAHL) have been queried using MeSH terms; Acute pain, Attitude, Attitude of health personnel, Clinical nurse specialist, Cognitive dissonance, Decision-making, Decision theory, Ethics, Ethnography, Knowledge and attitude, Inpatients, Interview, Nociceptive pain, Nurse clinician, Nurse-patient relationship, Nurse’s role, Nursing care, Nursing staff, Pain assessment, Pain management, Pain measurement, Pain, postoperative, Pain clinics, Prevalence, Qualitative research, Social psychology (see appendix 1). Additional search items included; pain, influence, context, factors, knowledge, barriers. Searching was limited to English language publications

References from key articles were hand searched, leading to an iterative refinement of the search strategy as keywords were added. Key researchers in the field were author searched including: Allcock, Brockopp, Brown, Bucknall, Carr, Closs, Dahl, Dalton, de Rond, de Wit, Dihle, Edwards, Estabrooks, Ferrell, Franke, Idvall, Jones, Kaasalainen, Lauzon Clabo, Layzell, Manias, McCaffery, Pasero, Rycroft-Malone, Scott-Findlay, Seers,

Sjostrom, Thompson, Tutton, Twycross, Ward, Watt-Watson, Yates. Articles were read for relevance and further references searched.

A number of journals were hand searched as they were published from May 2006 to the present including: Anaesthesia, Anesthesia & Analgesia, Applied Nursing Research, British Journal of Nursing, Clinical Journal of Pain, Contemporary Nurse, European Journal of Pain, Implementation Science, International Journal of Nursing Practice, International Journal of Nursing Studies, Journal of Advanced Nursing, Journal of Clinical Nursing, Journal of Pain, Journal of Pain and Symptoms Management, Nurse Researcher, PAIN, Pain Management Nursing, Worldviews on Evidence-Based Nursing.

Relevant articles were read and reference lists searched for further information.

This process has led to an EndNote X4 reference library with a broad and eclectic range of over 1,800 papers, reports, chapters and books. This library has been continuously updated since May 2006, with removal of no longer relevant articles as the research project became more focused, and regular additions as new reading led to the discovery of new and pertinent knowledge.

The next two chapters explore the literature, which informs the study. The literature selected for this review represents an emerging picture of how pain is perceived and managed. Older articles are included to give context to later findings. This chapter examines the literature around pain and pain management. A brief review of the meaning of pain through history leads to

an investigation of how much pain exists in society and briefly what pain means to the public and to healthcare professionals. An exploration of the literature determining why pain should be managed, leads to the larger part of the chapter discussing the role of the nurse in pain assessment and pain management in a hospital setting.

## **2.2 What is pain?**

This chapter initially considers the literature which describes what pain is and what it means to have pain. This section will examine the definitions of pain and will further examine what pain management means. This will be followed by a short review of the history of pain physiology, and some context to how the treatment and management of pain has developed.

The Oxford Dictionary Online (2012) defines pain as:

- “1. a highly unpleasant physical sensation caused by illness or injury.*
- 2. mental suffering or distress.”*

For health care professionals this explanation of pain may not be sufficiently comprehensive, given their knowledge of the complex nature of pain, though it does imply psychological elements may also be involved. Arguably the definition of pain best known to nurses is:

*“Pain is whatever the experiencing patient says it is, existing whenever he says it does.”* (McCaffery 1972 p. 8)

Nurses learn this quotation, and are able to recite it readily (van Raders 2003), though the extent to which it underpins their practice is unclear (Pesut & McDonald 2007). The definition could be said to be somewhat limited in its use by the exclusion of those patients who are unable, or unwilling to express their pain verbally. The International Association for the Study of Pain (IASP) defines pain as:

*“An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.” (IASP 1979)*

This definition has remained unchanged through three updates on taxonomy in 1986, 1994 and 2011, although the accompanying notes have been expanded. These notes develop the definition adding that the inability to verbalise pain does not mean the patient does not have pain or require pain management interventions. Included in this definition are the assertions that pain is a subjective experience, and that people learn to apply meaning to the word through their life experiences. The definition says pain experienced in the absence of any pathophysiological cause, but reported in the same way as pain caused by tissue damage, should be accepted as pain, avoiding tying pain with stimulus (IASP 2011). It is asserted that pain is always a psychological state, not due to activity in the pain receptors or the pain pathways, or caused by a noxious stimulus, but felt and perceived as such by our brains (IASP 2011, Moseley 2012).

This definition is perhaps the most useful for health care professionals as it incorporates pain felt with no visible cause, pain felt but not verbalized, and importantly builds on the awareness that pain is subjective and individual. Regardless of the usefulness of these and other definitions of pain, most people are aware of what it means to be in pain; it is normally an unpleasant state.

Pain management, while initially appearing simple to define, (to manage pain), becomes more complex when applied to nursing or medical practice. A useful concept analysis proposes the defining attributes of pain management in nursing are: the intention to modulate the patients pain or the response to it, the use of a multi professional and multimodal approach to pain, within a participatory relationship with the patient in pain, and with the aim of self-efficacy of the patient in pain (Larsen 2007). An overview of the literature follows on how we come to our knowledge of pain and pain management; what does the public know about pain.

### **2.2.1 History of our knowledge of pain**

The changing face of how pain is perceived over time gives a historical context to some of the knowledge, attitudes and behaviours around pain and pain management. Pain has always been with us; from an evolutionary perspective it can be seen much less sophisticated organisms than man have nervous systems which ensure withdrawal behaviours from injury or even a perceived threat of injury (Berg 1975, Kirmayer 2008). Hippocrates described pain as an indication of disease and this sense of pain as a

symptom has remained one of the most ubiquitous modes of thought in medicine (Morris 1993). One of the reasons for the pervasiveness of this opinion can be attributed to Rene Descartes. Descartes was a philosopher in the 17<sup>th</sup> century who, while renowned for his statement *cognito ergo sum* (I think therefore I am), was more influential in influencing how we thought about our bodies. Descartes saw the body as mechanistic, separate from our mind. His *Treatise of Man*, published posthumously in 1662 (translated in 1972) gave detailed descriptions of the mechanics of sensation, including pain.

*“If fire A is near foot B, the particles of this fire (which move very quickly, as you know) have force enough to displace the area of skin that they touch; and thus pulling the little thread [cc], which you see to be attached there, they simultaneously open the entrance to the pore [or conduit] [de] where this thread terminates [in the brain]: just as, pulling on one end of a cord, one simultaneously rings a bell which hangs at the opposite end.”* (Descartes 1972)

Descartes likened the process of pain sensation and transmission to that of pulling a rope and making a bell ring at the other end; a simple concept of cause and effect. Descartes’s hard wired concept of pain as a symptom of injury, published in 1662, remained the prevalent theory of pain until the mid 1960’s, when scientific advances in pain knowledge began to mean pain was seen as a multilayered experience composing of affective and evaluative as well as sensory components (Wall 1999).

A seminal paper in 1965 by Melzack and Wall described 'The Gate Control Theory'. This was a revolutionary idea that challenged the hard wired system of Descartes, with the proposal that pain sensations could be modulated, both in the dorsal horn of the spinal cord and by the brain with psychological factors seen as a fundamental element of pain processing and modulation (Melzack & Wall 1965). Although the neurophysiological details of the theory have since been updated, the essential insight of pain modulation has endured to this day (Kirmayer 2008).

Over five decades of research in pain physiology has seen an evolution of thought from the hard-wired pain processes to an awareness of a dynamic and plastic nervous system. Pain sensation is processed by interacting mechanisms including spinal bulbar systems, signalling chemicals, cell sensitization, ascending and descending pathways, spinal gating systems, central sensitization with neuroimmune and endocrine mechanisms also initiated (Brennan 2011, Jensen 2008).

Pain management has also changed with the development of more sophisticated knowledge and techniques. A pain problem in past centuries drew on only herbs or opium (mixed with a variety of substances including alcohol) to relieve pain. Opium and later heroin became readily available and widely used, and as addiction became an increasing problem this led to controls in narcotics legislation in 1914 in the USA and later in 1920 in the UK (Transform 2006).

Anaesthesia was developed in the mid 19<sup>th</sup> century and patients could now expect pain free surgery and childbirth, and with the manufacture of local anaesthetics, regional anaesthesia could be used in intractable pain conditions. Synthetic opioids were developed in a quest to eliminate addictive qualities, and aspirin further synthesised to produce additional anti-inflammatory medications (Meldrum 2003). In the early 1970s the interest in pain as more than a symptom lead to the formation of the International Association for the Study of Pain (IASP). The World Health Organisation (WHO) developed the pain ladder in 1982 - a guideline for the prescription of drugs for use in cancer pain, with regular administration and upward or downward titration as necessary (Meldrum 2003). Over the last 30 years the discovery of ever more complex pain mechanisms, with increasingly targeted analgesics, has improved the prognosis for many patients. However despite the advances in the knowledge of the mechanisms that cause pain, there is still a gap around the clinical significance of this knowledge - how this increased knowledge can improve pain management for patients (Jensen 2008).

There is now a recognition that thoughts and feelings are able to modulate neural transmission and change the perception of pain (Pesut & McDonald 2007). This realisation that pain processing involves an emotional element means that a range of factors including beliefs, attitudes and culture of a person experiencing pain will have an impact not only on the perception of the pain, but also on the behaviour that the pain produces in that person

(Moseley 2012). How culture influences pain expression will be discussed at more length later in this literature review.

This section has investigated what pain is, how it is defined, how it is perceived, and the meaning of pain management. The history of pain and pain management has been briefly reviewed to provide a context to some of the attitudes and behaviours regarding pain and pain management, which may be observed, in both the public, and within the health care professions. Now that pain and pain management are defined the next section will examine the literature regarding the prevalence of pain.

### **2.3 The prevalence of pain**

The prevalence of pain in Western society is examined firstly in the community, perceived largely as chronic pain. This provides the public context for the study focus on pain in hospital. Pain is a worldwide problem affecting people in all countries. Freedom from cancer pain has been recognised as one of the focus areas the World Health Organisation is working towards, with the recognition that 80% of cancer sufferers have no access to opioid analgesia (WHO 2007). There is a difficulty in determining how many people are living with pain, because while there is definitive information regarding patients who seek help for their pain management problem, those who avoid treatment, or do not access assistance are more difficult to count (Cosby *et al.* 2005).

Cosby *et al.* (2005) sought to overcome this difficulty using a random telephone survey design in Mississippi (n=604). Participants were asked about their pain in order to estimate prevalence, frequency, intensity and origin of pain and explore the cultural and societal aspects of pain management. A prevalence of 37% of participants with pain was reported, with over half of these stating they had pain on a daily basis. Significantly 62% of respondents considered pain to be a normal part of life, 55% considered painkillers should be saved until the pain became worse, and 22% believed 'good patients don't complain to their doctor about pain' (Cosby *et al.* 2005). Another more recent USA population based chronic pain survey (n=4090) again using a random telephone design reported somewhat more prevalence for chronic pain with 26% reporting pain every day (Toblin *et al.* 2011).

Similar population based studies in New Zealand (Dominick *et al.* 2011) and South Australia (Currow *et al.* 2010) report comparable findings, with 17% and 18% respectively of the sample stating they had chronic pain. The British population has been surveyed in a similar manner in 2002 (n=1000) (The British Pain Society 2002), and again in 2005 (n=975) (The British Pain Society 2005), using computer assisted telephone interviewing. Results from the two surveys were consistent in almost all questions, perhaps not surprisingly as they are only three years apart. One in four people surveyed had pain on the day, with this incidence increasing with age. One in ten people said they suffered from pain every day, with another 10% saying they had pain most days.

Arguably the biggest population pain prevalence study was reported in 2006, using computer assisted telephone surveys. This study was undertaken in fifteen countries in Europe plus Israel (n=46,394), and reported 19% of respondents had pain lasting more than six months and had experienced pain in the last month and several times during the last week. In depth interviews with 4,839 of those participants who reported this chronic pain demonstrated 34% had severe pain, with 66% having moderate pain. The effect on their daily lives was perhaps best indicated by findings which showed 21% had been diagnosed with depression, 19% had lost their job, and 13% had changed their job as a direct result of their pain. Two thirds of these people were taking prescription medications, though only 2% of these participants being treated by a pain management specialist (Breivik *et al.* 2006). This study concluded chronic pain was a major health care problem which remains hidden and largely untreated. As all patients in hospitals, and healthcare professionals, are firstly part of their community, the prevalence of pain, and the beliefs of people in the community regarding pain are relevant, however this study focuses on pain in patients in hospitals, specifically pain after surgery.

## **2.4 Pain as an inpatient**

In 1990 **it** was stated pain is one of the most common reasons for a person to seek medical attention (Graffam 1990). There were over 14 million 'finished admission episodes' in the 12 months from May 2010 to April 2011 (HES Online 2011). While the incidence of pain in these admissions is not

measured, many of these patients admitted to hospital through emergency department have pain (Todd *et al.* 2007), or they may require surgery, which can cause pain (Brennan 2011). One of the earlier indications of pain prevalence in inpatients was undertaken in 1973. While the study was designed to investigate the poor utilisation of opioids for inpatients, pain prevalence in the limited sample (n=37) was 73% in moderate or severe pain, despite a prescription for strong opioid analgesia being present (Marks & Sachar 1973).

When a cross section of inpatients was investigated in a large study conducted in Montreal (n=2415), 50% of patients interviewed had pain at the time of interview, with 67% having pain in the last 24 hours. Twenty-one percent of patients reported their pain as severe (Abbott *et al.* 1992). Similar results were obtained when inpatients were studied in Australia, reporting 79% of patients had experienced pain in the preceding 24 hours, and of those who did report pain, 33% of them described their pain as 'distressing', 'severe' or 'excruciating'. Thirty eight percent of patients reported that their pain was there all of the time (Yates *et al.* 1998). Inpatients in Sweden when investigated by survey (n=759) found 68% had experienced pain in the previous 24 hours (Wadensten *et al.* 2011). A Canadian study reported data collected in 2006 (n=114), which showed 71% of patients, had experienced pain in the past 24 hours (Sawyer *et al.* 2008). A year later another collection of data (n=242) was undertaken which indicated the pain prevalence had become worse with 84% of patients reporting pain in the

previous 24 hours, although the percentage with severe pain in that time frame had improved from 31% to 26% (Sawyer *et al.* 2010).

Pain prevalence in UK hospitals was highlighted by Bruster *et al.* (1994), who conducted face to face interviews with patients who had recently left hospital. Results found that 61% of these people reported pain while an inpatient, and of those who did report pain that is was moderate or severe in 87%, and it was present all or most of the time in 33%. Despite the pain being reported as moderate or severe in 87% of this patient group, only 17% felt it was worse than they had anticipated. Pain in medical inpatients was investigated more recently with 60% of patients reporting pain in the previous 24 hours, and 17% reporting a pain score as severe (Dix *et al.* 2004). An audit of pain in respiratory patients in a London hospital (n=101) found just over half reported pain in the previous 24 hours, and of these, 85% were assessed as having inadequate analgesia (Matthew *et al.* 2010). It can be seen from the details above, pain is prevalent inpatient in hospitals; even severe pain.

Arguably the most up to date survey of pain in England's hospitals occurs yearly. The Care Quality Commission (latterly The Healthcare Commission) surveys patients annually who have been in hospital regarding the quality of care they have received. Since 2002 there have been two constant questions regarding pain; '*Were you ever in any pain?*' and '*Do you think the hospital staff did everything they could to help control your pain?*'

In response to the question *'Were you ever in any pain?'*, the number of people saying *'No'*, demonstrates an improvement from 32% reported in 2002, to 34% in 2010. This change is reported as significant; the calculations to reach this conclusion are not clear although there is a comment, *"Some of the changes in the survey results are very small, but because of the large number of respondents that took part, they are statistically significant"* (Care Quality Commission 2011). In the 2010 survey 71% of respondents thought the staff had done everything they could to help control the pain, and again while reported as a significant (decreasing) change this had remained almost constant between 71 and 73% since 2002 (Care Quality Commission 2011). As with Bruster *et al.*'s (1994) study, surveys conducted after the inpatient event may say more about patients' general satisfaction with the hospital stay, than any single event within that stay. However this is the method used to monitor and assess nationally how patients experience pain management as inpatients.

These studies investigated pain in both medical and surgical inpatients. This is important, as many inpatient wards will care for a combination of surgical and medical patients. However pain prevalence of surgical inpatients has also been investigated. A prospective study (n=200) to investigate the time course of surgical pain experiences performed pain assessment and patient interviews at 4, 24, 48 and 72 hours after surgery. It found 88% of patients experienced moderate to severe pain at some time in this postoperative period (Svensson *et al.* 2000). Confirming these results, a further study using a telephone survey was conducted asking a random sample of

patients post surgery (n=250). These patients were asked about the severity of their pain and their perceptions of the pain treatment and medications. Around 80% of patients said they experienced pain postoperatively, and of these 86% said it was moderate, severe or extreme. The authors also found patients said the fear of experiencing pain postoperatively was a very common concern (59%). However 90% of patients reported they were satisfied with their pain treatment (Apfelbaum *et al.* 2003).

Sommer *et al.* (2008) also used prospective pain assessments of patients post surgery (n=1490). Pain assessments were obtained three times a day for five days postoperatively. They found 41% of patients experienced moderate to severe pain on the day of operation, reducing on the subsequent days (30%, 19%, 16% and 14%). Moderate to severe pain was highest in those patients who had abdominal surgery (up to 55% of patients had moderate to severe pain). They concluded that despite an acute pain service with protocols, postoperative pain treatment was unsatisfactorily.

A large study investigating retrospective data gives a good indication of pain after surgery, though the focus was a comparison of analgesic techniques, rather than prevalence of pain. Dolin *et al.* (2002) pooled data from 165 published studies from 1972 to 1999 (n=19,909), looking at the analgesic equivalence of IM opioids, patient controlled analgesia, and epidural analgesia. They presented data to show up to 33% of patients reported moderate to severe pain at rest, with the perhaps not surprising finding that as more sophisticated analgesic techniques became more commonly used, the incident of moderate to severe pain decreased (Dolin *et al.* 2002).

Within this section the prevalence of pain, both in the community and in hospitals, has been reviewed. Patients in hospitals have been shown to be experiencing pain, with about a quarter of study participants reporting it as severe. There are many patients who experience pain as an inpatient and postoperatively, and it appears the prevalence of this has not changed. There is a large body of robust evidence to support this, nationally and internationally, using both prospective and retrospective data. The next section will explore why the high prevalence of inpatient pain is important; why pain management as an inpatient matters.

## **2.5 The purpose of pain management**

Pain is described as unpleasant (IASP 2011). While pain is assumed to have a protective function physiologically (Wall & Melzack 1999), it has been demonstrated that many patients in hospital are suffering moderate to severe pain (Care Quality Commission 2011, Dix *et al.* 2004). This section reviews the literature regarding the importance of pain management under three interconnecting headings; humanitarian, physiological, and speed of recovery.

The joint working party report by the Royal College of Surgeons and the College of Anaesthetists (Royal College of Surgeons 1990 p. 3) stated:

*“Treatment of pain after surgery is central to the care of postoperative patients. Failure to relieve pain is morally and ethically unacceptable”*. The report stated the benefits for treating pain included humanitarian, cost effectiveness, improved respiratory function, cardiovascular stability,

gastrointestinal normality and amelioration of the stress response. Although this report is now over 20 years old the reasons for treating pain have not changed. Pain clinicians acknowledge that it is not always possible to relieve all the pain in every circumstance (Brennan *et al.* 2007), however while postoperative pain management offers an ideal opportunity to improve patient outcomes (Bonnet & Marret 2007), it has been shown to be unsatisfactory and inconsistent (Carlson 2009, Wadensten *et al.* 2011).

### **2.5.1 Humanitarian**

Freedom from pain is said to be a basic human right (Brennan *et al.* 2007, Graffam 1990). The under medication of pain has been described as being morally negligent (Hunter 2000). On a worldwide level poor pain management has been described as a 'global health tragedy', with inequalities in the ability to access pain relief highlighted by 13% of the world's population (USA, Australia, New Zealand, Canada and countries within the European Union) using 90% of the world's morphine (Lieberman *et al.* 2010). Through commitment to the Single Convention on Narcotics Drugs 1961, signatory countries were obligated to work towards access to drugs to relieve pain (United Nations 1961), although there are still significant barriers to full international implementation of this (Lohman *et al.* 2010). The Declaration of Montreal declares, '*the right of all people to have access to pain management without discrimination*', as well as acknowledgement of their pain and information about how it will be assessed and managed, and the right to access appropriately trained healthcare professionals (IASP 2010 p. 2674). On a national scale, while the UK is part of the group of Western

countries who are using morphine, postoperative pain management remains patchy at best (Carr 2009).

While opioids may be an element, effective postoperative analgesic pain management does not rely on them alone; other medications also provide effective analgesia. The Oxford league table of analgesic efficacy (Bandolier 2007) has calculated the efficacy of analgesics using published data from randomised controlled studies of patients with moderate to severe pain. The data are presented as the numbers (patients) needed to treat in order for one patient in moderate to severe pain to receive 50% pain relief over 4-6 hours. While examination of this evidenced based list includes some medications not commonly used in the UK, it could guide hospital based acute pain services protocols and policies.

It is possible that freedom from pain is incorporated within the United Kingdom's Human Rights Act (1998) in Part I, Article 3, "*No one shall be subject to torture or to inhuman or degrading treatment or punishment.*" (Great Britain 1998). While this has not been challenged by law with regard to pain management, there may be cases where it could be possible (Fins 2000). In addition to addressing pain management for humanitarian reasons, there are physiological related justifications for sound pain management in hospitals.

### **2.5.2 Physiological**

There are consequences to having pain in hospital. Pain leads patients to remain immobile which increases their risk of deep vein thrombosis or

pulmonary embolism (Chung & Lui 2003, Duff *et al.* 2011, Field 1996). A path of inadequate pain relief is described beginning with a voluntary reduction in muscle movements of the chest and abdomen to avoid pain, with small tidal volumes and high inspiratory and expiratory pressures resulting from this, leading to decreased vital capacity with resultant hypoxia (Dunwoody *et al.* 2008). A possible consequence of this disinclination to deep breathe or cough to clear secretions is lobular collapse and atelectasis (Cousins & Power 1999). Inability to co-operate with chest physiotherapy can further complicate treatment, prolong the course of any pulmonary complications and as such can extend hospital stay (Dunwoody *et al.* 2008, Heye & Goddard 1999). Effects to the immune system (Griffis *et al.* 2006), the gastrointestinal tract (Stephens *et al.* 2003), the cardiovascular system (Liu & Gropper 2003), the endocrine system (Ljungqvist *et al.* 2005), and cognition (Moriarty *et al.* 2011) have also been described (Dunwoody *et al.* 2008, Griffis *et al.* 2006).

As early as 1997 there was evidence to suggest uncontrolled postoperative pain can lead to chronic pain problems in the future (Carr 1997), though the mechanisms for this are still not fully understood (Dunwoody *et al.* 2008). While the reported incidence differs greatly depending on the study, persistent pain following surgery has been said to occur in 5-85% of operations. The incidence increases with some types of operation. Patients who have had an amputation have a 50-85% prevalence, but it is not uncommon for patients to have persistent pain following operations such as hernia repair, mastectomy or cardiac surgery (Macrae 2008). Persistent pain

after surgery normally presents as neuropathic pain, and while Kehlet *et al.* (2006) asserts the cause is surgical nerve damage, he does indicate the intensity of acute postoperative pain correlates to the incidence of persistent pain after surgery (Kehlet *et al.* 2006). The mechanism for this is thought to be central sensitisation, with the use of regional analgesia reducing the incidence of persistent pain after surgery (Richardson *et al.* 1994).

### **2.5.3 Enhanced Recovery**

The prevention of postoperative pain can lead to patients having a quicker recovery from surgery (Shang & Gan 2003). The recognition has emerged that patients have improved outcomes with reduced length of stay in hospital post surgery (Kehlet & Dahl 2003). Enhanced recovery programmes are being developed for different operations (colorectal, vascular, urology) all aiming for faster recovery. This clearly benefits patients, but there is a financial advantage for the organisation also as it decreases patient length of stay. These programmes are individualized for each operation and include many elements, pre and post operatively, with early mobilisation and oral nutrition key components. It is recognised that patients who are pain free are able to eat and mobilise, therefore effective pain management is essential to the success of any enhanced recovery programme (Kehlet & Dahl 2003). A focus group study with patients who had been part of a colorectal enhanced recovery programme reiterated the importance of this with patients who had experienced pain postoperatively reporting finding moving and eating more difficult (Taylor & Burch 2011).

This section has reviewed the reasons for managing postoperative pain. It is demonstrated postoperative pain should be treated for humanitarian, patient, medical and organisational reasons. Effective management of pain is essential for the present and continued wellbeing of patients (Cambitzi *et al.* 2000). Nurses are at the centre of providing pain management; it is an essential part of their role (Dunwoody *et al.* 2008, Hunter 2000). The next section reviews the role of the nurse in acute pain management in hospital.

## **2.6 The role of the nurse in inpatient pain management**

This section reviews the literature concerning the role of the hospital nurse in providing pain management. The concept of pain management is detailed and the elements that constitute the concept are explored further; pain assessment, non-pharmacological measures, and pharmacological measures. The literature regarding these elements is reviewed within the structure of what pain specialists think nurses should be doing in the clinical setting, what nurses believe they are doing, and what nurses are actually doing.

Pain management can be defined as the process of providing relief from pain and is generally provided by a multidisciplinary team, using a multimodal approach (Bucknall *et al.* 2001). However in a hospital ward environment, with pain assessment as the essential first step of the process (Lauzon Clabo 2008, van Dijk *et al.* 2012), postoperative pain management is an important nursing goal (McDonnell *et al.* 2003, Schafheutle *et al.* 2001). Nursing pain management measures can include pharmacologic measures,

non-pharmacologic procedures and action, which might also incorporate psychological measures (McQuay *et al.* 1997).

Non pharmacological methods of acute pain management include comfort measures such as positioning or touch, as well as more elaborate techniques such as relaxation, distraction (such as music), hot and cold therapy, or massage (Helmrich *et al.* 2001). Pharmacological pain management measures include analgesics and regional local anaesthetic blocks. These are normally regarded as effective measures, however they can be challenging because of patient variability (Gordon *et al.* 2008) and safety issues such as side effects (Gan *et al.* 2004).

Pain assessment however, is the first step to adequate pain management (van Dijk *et al.* 2012). If a patient's pain is not appropriately assessed or documented, it is difficult to defend the requirement for pain management actions, and as such any actions, such as analgesics given, may not be able to be justified (Manias *et al.* 2004b, Scott 1992). Pain assessment in a hospital setting is principally the role of the nurse (Lawler 1999, Subramanian *et al.* 2011). The following section discusses the literature reviewing pain assessment.

## **2.7 Pain assessment**

The purpose of assessing pain is discussed, followed by an exploration of how pain can be assessed. This explains the methods of pain assessment which pain management specialists have reported as best evidence-based

practice. This is followed by a review of literature that examines how nurses feel about pain assessment and how they are undertaking it.

Pain assessment is an exercise in information gathering to enable rational treatment planning (Lauzon Clabo 2008). There are a number of ways of assessing acute pain. The patient's report is the method pain management specialists would prefer to be used (Kim *et al.* 2005, Wadensten *et al.* 2011), however there are situations when this may not be possible, for example in an intensive care environment when patients are artificially ventilated (Gelinias *et al.* 2011). A review of pain assessment tools and in what circumstances they should be used is presented.

### **2.7.1 Pain assessment tools**

There are many pain assessment tools ranging from simple to very complex, which may be appropriate for different acute hospital settings. Largely they fall into self-report and observational. The score is used in clinical practice both to guide treatment choices and to evaluate treatment efficacy (Turk & Melzack 2011a).

Observational tools are useful in very small children, or adults unable to verbalise, such as cognitive disorders or unconscious patients (While & Jocelyn 2009, Zwakhalen *et al.* 2004). These use patient behaviours, or physiological signs to arrive at a pain score. Many nurses however, use these elements of observation to assess pain in awake patients, or to confirm the patient self report (Sjöström *et al.* 2000a).

The self report pain assessment tools generally used in clinical setting are the Visual Analogue Scale (VAS), the Numerical Rating Scale (NRS), or the Verbal Rating Scale (VRS) (Cambitzi *et al.* 2000, Mason *et al.* 2011). Most hospital inpatients are able to give a self-report of their pain, though some of the tools are complex and used in specific conditions. Chronic pain for example can involve both nociceptive and neuropathic elements as well as social and psychological components which require a more exhaustive pain assessment (Turk & Melzack 2011a). These more complex assessments may also be appropriate for postoperative patients; however the time they take to perform may not offer any real advantage in terms of outcomes (Mason *et al.* 2011). Pain assessment scales are, by the nature of the thing they are measuring subjective. None the less a pain score produced from a pain assessment scale can be useful for determining the severity of the pain at that moment to that patient (Turk & Melzack 2011a, Wadensten *et al.* 2011).

Widely used pain assessment tools in UK hospitals are the NRS '0 – 10', or VRS 'none, mild, moderate, severe' (Herr *et al.* 2004). But perhaps the most important thing is not what tool is used, but that pain is regularly assessed using a tool that nurses and patients understand, both the meaning of the tool and the reason for, and importance of, the pain assessment (Heikkinen *et al.* 2005). Pain management specialists have an expectation that nurses will assess pain in hospital inpatients using an appropriate recognised tool, when regular patient observations are done (as the 5<sup>th</sup> vital sign), at medication rounds, whenever the patient's pain changes, and following pain

relief measures to evaluate efficacy (Milutinovic *et al.* 2009). The section following reviews how nurses indicate they assess pain.

### **2.7.2 Nurses' and pain assessment**

There is a plethora of published studies regarding pain assessment by nurses. One of the widely used methods of studying this is part of a knowledge and attitude questionnaire developed and validated by Ferrell and McCaffery (1987) and subsequently updated as necessary, most recently in 2008 (Ferrell & McCaffery 2008). Within the questionnaire are two vignettes used to investigate pain assessment.

These vignettes show two patients who report the same amount of pain (8 out of 10), one of them is described as smiling and laughing (Andrew) and the other as grimacing and immobile (Robert). Participants are asked to document what pain score they would give for each patient; the 'correct' answer is cited as 8 (Ferrell & McCaffery 2008). These vignettes have been used many times since developed and the results can be roughly summarized. Nurses routinely document Andrew's pain as lower than Robert's, though both of the vignettes get an average score of less than 8.

In a study using these vignettes, to investigate how prepared student nurses were to undertake clinical pain management, participants were shown to be behaving consistently with the summary given above. Pain scores for Andrew were 'correctly' given as an 8 in 64%, with Robert 76%. Pain scores given for Robert were consistently higher than for Andrew, with an average

of 5.7 (range 0 – 8, n=120) for Andrew and an average of 7.2 (range 1 – 10, n=112) for Robert (van Raders 2003).

These vignettes were used again to demonstrate differences between groups of nurses with different pain management training. Although showing no difference between the groups in their overall scores, it is notable that 53% of participants 'correctly' documented Andrew's pain, while 77% assessed Robert's pain 'correctly' (Matthews & Malcolm 2007). Similar results were obtained in a study that used the same questionnaire in Italian hospitals, Andrew's pain score was correct in only 45.5%, while the Robert scenario achieved a 78.8% correct response (Bernardi *et al.* 2007). These examples and countless others seem to indicate that nurses are still using the patient demeanour as a way to assess pain, or to validate the patient's own pain score (Erkes *et al.* 2001, Plaisance & Logan 2006, Simpson *et al.* 2002) rather than asking the patient about their pain and trusting the response.

Within the Ferrell and McCaffery (2008) questionnaire there are a number of other questions regarding pain assessment. One frequently cited in study reports is the use of vital signs and behaviours as a reliable indicator of a patient's pain. Ferrell and McCaffery (2008) say the correct answer is 'False', although there may be occasions when the vital signs and patient behaviour are the only indicators.

A questionnaire study which included this question showed that over a quarter of registered nurses used vital signs and behaviours rather than the

patient's self report to assess pain. This rose to 80% for non-registered nurses (Gregory & Haigh 2008). Bernardi (2007) found more than 65% of registered nurses working in an Italian hospice, thought patients' reports of pain could be verified by changes in their vital signs. Coulling (2004) however, showed 68% of registered nurses in a UK hospital correctly answered this same question.

McCaffery and Ferrell's vignettes were used as a model to investigate if pain assessment was influenced by lifestyle and socio-economic status. One scenario is Mike, a businessman, married with two children, injured in a car accident; he has his wife sitting next to him. The contrasting scenario is Ben, an unemployed construction worker, injured in a motorbike accident, who had been drinking at the time; his unemployed friends are with him and they are laughing and drinking alcohol. Vignettes were sent to specialist and general nurses. Results showed 76% of the specialist nurses agreed with Mike's report of pain, while only 44% with Ben's. The general nurses follow a similar trend in agreeing with 77% agreeing with Mike and only 21% with Ben (Wilson 2009). This suggests not only vital signs and patient behaviour, but perceived lifestyle and social-economic status may influence pain assessment decisions.

A survey study (n=59) explored if registered nurses attitudes could predict the use of pain assessment. Reported attitudes to pain assessment were generally positive and a positive attitude predicted an intent to conduct pain assessment (Nash *et al.* 1993). A later study again using a survey design (n=443) found 73% of postoperative nurses reported doing systematic pain

assessment either sometimes or always. Somewhat less (58%) however said they sometimes or always accepted the patients' report of pain (Carlson 2009).

While results from surveys are more positive than findings from the vignette studies, what these studies fail to show, and largely fail to acknowledge, is nurses' behaviour does not always mirror what they believe they should do, or even what they believe they do (Coulling 2004, Dihle *et al.* 2006, Xia & McCutcheon 2006). To discover what nurses actually do it is necessary to use more observational methods of data collection.

A phenomenological investigation was undertaken to investigate the strategies used by nurses in postoperative pain assessment (Sjöström *et al.* 2000a). Health care professionals (n=60) were interviewed before and after an observed pain assessment episode. Findings from this study showed four categories of pain assessment criteria coupled with four categories of experience. The pain assessment categories were 'how the patient looks', 'what the patients says', 'the patients way of talking' and 'past experience of similar circumstances'. The experience categories were, 'I have learnt a 'typology of patients' [meaning the type of operation, anaesthesia, usual pain], 'I have learnt to listen to the patient', 'I have learnt what to look for' and 'I have learnt what to do for the patient'. The most common pain assessment strategy used was 'how the patient looked', with the primary experience category 'I have learnt a topology of patients'. This combination resulted in a high discrepancy between the nurses pain assessment and that of the patient, with a combination of 'I have learnt to listen' and 'what the

patient says', while being used far less frequently resulted in a greater concurrence between patient and nurse pain ratings (Sjöström *et al.* 2000a).

It is suggested that barriers to inadequate pain management commonly cited (poor knowledge of analgesics, inappropriate attitudes) may not play as significant a role as supposed, with the assertion that the use of the 'a typology of patients/how the patient looks' strategy, is adequate to explain the underestimation of pain assessment by nurses (Sjöström *et al.* 2000a).

While this study demonstrated the different strategies used by nurses to assess postoperative pain, with the findings being duplicated a number of times (Klopper *et al.* 2006, Sloman *et al.* 2001), it does not give insights into why nurses use, and continue to use, these pain assessment strategies.

An investigation of nurses' pain assessment practice was undertaken with a study design using observation and short focussed interviews (Manias *et al.* 2004b). During the study, 316 pain assessment episodes were observed (either patients or nurses speaking of pain, or the observer noting pain cues when the nurse was present). In 45% of these episodes nurses used simple questions to assess pain, eliciting a simple response. In 43% of episodes no formal pain assessment was performed. This lack of formal assessment occurred typically under certain conditions; if nurses believed the patient could not communicate, if pain was chronic, on medication rounds, or if nurses were involved in a nursing task, for example a dressing. In the 9% of pain assessment episodes when a numerical rating scale (NRS) pain scale was used it was not always clear if the patient and the nurse had a common understanding of the assessment tool or the resultant score. Manias *et al.*

(2004b) states frequently the pain conversations were “*shrouded in ambiguity and misinterpretation*” (p. 763), because the nurses did not seek to ascertain the complete picture of the patient’s pain, apparently content with the superficial questioning. Nurses were unaware of this ambiguity resulting in them making less than optimal pain management decisions. This study gives further information regarding the clinical context in which pain assessment occurs. Nurses are not seen to prioritise pain assessment, and are apparently reluctant and unsystematic in their use of pain assessment tools.

A descriptive study using observation and interview examined the gap between what nurses say they do and what actually occurs with regard to pain management (Dihle *et al.* 2006). When examining pain assessment, findings show nurses said they assessed pain by asking the patient and observing non-verbal cues. However observed pain assessments showed variability. Some nurses assessed pain by asking pain questions, ‘How is your pain?’, which allowed patients to start a dialogue about pain, while others simply asked ‘How are you?’, resulting in many less conversations about pain. The same variability was observed when non-verbal pain cues were seen, some noticed and acted on them, while other nurses seemed to listen to the comments about pain but did not take any action. Dihle *et al.* (2006) concluded nurses might be following the usual routines and habits of pain assessment present in the ward.

Pain assessment within two surgical units was examined by Lauzon Clabo (2008) using an ethnographic design. Observation of pain assessment

episodes, semi structured interview and focus groups were used to examine the role of social context in pain assessment practice. This study was shaped by the belief that pain assessment, indeed all nursing practice, is influenced by the specific environment in which it occurs. Nurses were found to generally use the same strategies to assess pain as described by Sjöström *et al.* (2000a), but a difference in the focus of pain assessment was seen between the two units. One unit used what operation the patient had to guide pain assessment. Nurses in the other unit while using the patient record as information, gave priority to the patient's report of their pain (Lauzon Clabo 2008). A model of pain assessment was presented describing three areas from which nurses' collect patient information; the patients' narrative, the pain behaviours exhibited by the patient, and the known trajectory of the patient's condition. Data from each of these three spheres are collected by nurses and then filtered by the nurses' perspective, what she believes and values about the patient's narrative, behaviour and condition, which result in a pain assessment for that patient. What this model adds is an explication of the impact the social context of the unit has on their nurses' values and beliefs. Nursing practice and therefore pain assessment are profoundly affected by the social context of the clinical environment, though it is suggested nurses do not recognise this influence (Lauzon Clabo 2008). What is unclear from this study is how the social context, and specifically the pain management culture, of a unit might effect how nurses deliver other aspects of pain management, or what might cause these pain management behaviours to develop.

This section has explored pain assessment literature from numerous vignette and survey studies. These studies while numerous, have findings which are largely repetitive, and as they are only asking nurses opinions, give little indication of how nurses behave in the clinical setting. Observational studies investigating behaviour begin to explore the influence of context in forming pain management practices within a clinical setting. In the next section the literature around pain management practices of nurses will be reviewed.

## **2.8 Pain management practices**

In the previous section pain assessment was discussed. Pain management incorporates what nurses do with this pain assessment information in order to manage the patients' pain. The 1990 Pain after Surgery report (Royal College of Surgeons 1990) called for the establishment of Acute Pain Management Services (APS) in all hospitals, and this guidance was reiterated in 2003 (Royal College of Anaesthetists 2003). While there is not yet complete compliance with these guideline, at least 83% of hospitals in England have this service, although it is reported only 30% are described by the respondents as thriving (Powell *et al.* 2004). One of the goals of APS within a hospital is to set the standards, policies and operational procedures for pain management within the health care organisation (Bardiau *et al.* 2003, Mackintosh & Bowles 1997, Mackrodt 2001).

The WHO guideline for the treatment of cancer pain was developed in 1982, and has become colloquially called 'the pain ladder'. This guideline has been further developed by many UK hospitals as a standard for treating

postoperative pain (Mackrodt 2001). The guidelines normally have three steps to correspond with mild, moderate or severe pain, with suggested analgesics and doses. The health care professional is directed 'up the ladder' as the pain increases and 'down the ladder' as postoperative pain improves. This 'WHO pain ladder' and local Acute Pain Services (APS) policies and procedures serve as fundamentals for postoperative pain management. Clinical nurses are directed to give analgesia as per the guideline, give non pharmacological pain management measures as appropriate, and to evaluate the results of the pain management measure used (Dunwoody *et al.* 2008).

When considering analgesic treatment for pain measures, many opioids for postoperative pain are prescribed as required (*pro re nata*, PRN). Gordon *et al.* (2008) used a web-based survey using vignettes to investigate nurses' opinions about the use of PRN opioids (n=602). Findings suggested as many as two thirds of respondents gave what the authors described as appropriate responses, though 25% consistently stated they would give ineffective opioid doses (Gordon *et al.* 2008). The questionnaire used had not been validated psychometrically, and the authors acknowledged decisions nurses make in clinical situations may have many more complex factors to consider than those presented in a vignette.

In order to investigate what postoperative pain management care nurses considered realistic to give in clinical practice, a study was using a complicated patient-nurse paired multi questionnaire methodology. Findings showed both nurses and patients felt nurses had delivered less pain

assessment and pain information care than was deemed by nurses as being realistic to give (Idvall 2004). What was missing from this study report was an indication of why this might be so, although context, though culture, leadership, evaluation, and facilitation was said to play a complex and interrelating part.

Nurses have their own experiences of pain management, and a phenomenological study was conducted to understand how three expert nurses experienced performing pain management (Richards & Hubbert 2007). Four themes emerged; considering the whole person, the art of nursing, the acceptance of the patient self-report, and a commitment to surgical nursing. The authors note, "*it was apparent that pain management was something that they had all integrated into their daily routines of caring for postoperative patients*" (Richards & Hubbert 2007). The authors highlighted the small number of participants in one location as limitations to the study. There are further limitations, not highlighted, including a reasonable flexible definition on what constitutes an expert surgical nurse (an RN for 5 years and 5 years working in a surgical environment), but also reliance that what the nurses said was what was actually occurring in clinical practice.

The studies above have used surveys and interviews to find out how pain management is performed. As previously said with regard to pain assessment, studies using only these approaches may not indicate what really happens with pain management in a clinical environment; a more

observational approach may give more depth to the knowledge (Manias *et al.* 2002).

This is shown very clearly in a study investigating how nurses experienced their pain management activities (Dihle *et al.* 2006). Nurses at semi-structured interviews (n=9) described giving pain management according to up to date evidenced-based guidelines; emphasising the need to give multimodal analgesia regularly. They said they considered analgesic requirements of the patient prior to mobilisation; that they considered use of non pharmacological measures, and that they routinely evaluated the effect of their pain management measures. Dihle *et al.* (2006) reported nurses participating in this study considered they are performing pain management appropriately. This data came from the nurses' interviews, which were preceded by observations of the same nurses; the last observation period was immediately before the interview. It is interesting to note that despite the nurses knowingly being observed very recently in clinical practice, they still maintained they performed pain management differently than was seen. They said they gave multimodal analgesics, both regularly and before patient mobilisation; there was little evidence to support this in the observational data. They said they always evaluated the effect of their pain management measures; this only occurred if intravenous medication was administered. There was no routine in the ward for evaluation of analgesic effect. The authors assert this gap between nurses perceptions of their pain management behaviours and what they were observed to be doing, constitutes a barrier to adequate pain management through the ineffective

transfer of theoretical knowledge into action in the clinical setting (Dihle *et al.* 2006). There was no indication given however of why this gap might occur, and there was no recommendation from the authors on how to investigate this.

An observational study in a single ward observed surgical nurses (n=30) as they undertook pain management in their clinical nursing work. Four themes emerged from the data: response to interruptions, attendance to patient pain cues, varying interpretations of pain, attempts to satisfy competing demands. These themes contribute to the emerging knowledge of the complex influences that impact on pain management (Manias *et al.* 2002).

Interruptions were found to be disruptive to most nursing duties, though pain management activities were observed to be more easily interruptible than interactions with other nurses, or tasks that required finishing by the end of the shift. This interruption to pain management activities continues to be a theme throughout the authors' further studies (Manias 2003a, Manias *et al.* 2005), but in later publications becomes part of the context of the ward referred to as 'busyness'.

Manias *et al.* (2002) found nurses were relatively inattentive to pain cues, unless these cues were given at time of medication or observation rounds; times when the nurse would be with the patient routinely. Nurses were never observed to assess for pain before patients mobilised. Although nurses did acknowledge patient complaints, they did not offer any analgesics, with one saying it was expected that patients would tolerate some pain during

activities. These findings confirm similar findings reported by Schafheutle *et al.* (2001).

Nurses were observed to identify pain as relating to the surgical incision, rarely looking further than the operation to explain any pain. This is in line with Sjostrom *et al.*'s (2000a) study where the most common form of pain assessment used was the typology of the patient. Manias *et al.* (2002) reasoned the competing demands of the multidisciplinary team may cause what might be considered uncaring behaviour, such as a nurse insisting a patient stay in an uncomfortable and painful position so as to remain easily observable for a medical inspection when it occurred. This demonstrates how themes emerging from data are often overlapping; it could also show inattention by the nurse to the patient pain cues.

To understand more specifically the role of context in how pain management is performed, Manias *et al.* (2005) used observation and interview (n=52) in a study, confirming many of the findings from the earlier investigation.

Interruptions were observed to continue to play a large part in the ward, as environmental factors during observation periods were analysed. A phone call being taken occurred during 88% of the observation periods, patient transfers and admissions were also frequent occurrences (58% and 49%).

While these environmental factors were described, they were not represented in the themes revealed through the study, becoming part of the discussion saying that ward environments were busy. The authors suggested the busyness of the ward prevents nurses from focussing on pain management as a priority. Six overlapping themes were identified from this

further data: managing pain effectively, prioritising pain management experiences, inattention to pain management cues, regulators of pain management, preventing pain and reactive pain management. What is missing from this study is an investigation regarding why pain was not prioritised, apart from the assertion that 'busyness' may have prevented nurses from exhibiting adequate pain management behaviours.

Of the 316 pain cases described by Manias *et al.* (2005), by far the most prevalent involved administering medications (38%). Discussing pain management options with patients occurred in 16% of the case, with discussions with other health care professionals being represented slightly more (17%). Non-pharmacological pain management measures included four hot baths, four massages and 35 positional changes, representing 13% of episodes. This is considerably more than nurses said they would use in other studies (Dihle *et al.* 2006). Maybe non-pharmacological measures, like a hot bath or positional changes are examples of good empathetic nursing care, and as such have no status and so are discounted as pain management activities (Tutton & Seers 2004).

## **2.9 Summary**

This chapter has reviewed the literature regarding pain and pain management. There has been a discussion exploring what pain is and how it has been expressed through history, to give context to how the public and health care professionals view pain. The prevalence of pain in the community has been explored to further understand the laypersons' view of

pain, with the extent of which pain is present in hospitals discussed in more detail. Effective postoperative pain management is necessary for humanitarian, physiological, and through enhanced recovery, financial reasons. Pain assessment is discussed and the role of the nurse in the clinical setting with regard to pain assessment is investigated through the literature. This section concludes with the suggestion that pain assessment, while nurses say it is important, and guidance asserts it is imperative, is still not routinely performed adequately in clinical practice. Finally, pain management literature is examined, again with the role of the nurse in the clinical setting being explored. This final section concludes similarly to that of pain assessment; it is said to be vital by nurses, guidance asserts its importance, but is not afforded priority in clinical practice.

The studies reviewed here have to varying degrees, informed the debate about pain assessment and pain management. Evidence from many survey and vignette studies show nurses failing to use pain assessment tools adequately and consistently. Evidence from studies using interview methods demonstrate nurses saying they use pain assessment tools effectively and they are able to give effective pain management. Survey and vignette studies however provide little evidence around the context of providing pain management in a clinical setting, and investigations using only interviews, concentrate wholly on the nurses' story, which may not accurately reflect their behaviour. What is more successful in illustrating the complex picture regarding pain management in a clinical setting, are studies which employ an observational component, looking at nurses' pain management behaviours.

Findings from these studies show nurses are not doing what they say they are doing. Patients' vital signs and behaviour are prioritised over the patient's self report, patients' pain cues are largely unattended, and pain management interventions occur mainly at medication rounds. Pain management is not prioritised it is said, because of the many interruptions occurring in a clinical environment and other demands on nurses' time. This assertion however seems to miss the question of why other activities are prioritised in the face of the same busyness and interruption. Why do nurses choose to use the look of the patient rather than a pain assessment tool to decide if they are in pain, or to give a soothing word rather than an analgesic medication to a patient?

The next chapter will begin to examine why this should be the case. Why are nurses, despite their own assertions of giving excellent evidenced based pain management care, not actually doing it consistently? Literature evidences many barriers to good pain management and these are reviewed. Nurses' clinical decision-making is explored, followed by a review of the reported difficulty in ensuring the use of evidenced based practice.

## **Chapter 3      Influencing factors or barriers to effective pain management**

*“Pain is a personal experience for patient and healthcare professionals and is influenced by the context in which it occurs”  
(Manias et al. 2005 p. 18)*

### **3.1            Introduction**

Many of the studies reviewed in the previous chapter have demonstrated that there are obstacles which prevent effective pain management. Dihle *et al.* (2006) demonstrated a gap between what nurses say and what they do. Manias *et al.* (2005) observed nurses were inattentive to pain cues, and in an earlier study showed that they had varying interpretations of pain (Manias *et al.* 2002). The purpose of this chapter is to review the literature discussing the context of how and why these pain management barriers might be formed and maintained.

Much of the literature describes ‘barriers’ to effective pain management, however in some cases the reports are detailing influencing factors rather than obstacles. It seems influencing factors and barriers are terms used interchangeably, although there might be many influencing factors of which the perceived barrier is only one. In describing what occurs in clinical practice, it may be more helpful to discuss influences on practice, as this will encompass both meanings. This thesis generally describes influencing factors, although ‘barrier’ is used if this is how it is referred to in the original study report.

Mann and Redwood (2000), in providing a context for the institutional changes their paper described, divided pain management barriers into four groups: public, institutional, patient, and health care professional. For this section similar headings will be used: institutions, the clinical area, patients, and finally nurses. The effect the institute or hospital has on clinical pain management practice, pain management influences within the clinical area, the patient factors which influence pain management, and the way healthcare professionals influence pain management care, will be presented in turn.

Clinical decision-making literature is reviewed. This section focuses initially on the theories of clinical decision-making, before moving to reviewing the literature around nurses' decision-making in clinical settings. Finally pain management decision-making studies are discussed. The chapter concludes with a summary of the literature reviewed, and an explication of the gaps in nursing knowledge which this study sought to address.

### **3.2 Institutional influences on pain management**

While any organisation will have its own culture, in the United Kingdom the National Health Service (NHS), led by the Department of Health, in part influences the culture of NHS hospitals. Targets are applied to healthcare organisations from the Department of Health, such as: eliminating mixed sex accommodation, waiting list targets, four-hour wait in the Emergency Department, infection control. While these targets have improved patient dignity, quality of healthcare, and hospital-acquired infections (Bevan & Hood

2006), there has not been a directive which says patients should have their pain routinely assessed, or analgesics given in a timely manner. Pain management has been shown to be ineffective before NHS targets began (Royal College of Surgeons 1990), however this lack of attention and emphasis on pain management through this 'target' route may have contributed to pain management remaining outside the public awareness.

Political barriers to effective pain management, also imposed by the Department of Health, include the continued restriction to prescribing controlled drugs by non-medical prescribers (Stenner & Courtenay 2007). The authors found 80% of pain management clinical nurses specialists in the study said lifting of these restrictions would enable them to provide more effective pain management. Up until very recently (April 2012), pain management clinical nurse specialists who held a non-medical prescribing qualification, were required to find a doctor to prescribe many controlled drugs. This process caused barriers to effective pain management by introducing increased possibility of prescribing errors, potential inequality of service provision to patients, and extra time to provide timely analgesia (Stenner *et al.* 2011).

Hospitals produce their own barriers to effective pain management. There is little good quality research into patients' postoperative pain experience while an inpatient. When research is produced that would impact positively on the patient experience, institutions can be slow to react to this new evidence and slow to change processes to enable this evidence to be used (Brockopp *et al.* 1998). The diverse nature of healthcare organisations with the

consequence differences in adoption of new working practices, may not allow for one a 'one size fits all' change to impact on pain management; it may be necessary to tailor strategies to fit to local context (Powell *et al.* 2009a, b).

Healthcare professionals are busy, with increasing staff pressures. There is an escalating burden of paperwork and inadequate funding available to permit any change to current procedures (Mann & Redwood 2000).

Commissioners of healthcare, and perhaps as a consequence, healthcare institutions do not give pain management a high priority (Allcock 2005), making any change more difficult (Brockopp *et al.* 1998, Powell *et al.* 2004).

Local hospital policies can also restrict pain management. Despite there being no legal requirement for two nurses to check controlled drugs (Department of Health 2007), almost all UK hospitals still maintain this practice. There is evidence to show the practice of double checking can lead to as much as a forty minute delay for patients to receive analgesia (Carr 2007), and that this practice may not be relied upon to decrease drug errors (Anderson & Webster 2001).

Brockopp *et al.* (1998) in a report of a study to improve pain management throughout a state in the USA, described personal barriers to good pain management: lack of knowledge, difficulty in nurse doctor relationships, fear of opioids. However the most frequent theme which emerged was the lack of attention and importance given to pain management by the participant's healthcare institutions. This report concludes with a statement that pain

management will not improve until it is considered a priority within the healthcare system (Brockopp *et al.* 1998).

Some years later in the UK, Powell *et al.* (2004) administered a postal survey to explore acute pain services within NHS organisations in the UK (n=325: response rate 81%), over a decade after the publication of a document which called for universal acute pain services in all surgical hospitals (Clinical Standards Advisory Group 2000). Findings indicated 83% of hospitals had an established acute pain service, although only 30% were described by participants as 'thriving', with a further 52% stating they were 'struggling to manage'. There was widespread agreement among the participants in the principles of postoperative pain management, including 24 hour cover, a multidisciplinary team, with corresponding general agreement on the need for the integration of acute and chronic pain management. The key difficulties in achieving the goals so widely agreed upon, was seen as lack of organisational support including funding of adequate resources (Powell *et al.* 2004).

Later work from the same group using a case study methodology looked at barriers to improving acute pain services in three NHS hospitals. They concluded acute pain services were separated from the broader organisational objectives, and were struggling to engage other healthcare professionals in the face of constant organisational change, competition for resources, and professional boundaries. They suggest postoperative pain management should be redefined as a quality improvement issue,

incorporating a whole organisational change strategy (Powell *et al.* 2009a, b).

Over thirty years ago findings from a study using observation and interview with staff and patients highlighted a problem with pain management; no one was accountable for pain management (Fagerhaugh & Strauss 1977 p. 278). If no one is delegated responsibility for pain management, and no one is held to account for failures in this responsibility, pain management can always be seen as someone else's duty. Ely (2001) found support for this when she asked paediatric nurses in a series of focus groups, about organisational barriers to effective pain management. The study found nurses reported the uncertainty of their position, and the perceived lack of power to effect change, as barriers imposed by their organisation.

Some of the factors which impact on how health institutions effect pain management have been briefly discussed. Healthcare organisations can influence how pain management is performed within their hospitals by not prioritising pain management. Hospitals may not give staff groups explicit accountability for pain management, and local policies around controlled drugs, made in the interest of patient safety, can result in patients not getting timely pain management. Nurses may feel they are unable to change pain management practice in the light of so many other organisational targets and with no explicit pain management priority.

What is unclear from this review however is how these factors influence pain management decisions in clinical areas. In the next section a review of the

literature will focus on the how the culture of clinical area can influence pain management at a local level.

### **3.3 Cultural influences on pain management**

The Oxford Dictionary Online (2012) defines culture as:

*“1. The ideas, customs, and social behaviour of a particular people or society. 2. The attitudes and behaviour characteristic of a particular social group”.*

In terms of pain management, culture can mean an ethnic group, with its own set of behaviours and beliefs about pain, but also a social group, or in the case of hospitals, a clinical group; the ward. However culture is not a single element of the group, or a description of the group, or a static collection of group norms. It is the patterns of behaviour and thought which are common throughout the group (Atran *et al.* 2005). People everywhere exist in groups, in different social situations and social contexts. These groups, these social contexts, create the behaviours and thoughts, the culture of the group, as people behave and think in ways which are specific to the group (Hogg & Reid 2006). The group culture however is a dynamic system. Group behaviours and thoughts are constantly being challenged by new information and the group culture will either embrace or reject these changes (Dimaggio & Markus 2010).

Culture is an important component of the Promoting Action on Research Implementation in Health Services (PARIHS) framework, initially proposed by

Kitson *et al.* (1998), to understand the process of implementing evidenced-based practice into healthcare. The three main elements (described as on a continuum from weak to strong) of the framework are evidence, context and facilitation. They are described as being in a dynamic relationship, where the success of the implementation depends on the nature of the evidence, the receptiveness of the context, and manner of the facilitation (Rycroft-Malone 2004). Culture is a sub element of the context domain, with leadership and evaluation, and it is proposed a clear defined culture, which values the staff and patients, and promotes learning, provides input into the context required to successfully implement evidence based practice (McCormack *et al.* 2002). McCormack *et al.* (2002) continue with a suggestion it is important to obtain clarity around the culture of the practice setting; or “*how things are done around here*” (Drennan 1992 p. 3) in order to facilitate successful change.

Lauzon Clabo (2008) used a social group framework in an ethnographic exploration of two nursing units within a hospital, investigating pain assessment practice. She described nursing practice as being shaped by the field in which it occurs. Findings from the study indicated that while the ‘field’ was similar in the two units, each unit had clear, but different patterns of pain assessment. Nurses’ assessment of patients’ pain on one unit was largely grounded in the patient’s type of operation. Pain assessment on the other unit primarily used the patient’s self report as the source of knowledge about their pain. In each unit a clearly defined culture of pain assessment was seen. This culture ensured the pain assessment behaviours followed

the norms of the culture, and these cultural norms were maintained by the nurses working within that culture (Lauzon Clabo 2008).

Although the intention of the study was not articulated as clearly, Manias *et al.* (2002) also demonstrated the influence of culture, using an observational study design to investigate the organisation of the ward, and how this organisation influenced pain management. They wished to explore how nurses prioritised their tasks, and how the pressures of a working shift influenced the pain management strategies they used. Findings showed that one of the major influences affecting nurses' responses to a patient's pain were the competing demands of nursing in a ward environment. The culture of the ward ensured staff appeared to give activities relating to patient comfort and pain control a low priority (Manias *et al.* 2002). This study highlighted how the prevailing culture of the environment can affect how pain management is performed.

Similar findings were seen by Brown and McCormack (2006) when they used ethnography to investigate what factors in the context of the field, inhibited or enhanced pain management for the older patient in a surgical ward. They found thirty-one complex and competing factors which impacted on pain management practices, which were separated into three broader themes: pain assessment and practice, knowledge and strategies to deal with pain, and organisation of care. Older people did not routinely have their pain management needs met; they were not listened to and did not have personal pain management plans. Nurses, while performing routine pain management effectively, appeared to have few strategies to deal with more

complex pain management opportunities. The organisation of the ward also influenced patients' pain management: the routine of only assessing pain at medication rounds, the difficulty in accessing a doctor for an analgesic prescription, and the number of interruptions nurses had to deal with, all affected pain management care. The authors discussed the effect of complex social systems such as a healthcare environment, saying these systems inevitably become established ways of working (Brown & McCormack 2006).

The influence of context on pain management culture was explored within the military using ethnography (Harper 2006, Harper *et al.* 2007). Pain behaviour in the armed forces was contextualised within the culture of 'no pain, no gain', although if pain was experienced it could also be seen to fulfil a 'roughie-toughie' philosophy. Findings indicated these were really the only acceptable pain cultures in the context of a military setting.

### **3.3.1 Clinical leadership and culture**

This section will review the literature which discusses clinical leadership in nursing and the role it has in the development and maintenance of a prevalent culture within a clinical setting. In the past the clinical leader of a ward concentrated on day to day activities, such as staffing and allocation of resources, however the ever changing and increasingly complex healthcare systems means clinical leaders must have more skills, especially in change management (Macphee & Suryaprakash 2012).

There has been much discussion of leadership styles, but little consistency in definition (McKenzie & Manley 2011). Arguably the terms most commonly used are transactional, associated with management rather than leadership, and transformational, described as a process where individuals are changed, transformed by setting of visions, and building relationships (Stanley 2006).

The effectiveness of transformational leadership training has been investigated using a one group pre – post test quasi experimental study, looking at the five leadership practices of transformational leaders (Kouzes & Posner 2008 p. 14): model the way, inspire a shared vision, challenge the process, enable others to act, and encourage the heart. Following a twelve month leadership course delivered through various means, findings supported other work which showed leadership courses are a good investment in improving nurses skills in clinical leadership (Martin *et al.* 2012).

The leader in an organisation can and should have an effect on the culture of that institution (Kouzes & Posner 2008 p. 11). Likewise the leader of any team, or clinical setting should have a similar effect on how what behaviours the team members exhibit (Laschinger *et al.* 2009). Florence Nightingale encapsulated the role of a clinical leader when she said:

*“Let whoever is in charge keep this simple question in her head (not how can I always do this right thing myself, but) how can I provide for this right thing to be always done.”* (Nightingale 1876 p. 24)

The culture of a clinical setting, how it delivers nursing care and patient outcomes, is influenced through leadership (McKenzie & Manley 2011). The Royal College of Nursing (2009 p. 17) states the clinical leadership role of the senior sister on a ward is to, “*set standards, know their patients and their healthcare needs, teach clinical practice and procedures, and role model good professional practice and behaviours*”. This report makes a very strong recommendation that senior sisters on wards should have supervisory status, rather than a daily clinical workload, to facilitate this role. This was somewhat strengthened by the report by the Prime Minister Commission on the Future of Nursing and Midwifery in England (Keen 2010 p. 88) which suggested, “*immediate steps must be taken to strengthen the linchpin role of the ward sister*”, with recommendations of regional leadership schemes to support clinical leaders.

Nursing leadership has been studied in the context of the implementation of evidenced based practice, and it is certain clinical leaders are key players in the shaping of the culture of the group, and so influence the culture of the practice setting (Rycroft-Malone 2004, 2008). Gifford *et al.* (2007) in a systematic review investigating the role of clinical nurse leaders in the use of research evidence conceptualised nursing leaders as having “*a multidimensional process of influence*” (p. 128) which included aspects of behaviours influencing individuals, their environment, and the culture of the setting.

The nurse leader in a clinical setting plays a fundamental role in providing the direction to ensure nurses deliver professional, high quality patient care

(Laschinger *et al.* 2009). They are the ones who can '*provide for this right thing to always be done*'.

A brief review of the literature has demonstrated how the culture of the clinical area can influence how pain management is performed. It is possible patients are also part of that clinical area culture. How patients may influence their pain management is discussed in the next section.

### **3.4 Patient influences on pain management**

This section reviews the literature investigating patient factors forming barriers or enablers to good pain management. As patients come into hospitals being members of the public first, a brief review of how the public view pain is important. This is followed by the role the patients have in their own pain management.

#### **3.4.1 Public influences on pain management**

There is little recent research performed in the UK regarding the public attitude toward pain, therefore the initial studies presented here refer to North American populations, followed by European studies. Often population studies focus either on cancer pain or chronic pain as pain models, to ensure homogeneity of findings. In terms of population studies, either can show how the public think about pain.

Public beliefs about cancer pain were investigated by telephone survey (Levin *et al.* 1985). Results showed the public in Wisconsin thought the disease cancer would be painful (54%), but treatments for cancer would also

be painful (48%). When asked to rate their concerns about the use of opioids for the relief of pain, the majority of participants were very anxious about side effects of taking these drugs, mainly addiction and mental confusion.

The Mayday Fund survey (Bostrom 1997) found 92% of respondents agreed pain was a part of life (41% strongly agree) and that people were more concerned with the meaning of pain, than the pain itself, with 88% agreeing that it is more important to treat the cause of the pain than the pain. When asked how they responded to their last episode of moderate to severe pain, only 30% said they acted quickly to relieve the pain, with 71% of participants generally avoided calling the doctor if they are in pain. Participants were afraid of becoming addicted or dependent on analgesics, with 82% agreeing that it is easy to become reliant on medication. The idea that if one took too much pain medication now, it would not be effective when you really needed it, was agreed by 72% of participants (Bostrom 1997). A commentary on this study cited addiction as '*the ultimate loss of control*' and suggested this was the reason so many of the public were reluctant to use opioids; even a vanishingly small chance of this loss of control occurring caused a barrier to receiving adequate analgesia (Fins 1997 p. 171). McCaffery and Ferrell (1996) suggests society's view around illicit drug taking, at the time strap lined by 'just say no', promoted misinterpretation of the role of analgesic medications among the public.

These results have been replicated many times; pain is a normal part of peoples' medical conditions and they just have to live with it, people were

uncomfortable talking about pain, they are worried about addiction, and good patients do not complain about pain (Allcock & Toft 2003, American Pain Foundation 2008, Cosby *et al.* 2005).

Although there has been a range of North American surveys investigating what the public think about pain, with similar results, there are further studies from the UK. Scott and Hodson (1997) investigated public perceptions of postoperative pain by having people who were attending their General Practitioner (GP) complete a short questionnaire (n=519). Most people (82%) agreed pain after major surgery would be unbearable and should be dealt with immediately. However there were less expected results shown; 17% of respondents felt they should be able to get by without strong painkillers, and nearly half of the participants agreed with the statement, 'you should put up with a bit of pain rather than complain'. The authors concluded the general population of the UK did not have very much understanding of postoperative pain, or of the methods used to treat it. The public were shown to have a great deal of confidence in the medical and nursing staff to treat pain, with 85% of participants believing hospitals were good at treating postoperative pain (Scott & Hodson 1997).

A small qualitative study using semi-structured interviews demonstrated how patients at a London pain management clinic viewed pain and the affect it had on their lives; their pain careers (Bendelow & Williams 1996). This study divided patients into two groups. A 'resignation' group with those people who felt their lives were wholly dominated by their pain, and an 'accommodation' group who were able to use other activities to distract

themselves from their pain. In this study the resignation group was the larger, they were the patients receiving the more medically focused pain management treatments, and had the poorer outcomes. The paper discusses the participants' view that their pain should be treated as 'real' pain, rather than dismissed as not treatable, and concludes with a suggestion for more research to examine the significance of patients 'pain careers'.

A very large study primarily investigating the prevalence and burden of chronic pain in Europe received 46,394 responses from sixteen countries around Europe (Breivik *et al.* 2006). The prevalence data has been discussed earlier, however participants were also questioned about their beliefs and attitudes to pain. Many of them (63%) were concerned about medication side effects with over a third (38%) worried they would become addicted to the medications. Three statements about medication beliefs and attitudes, 'I would rather take medications for my illness than my pain' (55%), 'my pain is not severe enough to take pain medicine' (25%), and 'I am taking so many medicines, I do not want to take pain medicine too' (23%), could be consistent with the finding reported by Cosby *et al.* (2005), 'pain is just a normal part of life'.

This section has briefly reviewed studies which examine how the public view pain. The public are experiencing pain, and on many occasions it is poorly treated (Breivik *et al.* 2006). There is some evidence that demonstrates the public appear reluctant to complain about pain, they are uncomfortable talking about it. They are unwilling to take painkillers for a number of

reasons, but many studies cite fear of addiction as a significant factor. In contrast, if patients are experiencing daily pain it seems pain can become very important, and completely dominate patients' lives to the exclusion of all else (Bendelow & Williams 1996). This disparity presents a complex picture of the public perception of pain.

This thesis focuses on pain in hospital, so the next section will investigate in more depth what patient factors influence pain management while they are inpatients.

### **3.4.2 The patient's role in pain management barriers**

Patients have been reported to contribute to their own poor pain management through a reluctance to report pain for a variety of reasons (Brown & McCormack 2006). They have an expectation health care professionals will be able to offer them effective pain management (Scott & Hodson 1997). However they are anxious about the side effects of analgesics, and may also believe painkillers would mask the effects of the disease process; the purpose of pain is to tell them what is happening to their bodies (Mann & Redwood 2000).

Ward *et al.* (1993) developed a twenty seven item Barriers Questionnaire (BQ) that measured the concerns or barriers of cancer patients, which may prevent them accessing good pain management. Fear of addiction was the biggest concern expressed by participants (79%). Side effects were also very high on the list of anxieties: constipation (85%), nausea (83%), drowsiness (75%) and confusion (70%). Tolerance was also a concern

(57%); the thought they should put off analgesics until they really needed them. The fear of both tolerance and side effects demonstrates patients have an inadequate knowledge of analgesics and methods to control side effects from analgesics. There are also the somewhat paired views that the complaining about pain was not done by 'good' patients (50%), and that doctors should not be distracted from their primary role of cure (60%) (Ward *et al.* 1993). The BQ was used to determine if patients without cancer had different beliefs about pain than people with cancer (Ward & Gatwood 1994). Results demonstrated no difference in the scores, the beliefs identified as important to developing patient barriers were not limited to those patients with a cancer diagnosis.

Beliefs and attitudes in patients in hospital with cancer has been investigated. Findings showed that despite 83% of patients describing that pain stopped them from living a full life, 39% would wait to take analgesics until the pain got too bad, because 42% of them thought that if they took too much now, it would not help when the pain is bad. A third of the patients said they had to be strong and not talk about pain, with 65% of these patients thinking they were in real danger of becoming addicted (Yates *et al.* 2002).

To further explore the role of the patient in pain management, two studies investigating the patients' pain management decision-making are reviewed. Manias *et al.* (2006) used an observational study to explore patient's decision-making around pain management. During the study 316 pain episodes were noted. The most common patient decision observed was to

be a passive receiver of pain relief (61%), with no apparent autonomy or input into the process seen. Some patients chose to discuss their pain problem with the nurses and together agreed on a possible solution (24%), while a more active decision-making process where the patient made the decision and communicated this to the nurse was observed on only 17% of pain episodes (Manias *et al.* 2006).

Similar results were reported when an investigation of chronic renal patient involvement with their pain management decisions was performed again using a similar observational methodology. Findings show 75% of patients made the decision to be a passive recipient of pain treatment, 18% used a collaborative process, with only 6% using an active decision style (Manias & Williams 2008). These studies concluded further research is required to investigate how best to ensure nurses involve patients in their pain management decisions, in order to ensure effective pain management for patients, while acknowledging there would always be patients who because of their circumstances preferred to be passive recipient of pain management.

The literature demonstrates how patients can contribute towards their own perhaps inadequate pain management. They have poor knowledge of analgesics and are afraid of the side effects; they know little about the risk of addiction but fear it greatly. Patients behave on the whole as passive recipients of pain management actions, rather than actively being involved in the decisions. The recommendation by Manias and Williams (2008) suggesting nurses need to involve patients in pain management decisions,

takes the discussion forward to the influence nurses have on patients pain management.

### **3.5 Healthcare professionals influence on pain management**

This section reviews the literature exploring the influences healthcare professionals have on effective pain management. It will begin with a review of the barriers described in literature, followed by a section on specific healthcare professionals' knowledge and attitude studies.

#### **3.5.1 Nurses' influence on pain management**

Influences discussed in the literature preventing healthcare professionals giving good pain management care include, less than ideal knowledge and attitudes regarding pain management and analgesics (McCaffery *et al.* 2000), insufficient education (Willson 2000), the myths and misconceptions about pain management and opioids (Mann 2003), lack of documented pain assessment (Schafheutle *et al.* 2001), and the lack of accountability for pain management (Mann & Redwood 2000).

Oates *et al.* (1994) using a survey found nurses thought the patient had a significant role to play in their own analgesic regime. Nurses used reasons such as; the patients did not ask for any pain relief, the patient was too sleepy, or they were concerned regarding addiction or respiratory depression, to justify not giving prescribed analgesics. When the authors investigated the analgesic administration times, a pattern was shown which corresponded with routine drug medication times, rather than the random

pattern one would have expected from patient requests for analgesics, a finding duplicated in a later study (Schafheutle *et al.* 2001).

Healthcare professionals reacting to the myth of opioid addiction was demonstrated in a pain management project involving a nurse and a physician, from six hospitals. The project, which included a three-day in depth and interactive seminar, had virtually no impact on pain management in the six institutions (Brockopp *et al.* 1998). Evaluation of the seminar and follow up visits to the hospitals provided information about barriers to effective pain management: lack of knowledge, unhelpful attitudes, physicians' fear of legal repercussions, and cultural and religious biases. The unhelpful attitudes to pain management included nurses' and doctors' unwillingness to believe the patient, the belief that suffering was of value, and again fear of opioids. Cultural and religious values underpin our beliefs and attitudes (Ajzen 2005 p. 134), and in this study, three physicians (out of a total of five) stated that pain had a value and should not be treated aggressively. One doctor had such fear of addiction that he would not prescribe opioids at all (Brockopp *et al.* 1998).

The doctors nurse relationship was described as a barrier to good pain management following a postal survey (n=1015) (Van Niekerk & Martin 2003). Nurses were asked to complete questions regarding their experience with pain management and patients in pain, and to indicate on a list of nine barriers to pain management, how many of these they had encountered. Results showed the nurse to patient ratio was one of the barriers most frequently felt by nurse to be stopping good pain management (68%).

Interestingly, and in agreement with Wallace (1995), the barrier least frequently reported by these nurses was their own lack of knowledge regarding pain management. Other barriers often encountered were those describing the relationship between nurses and doctors; nurses' belief of inadequate prescribing of pain relief medications by doctors (70%), doctors' knowledge and perception of pain (66%), and insufficient cooperation by the doctor to nurses' pain management suggestions (64%) (Van Niekerk & Martin 2003).

Nurses were shown to be failing to take responsibility for pain management in a study to investigate the barriers as perceived by staff nurses in a group of hospitals in USA (Wallace *et al.* 1995). Nurses were asked to complete a questionnaire to investigate the perceptions they had about pain management, rating the adequacy and importance of various statements. It is noted that the questions were devised from literature review and from the author's personal experience. Results show that nurses rated themselves as adequate in the practice, education and ethical subscales. The tool ended with an open question asking for three important pain management problems occurring in their practice within their hospital. Nurses reported the under medication of patients as the biggest pain management problem, but did not appear to take any responsibility for that situation themselves as the next problems most often cited were, inadequate education of physicians, and problems with the pain team. The report concludes that the reason pain management practices seems so unreceptive to change in the face of evidence may be because many practitioners do not recognise their own

inadequacies in this area and therefore see no need for change (Wallace *et al.* 1995).

Dawson (2005) demonstrated healthcare professionals did not only influence how pain management was performed, but also how the patient perceived pain. A telephone survey conducted with cancer patients in a primary care setting showed patient beliefs were an important barrier to effective pain management, however the healthcare provider's beliefs about pain were shown to have a bigger impact on the patient's recent pain. The authors concluded that the patient beliefs which could be barriers to effective pain management, may have arisen from the beliefs and treatment of the pain by the healthcare provider's pain management practices (Dawson *et al.* 2005). Many of the barriers or influences examined in this section describe lack of knowledge about pain management, and poor attitude towards pain management.

### **3.5.2 Nurses knowledge and attitudes to pain management**

Knowledge and attitudes of nurses as a barrier to pain management has been intensively studied and the literature informing this is examined with the view that knowledge and attitude could be considered a health care professionals barrier. Much of the knowledge and attitude literature builds on much earlier work, so there is discussion of these early studies, before moving on to the more recent literature.

As early as 1980, Cohen demonstrated that nurses have attitudes and beliefs which make effective pain management unlikely. While the study was

not specifically designed to investigate nurses' attitudes, but rather to examine the source of their analgesic decision-making, it is possible to extrapolate nurses' attitudes towards opioids and pain management from the results presented. Nurses did not expect to relieve all postoperative pain, and routinely gave the lowest dose of opioid prescribed, despite the same or higher dose not relieving the patient's pain earlier. The criteria used for deciding the dose of analgesia was more likely to be size of the patient, or type of surgery, than the severity of their pain. The nurses lack of knowledge of opioids side effects was demonstrated by 68% of nurses who felt the patient would become addicted to an opioid given for one week for postoperative pain (Cohen 1980). These results echo earlier findings presented regarding physicians' knowledge and prescribing habits of opioids (Marks & Sachar 1973). These results were corroborated by Weis *et al.* (1983), who surveyed hospital healthcare professionals (n=127: response rate 54%) and patients (n=81). Findings showed 41% of patients were in moderate to severe pain, with only 20% of healthcare professionals aiming for total pain relief. Exaggerated fear of addiction with the use of opioids was shown in 39% of physicians and 48% of the nursing staff, demonstrating a potential barrier to effective opioid administration.

McCaffery and Ferrell have been investigating the phenomenon of attitudes to opioids and addiction since 1990 (Ferrell 2000, Ferrell *et al.* 1991, Ferrell & McCaffery 1997, Ferrell *et al.* 1992, Ferrell *et al.* 1993, McCaffery *et al.* 1990, McCaffery & Ferrell 1992, 1995, 1996, 1997a, b). This work was started because of a belief that pain was undertreated by healthcare

professionals (Pesut & McDonald 2007). Early data by McCaffery *et al.* (1990) showed that less than a quarter of nurses correctly identified the risk of addiction as less than 1%, with over a fifth of nurses believing the addiction occurs in more than 25% of cases. Their discussion indicated that little if any progress had been made in correcting misconceptions about opioids in the preceding fifteen years. When this study was repeated in 1992 using an updated instrument, there was little difference with regard to nurses' understanding of addiction and opioids. When resurveyed (McCaffery & Ferrell 1995), or re-analysed (McCaffery & Ferrell 1997b) they stated in general, the longer nurses are exposed to correct information regarding pain, the better their knowledge of pain management becomes. This led to their conclusion that as education was making a small but significant difference it is important to continue this focus on nursing education. They added that it was important to instil responsibility for pain assessment and use of analgesics early in the educational input of nurses. Later studies evidenced little change, with Broekmans *et al.* (2004) finding 50% of Belgium nurses certain that addiction was a risk factor with the use of opioids. Only 33% of nurses would use opioids before the patient had a diagnosis, with 36% saying that to give opioids in these situations was not acceptable practice.

There is numerous research which examines knowledge and attitude towards pain (Coyne *et al.* 1999, Dalton *et al.* 1996, Howell *et al.* 2000).

Most of these studies use questionnaires as tools (Lebovits *et al.* 1997) with some using interviews (Ely 2001). These studies have looked at knowledge and attitude to pain management within the whole range of healthcare

providers including doctors (Visentin *et al.* 2001), oncologists (Levin *et al.* 1998), professions allied to health (Jones & Marting 2003, Rochman & Herbert 2000), student nurses (Allcock & Toft 2003, van Raders 2003), many with registered nurses (Cason *et al.* 1999, Fife *et al.* 1993, Matthews & Malcolm 2007, O'Brien *et al.* 1996). They report consistently: attitudes to pain management are poor, knowledge of pain and pain management are deficient, opioid addiction is seen as a serious risk to patients, and there is some hidden value in pain so total pain relief is not a goal. Almost universally they report that further education is necessary to improve the situation (Willson 2000), although better communication (Dihle *et al.* 2006), and additional investigation (Schafheutle *et al.* 2001) are also suggested.

Other studies have investigated educational strategies to change knowledge and or attitude to pain management (de Rond *et al.* 2000, Jones *et al.* 2004, Steginga *et al.* 2005) and they have shown education programmes can be effective and that the effect has been maintained over three months (McClement *et al.* 2005). It is unlikely however that education alone will improve nurses decision-making skills (Thompson & Stapley 2011), and knowledge alone is not sufficient to effect lasting change (Ely 2001).

Simons and Roberson (2002) used interviews with nurses and parents, and pain related nursing documents to investigate obstacles to pain management in postoperative children. They concluded nursing knowledge of pain management was poor, but also that the poor communication between nurses and parents led to increased difficulties in ensuring effective postoperative analgesia for the patients. They suggested this lack of both

knowledge and effective communication skills, was something which could be answered by further education and more research (Simons & Roberson 2002).

The first part of this chapter has reviewed the barriers and influences to effective pain management. They have been presented as belonging to different but potentially overlapping classifications, the organisation, the clinical area, the patient and the healthcare professional. The review has demonstrated how the institution within which it sits can influence the culture of the clinical setting, and how clinical leadership within that unit can influence this culture. Patients, through their behaviours or attitudes, can influence how healthcare professionals manage their pain. Healthcare professionals have their own attitudes and beliefs about pain management, in many cases not necessarily all that different from those of the patients, which may influence how they manage pain. The combination of clinical culture, patient barriers, and healthcare professionals' knowledge, attitudes and behaviours provides the context within which the nurses are making pain management decisions. The following section reviews the literature around clinical decision-making generally, and then focuses on pain management decision-making.

### **3.6 Decision-making**

There is a large body of work about how people make decisions. This knowledge is rooted in a number of disciplines: philosophy, economics including game theory, and psychology. However within this thesis the focus

will be on clinical decision-making. It is worth reflecting on the difference between clinical judgement and clinical decisions at this point as they are sometimes used interchangeably (Buckingham & Adams 2000). Clinical judgement can be considered an opinion, as 'an assessment between alternatives'. A decision is a 'choice between alternatives' (Thompson & Dowding 2009). A clinical judgement (this patient is in mild pain) could be one of the influencing factors in the decision leading to either an action (administer 1g paracetamol), or an inaction (wait to see if the pain gets worse) (Thompson & Stapley 2011).

Clinical decision-making is a complex process and theory informing it includes contributions from medical, nursing, and psychology knowledge base (Banning 2008). Banning's (2008) review of models of clinical decision-making built on earlier work which investigated decision-making in nurse practitioners in general practice (Offredy 1998). Offredy (1998) identified four relevant decision-making concepts: hypothetico-deductive method, decision analysis theory, heuristic or pattern recognition, and intuition. Later work investigating nurses' clinical decision-making, while retaining three of these concepts, has omitted decision analysis theory (Banning 2008). This may be because of the relative complexity of the theory with roots in economic and game theory, or because the process of making a decision in this way involves breaking down the decision into known steps or actions which need to be analysed individually and then reassembled to decide the rational option (Kahneman & Tversky 1979); a method which clinical nurses would have little time for. Clinical decision-

making will be discussed under the three concepts retained by Banning (2008): hypothetico-deductive, pattern recognition, and intuition.

Hypothetico-deductive reasoning involves a number of phases: gathering information (cue acquisition), possible explanations (hypothesis generation), examining cues for convergence with hypothesis (cue interpretation), and finally choosing an explanation that best fits the cues (hypothesis evaluation) (Elstein *et al.* 1978). This type of reasoning has been identified in studies examining how nurses make decisions (Manias *et al.* 2004a, Twycross 2007).

How children's nurses made clinical pain management decisions was investigated in two studies; one with surgical nurses (n=12) and one with medical nurses (n=15) (Twycross 2007). Nurses were presented with scenarios developed specifically for the two studies, and asked to 'think aloud' while coming to a decision. The authors concluded all participants used hypothetico-deductive decision-making, a non-expert strategy, despite the scenarios being commonplace occurrences. The expected difference between experienced and less experienced nurses was not seen. The authors did question if this homogeneity of results was an artefact of the 'think aloud' technique, however referenced examples when the technique was found to differentiate between groups (Twycross & Powls 2006).

Over two thirds of observed medication decisions made by graduate nurses, (within the first year of becoming a nurse), used hypothetico-deductive reasoning (Manias *et al.* 2004a). Graduate nurses were observed to gather

information such as pathology results or vital signs, and use these data to inform their decisions regarding medication administration. The same study also found newly graduates nurses used pattern recognition in 27% of decisions about medications; patterns relating to patient and medication characteristics (Manias *et al.* 2004a). Pattern recognition is a kind of heuristic, described as 'cognitive shortcuts' used to quickly arrive at a decision (Thompson & Dowding 2009). Heuristics are concerned with seeing patterns, recognizing the significance of the pattern, and using that pattern and the remembered consequences of it to make decisions. Pattern recognition is said to be as accurate as more complex decision-making strategies, but accuracy relies on people having sufficient experience to select the correct pattern (Gigerenzer & Gaissmaier 2011).

With increasing experience, nurses begin to use intuition (Benner 1984). Nurses decision-making has been traditionally viewed by some as intuitive (Buckingham & Adams 2000), and many have claimed it a legitimate technique (Benner 1984) for those more experienced or skilled nurses. However a more recent study with specialist nurses using focus groups, found while being aware of the possible role of intuition in their initial assessment of patients, they did not consider it valid in clinical decision-making (Traynor *et al.* 2010a). The study concluded these specialist nurses were trying to find a professional middle ground between using intuition (seen as dangerous and irrational), and protocols (seen as strict and disempowering), for clinical decision-making.

The number of decision cues critical care nurses detected was investigated using an observational 'think aloud' method (Hoffman *et al.* 2009). Findings demonstrated expert nurses were acquiring many more cues to decide how to manage their patients, were able to identify critical and pivotal cues, but they also clustered them in complex ways, to act proactively to prevent patient problems occurring. This aligns somewhat with what Thompson and Dowding (2009) described as pattern recognition. Hoffman *et al.* (2009) conclude with the suggestion that establishing how expert nurses use this cue identification and clustering to provide intuitive practice could be used to prepare novice practitioners.

Nurses clinical decision-making has also been described as functioning on a continuum, with hypothetico-deductive and intuition as the anchors, with pattern recognition being aligned closer to intuition (Hammond 1996, Standing 2008), and this has been seen in several studies as described in the next section (Lauri *et al.* 2001).

### **3.6.1 Clinical decision-making skills**

How nurses make clinical decisions has been extensively researched using both qualitative and quantitative methods; surveys, focus groups, interviews and observations or a combination of these approaches. A questionnaire was designed to explore problems nurses experienced with decision-making in a critical care environment (Bucknall & Thomas 1997). Two hundred and thirty nurses responded to the survey (response rate 59%), answering questions relating to the frequency of a number of decision difficulties

identified previously in literature. The questions addressed the frequency of problems in making decisions, time constraints causing decision-making difficulty, time constraints causing decision implementation, values conflict with others decisions, and disagreement with other nurses' and doctors' decisions. Nurses reported lack of time in which to both make and implement decisions, and disagreement with others' decisions, were the most frequent decision difficulties. The use of a survey design may have limited the findings to what the nurses thought they did, with the authors acknowledging this limitation and suggesting an interview design might have offered more insight (Bucknall & Thomas 1997).

A larger study using a 56 question survey developed from literature and the authors' previous work explored clinical decision-making in five countries: Canada, Finland, Sweden, Switzerland and the United States of America (Lauri *et al.* 2001). The aim was to identify the cognitive processes used in nurses' decision-making based on the cognitive continuum decision-making theory (Hammond 1996). Lauri *et al.* (2001) indicated nurses thought they used both analytical and intuitive modes of decision-making, the anchors of the continuum. Those nurses with more experience and education, used intuition when making decisions, while those with less education and experience, used more analytical decision-making models.

Studies using survey self report methods may be questioned regarding the veracity of the responses, due to the possibility of exaggeration (McCaughan *et al.* 2002). Qualitative methods such as focus groups and interviews could be said to have the same limitations, nonetheless they remain popular

research methods for examining clinical decision-making (Silverman 2011 p. 211).

A study investigated nurses' decision-making processes, with an emphasis on the degree of professional autonomy in this process (Traynor *et al.* 2010b). In a series of three focus groups, nurses were asked to reflect on what influenced their clinical decision-making. Findings demonstrated nurses drew on different types of knowledge in making clinical judgements. However rather than a continuum as described by Standing (2007, 2008), they seemed to use either rational objective clinical knowledge or more tacit ways of knowing, though occasionally these were used in combination. This study makes conclusions about how nurses are reacting to the significant changes in the nursing healthcare environment over the past few decades, primarily in the face of nurses' autonomy as professional decision-makers. While the authors speak of the importance of professional nursing discourse, they appear to overlook that this study only looks at what nurses say and perceive they do around clinical decision-making. The study might have had more impact if it had included an observation element, or limited the conclusions to comments around the place narrative has in nursing.

Using different methods, but with arguably the same limitations, researchers used six in depth interviews to explore what tools nurses found useful in their decision-making. Participants came from a medical inpatient ward, a geriatric rehabilitation ward, and a primary health care unit. Findings showed nurses felt their decisions were based on three factors: observation of patient cues, confirmation of information gathered, and implementation of patient

related actions (Hedberg & Satterlund Larsson 2003). They found nurses when unsure of their decisions, or perhaps to minimize the risk of making an incorrect decision, relied on the knowledge of their colleagues to corroborate their decision. This has been described in other studies, where a common way of making a decision was to ask a colleague (Bonner & Lloyd 2011, McCaughan *et al.* 2005, Thompson *et al.* 2001).

Studies which explore a clinical phenomenon using data taken only from what participants say, either in surveys, focus groups or interviews, may be overlooking evidence suggesting nurses will often say they do one thing yet do another when observed in practice (Dihle *et al.* 2006, Xia & McCutcheon 2006). Clinical decision-making has been investigated using observational methods.

Building on her earlier work exploring the frequency and problems associated with nurse clinical decision-making in critical care, Bucknall (2003, 2000) used observation and semi-structured interviews to examine the process more robustly. Eighteen nurses were observed for a two-hour period immediately following handover. A semi-structured interview took place within 24 hours of the observation period. The first paper examined the decision-making activities seen in the observation period (Bucknall 2000). Three decisions categories were seen: intervention, communication, and evaluation. Decisions were also designated as either 'new' decisions, or inactive decisions which maintained 'old' decisions previously made. Nurses in critical care were found to be making a patient care decision approximately every 30 seconds. Over half of the decisions were classified

as evaluation decisions (51%), with communication decisions (29%), and intervention decisions for (19%) being seen less frequently. Most of the decisions made, however categorized, were 'old' decisions (72%), with only 3.5% of all decisions being 'new' intervention decisions. The number of decisions made was examined using a number of variables, experience, appointment level, location, and shift. It was shown that both the individual and the environmental variables influenced the frequency of nurses' decisions. Nurses in one unit were more likely to make a wider range of decisions but to make fewer of them, while those staff in another made more decisions, but within a narrower scope. The author concludes with questions regarding to what extent the contextual influences on clinical decision-making influence patient outcome (Bucknall 2000).

A further investigation of the data with the addition of after-observation interviews, showed clinical decisions in critical care were strongly influenced by the context in which the decision was made - the clinical landscape (Bucknall 2003). The patient situation, resource availability and interpersonal relationships were found to be environmental factors influencing decision-making, though these were closely linked with time constraints and perceived risks. Again she concluded the impact of the contextual influences on nurses' decision-making should be studied with regard to patient outcomes.

Hancock and Easen (2006), while finding comparable results when using ethnography to investigate the decision-making process of nurses regarding patient extubation, showed an even more complex context landscape. A

number of personal, cultural and contextual factors were shown to be significant, including relationships, hierarchy, power, leadership, education, experience and responsibility (Hancock & Easen 2006).

The use of protocols in the decision-making process has been investigated recently (Rycroft-Malone *et al.* 2009). This exploratory case study used observation and interviews to explore how nurses used written protocols and guidelines to make decisions in two different clinical environments: a diabetic and endocrine clinic, and a cardiac medical unit. It was reported nurses were more likely to use protocols if they were integral to nursing documentation, or if the decision neatly fitted the scope of a protocol.

Nurses described internalising routine protocols as they were practiced, and as the nurses became more experienced, they no longer considered they were following protocols. Some nurses reported the culture of their clinical environment influenced whether protocols or guidelines were used to inform their decision-making, echoing Traynor *et al.*'s (2010a) finding that nurses were using their experience to decide to use their intuition or a guideline.

Nurses were more likely to value and use their own experience, or that of their colleagues, to make decisions, rather than approved standards, guidelines or protocols (Rycroft-Malone *et al.* 2009). Though not discussed within the study it may be this internalisation of protocols becomes part of "*how things are done around here*" (Drennan 1992 p. 3). This lower priority given to protocols could be seen as a barrier to the implementation of evidenced based pain management care.

Nurses' clinical decision-making has been reviewed briefly. If using self-report methods of investigation, nurses' decision-making is seen to fit along the continuum from analytical to intuitive. As more observational studies examine this area, it becomes clearer that the context of the environment in which the decision are made has an influence on that decision. In the next section decision-making around pain management is explored.

### **3.6.2 Nurses' pain management decision-making**

This section reviews the literature which examines specifically pain management decision-making. Different methodologies have been used to investigate this aspect of pain management.

Ferrell *et al.* (1991) used a survey design to explore how nurses make pain management decisions. Findings demonstrated the most frequently used method for assessing pain was reported as 'asking the patient' (91%); however only 45% of nurses in the survey regarded this assessment as useful. An almost equal proportion of participants thought the patient activity level and behaviour was the most influential factor in their pain assessment evaluation. The authors of this early study concluded nurses are making frequent pain management decisions. They discussed poor knowledge of pain management by nurses and doctors as barriers to good decisions, though ethical dilemmas involving over and under medication were also seen as a significant obstacle.

Horbury *et al.* (2005) also reported nurses' lack of knowledge as a barrier to good decision-making around pain management in a study using a series of

eight similar vignettes comparing age (25 year old and a 75 year old), and behaviour (grimacing and smiling). Behaviour was seen as the most important influence in the decisions nurses made about assessment, and how much analgesia to give (Horbury *et al.* 2005). A similar study also using vignettes with limited variables (in this case a married middle class man, and an unemployed labourer) investigated how patient social-economic and lifestyle choices of can influence pain management decision-making (Wilson 2009).

The reliance on the patient's behaviour to influence pain management decisions is a common thread through all pain management decision-making literature, with a customary call for innovative nursing education to ensure nurses are better informed, with the inference this education will change their behaviours (Brockopp *et al.* 2004a, Horbury *et al.* 2005, Kaasalainen *et al.* 2007, Pud 2004), or more research to investigate the problem further (Brockopp *et al.* 2004b).

Previous personal experience of the use of opioids was found to significantly influence nurses' decisions regarding pain management (Pud 2004).

Participants who had used opioids for their own pain were more confident in their ability to assess the cause of pain, more confident about determining a starting dose of opioid, and more confident with the use of opioid infusions.

Comparable findings were discussed following a series of interviews with health care professionals working with patients in long-term care (Kaasalainen *et al.* 2007), with difficulties around pain assessment, and lack of knowledge cited as barriers to pain management decision-making.

A pain knowledge questionnaire and a clinical decision-making questionnaire for pain management were used in a pre-post test study (Brockopp *et al.* 2004a). The intervention tested was small group training designed to ensure nurses considered how their preconceived ideas influenced their pain management decisions and practices. It was reported that nurses questionnaire scores and their pain assessment documentation increased, however neither the clinical decision-making scores nor more importantly patient outcomes changed (Brockopp *et al.* 2004b). The authors suggested nurses re-evaluated their attitudes about certain groups of patients following the intervention, however conceded more research was necessary to confirm this conclusion.

In common with the clinical decision-making literature, studies using a research design which relies on what nurses say they do, also relies on the assumption that nurses do what they say they do regarding their pain management decisions. Studies investigating decision-making in pain management using observational methods will now be reviewed.

Willson (2000) used ethnography to determine the factors which affected the administration of analgesics to patients following a hip fracture. The findings indicated time available to staff, the organisation of care, the multidisciplinary team, information giving, and concerns over opioids, were the factors influencing nurses' decisions. The author presented a theoretical framework which stated people, situations and the environment effected how nurses made decisions around administration of analgesics. This interesting theory

and framework, is somewhat reduced in impact by the limitation of a small sample of three patients and nine staff.

Shared decision-making refers to the involvement of the patient in the decisions made about their health. The relationship between a patient and their nurse is a complex one; it could be perceived as being between two people with unequal powers (Edwards & Elwyn 2009). Shared decision-making means a mutual sharing of information to enable both the nurse and the patient to reach an agreement on the preferred treatment. There is little literature discussing the role and use of shared pain management decision-making between nursing staff and patients though how patients are involved in their pain management decision has been investigated (Manias *et al.* 2006, Manias & Williams 2008).

The observational studies presented here demonstrate the rich contextual data which can be found when exploring a situation using observational methods. The culture of the practice setting can begin to be revealed through watching and recording what people actually do, and document, as well as what they say they do. Thompson and Stapley (2011) in their review of whether educational interventions improved nurses decision-making demonstrated education is not shown to be impacting nurses decision-making. From this it may be postulated that knowledge may not be a key element in improving pain management care. What the studies reviewed in this chapter suggest, through survey, interview and observational study design, is that pain management decision-making is influenced by the context of the environment, by the culture of the practice setting. What

remains to be explored is what elements of the culture impact on pain management; what factors influence nurses when they make pain management decisions.

### **3.7 Summary**

This chapter has reviewed literature around the barriers and influences affecting pain management. It has been shown through prevalence, survey, knowledge and attitude, interview, and observational studies, that pain management is poorly managed in the clinical setting. There are findings to suggest clinical leadership and the culture of the clinical setting can influence how pain management is performed.

The literature regarding clinical decision-making has been discussed and how nurses make pain management decisions has been examined. Context has been shown to be important for decision-making in the clinical setting. Pain assessment has been investigated and found to be shaped by the culture of the clinical environment (Lauzon Clabo 2008). The work of Manias and colleagues (Botti *et al.* 2004, Bucknall *et al.* 2001, 2007, Manias 2003a, Manias *et al.* 2002, 2006, Manias *et al.* 2004b, 2005) have described some barriers to effective pain management while beginning to reveal the complex culture of pain management in the clinical area. Dihle *et al.* (2006) added to the exploration of pain management culture with the discovery of a gap between what nurses say and what they do around pain management, although they fail to describe why this should occur (Dihle *et al.* 2006).

What has not been investigated is why the factors revealed are important in the pain management practice setting, and why they may be dissimilarly focused in different settings (Harper 2006, Lauzon Clabo 2008). An in-depth investigation of a single clinical setting may be able to give further information about nurses' motivation for their pain management decisions, and why a difference between what nurses say they do and what behaviour is observed around pain management exists.

The following chapter has two sections, methodology and methods. The first section begins with the explication of the research aims which were developed from the review of the literature. The philosophical underpinnings of research; ontology, epistemology and methodology are discussed, with an exploration of qualitative designs in more depth. Ethnography is determined as the most appropriate qualitative design for the purpose of the study. In the second section the specific methods used for undertaking this study are described.

*“... a curious kind of cross-eyed vision, one eye roving ceaselessly around the general context, any part of which may suddenly reveal itself to be relevant, the other eye focusing tightly, even obsessively, on the research topic”*  
(Gellner & Hirsch 2001 p. 7)

### 4.1 Research aims

This study seeks to reveal what it is like to manage pain in a clinical setting and how the culture of the practice setting effects how nurses manage pain, with other contextual factors considered.

The principal research aims are:

- What factors influence nurses' decisions about their pain management practice in a clinical setting?
- How does the culture of the clinical environment effect pain management practice?

Secondary questions are:

- What do nurses, both trained and untrained, other healthcare professionals and the senior hospital team understand are their responsibilities regarding pain management?
- What is the meaning of pain management to nurses, other healthcare professionals and the senior hospital team?
- Are there shared culturally determined pain management strategies that influence nurse's decision-making?

- How does the patient influence the pain management strategies used by the nursing staff?

It is clear from the literature that there is a difference between what people say they do and what they actually do (Dihle *et al.* 2006, Xia & McCutcheon 2006) so it may not be acceptable to rely only on self-report data to explore culture. The methodology best suited to explore culture is ethnography (Hammersley & Atkinson 2007 p. 1); “*the scientific description of peoples and cultures with their customs, habits, and mutual differences*” (Oxford Dictionaries Online 2012).

## **4.2 Introduction**

Methodology has been defined as the theory of how a study should progress (Seibold *et al.* 2007), while Strauss & Corbin (1998 p. 3) define it as “*a way of thinking about and studying social reality*”. This chapter sets out the methodology used in the research project. It begins with a broader discussion around philosophical underpinnings of research methodology; the epistemological and ontological positions that shape research. Methodology specifically is considered, with a discussion regarding quantitative and qualitative designs. Qualitative designs are further explored with examples of their use to study pain management. The philosophical paradigm, which underpins this research project, and includes the choice of ethnography, is stated.

Ethnography as a methodology is reviewed. The beginnings of the discipline are explored, and challenges and adaptations over time examined, as ethnography became more utilised within nursing. The assurance and maintenance of rigour within ethnography is discussed. Reflexivity, reflection in practice, is shown as a vital element of achieving this rigour. How this study was conducted within this paradigm and the requirements of rigour is demonstrated. Each sub section will begin with a review of the broader literature about that aspect of ethnography, and then focus on how this specific element was undertaken in this study. Throughout these discussions reflexivity as it was utilised in this study will be considered.

### **4.3 Philosophy**

In order to conduct coherent research it is important to consider ontology, epistemology and methodology, and to have a commitment to certain assumptions within these metaphysical beliefs. These beliefs shape the way a researcher sees the world (Denzin & Lincoln 2005 p. 6), and will influence how a research project is directed (Finlay 2006 p. 9). An articulation of an ontological, epistemological and methodological position is a paradigm, and has been defined as, “*a distillation of what we think about the world (but can't prove)*” (Lincoln & Guba 1985 p. 15). Another description defines a paradigm as a theoretical perspective or philosophical stance that provides the researcher with a set of beliefs about the world that are used to guide research (Holloway 2005 p. 294).

Even a beginner researcher will have some philosophical assumptions regarding the nature of reality, how knowledge of reality is learnt or discovered, and what approaches are most appropriate to discover this knowledge of reality (Racher & Robinson 2003, Travers 2001). Aspiring researchers have been advised to make an informed choice of an ontological and epistemological position, and to make explicit both the position chosen, and the way that position shapes and informs the methodology and methods used in the study (Holloway & Todres 2003).

This documented ontological and epistemological position should underpin the research project, providing a coherent and consistent approach to the choice of methodology, methods and analysis (Holloway & Todres 2003, Weaver & Olson 2006). Clark (1998) asserted there had been a tendency in nursing and the wider scientific community to fail to articulate or debate the philosophical underpinning of their research. This leads to evaluators of the published research making assumptions inferred in the paper regarding the philosophical position, which may not be correct.

The following section will discuss ontological, epistemological and methodological positions. This discussion will conclude with an explication of the paradigm supporting this study, which will help identify the appropriate research methods, assist in data collection, inform the analysis, as well as underpin any claims made by the study.

### **4.3.1 Ontology**

Ontology is the study of our conceptions of reality; the nature of our social world, the character of our being (Brown 2010 p. 128). It is a philosophy that questions our social world, what objects are in it, and how we and the objects interact (Finlay 2006 p. 261). Ontological viewpoints can be seen as a continuum, with realist grounding one end and relativist the other (Brown 2010 p. 131).

A realist maintains the world is made up of objects and structures which exist independently of our perceptions of them, relating directly in a cause and effect relationship to each other. A realistic standpoint holds it is possible to know the objective reality that is the world we occupy. The opposite end of the continuum, relativism, conversely asserts all knowledge is based in our perceptions, and says all perceptions are of equal value. A relativist makes no distinction between what is and what is not, merely what we think of it; the knowledge of our world can only be obtained through personal perception and linguistics (Brown 2010 p. 131, Finlay 2006 p. 20).

### **4.3.2 Epistemology**

Epistemology is the branch of philosophy that studies the nature of knowledge and belief (Brown 2010 p. 131). This field has focused on analysing the nature of knowledge and how it relates to the ideas of truth and belief. It also deals with the means of creation of knowledge. Epistemology can be said to primarily address questions such as, '*What is knowledge?*', '*How can we know it?*', '*What do people know?*', '*How do people get to*

*know?*' (Thompson 2003 p. 12). Denzin and Lincoln (2005 p. 22) add a further question, '*What is the relationship between the inquirer and the known?*'

The epistemological positions have been described by Lincoln *et al.* (2011) as positivist, postpositivist, interpretivist/constructivist and critical theories. They acknowledge some blurring of the boundaries between these positions, with elements inherent within a position found interwoven with others (Lincoln *et al.* 2011 p. 97).

The positivist assumption asserts it is possible to describe the world objectively; that all knowledge is measurable. Traditionally most scientific research took a positivist position (Whittemore 1999). The positivist researcher assumes there is a comparatively simple relationship between the object under investigation and the way it is perceived by the researcher. Nature is explained by testing a hypothesis in a controlled environment while manipulating any variables, in order to know the truth about the phenomenon. This truth becomes part of universal law and can be generalised in identical or similar environments (Poole & Jones 1996).

The randomised controlled studies investigating the safety and efficacy of new pharmacological agents, and the studies exploring pain pathway physiology are largely underpinned by a positivist epistemological position (Whittemore 1999). Positivism may not be consistent with the complex environment within which nursing practice is performed (Seers *et al.* 2004), claiming as it does to produce universal truths, from value free observations

(Weaver & Olson 2006). Positivism supports the Cartesian dualist concept of the separateness of mind and body and positions the investigator outside of the research process (Clark 1998). Conversely constructivists, see the role of the researcher as being a key element of the data created; they are part of the world they are studying.

Post positivism arose from an increasing awareness of the limitations of positivism (Weaver & Olson 2006). This position recognises the difficulty in gaining a definitive knowledge of the truth about objects, and asserts the truth can be assumed from the data (Lincoln *et al.* 2011 p. 98). From this perspective it is possible to have real transferable knowledge of the world, that it is the role of scientific enterprise to describe and document reality, within the boundaries of these presumptions (Finlay 2006 p. 18). Post positivism recognises the influences the investigator has on the subject under investigation with certainty no longer attainable (Whittemore 1999).

The positivist and postpositivist philosophical position is contrasted by that of constructivism, which says reality is a conceptual construction and our view of the world is built from our experiences. Proponents of this position believe research should investigate how individuals construct the meaning of their world (Brown 2010 p. 133). It draws attention to the way our perceptions and experiences are influenced by society, culture, history and language. Any findings from data inform researchers regarding both the object of the study, and of their own expectations and cultural behaviours towards the object. In this way any understandings obtained through the research process remain dependant on the context in which the research was

performed rather than being generalisable to a larger population (Gibbs 2007 p. 17, Savage 2006).

While the medical model with its positivist epistemological position dominated early nursing research (Weaver & Olson 2006), this philosophical position with the emphasis on studies which attempt to control all variables, may not be useful in contemporary nursing research because the complex context influenced environment ensures variables are difficult to control (Clark 1998, Seers *et al.* 2004).

#### **4.4 Methodology**

The methodology of a research project emerges from the philosophical assumptions, both ontological and epistemological, which guide the study purpose; it emerges from the question which the research wishes to answer (Silverman 2010 p. 117). In the social sciences two main methodologies are reported which are traditionally described as opposed; quantitative and qualitative. The usefulness of this dichotomy for current healthcare research is increasingly challenged with the awareness these represent different ends of a continuum rather than disconnected points (Creswell 2009 p. 3).

Traditionally quantitative research is grounded in a positivist epistemology with a realist view of reality. Objects exist independently of the researcher's view of them, and these objects can be broken into composite parts and each part measured independently in isolation. By controlling any variables

which may interfere with the object of interest, a true context free picture of the object can be obtained (Marcus & Liehr 1998).

If researching people using a quantitative methodology, it is the human experience that is broken into composite parts and measured, with the variables controlled as far as possible in order to get a 'true' picture of the human experience, or a 'true' picture of a composite part of the human experience. A study using a quantitative survey design with pre and post test found an increase in the number of pain assessments performed by the nursing staff in the intervention group, and concluded the education programme was an effective way of affecting an improvement in postoperative pain management (Ravaud *et al.* 2004). Studies of this quantitative nature, however allow us to investigate only one small part of the human experience.

To study a healthcare setting by randomisation may disregard too many variables which may also have effected the observed change (Seers *et al.* 2004). Questions that might increase our knowledge of the phenomena of postoperative pain and the part pain assessment, and documentation of that assessment, were not examined by Ravaud *et al.* (2004). Neither did the authors examine the influences of the clinical environment, the expectations of clinical managers, or the professional and life experiences of the practitioner, on how that nurse performs an assessment of a patient's pain.

In contrast qualitative research is largely grounded in a constructivist epistemology with a more relativist view of reality. The picture of the human

experience can best be obtained by examining the whole person or group, investigating how they understand their world, and how they construct meaning about their world from that understanding (Creswell 2009 p. 4). Qualitative researchers describe 'multiple realities' emerging from the data (Hammersley 2002 p. 67). Variables are not controlled, they are accepted as a rich and invaluable contribution to the data generated from the research. Data collected using qualitative methodologies are usually non numerical, and not easily accessible to statistical analysis, as they are based in words or pictures (Silverman 2011 p. 57).

Some research questions may require both qualitative and quantitative data to ensure such questions are comprehensively addressed. This multimodal approach has been called triangulation (Williamson 2005), though there is increasing literature describing this as mixed methods research (Creswell 2009 p. 4).

There is some overlap in the way the term triangulation is used. When Denzin and Lincoln (2005 p. 5) describe qualitative research as multimodal they are focussing on a triangulation of methods of data collection, while triangulation of sources, investigators and theories is discussed by Lincoln and Guba (1985 p. 305) as a means of validation of the study results.

Williamson (2005) suggested it is worth investigating the triangulation of methodologies as a means of illuminating situations.

The choice of research methodology is guided by the philosophy underpinning the paradigm, which influences how the research question is

framed. The most appropriate study methodology to answer the research questions for this study is now discussed.

#### **4.4.1 Explication of study research methods**

The literature review has shown that pain management is not ideal. It has been demonstrated using both quantitative and qualitative methodologies, but the majority of the evidence for this assertion comes from surveys; knowledge and attitude questionnaires, examinations of barriers questionnaires. These studies demonstrate that pain management is ineffectively performed, assert there are barriers to good pain management, and that poor knowledge and unhelpful attitudes contribute to this problem. These studies repeatedly conclude there is a need for more education (Horbury *et al.* 2005, Kaasalainen *et al.* 2007) or further research (Dihle *et al.* 2006, Harper *et al.* 2007) into aspects of pain management for nurses. What the majority of these studies cannot do, underpinned as they are by a positivist ontology, epistemology and methodology, (although this is largely not articulated in the publications), is describe what happens when nurses provide pain management to patients.

The articulation of the philosophical assumptions of relativism, constructivism, with a qualitative methodology describes the paradigm that underpins this research. The research aims were detailed at the beginning of this chapter (section 4.1). As this study sought to gain an understanding of what it is like to manage pain in a clinical setting, and understand why things did or did not happen, ethnography, a research design which allows

the social behaviours in a natural setting to be revealed, was chosen (Hammersley & Atkinson 2007 p. 2).

## **4.5 Ethnography**

The following section discusses ethnography and why it is the methodology best suited to answer the research aims. A brief history of ethnography is given to provide context to a further discussion about the use of ethnography in nursing research.

Ethnography has been defined as a research methodology, but also as the product of the research project; the written text (Fetterman 2010 p. 1). It is the process both of studying a situation and writing about it. Spradley (1980) described it as the work of describing a culture from the native point of view, again defining it as both the subject of the research and the description of the culture (Spradley 1980 p. 3).

Ethnography is the study of people in their own setting by methods which try to explain their social meaning and ordinary activities. The researcher is directly involved in the setting in order to collect data to understand the culture, but without imposing the researcher's meaning; the researcher tries to gain a knowledge of the culture through the values of the participants and not the values of the researcher (Laugharne 1995). Researchers are however a product of their own experiences and culture and therefore will have their own assumptions and values. These beliefs and values of the researcher need to be made explicit throughout the study, and the culture

studied objectively (Fetterman 2010 p. 24), with an acknowledgment of the effect they will have on the data (Barton 2008).

Brewer (2000 p. 11) describes ethnography as style of research with an objective to understand the meaning of social activities of people in their natural settings. The central aim is to understand people's actions and experiences, and the ways their "... actions arise from and reflect back on these experiences". This knowledge of people's social world is acquired from the researcher's intimate day to day immersion in it (Brewer 2000).

Savage (2006) however, suggests the absence of an established definition of ethnography, contributes to its under-utilisation in healthcare. It may be easier to describe what ethnographers do rather than what ethnography is (Lambert *et al.* 2011). Ethnographers do fieldwork; the researcher goes into a field to gather information about people. The ethnographer looks for patterns in observed behaviour which they interpret; they try to discern and make visible the culture of the field (Lambert *et al.* 2011).

Ethnography literature discusses two perspectives as essential in order to understand a culture: emic and etic. An emic perspective is that of the native in the field, said to be at the heart of all ethnographic work (Fetterman 2010 p. 20). It is the voice of the members of the culture as they reveal their view of the social situation. Etic refers to the lens the researcher observes the culture through; her position and understanding of the research paradigm being employed (Whitehead 2004). Both these perspectives can be used with the researcher in either an insider or outsider role (Lett 1996), and both these epistemological positions are necessary for successful ethnography.

Emic to gain an empathic understanding of the culture, and etic to contextualise and disseminate this knowledge (Maxwell 2002 p. 49).

This study looks at what happened when nurses manage pain, what decisions are made, and how the environment and culture influences these decisions. Ethnography is the most appropriate methodology to investigate how pain management operates within a ward culture. A brief history of ethnography is presented next, with a more detailed review of how ethnography has been used in nursing.

#### **4.5.1 History of ethnography**

Ethnography has its beginnings in the field of anthropology. As the world outside Europe was discovered, with its very different peoples and customs, it became necessary to understand the cultures and groups that Western countries were seeking to rule, making anthropology and early ethnography the handmaiden of colonialism. Arguably the father of modern British anthropology and one of the first ethnographers (Macdonald 2007 p. 60), Malinowski (1922) lived for two years with the people of the Trobriand Islands, immersing himself in the daily lives of the natives. He believed the totality of the social, cultural and psychological characteristics of the community should be examined, as they could not be separated (Malinowski 1922 p. xvi). Traditionally anthropologists undertaking ethnographies lived in communities quite different from their own, describing ways of life foreign and exotic to Westerners, what Malinowski labelled “*a new vision of savage humanity*” (Malinowski 1922 p. xvi).

During the early twentieth century anthropologists began to use ethnography to describe discrete communities in North America and Western Europe (Hammersley & Atkinson 2007 p. 1). At about the same time the Chicago School of Sociology used ethnographic techniques to observe groups marginalised by urban industry in North America (Taylor 2002). Since then ethnography has moved from anthropology and sociology to into other social sciences, including education, social work, allied healthcare professions and nursing (Brewer 2000 p. 13).

#### **4.5.2 Ethnography in nursing**

Comprehensive or macro ethnographic research, the traditional model of anthropology, would usually have an element of healthcare within it, as healthcare is an important aspect of any culture. However ethnography as a method to reveal specific healthcare culture has become more common, and is particular suited to nursing (Borbasi *et al.* 2005). Nursing ethnographies are inclined to be micro-ethnography, within either multiple or a single social situation. Researchers seek to find how patients, or staff, see and understand a specific environment, illness, or process (Roper & Shapira 2000 p. 27).

Ethnography is an increasingly used research design in nursing as researchers ask specific questions to gain an understanding of the culture of a situation. It is become recognised within healthcare that ethnography can be applied to practical concerns: what prompts nursing staff to answer call bells swiftly (Deitrick *et al.* 2006, Deitrick *et al.* 2010), how do children

communicate with their care givers (Lambert *et al.* 2011), what meaning chemotherapy patients give to side effects (Bell 2009), how children experience long term renal disease (Waters 2008). Using ethnography in this way allows an in-depth investigation of a facet of nursing care which brings a greater understanding of not only that specific nursing issue, but how it is situated with healthcare (Deitrick *et al.* 2010).

Lauzon Clabo (2008) used ethnography to investigate specifically how the culture of the clinical environment influenced the way pain assessment was performed in two nursing units. Two general surgical wards within a single hospital were chosen to participate. These units had many commonalities; the same organisational mission, senior nursing administration, nursing policies and procedures. The researcher through a combination of observation, interviews and focus group revealed each unit's specific models of pain assessment. One unit's nurses principally used the nurses' experience of postoperative patients and knowledge of their operation to judge and assess pain. Nurses in the other unit used the patient as their reference point for pain assessment. These separate ward cultures were seen to be maintained through the study period, with nurses describing how practices not in line with the prevailing culture were ameliorated. The use of ethnography allowed an in depth investigation of how a specific element of nursing care (pain assessment) was performed within a culture. The author failed to discuss why these different cultures may have developed, though did consider the pervasive influence of the ward culture on individual nursing practice (Lauzon Clabo 2008).

The use of ethnography in nursing has been reviewed and the value these studies have brought to nursing acknowledged. An important consideration for any nursing research project is the question, is this research robust? This question leads the discussion to the quality of an ethnographic study.

#### **4.5.3 Quality in ethnography**

Research concepts around rigour more popularly understood such as validity and reliability are described in a different way in ethnography. Concepts such as reflexivity, trustworthiness, and transferability more readily fit with the naturalistic paradigm within which ethnography sits (Ballinger 2006 p. 239).

Reflexivity is a difficult concept to define, though has been widely accepted (Salzman 2002). It is engaging in reflection about the research process while it is ongoing (Travers 2001 p. 137). Reflexivity is ensuring the researcher's place in the field, and how this position effects the field, is made explicit, critically reviewed (Carolan 2003), and becomes part of the ethnography. Another definition suggests reflexivity as a 'stepping back' from the field to gain an awareness of the researchers taken for granted assumptions, and an appreciation in the field of their prejudices (Potvin *et al.* 2010 p. 447). Researchers should recognise, and reflect on the effect of, their assumptions and prejudices within the field. Reflexivity however, is not merely reflection; it is investigating via introspection as events occur and reflecting on any thoughts and feelings about the results of the event (Arber 2006).

Conversely Salzman (2002) rejects reflexivity, asserting self-reflection has no meaningful place in science. He asserts it has become ubiquitous in ethnography to ignore objectivity, pandering to the positivist idea that only knowledge which can be seen is real. He contends ethnography is enough in itself, with reflexivity being unreliable, although he does acknowledge it can provide ideas, which if pursued can provide useful understanding (Salzman 2002). However, on balance, reflexivity seems fundamental; "*we are part of the social world we study*" (Hammersley & Atkinson 2007 p. 18), and this connection should be made explicit. The way reflexivity was ensured and used during this study is incorporated in later sections.

During data analysis and report writing it is also vital to continue to use reflexivity, as a researcher's own values and beliefs, conscious and unconscious, shape the analysis and frame the narrative. If the reflexive process is not fully utilised, researchers can leave out participant experiences from their texts because they are deemed unimportant; they do not tell the whole story as it was found (Manias & Street 2001).

The trustworthiness of ethnography can be strengthened by consideration of credibility, dependability, transferability, and confirmability (Shenton 2004).

As these concepts are briefly discussed it can be seen reflexivity is a common thread throughout. Credibility asks the question, is this real? Is the information credible? Shenton (2004) advises in order to ensure credibility, it is important to fulfil a number of criteria, some of which can be applied to the other concepts. The study should include known research methods, with triangulation further strengthening the methods. There should be prolonged

immersion in the field, with a reflexive narrative explicit, and frequent debriefing to ensure developing ideas and concepts are tested. There should be 'thick descriptions', detailed accounts of what occurred, including contextual factors. Silverman (2011 p. 356) suggests further requirements for credible ethnography including paying attention to alternative explanations and negative findings. These concepts combine to provide assurance to the reader that the data provided is an accurate depiction of what did occur in the field.

Dependability refers to the concept of the study findings being reproducible; if the research project was to be done again, by someone else, the findings would be the same. Angrosino (2007 p. 58) suggest many researchers recognise much of what is done throughout an ethnographic project is not reproducible, and things that occur in situations are mostly unique.

Nonetheless there are some techniques which can be used to make ethnography dependable. Within the field care should be taken to be consistent with data collection methods (Angrosino 2007 p. 59), and record keeping should be meticulous (Mays & Pope 1995). The explication of the research process, (design, data collection, analysis and reporting), as well as the reflexive narrative, if reported in detail may assist in dependability.

Transferability refers to the idea that research should be able to be true in other settings and situations. Ethnography aims to discover the unique meanings in the culture of the chosen field. However, if adequate contextual detail about the field is included, it enables the reader to judge whether the

knowledge could be transferred to other settings and situations (Shenton 2004).

And finally confirmability, the assurance that the findings are the result of the participants in the study and not of the researcher, can be obtained again through the explicit reflexive commentary (Shenton 2004). A full and detailed audit trail of the decisions made within the project should be explicit in the study report. This assures the readers that all parts of the participants' stories are revealed, not simply those which support the researcher's chosen story.

The first part of this chapter has dealt with philosophy, methodology and ethnography, setting out the assumptions underpinning the research and ethnography, and explaining why this methodology is the most appropriate for the research aims. The elements which ensure ethnographic rigour have been outlined. The second part of this chapter describes the methods used to undertake the ethnography. As each of the elements are reviewed, the specific methods used in this study are presented.

## **Chapter 4 – Section 2      Research methods**

The ethical dimension of every research project is vitally important. As ethnography involves prolonged immersion in the field, some ethical elements are even more significant. These elements are discussed following an exploration of general ethical considerations. The ethnographic field is described, with discussion around how the researcher is positioned within the research, and how this may have affected elements of the study.

Fieldwork is the activity ethnographers do. The elements of fieldwork are discussed with specific issues arising from this study presented. Finally the process of data analysis is reviewed and the main themes which emerged from the data presented.

### **4.6            Ethics in ethnography**

Ethnographers work with people; they observe and interact and talk to people. Our normal social interaction is governed by ethical considerations: beneficence, non-maleficence, autonomy, and justice. When conducting social research the researcher must ensure the same ethical issues are considered (Murphy & Dingwall 2010 p. 339).

Beneficence and non-maleficence within social research are commonly considered together; the research should not harm participants. It is the responsibility of the researcher to consider these ethical principles even if the participants seem to disregard them (Murphy & Dingwall 2010 p. 347).

Ethnography does not usually involve the same type of potential harm in, for example clinical drug trials, however to say there is no harm is erroneous. Observing people and questioning them about their behaviour can make them nervous and anxious, which can damage their self-esteem (Hammersley & Atkinson 2007 p. 214). There is the risk of establishing close professional or personal ties with members in the field, which may not survive the end of the study, causing loss and distress (Murphy & Dingwall 2010 p. 340). They suggest that harm can also come from the consequences of participation in research; the participants changed perception of the field. Participants may become disillusioned with the situation they are in, having examined it more closely during the study.

#### **4.6.1 Confidentiality**

Ethical dilemmas over confidentiality issues may occur concerning the uncovering of additional unexpected or uncomfortable information, or unethical or even illegal behaviour by participants (Goodwin *et al.* 2003).

How an ethnographer will deal with these issues, should they arise, needs to be considered carefully before the research begins. Using reflexivity throughout the project also ensures any confidentiality issues which were not foreseen, but which have arisen are recognised and appropriately acted upon.

While there are confidentiality problems raised in data collection and data analysis stages of the research, it is when publishing the ethnography that the issue of anonymity is amplified. Privacy and anonymity are contentious

ethical issues in ethnographic research, with some saying it is unachievable (van den Hoonaard 2003). Many nursing ethnographies are conducted in a single healthcare setting and with the publication of the research it might be easy to deduce a great deal about the setting and thus the research participants. The way the data is presented in the published article can go some way to mitigate this risk, however most journals publish the address of at least the principal author in order to facilitate correspondence and comment, and this alone might tell the reader more than the author wishes.

Ethnographers protect research settings and participants by removing identifiers and providing pseudonyms, however it seems disingenuous to assume changing names and making no reference to appearance, race or gender of the participants, can truly make them unidentifiable when the data is published (Murphy & Dingwall 2010 p. 341). Clarke (2006) points out participants could be identified by their stories. Professional and social circles can be small and simply the omission of names may not confer sufficient privacy to participants (Anastas 2004). This lack of privacy could lead to harm being done to the participant or the organisation in which the research occurred.

#### 4.6.1.1 Confidentiality in this study

To safeguard confidentiality, the hospital Trust, the ward, any personnel and all ward staff are referred to only by pseudonyms. The clinical setting is called Newcastle Ward, and the Senior Sister Alexandra. To further ensure the anonymity of the ward staff, the pseudonyms are all European and

female, taken from friends and family, and allocated in an arbitrary fashion to the staff.

#### **4.6.2 Security of data**

Ethics committees insist all data collected including field notes and interview transcripts are kept in a manner that will maintain confidentiality, however realistically while a researcher may sincerely endeavour to fulfil the criteria, houses are burgled, computers are hacked into, lost or stolen, field notes intercepted and read (Goodwin *et al.* 2003). Data collected and transcribed should be stored without identifying notes or information in order to decrease this risk.

##### **4.6.2.1 Security of data in this study**

In this study data were kept in a number of places. The little notebooks used for field notes were kept with me while in the field. These notebooks were small so would fit easily in a pocket. As a notebook was filled, the information was transcribed, and it was then kept in a locked filing cabinet. Audio recordings taken in the field were downloaded at the end of each observation day, deleted from the recording device, and transcribed within a week. A secretary with no knowledge of the field of pain management transcribed most of the interviews. Confidentiality was discussed with the secretary before transcription began and I was assured she both understood, and would comply with the standards. Any data on paper was scanned, and then stored in the locked filing cabinet, without identifiers. Data held electronically had any participants identifiers replaced with participant

numbers. The key was kept electronically though separately from the other study data. The computer was password protected and only I had access to the data. Data were backed up securely and the password protected drive kept at my workplace where it could not be accessed, as it was not NHS equipment. I reflected on these means frequently to provide assurance they met the rigorous standards set by ethical considerations.

#### **4.6.3 Informed consent**

The ethical issue of autonomy considers a participants self determination. In research terms this risk is usually mitigated by the presence of informed consent. Informed consent is at the heart of all research involving people as participants. The RCN Research Society asserts it is “*essential that those who participate in research understand exactly what the research involves for them, and freely agree to participate in it*” (RCN Research Society 2011 p. 3). The report lists sixteen points which participants must understand in order to have given truly informed consent. Social research in a clinical setting requires signed consent forms from all participants, with part of the consent form seeking to give assurance the participant has read the participant information leaflet describing the research and setting out their role in the study. A signed consent form however, does not guarantee the participant understood the information, or has all the information they need regarding the study (Murphy & Dingwall 2010 p. 342). As participants will largely be unfamiliar with the process of ethnography, this informed consent may have to be renegotiated at different points of the study, as participants may become familiar enough with the researcher as to forget they continue

to be a part in the process. It could be argued it is difficult to ever tell everyone involved in the study, everything about it; some people will not want all the details and to force these on them could be intrusive (Hammersley & Atkinson 2007 p. 210).

#### 4.6.3.1 Informed consent in this study

All participants in this study gave written informed consent, to be observed, for informal conversations, and for formal interview. Information detailing the study was on display in the ward office throughout the study. At the beginning of the study all staff were given a copy of the participant information sheet in their 'mail boxes', and had an opportunity to give consent at any time they wished.

In practice the consent process normally occurred on the day of observation, as the participant was to be working with me for the day. The participant received another copy of the patient information sheet, which was discussed, before the participant signed two copies of the consent form. Participants had one copy of the consent form, and the information leaflet to keep; a signed copy of the consent form was kept in the study folder.

Before any observation session, verbal consent for observation was taken, whether a consent form had been signed previously or not. There were occasions where observational data had been collected which involved a nurse or patient who had not yet given formal consent. If this occurred it was always asked if the participant gave consent for any data obtained before

this time to be used. This request was on all occasions granted, and consent for this was noted in the contemporaneous field notes.

On each occasion of observation, I established that everyone being observed continued to give consent to this observation and informal conversation. At no time did any participant withdraw their consent. Some patients refused to give consent (n=3), while others indicated they preferred to be observed at another time.

Prior to any formal interview, consent was verbally reconfirmed, and as participants were to be audio-recorded, verbal consent for this too was obtained. One nurse while consenting to the interview, did not consent for the audio recorder to be used, so comments were written down throughout the interview and reviewed immediately afterward. Some interviews were performed with staff who had not been observed previously. In these cases formal written consent was obtained prior to the interview.

#### **4.6.4 Justice**

Justice is the final ethical issue to be considered. Justice is concerned with dealing fairly and equally with all research participants (Murphy & Dingwall 2010 p. 346). In a healthcare setting it may be easy to overlook the voice of the more junior or untrained nurses, or that of the patients. Ethnography aims to hear the voices of all the people involved in the exploration of the field (Shenton 2004). Using reflexivity and in discussion with university supervisors, the views and perceptions of the staff which came from the data, were considered and presented in the written ethnography.

In order to ensure all research undertaken in the UK abides by the overarching ethical principles any research which involves people (and many others) is required to be presented to ethical committee review and obtain approval. The process of this review and subsequent approval is presented in the next section.

#### **4.6.5 Ethical committee review**

In line with the Department of Health Research Governance Framework protecting people involved in clinical research, this study was presented to an Ethics Committee (08/H0311/36). Initially the research was to take place in the NHS Trust where I worked, and was sponsored by that organisation. The Ethics Committee however did not approve the submission, citing the reason; *“The research should be carried out in a different Trust to the one within which you work.”* As the submission was presented to the ethics committee, it was clear the committee was concerned that as I, the principle researcher, was well known to the proposed ward and the nurses working there, and in a relative position of power, staff may have felt coerced to consent, although this was not made explicit on the letter from the Ethics Committee (Appendix 2).

Other concerns expressed dealt with ongoing consent being reaffirmed at each observation period, and the audio recording of informal conversations. The letter in reply addressed all concerns.

- Another hospital was chosen in which to undertake the research

- The participant information sheet was changed to reflect ongoing consent affirmation
- The refusal of the ethics committee to allow the use of audio recording outside of the formal interviews was successfully renegotiated.

Following notification of a change in sponsorship from the NHS Trust to the university, formal Ethics Committee approval was granted 26 June 2008 (Appendix 3). Approval had been given for collection of data from participant and non-participant observation, formal interviews, informal conversations, and document analysis which included all patient and non-patient documentation on the ward.

#### **4.6.6 Ethical issues which arose during the study**

The ethics committee had approved the submission which stated, *“If the practice is certain to harm the patient, I will intervene to stop it happening. If it is poor practice that may harm the patient later, I will report it to the person in charge of the shift.”*

There were some occasions during the study where it was felt a patient might be harmed. Actions were taken as approved by the ethics committee.

*I am worried about a patient (PT6), he is not looking as bright as he was yesterday, he is a little confused, when he was not at all yesterday. I was worried he might have a chest infection. I spoke to the Nurse in Charge about him, however she did not do anything, being busy with another patient. After some time I spoke to the physio on the ward,*

*who said as he is an orthopaedic patient I needed to get the orthopaedic physio. I went to the orthopaedic ward and told the physio there, who said they would come, though he was pre op so was not a priority, although I explained that I was worried about a possible chest infection. When nothing happened for an hour or so, I asked HCA Cheryl (P26) to check the patients observations. She found oxygen saturations of 53%, and immediately told the relevant people. Now people are here, the oxygen is on, doctors are doing ABGs. He was transferred to CCU having had an MI [myocardial infarction]. (FN15 L33)*

The ethics submission goes on to state, *"I believe that there is poor practice regarding pain management occurring in the clinical setting, and I may see many instances where I will have to let this practice go unchallenged in order to collect the data. I think I will find this personally very challenging and upsetting."* There were indeed occasions when observed pain management practice was challenging and upsetting. What was done depended on the level of harm which was felt to occur to the patient.

*A patient (PT6 - elderly gentleman with fractured neck of femur, pre operative) is complaining of pain in his heel. I spoke to SR Alexandra about this. She started to give me instructions on what to do, mostly it seemed to be about a care plan. I feigned ignorance (not sure it was pretended) and she rushed off and got jelly heel things, which we put on together. Alexandra was very gentle but did not ask about the patient's pain, and it must have hurt as we lifted his fractured leg and*

*played around with some sock things to keep the heel pads on. She was very concerned about his pressure areas, but never mentioned pain, pain assessment or analgesia. (FN14 L39)*

There were issues in the field in consideration of the ethical principle of justice; to ensure all the voices in the field were heard. I was often frustrated and angry at the pain management care patients were receiving. I felt a real tension between my role as a senior and a specialist nurse, and my role as a researcher, an observer. This issue was discussed at many supervision sessions and eventually a set of rules, a study code of conduct, was established. There was a copy in each of the study notebooks which I referred to if I was concerned or felt I was in danger of stepping outside of my role as researcher. See appendix 4.

#### **4.6.7 Ethics in ethnography summary**

The ethical considerations of ethnography as a methodology, and those of this ethnography have been discussed. Reflexivity is used throughout the study to ensure the ethical concepts of beneficence, non-maleficence, autonomy and justice were central to all research discussions, either occurring in the field or later in the data analysis. The means, including reflexivity, used to ensure rigour and quality in this ethnography are discussed throughout the relevant sections in this chapter.

The next section describes the ethnographic field, the setting which is under observation, in this case Newcastle Ward. How access to the field is given is considered. Once in the field it is important to consider how a researcher is

positioned within that clinical setting, and how key informants and a sample of participants is selected.

## **4.7 The ethnographic field**

Ethnographic research can take place anywhere; the ethnographic field can be as small as a single room, or as large as a village or town. The field can be a familiar setting to the researcher or an unknown location. Any ethnographic field however has the possibility of investigating the relationships within the players on the field (Hammersley & Atkinson 2007 p. 63), if one can gain sufficient access.

### **4.7.1 Gaining access to the field**

The process of an ethnographic study begins with the challenge of gaining entry into the field. There are gatekeepers who allow a researcher access to the study field, often the initial point of contact (Hammersley & Atkinson 2007 p. 49). The problems which could be encountered in this process will depend on many factors, if the researcher is already a member of the community, or is an unknown outsider. If entering a professional field, access may depend in some way on the recognised professional level of the researcher, the level of access required, and the perceived appropriateness of the request (Simmons 2007). Toffoli and Rudge (2006) discuss the issue of gaining access for healthcare professionals by suggesting researchers will have to demonstrate their research will not interfere with the work of the healthcare setting, interviews with staff will not take them away from patient

care, or the research will not result in the workings of the healthcare setting being exposed to negative review from outside the local setting.

#### 4.7.1.1 Gaining access to the field in this study

In order to undertake a study at any NHS Trust it is a requirement to have management approval. This is Research and Development (R&D) approval, in accordance with the NHS research governance arrangements (Department of Health 2005). This process was begun in tandem with the Ethics Committee submission and R&D approval for the NHS Trust was granted 28 August 2008. Contact was made with the Director of Nursing and through a process not made explicit, a ward was selected and approval for the study to proceed was given. The name of the ward Senior Sister was made known to me and on making an appointment with Alexandra, access to the field was made. The first observation period was on 8 December 2008; the three-month delay in beginning the data collection was mainly caused by changes in Trust executive officers meaning negotiations with the Trust regarding the ward were protracted.

#### 4.7.2 Positioning within the field

The ward was selected as the research environment by the Director of Nursing; it was the major surgical ward in the hospital, and though it did not have a direct comparator within the Trust, could have been typical of any surgical ward, in any District General Hospital in the UK (Dr Foster 2012).

The task of early ethnographers (largely anthropologists) was to make the strange familiar; to examine strange and exotic cultures so their customs and

rituals could be understood by the Western world (Macdonald 2007 p. 60). As ethnography became a tool to be used to examine aspects of our own cultures, this focus changed to making the familiar strange (Wolcott 1999 p. 244). This phrase was first used by Novalis, a French philosopher and poet (1772-1801) who is asserted to have said:

*“To romanticize the world is to make us aware of the magic, mystery and wonder of the world; it is to educate the senses to see the ordinary as extraordinary, the familiar as strange, the mundane as sacred, the finite as infinite.”* (Beiser 1988 p. 294)

This idea is also found in the works of other Romantic poets, Wordsworth and Coleridge, with the reference becoming changed to ‘making the familiar strange and the strange familiar’ (Eliot 1932), although the providence for this change seems to be lost in time.

Art, semiotics, sociology, anthropology and later ethnography took up the phrase as their own, each using it to ensure familiar objects in our familiar world are examined by attempting to remove the elements of our knowledge and experience which add context. This strategy of ‘making the familiar strange’, however needs to be combined with an awareness that while we may try to look beyond to see an object, we can never escape framing new experiences with our knowledge gained by past experiences (Wiseman 2011 p. 8). Because of this it is important to make the position of the researcher within the field visible.

#### 4.7.2.1 Positioning within the field in this study

There is always a danger familiarity with the area under examination will lead to assumptions being made, meaning appropriate clarifying questions are not asked (Bonner & Tolhurst 2002). However as I had not worked as a ward nurse since finishing nursing training twenty years earlier, there was felt to be enough distance to be a 'stranger' within a surgical ward, with enough experience to have sufficient familiarity to enable appropriate data collection.

When I started this ethnographic study I had been working as a Senior Clinical Nurse Specialist in Pain Management in a District General Hospital for almost two years. Previous to that position I had worked for over six years as senior nurse in a research team conducting pain management related clinical trials for the pharmaceutical industry. Following the literature and ethical committee review to inform and legitimise the project, data collection began. I was a senior nurse, with little ward nursing experience, and my significant research experience was almost wholly quantitative in approach. To try to become part of a surgical ward, working initially in a health care assistant role, observing nurses practice in a field I was an expert practitioner in, while using an unfamiliar methodology, felt very uncomfortable.

Newcastle Ward was in a hospital where I knew no one, and no one knew me, aside from the Pain Management CNS's who I had met previously professionally. As would anyone in a new environment I sought to be amiable, to become friends with my new colleagues. There was however a continual tension between, my position as a senior nurse with expert pain

management skills, the unfamiliar observer role required for ethnography, and my natural inclination to make friends and help people. I was in a situation where the normal social integrations had to be carefully negotiated; not too friendly otherwise I could lose perspective or contaminate the field, however not too formal and aloof to prevent losing data by being not immersed enough in the field. This negotiated social situation ensured constant monitoring of appropriateness of my conversations and behaviour.

I saw situations where pain management was, in my opinion, poorly and inadequately performed, which left me frustrated and anxious. I found it difficult on occasion to judge how much staff should have known about pain management, and may sometimes have been unrealistic about their level of pain management knowledge and skills. I found there was again a considerable tension between gathering data of what was occurring and wanting to change pain management practice by education or direction. These tensions formed an extensive part of the supervision sessions as it became evident I was judging the ward staff by my own standards of pain management care, rather than understanding the wards staffs' perception of giving pain management care. As the observation period progressed I was assisted, through reflexivity and supervision to largely move to the latter position.

### **4.7.3 Sample**

Angrosino (2007 p. 48) suggests the question of how many people to sample in an ethnographic study is a complex one, arguing it depends very much on the characteristics of the group under study, legitimate limitations on the

researchers resources (time, access), and on the objectives of the study.

Many of the nurse researchers using ethnography in clinical settings used a group of nurses either selected from the pool of nurses (Dihle *et al.* 2006), or self selected by agreement to participate (Brown & McCormack 2006).

#### 4.7.3.1 Sample in this study

Sampling for this study was one of convenience; all staff on the ward were invited to participate. Over the course of the study there were 44 ward staff available to be participants: 30 Registered Nurses (RN), and 14 Health Care Assistants (HCA). One RN was on maternity leave for most of the study, she gave consent but was not observed or interviewed, while five RNs left the ward during the study, and were again neither observed nor interviewed. All twenty-four available RNs consented and were included as participants in the study. Five of these twenty-four RNs were not observed; two were part time and did not work with me, one was on permanent night duty, and the other two RNs were very new to the ward when the interviews were occurring (the observations had finished). One of the RNs who had consented did not have an interview as she was on extended annual leave at the time the large majority of the interviews were occurring. All RNs available at the time, consented to be interviewed (n=23).

Two HCAs left before being observed or interviewed, and another two left the ward after some observations had been done, but were not available to be interviewed. Nine out of the available twelve HCAs gave consent to the study (75%), of these six were observed (50%), and five interviewed (42%),

with one neither observed nor interviewed. Three HCAs who did not consent were on permanent night duty.

#### **4.7.4 Key informers**

The success of any ethnographic research relies heavily on the richness of the data collection. Key informers can be central to obtaining this depth of data. Once access has been obtained to the environment or as part of the gaining access process, key informers are identified (Agar 1996 p. 168).

Agar (1996) defines the role of the key informer as broadly knowledgeable about the culture and able to fairly reflect on the culture. They may be able to validate information obtained from other sources and inform the researcher about the social complexities of the setting. Bailey (1997) asserts however it is important not to rely over much on the information given by the key informer as they will have their own perspectives on the culture and should be considered only one of the many voices of the culture. Fetterman (2010 p. 52), while acknowledging the usefulness of key informers (he called them key actors), suggests that maintaining some independence within the culture will leave open other lines of communication.

##### **4.7.4.1 Key informers in this study**

Within Newcastle Ward, all staff members agreed to be questioned about their practice. If I was enquiring around an issue with health care assistants, two of the HCAs (Kirsten and Cheryl) were keen to provide extra detail regarding roles and culture. Similarly familiarity gained with one of the senior nursing team (Danielle), and one of the registered nurses (Lorraine), meant

significant extra insight into their roles and the culture of the ward from their perspective were revealed. The information obtained from these nurses was used within the reflexive framework, acknowledging their usefulness while placing it within the wider context of the ward.

#### **4.8 Fieldwork**

Fieldwork is the work ethnographers do when they are in the field. It usually includes observation, informal conversations, formal interviews, and document analysis. All of these will be themselves documented in the field notes, which are another source of data.

As the researcher enters the field they must make decisions about their participation in the field (Allen 2010 p. 356). There is some debate about whether an insider or an outside role is more appropriate; whether researchers should investigate their own settings (Simmons 2007). However this debate can neglect the understanding that how a researcher is situated within a social setting is flexible, and that a fixed identity may not be able to be assigned (Kusow 2003). Hammersley and Atkinson (2007 p. 86), refer to the insider and outsiders 'myths'. The 'myth' they wished to dispel says, only an outsider possesses the emotional distance from the field to view the observations impartially, and only an insider can develop the rapport with participants to ensure an authentic account. An insider may have an easy means of gaining rapport and confidence of the subjects, as well as the insider knowledge of the 'norms' of the environment enhances the identification of any deviations from it (Goodwin *et al.* 2003). Ethnographers

can use one aspect of themselves to build rapport as an insider, however because of their experiences will be also be able to take an outsider view (Hammersley & Atkinson 2007 p. 87). They continue with the assertion that without both sorts of information, that seen as an outsider, and as an insider, the observed behaviour could be misunderstood. The next section will review observations in the context of the ethnographic tradition and concludes with how observations were undertaken in this project.

#### **4.8.1 Observations**

Participant observation has been the principal data collection method in ethnographic studies (Baillie 1995, Simmons 2007). Spradley (1980 p. 54) describes it has having two purposes; for the researcher to engage in appropriate activities within the field; and to observe the people, their behaviours, and the physical characteristics of the field.

Participant observation can be overt or covert. Explicit covert observation methods, where the research subjects have no knowledge of the surveillance and therefore have not consented, may be considered a violation of a person's autonomy and could be deemed unethical in many situations. However Baillie (1995) suggests it is not always possible to conduct participant observation overtly. Ethnographic researchers do not always have control over who comes into the setting, and it may be unrealistic even to aspire to the written consent of all those who enter the field (Murphy & Dingwall 2010 p. 342).

The levels of observation described in ethnographical research are participant only, participant-as-observer, observer-as-participant, and observer only (Gold 1958). These are said to be a continuum with participant only at one end (the most involvement in the research setting), and observer only (the least involvement) at the other. Most studies will have researchers moving from one point to another along this line during the data collection, though Roper and Shapira (2000 p. 21) state most ethnography is undertaken with the researcher as participant-as-observer or observer-as-participant.

Ethnographers assert field notes should also include observations of the physical environment, and researchers should also take note of the lighting in the setting, the colours seen, the smell of the environment, the temperature and the weather, the background sounds and activities, and the non verbal clues of the participants rather than rely solely on people and conversations (Baillie 1995, Spradley 1980 p. 78).

As participant-as-observer, the nurse researcher should move between that of nurse and that of observer seamlessly (Roper & Shapira 2000 p. 21). Kite (1999) however writes that as a relative insider to the research environment she found it impossible to perform research as a participant-as-observer. Though she thought at the beginning of the research process she was achieving this role, she discovered through reflexivity she was a 'peripheral observer'. This may be because of her strong personality which comes across even in the article, but it could be other nurse researchers have experienced this problem, but perhaps not reflected on it with such insight.

Bailey (2007) describes a struggle to see where her role as a nurse ends and her role as a researcher begins.

A participant-as-observer will be expected to play an active part in the clinical environment, and yet continue to observe the setting. A lack of recent clinical experience in the area may make some nurse researchers anxious undertaking the participant role (Bailey 2007), and the observer/researcher role may be more difficult for clinical staff to warm to. Researchers may be treated with suspicion or assigned a 'senior' role (Simmons 2007). A learning and comfort gradient has been described as the observational study goes from beginning to end, but the stress of being both participant and observer, with differing degrees of emotional involvement and required detachment, may leave the researcher continuously under pressure (Gerrish 1997).

Observation in an ethnography, whatever degree of participation is required, is demanding, and loss of concentration can mean loss of data (Briggs 2003). Researchers have used different strategies to overcome this. Briggs (2003) used non-participant observation periods of four hours to investigate pain management interactions in postoperative patients. Non participant observation of four hours was used again as part of a study examining 'caring for' behaviours in ward environments (Henderson *et al.* 2007).

Participant observation was used to examine children's pain, with observation periods lasting from two to eight hours (Woodgate & Kristjanson 1996). Brown and McCormack (2006) however, did around the clock observations in two-hour intervals to investigate pain management strategies

used for postoperative patients. A study to investigate the barriers to effective pain management undertook observation on five complete shifts, covering both day, evening and night shifts, however there is no mention in the published report regarding breaks (Dihle *et al.* 2006) and to maintain concentration for an entire shift seems difficult. Two-hour periods of observation at six fixed times were used to assess pain management strategies in Australia (Manias 2003b, Manias *et al.* 2004b, 2005).

#### 4.8.1.1 Observations in this study

For this study it was considered likely to be through a combination of the participant-as-observer and observer-as-participant roles, a continual assessment of which role best suited any given situation, with informal conversations to clarify questions which arise, would be the most appropriate data collection route. There were 157 hours of observations, from December 2008 to August 2009. This covered every day of the week, and all hours of the day from 0700 to 2200. Observation sessions ranged from 2 to 4 hours, depending on what sort of activity was being observed. For example a drug round may be observed in the morning lasting up to 2.5 hours, while in the afternoon observations might occur with the nurse in charge for around 3 hours. Breaks were had either with the observed staff member, or alone, at the end of the activity. Break times were a good occasion to reflect on the field notes, completing details which were not able to be written down in entirety during the observation.

The observations begun with me working as a full participant in a Health Care Assistant role. A white tunic was worn, suitable for clinical work, though not the uniform of any of the ward staff. Working as participant-only can limit the interaction with the field, however it is a way of becoming known and credible in a professional field (Simmons 2007). After a few shifts this role changed to being assigned at handover to one of the registered nurses to observe the drug round. This became an important opportunity for data collection, as it is a rich source of potential pain management interaction.

After about five months of observations (94 hours), it became obvious little non participant observation was occurring as the research appeared fixed in participant mode. I had been fully accepted by the staff on Newcastle Ward, and was frequently given patient and ward duties to do, which while maintaining an insider place in the ward team, limited observations.

Reflecting on this, and following a discussions with my supervisors and the ward staff, I began wearing smart office clothes instead of the uniform tunic. Wearing smart office clothes ensured a distance from the clinical work could be maintained, and while still able to assist with small tasks, I was no longer expected to play an active part in the ward setting.

Typically I would be assigned or would attach myself to a staff member to observe for a period of time. This might typically involve a task such as a drug round or a medication round, or observing the 'sister in charge' as the ward co-ordinator. On occasion observations would take place in a single position in the ward, (a bay, the nurses' station, the clinical room).

The literature regarding observations has been reviewed and how observations were used in this study has been presented. Observations are part of the data collected in field notes. How field notes are used in ethnography, and in this study, are presented in the next section.

#### **4.8.2 Field notes**

Field notes are an important part of the data collected from an ethnographic project. Details seen, conversations heard, or feelings present, during observation sessions are noted down in contemporaneous notes. Field notes are a written representation of what the observer saw, although it is warned, only those things the observer thought important enough to write down (Emerson *et al.* 2007). It is not simply observations which are noted, notes are made after informal conversations, formal interviews and during document searches. This leads to field notes being a rich and complex (and often tatty) set of descriptions of events, including initial ideas for analysis as they occur, a diary of the researcher's feelings and anxieties, notes of conversations and memos to ensure certain questions are asked.

Field notes are the traditional method observational data is recorded in ethnography (Hammersley & Atkinson 2007 p. 141), though there is very little in the nursing literature regarding field notes (Mulhall 2003). In many cases it seems self evident that there must have been some (Dihle *et al.* 2006), but there is not explicit mention of them. The most obvious tool used by ethnographers is pen and paper, indeed Hammersley and Atkinson (2007

p. 140) say newer technologies have not given us anything to replace it without their own burden of problems.

Field notes should not just be notes of the conversation that are observed, or even the events that occur, but should also include the environment in a detailed manner (Schensul *et al.* 1999); detail will put the observation in the context of the surroundings. There are nine dimensions to a situation which can assist the researcher in making sufficiently detailed observations (see figure 1) (Spradley 1980 p. 78).

<i>Figure 1. Nine dimensions of detailed observations</i>	
Space:	the physical place
Actor:	the people involved
Activity:	a set of related acts people do
Object:	the physical things that are present
Act:	single actions people do
Event:	a set of related activities people carry out
Time:	the sequencing that takes place over time
Goal:	the things people are trying to accomplish
Feelings:	the emotions felt and expressed.
(Spradley 1980)	

Field notes should be as contemporaneous as possible. It may not be possible to write full notes as things are happening, but a quick word or phrase will act as an aide memoire when there is time to write fuller notes.

All advice on field notes emphasizes the need to transform the sketchy detail of the field notes to full descriptions as soon as possible, and in a private place (Hammersley & Atkinson 2007 p. 144, Roper & Shapira 2000 p. 84, Schensul *et al.* 1999). Gibbs (2007 p. 29) asserts field notes are for the

researchers eyes only so they can be candid and unguarded; they are a record for the researcher alone. Others see transparency as a practice which establishes reciprocity, with participants reading field notes and interview transcripts (Manias & Street 2001).

#### 4.8.2.1 Field notes in this study

In this study field notes were written in little notebooks. Observations were written on one side of the page, and thoughts and feelings on the other, with time noted in a column in the middle. As the study progressed the complexity of the detail noted improved, both in observations and impressions, with more of the nine dimensions recorded. As immediate as possible post observation the field notes were reviewed, and with any audio recordings taken, transcribed. As the daily data was transcribed reflexivity was used to ensure all the voices had been heard, and while acknowledging my voice was crucial, ensuring it complimented rather than overshadowed the observation. A reflexive diary was also kept, growing organically out of the study notebooks kept during the planning stages of the study and continuing to date. During the data collection period events of the day were frequently reflected on during the drive home using the recorder and these were transcribed and became part of both the daily transcripts and the reflexive diary.

Observation had been intended to be a major part of data collection, though as Barton (2008) described the dialogue at both informal questioning and

formal interviews was also an important data source. Interviews as a data collection strategy are discussed next.

### **4.8.3 Interviews**

Interviews have been defined as a technique of directing a conversation in order to collect data from it (Angrosino 2007 p. 42). Interviews can be a rich source of data within the framework of an ethnographic study. They can put what the ethnographer has seen and experienced into context (Fetterman 2010 p. 40). Interviews within this ethnography fell into two categories: informal clarifying conversations in response to an observation, and individual semi-structured interviews.

Informal interviews can be useful for clarifying queries that have arisen from the observation data. They are not pre-arranged but occur in the here and now of the participant observation research setting. They may be used to help illuminate the reason a participant acted in a specific way, or elucidate what thoughts the participant had that led to a particular decision. This allows for immediate feedback about the meaning behind activities which have been observed (Roper & Shapira 2000 p. 74). While these questions may seem casual they are often a way of ensuring every participants voice is heard, as well as a way of continuing rapport (Fetterman 2010 p. 41).

In order to maintain the rapport it is important the questions asked are seen as appropriate conversation. This will change of course depending on the nature of the field. The sentence structure of the question will determine the response; it can reduce the choice of responses, limit the length of the

answers, or lead the responder towards a particular response (Dickson & Hargie 2006). In the healthcare situation of this study, these questions were normally phrased beginning, '*I noticed you did ..., tell me more about how that felt to you?*', or '*I am very interested in how you are feeling about ...*', '*Tell me more about what was going on then?*' It is important that the questions are asked in a non threatening, non judgemental way in order not to damage the rapport built up between researcher and participant.

Qualitative interviews seek access to participants' knowledge and experience (Kelly 2010 p. 309). They serve to compare and validate the data from the observations. Some have suggested that using triangulation of methods will support data collected using another method, for example observation (Silverman 2011 p. 370). There has always been the acknowledgment in the ethnographic literature that there may be a discrepancy between what people say they do in an interview, and what they are seen to do under observation. It is clear from nursing literature that what nurses do and say about pain management (Dihle *et al.* 2006) can be conflicting and may be opposed. Because the interview is a simulated setting governed by conversation rules where the subjects main aim may be not full disclosure, but to appear credible and competent, the use formal interviews in ethnography may show that people act differently from what they say they do without eliciting any information about why this activity/thought gap exists (Dingwall 1997). Conversely Hammersley and Atkinson (2007 p. 109) assert while the participant perspective gained from interview data does not provide direct access to the cognitive or attitudinal

basis for a behaviour, it may be capable of revealing more about the behaviour.

A semi-structured interview can begin with a list of focused questions to be asked, these encourage the participant to start a conversation about the research topic. They are the skeleton of the interview (Rubin & Rubin 2005 p. 134), with another list of prompts and follow-up questions to further explore what the participant has said (Kelly 2010 p. 318). Main questions can be prepared beforehand, so they flow naturally from one to the other, however conversations can take unexpected turns and the researcher is required to be flexible. Follow-up prompts should occur naturally throughout the interview to clarify participants' experiences and meanings.

Inconsistencies can be explored, however Rubin & Rubin (2005 p. 138) suggests if used too often the interviewer may sound like an inquisitor.

Again probing questions, to elicit further information, need to be used judiciously lest the interviewer appear to interrogate the participant in their enthusiasm (Price 2002).

#### 4.8.3.1 Interviews in this study

During this ethnography thirty-five interviews were conducted. As well as the Newcastle Ward staff (RN n=23, HCA n=5), a number of other hospital staff were interviewed, pain management clinical nurse specialist (n=2), outreach clinical nurse specialist (n=1), ward pharmacist (n=1), senior management (n=2), and members of other wards (n=3). These other interviews were planned as part of the study to give a broader picture of the culture of pain

on the ward, however largely these staff were not observed on Newcastle Ward, so the influence they had on the environment, or how they were seen to interact with the culture of Newcastle Ward, was missing. So aside from the pain management nurses, and the senior management team, data from these interviews was not used for the analysis.

There was an interview schedule prepared as part of the ethics committee submission (appendix 5). All formal interviews followed this framework, although other questions were asked as responses to remarks made by the participants. All interviews except one was audio-recorded. One participant refused permission to audio-record, so notes were taken throughout the interview and immediately following the notes were reviewed and read into the audio recorder. All interviews were done away from the ward, at a time convenient to the participant and the ward routine. For the staff of Newcastle Ward many of these were in the 'sister's office'. All were private and largely uninterrupted, lasting from twenty minutes to ninety minutes. The interview recordings were transcribed.

Another source of ethnographic data is analysis of the documents used and produced in the setting. The following section will discuss this data source and how the collection of documents proceeded on Newcastle Ward.

#### **4.8.4 Document analysis**

The analysis of relevant documentation can be a valuable source of information to an ethnographic researcher. Fetterman (2010 p. 63) describes documents as both time saving and valuable data sources. In a

healthcare environment documents for analysis could include patients' medical notes, nursing notes, observation charts, ward handover notes, but could also include guidelines, procedures and policies. It can be used to triangulate data collected by observation or interview (Denzin & Lincoln 2005 p. 6).

#### 4.8.4.1 Document analysis in this study

The intention was that all clinical documents pertaining to patients would be collected and form part of the analysis. However as the fieldwork progressed it was clear the nature of the data collection changed.

Information on patient observations (pulse, blood pressure, pain score) and prescription charts, if relevant, was included in the field notes. Nurses on Newcastle Ward did not write in the medical notes.

Nursing notes and care plans were not examined. Early reflective field notes discuss not wanting to be seen as 'checking up' on the nurses. Observation routinely took place during a portion of a nursing shift; the nurses who had written the nursing notes or care plans would almost always have been present on the ward, and there was some discomfort noted in the field notes about examining these reports while they were still there. As the frequency of observation sessions was variable because of other commitments, it was not often possible to look at nursing entries the next day. Consequently this type of data was not collected.

The guidelines, procedures and policies pertaining to pain management which were available to the nurses on Newcastle Ward formed part of the

analysis of documents. They were also used to explore, at informal or formal interviews, some nursing practices which had been observed.

#### **4.8.5 Fieldwork summary**

This combination of methods, observation, interview, and document analysis, with the support of field notes and a reflexive diary, forms the basis of data collection in this ethnographic research. This forms a triangulation of data collection methods with each being used to illuminate claims made from data collected by other methods (Hammersley & Atkinson 2007 p. 183).

Following the collection of any data the analysis should begin. The next section describes ethnographic data analysis, and details the specific processes used in this study.

#### **4.9 Ethnographic data analysis**

Through ethnographic analysis a researcher constructs an image of the culture as it is revealed through the data collected. Ethnographic data analysis should be “*an iterative process in which ideas are used to make sense of the data and the data is used to change our ideas*” (Hammersley & Atkinson 2007 p. 159). Data analysis in ethnographic research is not a discrete stage; rather it begins with the data collection. Some contend it begins before entering the field with the formulation of research questions (Hammersley & Atkinson 2007 p. 158). While there is a phase in which data analysis may be the predominant research activity, even as the ethnographic

report is being written this evaluation of data continues (Fetterman 2010 p. 93).

Analysis of ethnographic data is said to have two distinct processes. The *office* process where the enormous amount of data produced by ethnography is sorted, filed, indexed, coded, and the *interpretation* phase, where data is begun to be understood, where imaginative and speculative ideas of how participants explain and frame their world are revealed (Gibbs 2007 p. 2). Others state ethnographic analysis is the search for patterns in the data. Spradley (1980 p. 85) suggests analysis involves searching through field notes to discover cultural patterns. It is difficult to find a recipe for qualitative data analysis, though many authors agree it can be time consuming, and somewhat daunting for a novice (Gibbs 2007 p. 39, Silverman 2010 p. 61). Ethnographic researchers also agree the most useful tool is thinking; thinking about the data, the ideas generated, the patterns seen. Hammersley and Atkinson (2007) assert there is no recipe for ethnographic data analysis, and no course which will assure success. They add "*data are materials to think with*" (Hammersley & Atkinson 2007 p. 158).

Nonetheless the process of analysis begins with reading and coding the data (Elo & Kyngas 2008). Codes are like placeholders; here this is happening, here this was said. They begin by being descriptive labels which arrange the data into smaller more manageable pieces (Roper & Shapira 2000 p. 94).

As more of the data is coded, the codes can be sorted into patterns, and then combined into themes. This coding and theming process is inductive and iterative (Thorne 2000); as the researcher thinks more about the data,

the codes, the patterns and the overarching themes will change, and the process will be repeated. Throughout the analysis the researcher will have ideas and insights, which are recorded as memos. As the process continues, the codes and patterns move from being descriptive to becoming categories and progress towards analytical themes (Elo & Kyngas 2008).

The use of computer-assisted qualitative data analysis systems (CAQDAS) has become common within qualitative research (Fielding 2007 p. 453).

There are a number of systems which provide computerised support for data analysis, and while each offer slightly different functionality, they are there to assist the researcher organise the data. While there are obvious advantages to the assistance of a computer, ethnographers also warn of the dangers of over reliance on computer programs. They list separation from data, and the over dependency on codes and coding, rather than interpretation and thinking (Hammersley & Atkinson 2007 p. 156). It is emphasised the role for CAQDAS is to organise and assist; no computer program can replace thinking about and reflecting on data (Gibbs 2007 p. 105).

This overview of data analysis in ethnography briefly describes some of steps in data analysis. The next section will explain the process which allowed the researcher to generate the themes discussed in the following chapter.

#### **4.9.1 Data analysis in this study**

The CAQDAS used for this project was QSR International NVivo (version 6, 7, & 8). One of the issues was the learning curve required to learn, not only

a new way of thinking and observing (Spradley 1980 p. 55) but also another computer program.

The study produced twenty-five daily accounts of observations. These were transcribed reports of field notes taken, informal conversations recorded and reflections on observations, separated into days for convenience. Thirty-five interview transcripts were also produced. While I produced all of the daily account transcripts, most of the interviews were professionally transcribed (n=26). This may have meant less immersion in the data (Gibbs 2007 p. 15), however in the context of limited time it was decided to pay to have secretarial input for this aspect. All transcriptions were checked when they were returned, and listened to carefully, which meant I could stay close to the data (Hammersley & Atkinson 2007 p. 162). Reflections on the interview narrative were included in the transcripts as they were read.

The daily account transcripts, the interview transcripts and the documents collected, were read individually and then transferred to NVivo. While the information collected was reflected on from the beginning of fieldwork, the coding of the data did not begin until the fieldwork had progressed to interviews rather than observations. This could be seen as a limitation of the study, as ethnographers are entreated to allow patterns and themes from data coding to direct the observations (Roper & Shapira 2000 p. 92). In mitigation of this potential limitation the data was transcribed, if not immediately, as least within the week. This allowed me to engage with the data (Hammersley & Atkinson 2007 p. 162), and discuss ideas informally and through supervision, as they appeared within the data. These emerging

ideas were used to direct further queries in the observational periods as suggested by Roper (2000 p. 92)

Initially the coding was very descriptive, as I struggled with learning the skill. The number of codes developed into hundreds, which no amount of thinking and conceptualising seemed to sort into categories, or be able to applied thematically (Coffey & Atkinson 1996). This impasse was reflected on and following a discussion with my supervisors, and with great reluctance to waste valuable effort and lose work (no matter how fruitless it had become), that version of the ethnography database was archived and coding began again. By this stage all fieldwork was completed, meaning the final part of data analysis had become a separate stage of the project and could not impact on the questions asked at the data collection.

The second attempt at coding the data was more successful. Descriptive codes became categories and fed into themes (Hammersley & Atkinson 2007 p. 161). The themes developed from the data seemed to fit into broadly '*ward*', '*nurse*' and '*patient*'. In an attempt to make the themes more original and erudite, a second version of the database was archived and the coding process began again.

The third coding was more of a progression from the second rather than a complete rework. Again codes began as descriptive accounts '*Patients not seen to be in any pain*', '*watching facial expressions*', developed into patterns, '*non verbal*', and categories '*influencing factors*' and finally, the overarching themes of ward, nurse and patient again emerged.

The three principle themes which emerged from the data were:

- maintenance of ward culture
- nurses' responses to pain management decision-making opportunities
- nurses' expectations of patient behaviours and knowledge.

#### **4.10 Summary**

This chapter begun with a discussion about philosophy. How a researcher's concept of how the world is perceived, and how knowledge is gained, underpins the research question and the methodology used to answer the research question. The methodology chosen, ethnography, has been explored, initially through a historical perspective and then looking at the contribution ethnography has made to nursing. Ethical issues are a critical part of any research project, and they were explored followed by a description of the ethics committee submission and approval process. The research methods used in ethnography were discussed, with more detailed description of how the methods were used in this study. Finally data analysis in ethnography was discussed and an explication of the broad themes emerging from the data given.

The following chapter will discuss these themes in more depth, and will demonstrate findings to show what factors influence nurses when they make pain management decisions in the clinical setting on Newcastle Ward.

## **Chapter 5 Findings**

*“The tightly woven pieces of cloth which appeared to make up a single fabric have been torn apart, revealing that the seams have always been there, perhaps more real than anyone was willing to admit.”*  
(Spradley 1970 p. 3)

### **5.1 Introduction**

This chapter will present the findings of the study. This study sought through observation, interview and document review to reveal what factors influenced nurses when they made pain management decisions, and how the culture of the clinical environment impacted on pain management practice.

Over eighteen hours of formal interviews, informal conversations, and one hundred and fifty seven hours of participant and non participant observations have been transcribed and examined for themes as discussed in the previous chapter. The themes are presented in brief in the initial section, with the chapter structure following the pattern set by these themes, dividing into three main parts.

The physical layout of Newcastle Ward is described, and some of the routine processes are discussed. The formal arrangements, which should guide pain management within Newcastle Ward, are described. There is a presentation of the findings exploring how nurses viewed working on Newcastle Ward and how they perceived pain management, how important it is to them, and what role it plays in their daily working lives. A presentation of findings regarding pain management communication within the ward reveals a new finding of the silence of routine pain management

communication. This phrase is used throughout the thesis to denote the situation of nurses not talking about patients' pain management as a matter of routine. Pain management was not part of the information nurses communicated about most patients; they would only mention pain management for those few patients who were seen as difficult pain management patients. Exploration of this theme includes findings from formal shift handovers, with two handovers beginning described in more detail, followed by descriptions of the pain management communications which were observed. How pain management tasks and roles are allocated to staff is presented further reveals that pain was not a priority.

The second part of this chapter presents the findings regarding nurses responses to pain management decision-making opportunities. Pain assessment is arguably the first decision nurses would make within the process of pain management. How nurses on Newcastle Ward inform themselves about a patient's pain, and how this information is used to influence pain management decisions is demonstrated. A lack of pain management knowledge has often been cited as a barrier to effective pain management; findings demonstrating Newcastle Ward nurses' pain management knowledge are presented. The medication round is a significant task in any ward, so how Newcastle Ward nurses used medication rounds as a pain management tool is explored, followed by an examination of the findings around the use of more sophisticated pain management devices. Inattention to pain cues is explored, and in more depth a new finding which reveals nurses on Newcastle Ward are making a single pain

management action following a pain management decision. This phrase is used throughout the thesis to describe how nurses were seen to approach pain management tasks. They were observed to undertake one activity related to pain, and without a second pain action to gain assurance the first was effective, or a further activity if it was required, they would appear to assume the first activity was sufficient; a single pain management action.

The concluding part of the findings chapter explores the role Newcastle Ward staff expect the patient to play in their own pain management.

Findings are presented which demonstrate how nurses and health care assistants think patients should look and behave if they are in pain, what they should say if they wish to have analgesia, and how much they should know about the cause of the pain, and the consequence of both the pain and proposed pain management activity. This section closes with presentation of findings which relate to those patients who do not conform to the ward staff's expectations.

It should be noted that although the themes are presented separately for clarity, there is interlinking between them.

## **5.2 Themes**

On analysis of the findings three overarching themes emerged from the data: maintenance of ward culture, nurses' responses to pain management decision-making opportunities, and nurses' expectations of patient behaviours and knowledge.

Within each main theme there were subthemes as detailed below.

Maintenance of pain management ward culture:

- Newcastle Ward: the environment of pain management
- Pain management communication
- Pain management roles and tasks

Nurses' responses to pain management decision-making opportunities:

- The culture of pain assessment
- Nurses' knowledge of pain management
- Inattention to pain cues
- A single action following pain management decisions

Nurses' expectation of patient behaviours and knowledge:

- How the patient should look
- What the patient should say
- What the patient should know
- Patients who do not conform to expectations

Excerpts from field notes are used throughout this presentation of the themes, as well as quotes from participants from both the interviews, informal conversations, and reference to nursing documents, to contribute to the overall picture of pain management nursing on Newcastle Ward.

For the presentation of the data, all participants have been given pseudonyms. The names are all European and female, and are taken from

family, friends, and colleagues, allocated arbitrarily to the staff to preserve their anonymity. The main groups of staff in Newcastle Ward are registered nurses and health care assistants. For consistency and clarity, if the story is referring to both groups they are described as ward staff; otherwise 'nurse' means registered nurses. Where an excerpt from field notes or a transcript is used, the pseudonym of the participant is given, as well as their role (SR: sister, SN: staff nurse, HCA: health care assistant), their participant number, and the source and line of the transcript.

### **5.3 Maintenance of pain management ward culture**

This section will discuss the theme, maintenance of pain management ward culture, firstly with a description of the physical ward, and some of the pain management processes, and then further exploration of the ward using the sub themes as a guide. This section will establish some of the context within which the pain management takes place on Newcastle Ward.

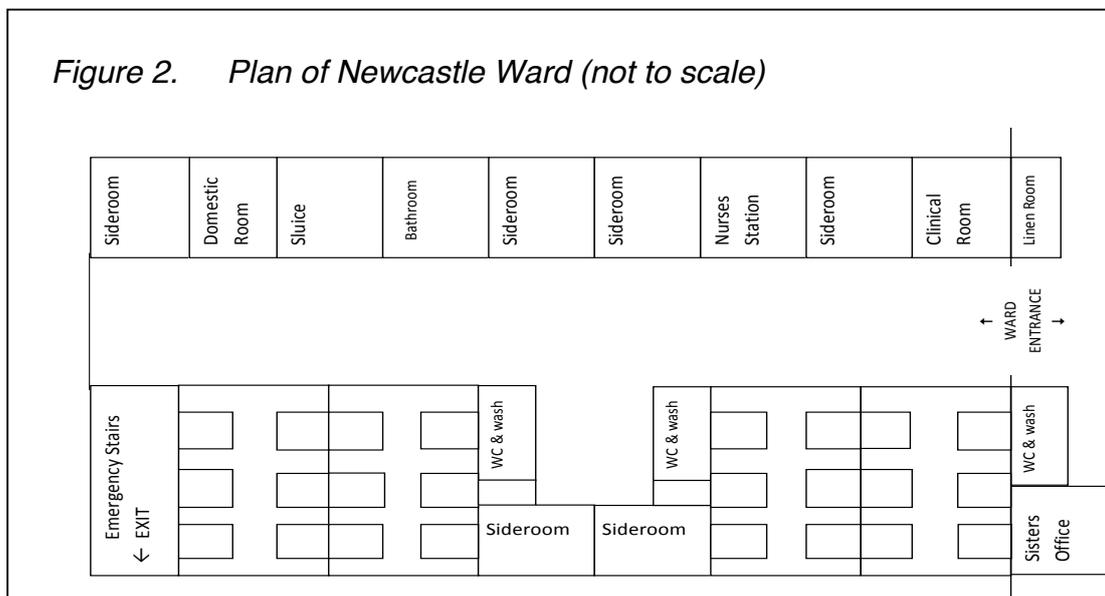
#### **5.3.1 Newcastle Ward: the physical environment of pain management**

Newcastle Ward is a single unit within a District General Hospital. It is a surgical ward, with some subspecialties which will not be revealed least the ward becomes recognisable to the reader.

On Newcastle Ward the shift framework worked around two twelve and a half hour daily shifts, though it also accommodated a number of individual patterns for staff with small children or other obligations. The majority of staff

started work at 0730 for a twelve and a half hour shift, or 2000 for another twelve and a half hours.

In a fairly standard Western hospital configuration, the ward has a combination of six bedded bays and single side rooms. Figure 2 shows a layout map of the ward. The physical layout of the ward influenced the staff allocation. Nurses were allocated per shift to be in one of two teams: to work in the two female bays and three side rooms (those closest to the female bays), or to work in the two male bays and the other three side rooms.



This was known as being allocated to ‘male’ or ‘female’ end. There was always a ‘nurse in charge’ and this would be the most senior member of the nursing staff, unless that sister had an ‘office’ day, in which case it would be the next most senior nursing staff member. The use of some of these rooms or areas requires further description.

#### 5.3.1.1 The sisters' office

Newcastle Ward's sisters' office had a desk, with shelves above, two filing cabinets and a set of small A4 draw files each named in alphabetical order for each staff member. There was a small fridge in the corner opposite the desk with a kettle, and coffee, tea, sugar, and some cups on it. There were about ten chairs along the walls of different sorts, some more comfortable than others. There were handbags and rucksacks under the chairs and many coats hanging behind the door and on the chairs. Staff used this room to store their handbags and coats while they were at work.

The room also served as an office. Throughout the study, this room was used for new staff interviews, appraisals, disciplinary meetings, doctors meetings, family meetings, and in fact for all occasions that required some privacy by any staff attached to the ward, including the Matron, the General Manager and medical consultants. Many of the study interviews were conducted here. The 'engaged' sign on the door was not working and the window in the door was always obscured by coats, meaning that any meeting was frequently interrupted unless an additional sign was put up, for example, 'Interview in progress, do not disturb'. As the office was also used as the only staff lunch and rest room for Newcastle Ward, this somewhat impromptu office arrangement occasionally left staff with nowhere to go for their breaks.

#### 5.3.1.2 The nurses' station

To call this area of the ward 'the nurses' station' is a common though

somewhat inaccurate label. All health care professionals who came to the ward used this space; it was rare to see patients in this space. During the day there would mostly be the ward clerk, two or three nurses and two or three doctors. If there was a consultant ward round or two occurring, there could be many more people. As the medical notes were kept here any healthcare professional who is looking at or entering patient information remained in the area. The nurse in charge for the shift was usually here, coordinating the ward. Training on any new computer system for the nursing staff also occurred in this space, which led to further congestion.

Both telephones were frequently ringing for a long time; often they will ring out without anyone answering them. Nurses rightly prioritised patient care over answering the phone, while doctors and the other healthcare professionals in the ward would usually only answer the phone if they were awaiting a return call. The call bell system ended at the nurses' station also with the buzzer sounding there, as well as a light signalling where the call had originated. The call bells again were frequently sounding, though they did not time out, so continued to ring.

#### 5.3.1.3 The clinical room

The clinical room or treatment room is where all clinical equipment was kept. Immediately inside the room on the left were the drug cupboards with the controlled drug cupboard inside it. There were two sets of drug keys for these cupboards; the nurses assigned to do medication rounds kept these. There was a bench where all medication preparation is completed; there

might be any number of paper mulch kidney dishes with intravenous drugs ready for administration, though IV fluids were not kept in this room but in a cupboard at the other end of the corridor. There are a number of small trolleys, used for dressings or medication rounds, and on the far wall cupboards and trolleys with shelves above for all dressings, cannulas and other equipment of nursing care.

The sisters office, nurses' station and clinical room are places where staff would meet. The clinical room was where nursing staff would go for respite from patients or their colleagues, it was seen as a nurses' place.

#### 5.3.1.4 The pain management team

While discussing the ward it is interesting to understand how nurses are supported in their pain management. The following section outlines the policies and guidelines available to them. The support mechanisms available to the nursing staff in Newcastle Ward are examined; how important were they, and how relevant to the nursing staff and their practice. The impact this support had on the ward, the nursing staff and the patients is considered.

One of the questions asked of the nurses at formal interview was, 'Can you tell me what you think the Trust's view is regarding pain management?' This question was trying to get a sense of how nurses felt they were supported by the Trust in their pain management. The pain nurses, Mieke and Mandy, gave a reply with a corporate feel to it.

*The official view is no needless pain. (Mandy, Pain Nurse, interview L21)*

*That is what we are supposed to be aiming for - no needless pain.  
(Mieke CNS Pain Management, interview L22)*

No other nurse was able to state this corporate objective; nurses spoke about Trust support in terms of the existence of a pain management team.

*Yeah I would think so, we have a Pain Nurse Specialist here and she's always around the wards. (SN Michaela P12, interview L11)*

There were two pain nurses employed by the Trust, with the support of the anesthetic department for after hours care and additional assistance during the day. Mieke was a Senior Clinical Nurse Specialist, and worked full time, with Mandy as Pain Nurse, employed part time (the rest of her work was as an anesthetic nurse within the Trust).

They were knowledgeable and committed to ensuring that patients in hospital are pain free.

*We get our fingers in all the pies, we teach them all the time and if we pick up something we don't like, we are not frightened to address it with anybody, whoever it is. I think that is the thing, not being frightened to challenge bad practice, ... so every opportunity to educate we do.  
(Mieke CNS Pain Management, interview L95)*

The ward staff were very used to deferring to the pain team, and were grateful for their support. They preferred to call the pain nurses during the

day however, rather than the anaesthetist who was on call for the pain management team after hours.

#### 5.3.1.5 Policies

The Pain Management Team had developed a Pain Folder (see appendix 6) - an A4 lever arch file with numerous documents. This folder was new; it had been introduced within the last month (May 2009). This was a very comprehensive resource for Newcastle Ward. It contained in hard copy the most up to date policies and guidelines regarding pain management:

- Pain assessment in adults guideline
- Oral analgesia in adults guideline
- Entonox policy
- Patient Controlled Analgesia policy
- Epidural policy
- Patient Group Directions for adult analgesia
- Guidelines for administration of IV opioids
- Policy for administration of IV opioids
- Facio illiac compartment block policy

Throughout the observations or interviews there was no occasion when a nurse mentioned that she had referred to any of the policies. Field notes report:

*I arrived about 1000 and sat at the nursing station looking at Pain Matters folder dated 1 May 2009. I asked a few nurses if they knew it*

*was there. Yes they all said, but none of them had read it when I questioned them further. (FN16 L15)*

This is in common with findings that nurses are not seeking assistance from policies and guidelines to support their decision-making. Although it was less clear if this was because they use their own experience, mental flowcharts or support from colleagues as found by Rycroft-Malone *et al.* (2009).

#### 5.3.1.6 Pain control leads

The Pain Management Team had recently developed a new system for pain management support within the wards. Pain Control Leads were established within many wards; these nurses were recruited with the help of the ward senior sisters. In order to become a Pain Control Lead there were twenty tasks which they had to perform, including spending a day with the pain management team, and undertaking a small pain management project within their ward. Pain Control Leads were presented with a Pain Control badge in a Trust ceremony and were expected to '*... take overall responsibility*'. (Mieke, CNS Pain Management, interview L138)

*I've tried to recruit a Pain Control Lead on Newcastle Ward and I've been given ineffectual people and I've said I'm not happy with these nurses. The best person is a health care assistant who is absolutely amazing and she will always bleep me if there is anybody in pain. Now if an HCA can do it, I'm sure that a qualified staff can do it. (Mieke CNS Pain Management, interview L84)*

Mieke did not feel the nurses recruited from Newcastle Ward for this role were as committed as they should be. When asked at interview who the Pain Control Leads for Newcastle Ward were, SR Danielle was unable to name the nurses. This may be an indication of the lack of value assigned by the clinical leaders to Pain Control Leads and pain management.

#### 5.3.1.7 Dissemination of research

The Pain Matters folder was designed to be the main immediate source of dissemination of new research. Mieke and Mandy were planning to put any new information in the folder, relying on the Pain Control Leads to disseminate this research to the ward team and use this information to affect change in practice.

There was a mandatory requirement within the Trust for all staff to attend an annual update. Pain management was part of this mandatory requirement and every Monday morning, either Mieke or Mandy would give a thirty minute presentation to a group of clinical staff.

*Mieke usually does it. She normally talks for about 30 minutes, she starts off with giving us a quiz as well to establish what people know already and what they should have known from the year before etc., then she'll update us with new information. (SR Danielle P1, interview L51)*

All the nurses interviewed were asked a question about training, 'Could you tell me about the education you've had regarding pain

management?' It was rare however for the nurses to mention the mandatory training. SR Danielle was concerned about this aspect.

*I know that every single member of staff on this ward has stat training ... I wonder if they don't count it, if they don't think it's important, I have learnt something new every year. Maybe it is because it is a Monday, they're not listening, whether they don't think that mandatory training is important so they don't engage with it. Because I can't think what other kind of training they could have had apart from obviously on the ward, on the job training as it were.*

(SR Danielle P1, interview L152)

It could be said that this compulsory training, though a common model throughout the UK is not having the desired outcome around pain management decision-making.

The physical environment and a number of the pain management processes of Newcastle Ward have been outlined. The following section begins to demonstrate the culture of the ward, and how pain management is viewed within the ward, to provide some understanding of the context to the pain management culture which is revealed later in the thesis.

#### 5.3.1.8 Nurses' view of pain management in this environment

Nurses' beliefs about pain management are explored through responses at interview and in informal discussions following observations. Nursing

participants were asked at interview what pain management meant to them, and how important they thought pain management was in their nursing role. Replies indicated nursing staff felt they were involved and engaged in pain management.

*Pain management is making sure that the patients are actually pain free. (SN Lesley P10, interview L22)*

*Relieving the patients of pain, I don't think anybody should be in pain, even if it's 2, 3, 4, it doesn't matter, I don't think anybody should suffer in pain. (HCA Cheryl P26, interview L9)*

These quotes suggest that some nursing staff at all levels saw pain management as patients being pain free. Other staff thought it was not likely that they would be able to achieve this:

*Trying to keep a patient as pain free as possible, although it's not always achieved. We do try, but that's what it means to me. Trying to keep people pain free. (SN Michaela P12, interview L5)*

*Keeping patients pain free as much as possible, controlling their pain to the degree they can cope with. (SR Rene P7, FN21 L3)*

While others seemed to think it was out of their control:

*I do it every single day and sometimes it's a bit hit and miss as to what's prescribed and what you give and its trial and error sometimes. (SN Lorraine P8, interview L15)*

SN Therese said, *'I try to do the best of my ability, sometimes it's not always enough'*. When asked to comment further on why Therese felt this way she said:

*I think it's just the time factor. You try to prioritise, but there is always something getting in the way... it depends on how you manage your time.* (SN Therese P19, interview L6)

When asked how important it was to their nursing responsibilities and how much time they spent actually doing it, many felt it was a very big part of their role. Most said that pain management was very important:

*Very, I think it is one of the most important things that should apply to any patient.* (SR Rene P7, interview L26)

*It is very important; it is a major problem for most of the patients.* (SN Suzanne P29, interview L25)

Some nurses felt they were able to pinpoint exactly where pain management lay within their priorities and precisely how much time they would spend on it.

*I think that about 90%, yeah because you know if the patient is suffering too much I can offer to painkillers and everything, but it's not 100 because I can't tell if I need to start the PCA.* (SN Claire P11, interview L48)

*I'd say about 50% at most. Yes 50% roughly, yes like the drugs for the patients.* (SN Michaela P12, interview L30)

Some used their personal experience to explain their priorities.

*I think it's very important and I think it's one of the priorities as well, it's a priority to me because it's the worst thing, you have to experience for yourself to know what it's like to be in pain and I know what it's like. I've been an inpatient you see. I know what it's like, you're in pain you need something now, not as I said 10-15 minutes. (SR Jana P31, interview L66)*

Nurses indicated that they thought pain management was very important, with some feeling they could articulate exactly how much of their time they spent 'doing pain management'. While some of the nurses seemed unsure if they could achieve their own ideals, most nurses indicated they were committed to ensuring patients were pain free. All of the examples above are taken from the interviews, where nurses were asked directly the meaning of pain management for them. During the observations nurses did not speak about pain management unless asked specifically, so there are no quotes recorded in the field notes from participants to give an indication of how important they think pain management is. Their observed actions regarding pain management are described later.

The next section demonstrates what it was like for nurses to work on Newcastle Ward. Findings show the nurses anticipated the ward would be busy. The importance of this busyness to pain management decision-making has been demonstrated (Manias *et al.* 2002), so it seemed important to present these findings.

### 5.3.1.9 Anticipation of busyness

Newcastle Ward is an acute surgical ward and most nurses described the ward as a busy, challenging area, with a varied and diverse group of patients.

*It is a ward that is incredibly challenging, it's a ward that is very demanding, it's a ward which caters for patients with chronic illness as well as acute. (SR Alexandra P32, interview L2)*

Many nurses described the ward in very similar terms.

*It's challenging, very challenging, very demanding, very demanding ward, very stressful ward because of the turnover of patients coming to the ward. It's not just a surgical ward ... you've got a mixture of everything coming to the ward. (SR Jana P31, interview L2)*

*It was really, really, really manic and clinically very heavy. (SN Andrea, P24, interview L78)*

Staff mentioned feeling stressed and time pressured when describing the ward.

*Tiring, stressful, depressing sometimes. It's all right. Often we can cope with the work but sometimes I am not, I'm sure you have noticed that we are very, very busy compared to other wards, you can't sit down. (SN Kay P10, interview L2)*

*Busy, very, very busy, stressful. (HCA Denise P33, interview L3)*

Other staff felt that the ward was busy because it was short staffed.

*More staff! More staff in my role, you know, I'm sure some wards it probably easier than on this particular ward, it's so busy, I am sure other wards they might manage it more effectively, but for me I think more staff, more staff. (SN Michaela P12, interview L80)*

The patient mix on Newcastle Ward is diverse and was described in these terms.

*Generally, very busy, very, we have very diverse amount of patients with all sorts because apart from our speciality they always have something else wrong with them and its busy all the time. (SN Alana P14, interview L2)*

*This is a type of ward where the patients will have had big surgery or no surgery but come in with [a condition], become very unwell, go to HDU, come from HDU, come back to the ward, go back, so this is not a recovering ward, this is a ward that has very sick people who can clinically deteriorate very quickly and therefore we are reactive rather than managing. (SR Alexandra P32, interview L182)*

Many nurses felt this affected the quality of care they were able to give.

*It's very busy and you are just rushed really, you don't get a little time for patient care, I'm being honest. I feel, I do go home frustrated knowing that I probably could have done a bit more for my patients. (SN Therese P19, interview L3)*

*Sometimes it's a busy ward and it's something so very demanding so sometimes you don't get to really look after the patient as in like you're care for the patient is not really 100% because there's no like sometimes there's no time to do it. (SN Lesley P10, interview L4)*

Some nurse felt their education suffered because of the busyness.

*But it's finding the time to get down there [education centre]. I've never been able to get down there. It's about an hour once a week, but you just can't get off the ward, that's the problem here. (SN Michaela P12, interview L58)*

It seemed other staff within the Trust acknowledged the busyness of Newcastle Ward. This excerpt came from a conversation with the senior sister.

*I was just speaking to the bank office and said the two agency nurses we had last night got moved and they said, 'why are they moving them off your ward, your ward is the busiest in the hospital. Why are they doing that?' (SR Alexandra P32, FN10 L133)*

Despite the perceived busyness, many nurses said they enjoyed working on the ward; they felt part of a supportive team.

*Hard, heavy but good fun. I love the staff and that's why even when you're very down in the dumps and moaning all the time, but you don't move on because I just like, love, I love surgery I really do, so I've learnt so much. (HCA Isabelle P28, interview L6)*

*The first thing is it's a very busy ward, very busy ward, but it's a lovely ward to work with, you learn a lot, good staff, lovely staff.* (HCA Ceri P36, interview L9)

The ward staff saw the ward predominantly as a busy environment, with a changing group of often complex patients with diverse requirements. There was observed to be a easily accessible description of the ward culture that staff used when they were asked to describe the ward: 'busy, short staffed with a complex group of patients'. Even staff who had been working on the ward for a short time (2 weeks) described the ward as, '*so busy here, because I think we are still understaffed*'. (SN Chrissi P34, interview L7). While this busy setting afforded them opportunity for experiential learning, many found it stressful as they were unable to care for patients as they wished, or too busy to allow them the possibility of learning off the ward in a more formal environment. While a few ward staff spoke at interview or during observation as wishing to leave the ward, most found the work rewarding, and described good collegial relationships.

Within the next section the findings relating to pain management communication on Newcastle Ward are explored, with a new finding of the silence of routine pain management communication presented. Shift handover, including the handover sheet, was seen as the principle tool for communication on the ward. The shift handovers are described, with two specific handovers presented in more detail, followed by findings which demonstrate the other opportunities for pain management communications within Newcastle Ward.

### **5.3.2 Pain management communication**

In order to make effective pain management decisions, ward staff need to have the correct information about their patients. Nursing handover has been shown to be necessary for the continuity and consistency of patient care within a ward (Sexton *et al.* 2004). Findings demonstrating how nursing handover is performed on Newcastle Ward, with a particular emphasis on how pain management information regarding patients is transferred, are described.

Newcastle Ward used a variety of nursing handover models during the observation period. For the first few months the allocation to teams was done by the most senior nurse present and then a bedside ward round was done, followed by a 'safety briefing' in the clinical room. The safety briefing was an opportunity for the nurse in charge to address all of the staff on shift, and was used both to give broad information regarding, for example, Trust initiatives, or specific cautions regarding clinical incidents which had occurred.

After a few months the handover was changed from the bedside round, to separate team handovers, held for one team at the far end of the ward by the desk in the corridor outside of a side room, with the second team in the clinical room, again meeting for a safety briefing in the clinical room at the end. The handover model was changed as it became clear the bedside handover had the potential to disclose confidential information about patients. A field note made just before the change said:

*The handover was the same end of the bed. I went on male handover. At one gentleman's bed a nurse said he was 'not for CPR', while another described him as 'all very argumentative'. (FN4 L5)*

At the weekends and for night shifts, handovers were done with all the incoming shift's staff in the sisters' office. Towards the end of the year of observations, comments from patients in the side-room at the end of the corridor, again regarding potential breaches of confidentiality, lead to a further change where all handovers were undertaken in the sisters' office.

Unless the sister on that day was on an 'office' day (when they were not expected to undertake any clinical work), the sister would participate in the handover. If the handovers were separated, there was a third handover following the safety briefing between the nurse in charge and the most senior of the nurses from the other team. Handovers took about thirty minutes regardless of the model used. Either one nurse in charge of the previous shift or occasionally the nurse in charge of the team would do the handover.

In terms of revealing the culture of Newcastle Ward with regard to pain management decision-making, handover periods were a rich source of data from two sources: what was written on the handover sheet and what was said.

Handover sheets are a vital part of a nurse's knowledge about patients, and are routinely taken in and out of pockets all day, as discussions are had about patients with colleagues or relatives. Newcastle Ward's handover sheets were printed on two sheets of A4 paper, divided along the lines of the

allocation, male and female. As part of the field notes twenty-five handover sheets were compiled with contemporaneous notes written as the handover was being done.

There are eleven columns: bed number, patient name and age, consultant and date of admission, diagnosis and past medical history, diet, intravenous infusion, intravenous drugs, catheter, blood sugar levels, social services referral and handover notes. The diagnosis and handover notes columns contained the most information, with many abbreviations being used, some common nursing terms, and some particular to Newcastle Ward.

The number of patients on the ward as stated on the handover sheet was only correct at handover time, due to the frequency with which patients were discharged and new ones admitted. The number of patients in Newcastle Ward at these handovers was 21 – 30, with an average of 27 patients. This information could inform how busy the ward was, though clearly does not indicate patient complexity. Appendix 7 has a more detailed examination and analysis of the handover sheet information. Two handovers, chosen as being typical, are described in more detail to demonstrate how pain management information is communicated.

#### 5.3.2.1 Handover twenty-one (HO21)

The handover was for twenty nine patients. The handover sheet had the word pain documented in six patient diagnosis columns, five within the context of '*abdo pain*' and once '*RTA [road traffic accident] pleurite [sic] chest pain # sternum*'.

During the oral handover there was no mention of pain, analgesia or other pain management for four of these six patients. One of those patients who had a diagnosis that contained '*abdo pain*' had the comment '*...pain score of 3 this morning*' included in the spoken handover, while '*just for analgesia*' was the oral handover for the patient with the fractured sternum.

The handover notes column mentioned pain related topics five times, only one associated to pain was mentioned in the patient's diagnosis column; that of the fractured sternum patient which stated '*admit for obs and analgesia*'. There were two notes of '*PCA*' meaning that a Patient Controlled Analgesia (PCA) pump was in use, one '*BD MST*' (twice daily long acting morphine), and another for a patient with '*?#NOF [fractured neck of femur] and #wrist*' stating '*if in pain for MRI*'.

At oral handover for these patients, comments included '*continue ... [BD MST]*', '*pain score is about 4*' [PCA]. For the other PCA patient it was mentioned that the '*IV cannula is out*' without any further comment. As PCA devices on Newcastle Ward were always run intravenously this statement meant the PCA was not longer being used. I noted '*how is the PCA going then, seemingly no one is worried about that*', as I wondered what the plan was for this patient's pain management if the PCA was not continuing; this was not discussed. For the patient with the unconfirmed fractures it was handed over as it was written '*if in pain she needs an MRI*', but there was no mention of whether the patient was in pain and no one receiving the handover inquired about it.

For eighteen of the twenty-nine patients that morning there was no mention of pain, analgesia or other pain management in the handover; there was little discussion regarding pain management for any of the patients. There seemed an absence of consideration of pain management for patients' with diagnosis which included, '*Wound dehisced*', '*Acute pancreatitis*', '*Tendon reconstruction*'. When it was said of a patient with obstructive jaundice and cancer of the pancreas, '*... pain unsettling, given oramorph, but prefers paracetamol*', I have noted in the field notes, "*why no questions here, how much, how often, why not another drug, what is pain score?*" (HO21). This apparent limited involvement in pain management is discussed further under the theme describing single pain management actions, but the silence of routine pain management communication is becoming evident.

#### 5.3.2.2 Handover twenty-four (HO24)

A few weeks later another morning handover sheet for twenty-five patients had ten mentions of pain in the diagnosis column; seven included '*abdo pain*', one '*ureteric pain*', one '*flank pain*' and one '*upper Q [quadrant] pain*'.

The handover notes column mentioned pain, analgesics or other pain management for six patients; one '*abdo pain*' patient had '*PCA*' noted, though it was not discussed in any way during the oral handover. One patient had '*BD MST / Not for PCA / PRN Entonox*' written in the handover notes column. Following the brief oral statement about this patient, the nurses felt they had something to add about her. The field notes recorded:

*Everyone had something to say. 'The consultant said there was nothing wrong with her', 'she is just drug seeking', 'she is not really in pain', 'consultant says strictly no PCA or entonox', 'drug dependent', 'she hasn't asked for entonox, only PCA', 'seen by pain team', 'need to take entonox away'. (FN24 L7)*

With a further comment:

*Some of the things said were contradictory, for example the entonox. Everyone had an opinion and it seemed to not really matter what was said but to get it said, get it off their chests about this patient who was a 'bad' patient. (FN24 L11)*

Another patient caused further discussion; this gentleman had a diagnosis that included "ureteric pain..."

*SN Andrea handed over, 'He complained of pain all night long but still managed to get downstairs. He wanted to talk to doctors and when they came the first time he wasn't here. He insisted on talking to a doctor so they had to come up again'. SR Danielle asked 'What did he have for pain?' The reply from SN Andrea was 'analgesia'. (FN24 L15)*

The field notes recorded here were:

*There was no follow up question about the type of analgesia, or pain scores, or how was he now. There seemed a general acknowledgment that he was drug seeking. (FN24 L18)*

The gentleman who had a diagnosis on the handover sheet of '*flank pain*', was described by SN Andrea as, '*This man is really in agony*'. (FN24 L22)

The field notes recorded:

*Is this a figure of speech or some way to differentiate between those patients who are pretending to be in pain and those who are genuine?*

(FN24 L22)

*SR Danielle asked 'How is his pain now? When I saw him this morning he was kneeling by his bed in pain'. SN Andrea said, 'Still in agony'.*

(FN24 L26)

The handover at that point moved to the next patient and field notes recorded:

*I found this very disturbing. He was in pain (agony) yet no one was doing anything, they had done all they could do, call the doctor, give oramorph (10mg I checked later), not give diclofenac (as it was prescribed incorrectly, protecting themselves or the patient?). It was important that they had done these things, but there was no sense that they could do any more. (FN24 L30)*

While demonstrating what happened around pain management communication on Newcastle Ward, again these comments also link to the theme regarding single pain management actions.

There was no mention of pain, analgesia or pain management in the oral handover for twenty-seven of the thirty patients. There had been a great

deal of discussion about two patients who had more complex pain management needs with the tone suggesting the nurses thought the patients were not in pain, but nothing was said for example about a young patient who was awaiting surgery for '*? perforated appendix, cholecystitis, peritonitis, small bowel obstruction?*', a condition which may have been very painful.

This could demonstrate a culture of acceptance of pain as normal, though when asked at interview about how important pain management was, nurses said it was very important. These findings could also be linked to the subtheme 'inattention to pain cues' where nurses did not appear to consider pain when given an opportunity, though it seems more of a general inattention to pain management because pain was not a priority.

#### 5.3.2.3 Other pain management communication opportunities

When SR Danielle was asked, as a clinical leader, to explain how she decides what information to put on the nursing handover sheet, she replied:

*Things that are relevant, there's lots of things that are put on here that aren't relevant and I don't know about you but when I look at handover sheets and see loads of stuff on there I don't actually read it, so I try to take out some of the stuff that isn't relevant. (FN13 L249)*

On another occasion SN Janine (P23) who had given the outgoing handover that morning, was questioned how she decided which patients required pain management issues discussed at handover.

*Some of them if their pain tolerance may be different, and they keep asking for their painkillers every 2 hours, every half hour, ... so we need to consider more about giving painkillers. We don't mention those on regular painkillers who are fine with that, for them ... we know not to be over concerned about the pain for them. (FN22 L11)*

*I think people mention it if it's been an issue on their shift, so if someone has had IM morphine every four hours then ... it will be brought up, but if someone is just on regular analgesic, and maybe they haven't had any PRN, or maybe they've had it once in a 12 hour shift it probably won't be ... it does depend on who's handing over again. (SN Tracey P37, interview L64)*

SN Lorraine was asked how she felt about the handover that had occurred that morning; this was a Saturday morning with a handover for twenty-five patients, with a discussion or mention of pain management for three of the patients. The handover is detailed previously.

*I was trying to get some more information about why only three people were spoken about regarding pain, and what effect this had on how she thought about the patients. She did not think that handover affected her views at all about patients. I asked her specifically about the gentleman who had been described as 'really in agony' at handover, but his pain is better now so Lorraine appeared to think my questions about him irrelevant. (FN24 L96)*

It seems nurses felt a discussion of a patient's pain management on Newcastle Ward was only required for those patients where the management of the patient's pain was more challenging; there was a silence of routine pain management conversations.

It appeared this silence of routine pain management communication is founded within the culture of Newcastle Ward specifically, as supported by a field notes reported:

*Handover for the bay was by an agency nurse, she mentioned pain for all her patients 'No pain overnight', 'prn oramorph'. Once her handover was completed SN Emma did the other bay and it was back to what I found more normal for the ward, NMOP [no mention of pain]. (FN11 L9)*

Nursing handover in Newcastle Ward could be a lengthy resource heavy process with up to ten people being involved for that time. Very little pain management information was offered and the incoming nurses rarely asked for clarification. The pain management information on the written handover sheets was largely restricted to pain management pumps (PCA, epidural, syringe driver), or long acting analgesics (BD MST, BD OxyContin®, fentanyl patch). The majority of patients did not have pain management discussed in the oral handover, and those who did were those patients which the nurses were concerned about for a number of reasons. They divided largely into two groups: the bigger group were those patients who were perceived as

having dissonant pain and analgesic needs, and a smaller group whose pain was seen as genuine and difficult to manage.

There are other handovers of patient information; other opportunities to discuss pain management and gain information to inform decision-making. Below are some comments from a brief informal catch up with the nurse in charge and staff members from the male team late morning. Pain was discussed for four of the fifteen patients:

*'How's his pain?' was asked, SN Lorraine replied, 'he has been asleep and walking around'. Nothing further was said, the implication is that there was no pain.*

*Another patient was described as, 'He was in tears, so I turned him'. There was no further discussion about this, the implication that this simple comfort measure was enough.*

*SR Danielle said another patient 'needed a pain care plan'. There was no discussion about why he needed this or any question about how his pain was, only that he was missing this piece of paper.*

*And a further patient: 'How's his pain?' 'He is in no pain, much better than before'. (FN24, L114)*

Handovers for patients being admitted to the ward were another opportunity to communicate routine patient pain management details. SR Danielle was asked about her decision not to seek pain management information at the

handover of a new patient admission. She replied, *'The patient looked comfortable and the other nurse did not mention it'*. (FN13 L82)

When she was asked for her thoughts around this she said:

*I guess nobody actually brings it up that pain is being a problem. We just assume that the pain is being controlled and I saw the patient arrive on the ward and she looked comfortable so, I suppose I didn't ... if she was showing signs of being in pain, I would have questioned, but because she looked comfortable and because there was nothing mentioned in the handover about her requiring analgesia or that she was in pain, I didn't.* (FN13, L207)

Findings demonstrating the silence of routine pain management communication within Newcastle Ward have been presented. It has been shown that during handovers of patient details, either formally at shift changes or more informally throughout the day, pain management is mentioned only for those patients where the pain is difficult to manage; it is not routinely discussed.

It could be said that at formal, and informal, handovers nurses were not getting sufficient pain management information about their patients to make effective pain management decisions, although they may have been getting it from other sources.

The next section will examine how pain management is done on Newcastle Ward within the roles and tasks and how these fit into the hierarchy of the ward environment.

### **5.3.3 Pain management roles and tasks**

On any nursing unit there are routine tasks that are required to be done at different intervals: daily, hourly, weekly. Within different units the significance of these tasks may be different; an elderly care ward may have more emphasis on nutrition or personal care, while on a short stay surgery ward, observations or mobilisation may have a higher priority. Within Newcastle Ward there were also regular tasks that were required to be done. What significance and emphasis was placed on them can illuminate the culture of the ward, as does the grade of staff allocated to perform them. When the nursing handover was completed, the staff would be allocated to teams and bays. A number of tasks were then detailed and allocated to teams, and then to individual members within the teams. At one handover the instructions given by SR Danielle were noted.

*Following the handover I counted the instructions Danielle had given to the staff. There were 14 weights [part of a routine nutrition assessment], 6 MUST care plans [nutrition assessment], 5 turns [formal turning of a patient to avoid pressure areas], 5 dressings, 1 drink [encourage], 1 stoma teaching, 3 catheter care plans, 6 manual handling care plans, and 1 syringe driver check. Pain care plans, or pain assessment or any mention of pain – none. (FN26 L25)*

One of the staff nurses at interview stated that the sisters did speak about pain tasks following the handover

*[SR Alexandra] will, in the morning we have handover and then she runs through any points and she'll often mention pain, 'make sure, you know if they've had so many doses of oramorph'. Alexandra does and Danielle, Jana and Rene they sort it out as well if they are leading the handover, they will bring it to light every so often. (SN Tracey, interview L54)*

During the observations, there was no handovers which detailed any specific pain management tasks, nor was pain management mentioned at any of the observed safety briefings.

SR Danielle explained her view of the pain management roles within Newcastle Ward, when she was asked at interview whose role pain management was.

*All of us on the ward, down, from the HCA doing the observations and actually asking the patient their pain score to the staff nurses who are giving out analgesia and again are assessing patient's levels of pain, right up to us, you know obviously dealing with any problems, making sure that the patient's pain is managed, it is very important. (SR Danielle P1, interview L35)*

Pain management tasks, as described by the nursing staff in interviews and seen at observations, were pain assessment, comfort measures,

administration of analgesia, and care of pain management pumps (PCA, epidural and syringe drivers).

Pain assessment is considered part of the routine observations, while administration of analgesics is usually part of the drug round. The care of pain management pumps was seen to be outside of the drug round, but was a nurse's task, while all staff used comfort measures.

SN Jennifer, a relatively new nurse, said at interview:

*[The HCA will] be going round every couple of hours doing the obs [observations] or she will interact with the patient if they need to go to the toilet or she's taking commodes and we're quite busy doing drugs, so she'll be there, more hands on, to be doing more of those things, so she'll be the one who probably they'll talk to first and say to her oh I've got some pain actually. (SN Jennifer P35, interview L87)*

Pain management did not seem to feature as an integral part of HCA activities however as seen from this field note:

*[I assisted HCA Kirsten (P5)] with washes and bed making. No one mentioned pain. Kirsten did not ask patients about their pain, or if the washing or movement out of bed were painful. (FN1 L113)*

*HCA Kirsten is helping a lady behind the curtains to transfer from bed to chair. I am unable to see but can overhear. Kirsten appears to be ensuring that the 100 year old lady, with a query bowel obstruction, moves by herself. This may be appropriate, however the whole time*

*the lady is making 'ooh, ooh' sounds. Kirsten did not ask about pain, though when [the patient] was in the chair she did ask the patient if she was cold and when the patient replied 'Yes', went to get her a blanket. I asked Kirsten if she thought the lady was in pain and she replied 'she did not say she was in pain, only that she was cold'. (FN25 L40)*

Field notes record further:

*Kirsten only asked about the cold, and not the pain. Is this because she could do something for the cold (blanket), but as an HCA did not have the ability to do anything about the pain? Or did she just ignore the possible pain cues because the lady was so old she was bound to have some pain, or because they were small little noises that old people make anyway. (FN25 L43)*

The pain management tasks performed by the two different staff groups within Newcastle Ward appeared embedded with the culture; a culturally shared pain management strategy. Pain assessment was considered part of the regular observations and the HCA did those. Administration of analgesia was routinely performed during medication rounds, and this was a nurses' role, the only sister who would do a drug round was the junior sister, if there was more than one sister on. Pain assessment did take place at the medication round, but rarely were the documented pain scores discussed or considered. The nurse in charge was considered to have the overall picture of the ward, and would take feedback from the other staff.

### 5.3.3.1 Medication rounds

One of the first tasks of the day for staff nurses was the medication round. As indicated earlier, this activity routinely took a number of hours, and was the nursing activity where most pain management decisions were observed. Immediately following the handover, one of the staff nurses allocated to each team would start this task. In the clinical room they would prepare their trolley with simple analgesics and other more commonly used medications, and normally some means of writing notes to themselves or the doctors. They would normally start the round in one of the bays, though may go to a specific patient, out of order, if they had been discussed at handover first.

*I allocated myself to SN Andrea – she was ‘doing the drugs’. The two nurses doing this task for each end began by preparing their trolleys in the clinical room. Andrea got simple analgesics, a common proton pump inhibitor, a few build-up drinks, a few paper kidney dishes, a piece of paper towel (to write notes on). She put these on the trolley or in the trolley drawer. She got a small pad of post it notes out of her pocket saying that this was so she could put notes on the drug charts for the doctors. (FN4 L33)*

The nurses were very focused on the task at hand; this is accepted good nursing practice to lessen the chance of medication errors. The nurse rarely got involved in any other ward activity, though they were routinely interrupted. It appeared the focus however, was on getting the drug round

finished; the measure of success was to complete the task as quickly as possible.

*I was doing the drugs this morning and I didn't finish until quarter to eleven and I always like to finish by 10. (SN Karen P3, interview L157)*

*'Do you think you need paracetamol?' The patient replied 'I am in a bit of discomfort so would like it'. SN Lorraine says 'I will bring that back in a while' [IV paracetamol]. (FN25 L167)*

When Lorraine was asked why she made a decision to not give the IV paracetamol right away she said:

*I will do all those extra things at the end of the round, otherwise I will never get it finished. (FN25 L169)*

Some pain management decisions were made on the medication round.

*SN Lorraine (P8) is checking on what the patient has had in the past for her pain. 'She has had codeine and tramadol but I don't want to give her tablets as it may make her feel sick, so I will give oramorph. She is prescribed 2.5 to 5mg. I want to give her 5 but she is old [100 years old] and maybe we should start with 2.5, we can always give her more'. (FN25 L103)*

Many nurses at medication rounds were observed to only give the analgesic medications which was prescribed regularly, rarely appearing to consider the PRN medication available.

*SN Cecilia does not ask about any PRN medication, she simply hands out the tablets. I do not hear her ask about patients' pain. She moves quickly round the bay and is gone. (FN14 L22)*

When asked about this Cecilia said, '*No one had any pain, so what they were prescribed was okay*'. (FN14 L24)

#### 5.3.3.2 Clinical leadership

As the roles of the HCAs and nurses were different, in relation to pain management, so were the roles of the sisters.

As may be expected, the role of the senior sister was that of management of the ward, although there was an expectation that SR Alexandra also worked clinically.

*I think it's my duty to make sure that none of the patients are left in pain and I think it's my duty to guide and instruct the staff to communicate better with the patients. (SR Alexandra P32, interview L13)*

Newcastle Ward staff establishment is such that all day shifts had a designated supervisory nurse. During any observation this was always the most senior nurse on the shift. If SR Alexandra was on the ward it would be her, if she was assigned an 'office' day it would be the next most senior nurse. It was almost always a sister, though occasionally it would be one of the most senior nurses. The tasks they completed were largely the same. They infrequently got involved in anything clinical and mostly did not answer the patient call bells. They would position themselves at the nursing station

and rarely move from there, unless there was a doctor's ward round, when they would accompany them. They would update the patient board, update the nursing handover sheet, answer the phone, and liaise with doctors, allied health professionals, and any management request. It seemed clear the nurse in charge role was taken seriously by all, and was seen as a somewhat privileged role to have, with the ability to direct nurses to perform tasks.

One morning I was accompanying SN Lorraine on the medication round. She had assessed a patient as having pain (8/10) and we went to the clinical room to get morphine for the patient.

*While we were there SR Danielle stopped Lorraine administering the CD [controlled drug], and asked her to put away some oral medications that had been left out. I wondered if she had not noticed what Lorraine and I were doing? Was she prioritising her concern regarding drugs left out over the administration of analgesia? It did not seem administration of morphine was her priority. (FN25 L57)*

SR Danielle was certain of her role as Sister.

*If there was a problem I tend to get to find out about it and then I become involved, so I wouldn't necessarily be involved in pain management of every single patient on the ward but if there was an issue that arose, like this morning - things that cropped up in handover, like the guy in the side room with the PCA - then I would take a bit more of a focus. (SR Danielle P32, interview L20)*

SR Jana felt her senior role was important in ensuring pain management for the patients.

*Because as a sister in charge of the entire ward I have observed for myself when the HCA come to the nurses saying the patient is in pain, they act upon it. Because I do observe things and if they don't then I have a go at them with why haven't you acted upon what the HCA has said with the patient in pain, that is a priority do that now, and leave whatever it is that you are doing ... and sort the patient out. (SR Jana P31, interview L44)*

Findings have been presented which begin to reveal some context around working on Newcastle Ward; what it looks like, how it works and how nurses feel about working there. How the ward staff viewed pain management has been presented, and the exploration of the clinical tasks, and the allocation of these tasks, sets the scene for a more in-depth discussion around pain management.

There is beginning to be a sense of the pain management culture within Newcastle Ward; a role defined structure where each staff group had its own pain management tasks to perform. Despite nurses saying pain management was very important, a new finding has been presented of the silence of routine pain management communication, with conversations about pain restricted to those patients whom nurses perceived as difficult to manage.

In the following section the theme describing nurses responses to pain management decision-making opportunities is explored, looking specifically at sub themes of, the culture of pain assessment, and nurses' pain management knowledge and how these impact on decision-making. Further findings are presented showing how nurses respond to cues regarding pain with apparent inattention, and a new finding a single action following a pain management decision.

#### **5.4 Nurses' responses to pain management opportunities**

This section will explore the second main theme of how the ward staff responded to pain management decision-making opportunities. Nurses on Newcastle Ward used a variety of sometimes inconsistent strategies to assess pain and this is described further. When the nurses had reached a judgement of how much pain a patient was in, they were often seen as uncertain in their decision about what pain management measures to use. Examples of the strategies used are described. Findings are presented which demonstrate nurses are inattentive to pain cues. In parallel to this inattention to pain cues, which has been presented in nursing literature, a new finding is presented which suggest ward staff make a single pain management action following a decision.

##### **5.4.1 The culture of pain assessment**

Pain assessment is crucial as a first step to accurate pain management (van Dijk *et al.* 2012), however during interviews, nurses did not indicate pain

assessment was a key component of their pain management strategy. Many nurses did not mention pain assessment or if they did discuss it, they focussed on the role of the patient to inform them about the pain, seeming to overlook the opportunity for the nurse to find out about the patient.

Health care assistants did speak at interview about assessing patients' pain, using the numerical pain score and added the element of movement. This discrepancy between how nurses and health care assistants discussed pain assessment fits into the allocated roles of the nurse and HCA within Newcastle Ward.

*On movement, what is your pain score from 0 being calm to 10 being the most horrendous pain ever, and obviously what they tell me I put down. (HCA Isabelle P28, interview L64)*

*When I do the obs [observations] and I ask what your pain score is if they say 0, I then say what is your pain score on moving, cos then more often than not they are saying oh yes it's like a 5 on moving. (HCA Denise P33, interview L136)*

While many staff nurses at interview did not refer to a numerical pain assessment tool as a means of pain assessment, a small number of staff nurses said they used the tool, in this case to inform their subsequent pain management decision.

*I need to know how they assess the pain, they rate the pain, at what score so that I will know which one to give. If it's just a pain score of 4,*

*I will not have to give morphine, the oramorph, but if it's a 6 or a 7, I would have to give the oramorph and paracetamol as well. (SN Cecilia P15, interview L66)*

Some nurses made it clear at interview that they thought assessing pain this way was not really relevant.

*When we go around doing the obs [observations] we can ask them, or if we are doing the drugs we'll ask them, but I don't automatically. (SN Michaela P12, interview L95)*

*PvR: 'There is a pain tool but you don't use it?'*

*'No because I look at them more and I just say to them, are you in pain yes?' (SN Karen P3, interview L248)*

When Helena was asked a specific question about pain assessment on movement at interview, she thought it was important to get as much information as possible from the patient.

*How is the pain, is it pain on movement? A lot of people do, especially surgical patients, they tend to lie there, but they'll say oh when I moved to this side it hurts. But I suppose that's normal, because I do tell them, where is the pain, how is the pain, when does it come, is it sharp, how does it feel, all the questions. (SN Helena P18, interview L97)*

Prior to this interview, when SN Helena was being observed at a medication round, she was not seen to exhibit this behaviour.

*SN Helena restricted her pain assessment questions to patients who*

*volunteered they had some pain. Then she would ask, 'what is the score, 10 being the worse'. When I questioned her she expanded, 'if it is 8 to 10 and they look red, then I would say, 'is it bad enough that you need oramorph, do you want it?'* (FN16 L219)

At interview SR Alexandra said how important it was that it was communicated at the patient's level.

*Again it's about communicating with the patient on the patient's level, asking, you know where is it and how long have you had it for, does it go if you move.* (SR Alexandra P32, interview L250)

Matron Charlee, the Matron for Newcastle Ward, at interview said in her experience it was not particularly useful to use a pain assessment scale. How much pain a patient was experiencing was better judged by the nurse from looking at the patient, and by the patient's diagnosis. She felt nurses should be acting as the patient advocate, by checking how patients are doing and asking about pain when administering medications. She did not feel she had any influence on the ward staff in terms of pain management, beyond her aspirations, noted below at interview.

*I would really, really hope they are doing that, though I can't really influence them.* (Matron Charlee, IP4 interview L78)

Harriet (IP3), a member of Trust management associated with the ward, when interviewed described the pain management service as, '*a sort of overhead on the main service that the patient experiences when they come*

*in'*. (L35). She indicated she had an expectation that a pain assessment tool was used widely, however asserted that as a non-clinician her influence in effecting clinical practice was limited.

*If you were walking through a ward and you see someone who is obviously in pain, calling out, I would ask the sisters ... but I have always come away with the impression if there is that sort of thing going on then it is under their control, not something I can change.*

(Harriet IP3, interview L95)

These findings appeared to demonstrate the senior Trust staff both felt they were unable to influence, and indeed had no influence on, the way pain management was performed on Newcastle Ward. The nursing staff felt the Trust thought pain management was important, almost solely because the organisation had invested in a pain management team. The pain management team wrote the evidence based policies and guidelines, setting the standards for pain management care, and the ward staff are certainly happy with the relationship but it did not seem the education, standard setting and role modelling from Mieke (Senior CNS Pain Management) and Mandy (Pain Nurse) were having an enduring influence on the ward with regard to pain assessment techniques.

Data from observation did not confirm the use of the recommended pain assessment tool by nurses, though many health care assistants were observed to routinely use a verbal rating scale to assess pain and did document it, though movement was rarely a component of the assessment.

*'Do you have any pain? On 0 – 10 with 10 being worst pain ever?' The patient said 6, and it was documented as 6. (HCA Kirsten P5, FN12 L74)*

Commonly the pain management question to patients by health care assistants and nurses was *'Are you in pain?'* If the reply was negative mostly nothing further was asked. If an indication of pain was given by the patient sometimes the numerical scale was asked.

*'Are you in any pain?' [Patient], 'No', 'No', with no further questioning. (HCA Kirsten P5, FN22 L158)*

*'Any pain at the moment?' Patient 'yes', 'What would you say 1-10?', patients says '5', 'Belly?' and the patient asked if she could be repositioned. Rebecca said 'I will come back, I've some more to do'. (HCA Rebecca P9, FN19 L63)*

Rebecca's comment above could demonstrate she minimised the effect the pain would have on the patient and deferred the request for repositioning because she was too busy to do it. The field notes recorded *'repositioning for pain or any other reason is not seen as cause to stop the observation round'*. (FN19 L65)

Observation data suggested pain on movement was considered occasionally.

*'When you move your pain is still mild?' [Patient] 'Yes it is, it's about a 2'. (SN Lesley P10, FN9 L69)*

The field notes continue this observation with, *'this is the first time I have heard anything about pain on movement'* (FN9 L70). At this stage there had been around 50 hours of observations.

Occasionally questions were asked, which the nurse apparently thought of as pain assessments.

*'Have you got any pain?' to the patient and then, 'Do you want your diclofenac PR?' The patient did not appear to know what this meant and said 'What?' SN Andrea (P24) then changed it to repeat, 'Have you got any pain?' The patient said, 'Not with this', indicating the PCA button. The pain score was documented as 0. The diclofenac was marked on the drug chart as 3 [indicating that the patient had refused to take this medication]. (FN4 L74)*

PR is a common medical term for per rectum. Diclofenac PR as described here is analgesia in a formulation designed to be absorbed through the rectum; a very effective painkiller. However it is unlikely that a patient would understand the term PR. A more common explanation might be 'up your bottom'; patients who have experience with this route would probably know whether or not they wish to continue it. Andrea is a senior staff nurse of many years experience, when she was asked for more information about this incident she said, *'he had it before PR, he should know, he said he did not want it, it is up to him. I can't make him have it if he does not want it'* (FN4 L83). This seemed to indicate there was a certain level of knowledge the patient was understood to have; it was the patient who was making the

decisions. Some further questions Andrea asked during this observation period were, *'Did the oramorph work?'* and, *'Do you have any pain?'* She gave all regular analgesics as they were prescribed, but did not do any pain assessments, did not document any pain scores, and did not give any patient any further 'as required' analgesics. In the field notes is a comment that maybe finishing the drug round was the most important task.

As demonstrated previously it seems unlikely the formal handover is providing nurses with sufficient pain management information to make pain management decisions, and findings above show little effective pain assessment to inform these decisions. It may be that nurses are getting pain management information from other sources. Nurses were using other signs to assess patients' pain, and these did have an influence on both the documented score, and the decision made about the pain management measure employed following the assessment.

Many nurses seemed very certain that they could assess pain by non verbal cues, and were clear they considered this a more reliable source of pain information than a numerical pain score. This was apparent from the interviews, with many health care assistants and nurses giving consistent responses. All the sisters at interview however, said they would ask the patient for a verbal pain assessment score, unless the patient was not able to verbalise.

*So like non-verbal signs of pain? Yeah, particularly with the patients that are maybe tlc [tender loving care] that can't tell you that they are in*

*pain, yeah look for movements, facial grimaces, movements, groans.*

(SR Danielle P1, interview L119)

Nurses and health care assistants had a different perspective. Many of them seemed certain that they were able to best assess a patient's pain by looking at them.

*Well, you could see by, they either tell you or you can see by their facial expression or body language – you know, you just know, don't you.*

(SN Michaela P12, interview L92)

*I think facial expression can give it away as well. If they are lying in a bed and they are all hunched up, you can see pain you don't have to hear that they are in it, you can see the signs of someone in pain.*

*Sometimes you can see it in their eyes and sometimes in facial expressions, body movements if they are, as I said if they're curled up.*

(HCA Cheryl P26, interview L77)

Data from both observation and informal conversations shows how the patient looked was a preferred way of assessing pain and did on occasion serve as the only pain assessment.

*She seems comfortable, her face isn't showing any signs of pain.* (SN Therese P19, FN23 L12)

*Alana did not ask any pain questions, when I asked her about this handover she said, 'the patient looked alright and if there had been any problems the recovery person would have said something'.* (FN8 L18)

Patients' physiological observations are another parameter that nurses used to form part of the pain assessment. Joanne was asked if she would believe a patient who was saying they were in severe pain.

*No, not always – I would observe them, their pulse and BP and everything; how is the situation and everything, and how they are tolerating the situation. If they are in severe pain they can't tolerate it.*

(SN Joanne P25, interview L79)

*Observations, the blood pressure could be high because they are probably in pain.* (SN Therese P19, interview L65)

Patient behaviour is also seen as a reasonable method of pain assessment.

*She has not been complaining of any pain, she slept well so that means that she is not in pain, I assume.* (SN Janine P23, FN22 L22)

*How they look, how they feel, what they say, if you ask their pain score, sometimes I ask a few questions because the score and the patient doesn't look the same, they say 9 when they are sitting telling jokes to the patient next to them, doesn't mean they don't have pain but sometimes not quite a 9 that's the only thing.* (SN Alana P14, interview L92)

SN Helena (P18) seemed conflicted about using behavioural cues with all patients and said at interview:

*The patient's facial expressions and their colour, sometimes I notice when the patient's in a lot of pain and slightly tachycardic and maybe*

*the temperature is a bit high and they have a certain degree of distress on their face, or they'll be curled up. But some people haven't got any symptoms at all, so I can't really just judge on somebody's look; I can only judge by if they tell me how they are and how they feel. (SN Helena P18, interview L91)*

Some nurses used other factors to influence their pain assessment. SR Rene (P7) thought the age of the patient would influence when and how often she asked pain management questions.

*Different patients and their reactions, especially the elderly, they won't tell you they are in pain, they just sit there. You can see by their expression and you say to them 'would you like something' and they say 'no, I'm fine' and they will wait all day without having anything. You have to be sort of cautious with them, I think anyway. (SN Rene P7, FN20 L172)*

While other nurses thought age would affect how much pain a patient might have.

*The older that the person is their pain tolerance level is slightly lower. (SN Helena P18, FN16 L176)*

The type of operation or condition that the patient had would influence the pain assessment process in many cases.

*What operation they had, if it's a big op [operation] obviously the pain is going to be increased. (SN Andrea P24, interview L67)*

*Well I look at the patient obviously, you need to look at the patient, the type of surgery that they have had because they have major surgery and the pain can be very high in people who have had major surgery.*

(SR Jana P31, interview L104)

A patient's medication history was also seen to have validity when making a pain assessment decision.

*And you look at their past history as well because sometimes a patient will actually come in with opioid drugs, so you have to take into consideration their history and why they are on these opiate drugs.*

(SR Jana P31, interview L107)

Nurses' decisions about whether or not to perform a pain assessment seemed to be based principally on whether the patient looked like they were in pain, or if they had a condition which was perceived by the nurse to be painful.

The health care professional's experience with patients, or looking after specific patient groups, also influenced how they would perform a pain assessment. An orthopaedic doctor who was called to the ward to review a patient in a great deal of pain following a repair of an ankle fracture, spoke at length of her knowledge and experience in dealing with patients and said with a great deal of conviction:

*In my experience ankle fractures are not that painful and these patients never need PCA's.* (DR Becky IP1, FN5 L52)

While a nurse felt that she was gaining the experience and communication skills required to be able to better make pain assessment decisions.

*Sometimes it is a case about communication between the patients and the staff. You could have a patient that looks fine and when you ask them if they are in pain they say, 'no', but their family might come up to you later and say they are in agony and yet there's absolutely nothing to tell from the patient. I think it comes from experience, knowing – so I'm getting better at it as time goes on. (SR Lorraine P8, interview L63)*

Another nurse felt that there was a cultural aspect to pain assessment, using her experience in her home country to assist her with pain assessment in the UK.

*I observe, they will say - because pain is basically it's personal, because it's really subjective - they will say that are in pain but not actually in their face, but we can understand that feeling because they don't want to feel in pain, but in our country you can see that person is really suffering pain because especially if it severe, it's really seeing through their face, through their action, through their guarding behaviour, but here they will say that yeah I feel pain, it's 10 but it's not really visible in them. (SN Chrissi P34, interview L33)*

Clinical Nurse Specialists (CNS) in Pain Management have an expectation, and certainly educate at length, that any assessment of pain includes the patient completing a pain scale, and those associated with Newcastle Ward were no exception.

*I expect them to ask for a pain score of 0-10 on movement on coughing or deep breathing. I expect them to ask and that's the pain score.*

(Mieke P20, Senior CNS Pain Management, interview L24)

When asked if this pain assessment standard is taught during any training Mieke replied:

*Yes we teach on stat [statutory] training once a week so we capture every single nurse and health care assistant in the hospital at least once a year. We run workshops on the wards, we do study days, training days, we do one to one training with them.* (Mieke P20, Senior CNS Pain Management, interview L29)

Pain assessment is taught at statutory training, which is offered to all staff, nurses and healthcare assistants. However despite this training, observed informal training on the ward by the pain management team, and what ward staff said they would do, during the 157 hours of observation, while there were many assessments of pain observed, it was very rare to see a pain assessment that took the form that was taught and expected to be done; a verbal rating scale (0-10) on patient movement. When a pain assessment tool was used, it did not always appear the score was used as part of a pain management decision. Findings supporting the subtheme of the nurses' knowledge of pain management are presented in the following section.

## 5.4.2 Nurses' knowledge of pain management

This section will describe findings regarding nurses' perceptions of their knowledge and pain management techniques. While it is certainly true there are many other aspects of pain management which do not involve analgesia, the lack of analgesic knowledge has often been described as a barrier to effective pain management, therefore this section will begin with findings relating to how nurses used analgesia. Findings are presented relating to ward staffs' knowledge of the consequences of giving or withholding analgesics and how previous experience with pain or analgesics can determine how these decisions are made. Ward staff's knowledge about, and apparent attitude to opioid addiction is discussed, both the anxiety they may cause it and the concerns they had when they were presented with it. Findings regarding nurses' perceptions of their knowledge about, and their reaction to pain management involving more sophisticated methods (PCA, epidural, syringe drivers) are presented.

### 5.4.2.1 Pain management knowledge

When asked, many nurses said they thought they had a reasonable knowledge of pain management and analgesia.

*I think my knowledge of pain control and of drugs is fairly good, I wouldn't say I'm an expert. (SR Alexandra P32, interview L62)*

*To quite a good degree and I know what ones you can give with a mixture of tablets so that you can actually adjust from one to the other.*

(SR Rene P14, FN20 L64)

There were other nursing staff who were not so certain of their knowledge of analgesia.

*As for the pharmacological side, with the medications, I don't know as much; I do know the basics like paracetamol, diclofenac and what not but apart from that not really much.* (SN Helena P18, interview L58)

*When asked how she felt her pain management was, she said that, 'though she is quite junior she really did care about patients pain and thought it was very important'.* (SN Lorraine P8, FN5 L96)

Some nurses did consider they had gaps in knowledge regarding analgesics, and at interview stated that they would check before giving an analgesic they were uncertain of.

*I know I still hesitate on a lot of things, or I'll double check that and sometimes I even go round to HDU and say is this right, should I be doing this?* (SN Tracey P37, interview L287)

#### 5.4.2.2 Medications

Nurses seemed certain in their knowledge of simple analgesics.

Paracetamol was both widely used and widely encouraged in all patients.

The ward had recently started using an intravenous (IV) paracetamol preparation and the nurses seemed keen to use it.

*SN Lorraine (P8) asked a patient who was immediately post operative ERCP, 'have you any pain?', the patient replied 'no'. Lorraine said, 'are you sure?', to which the patient replied, 'it just hurts a little here, about a 5'. Lorraine looked at the drug chart and said to me, 'she is due IV paracetamol at 1830 [it was now 1810]. She wrote a little note to remind herself to give the IV paracetamol and wrote 3 (patient refused) to the regular ibuprofen and codeine that was prescribed. When I asked her why she had done this, she said, 'well I will give the paracetamol IV, it is so good, in my experience that is what will do the trick'. (FN5 L88)*

*SN Tahlia (P2) said that being able to give paracetamol IV had made a 'really big difference to the way we can treat pain, it works much quicker'. (FN1 L123)*

Or in this case even if it was not prescribed.

*SN Kay (P16) was going to give her IV paracetamol and oramorph, although paracetamol is only prescribed orally. She wrote a note on the drug chart to request it IV and was happy to give it like this before this change to the prescription. (FN22 L134)*

Many nurses were sure of their knowledge of non-steroidal anti-inflammatory drugs (NSAID) and were observed to use them appropriately following good pain management processes.

*SN Louise (P22) was thinking aloud, 'You had some oramorph last night, oh there is another tablet I can give you. Diclofenac works really well together with the others', and she gave diclofenac. (FN21 L85)*

One nurse was clear about of her knowledge of NSAID doses to refuse to give a medication with an incorrect dose prescribed.

*I was concerned overnight and called the doctors, oramorph was changed from 4 hourly to 2 hourly and codeine changed to diclofenac, but the prescription is written wrongly, is it 150mg TDS, so we were unable to give it. (SN Andrea P24, FN24 L23)*

Nurses seemed to be aware of the consequences of not giving analgesia, though for a variety of reasons. Some felt the ability to mobilise was important.

*Mobility is normally zilch if they are in pain, they are like this in bed and don't want to move, not eating because of the pain, not drinking because of the pain, so you're going to have low urine output, it affects everything. (SN Therese P19, interview L67)*

A comment was made about the importance of breathing to post operative patients.

*I mean when they are talking to you some of them can hardly speak because the pain is so severe, I just go and tell the staff nurse, so and so is having problems, because obviously it affects their breathing. (HCA Isabelle P28, interview L66)*

Others appeared to understand the importance of pain management to the patient experience.

*For me it's quite important because I feel that patients don't get their pain relief quick enough and if it was given to them then they wouldn't be agitated and they wouldn't be rude or sarcastic to us ... then there wouldn't have been a confrontation. (SN Karen P3, interview L12)*

*Of course we want it to be top priority for patients, because if they are not in pain they're much happier aren't they. If they're in pain, that's when you get complaints. (SN Michaela P12, interview L31)*

It was opioids both weak and strong that appeared to be causing the most concern to the nurses. Of the opioids codeine was a drug they felt more at ease with, though seemed uncertain if they should be using 30mg or 60mg, with most deciding to use the lower dose, a position taken consistently with most opioid doses where there was a choice.

*Lesley was giving paracetamol and ibuprofen and codeine. When she was asked why she was only giving 30mg, she said because the patient was 'having the others as well, I can always give her the other 30mg later if I need to'. (SN Lesley P10, FN9 L103)*

There was awareness of drug side effects and interactions and this was used to inform analgesic decisions.

*One of the patients complained of stabbing abdominal pain when asked 'Any pain?' The drug chart said PRN codeine but Lorraine (P8) said,*

*'no codeine, bit bunged up', and 'she was on tramadol but it interacts with something'. (FN5 L76)*

*A patient had both meptazinal and tramadol prescribed, with the tramadol being increased in the last few days from 50mg to 100mg. SN Michaela (P12) wrote a note to pharmacy to review the two drugs and decided to only give the meptazinal. (FN10 L88)*

Oramorph (an oral morphine solution) was readily given at a dose of 5-10mg orally PRN, with nurses displaying no uneasiness with administering at this dose. Field notes have recorded *'[SN Claire] was happy to give 5mg of oramorph. (FN8 L31)*

*A patient asked for oramorph. As we were doing this I asked SN Claire, 'tell me more about how you decided what dose to give this patient'. She replied 'it is prescribed 5-10mg and he is having too much pain so I will give him 10mg 5 M L'. (FN10 L48)*

On this occasion it is apparent Claire used the pain assessment (too much pain) to influence her decision to give the higher dose prescribed. Doses higher than this however did not seem to be given or prescribed. Field notes record:

*I asked SN Lesley (P10) if most people get 10mg oramorph and she said 'it depends on who is prescribing it, because they normally give 10-20'. It is interesting that she thinks this because I have never seen it and the CD book shows only 5 or 10mg as given. I asked her what she*

*thought of these doses and she said, 'no 5mg would not help, it depends on the size, for big people they need more'. (FN9 L81)*

Nurses appeared less familiar and consequently perhaps more apprehensive with high dose morphine prescriptions.

The side effects and consequences of opioids were often misunderstood or overstated. There was a fear of producing respiratory depression in a patient because of giving too much opioid. This was discussed with SN Lorraine (P8) when she had given a 3mg bolus of morphine to a patient as a clinician bolus [an extra dose of IV morphine, normally 1-3mg authorised as part of the PCA prescription which a nurse can administer to the patient through the PCA pump if they require it].

*I asked her about this decision, Lorraine said, 'I mostly give 2, but he said he was in a lot of pain, and I believed him, so I gave 3. Others have been giving him 5, Cecilia gave him 10 this morning, but I am not sure I am game to give that'. When I asked for more, Lorraine said 'on two occasions in the past I have given 10 and both times they got respiratory depression and I had to stay there'. (FN16 L64)*

A few months later with a different patient, Lorraine's reaction was exactly the same.

*Lorraine went straight to the side room as it was said at handover he was in pain. 'Hello, the nurse said that you were in pain'. The patient said, 'My leg is going click click'. Lorraine appeared to disregard this*

*and asked, 'How is your pain from 1 – 10?' The patient replied '8'. Lorraine (thinking aloud) said, 'Kay was giving 5mg bolus but I am not going to give him that'. When asked about this decision she said, 'I have knocked off so many people in the past'. When questioned further she said, 'I have dropped patients respiratory rates by giving too much, I am very wary of that'. (FN25 L12)*

It appears here Lorraine was using her own experiential learning to make decisions. She was not being led by what her colleagues were doing, or using pain management guidelines available to her.

While another nurse when asked at interview how comfortable she felt giving IV opioids replied.

*I'm not that comfortable to be quite honest because of the breathing, it does affect the breathing doesn't it and this is why we have to make sure we give it slowly and make sure we stay with that patient for 10 minutes. (SN Therese P19, interview L100)*

The staff on Newcastle Ward were observed to be apprehensive about opioid addiction in their patients, and patients were themselves concerned. Healthcare professionals and patients sometimes feel patients can become readily reliant on opioids (Pud 2004).

*I think they do a lot of them especially the elderly ones, they think they shouldn't have morphine and they shouldn't have anything quite potent*

*because it's sort of like, they can become reliant on it. (SR Rene P7, FN20 L134)*

*SN Kay (P16) told a patient, 'Don't hesitate to ask if you are in pain, I can give you some morphine syrup'. 'Oh no', said the patient, 'I am afraid of taking that in case I get addicted to it'. There was no further conversation about this, Kay did not try to talk the patient into taking it, and did not say anything about the real risk of addiction. (FN22 L134)*

Following the drug round Kay was asked about this comment from the patient, and replied:

*Oramorph is not addictive. I would have told her that I don't think it is addictive, as long as she is in pain she would need it, because what is important for her now is to get well, and not for the pain to stop her from getting well. Addiction wise, if the oramorph is helping with her pain, why can't she have it, if its helping then the time will come when she is using it less and less. (SN Kay P16, FN22 L200)*

*She clearly knew what was the correct thing to say, but she did not tell this to the patient, she did not say anything to her. I wonder if this is about the patient knowing what the nurse knows, or whether she thought she said it, though she was speaking to me as if this incident had occurred to someone else. (FN22 L205)*

SN Cecilia (P18) is from another country and is using her experience there as a reference point.

*You're so free with the opioids here and you know sometimes you get to develop this patient's dependence on the opioids. And then I think that's the bad side of your pain management here because some patients have got 160mg morphine BD and 60mg of oramorph 4-hourly.*  
(SN Cecilia P18, interview L124)

It seemed throughout the observations nurses were making opioid decisions based largely on the avoidance of side effects to these medications, in order to minimise what they felt were real dangers for the patients. Decisions made about opioid administration however, if based on only avoidance of side effects rather than the risk balanced against analgesic efficacy may result in less than optimum pain relief.

#### 5.4.2.3 The use of sophisticated pain management devices

Trained nursing staff to varying degrees felt competent with the more technical forms of pain management like PCA, epidural and syringe drivers, though as most of the drugs used in these devices were opioids there was some concerns seen.

*I was scared in doing IV morphine, you know, and touching epidural bags as well and PCAs.* (SN Kay P16, interview L75)

When asked at interview what further training nurses felt they required regarding pain management, many spoke of their need to learn more about the technical techniques such as epidurals and PCAs.

*Yes I have had some training but I wouldn't say I was 100%, I sometimes have problems with them. (SN Michaela P12, interview L57)*

*We're getting a lot more machines now that help with the pain, because the new one I've seen is the epidural PCA special control, it's a fairly new one to me. (SN Alana P14, interview L18)*

Patient Controlled Analgesia (PCA) was widely used on the ward. The nurses were observed to be assured with the pumps, able to give a clinician bolus, if the patient required it.

*A patient who had a PCA, when asked his pain score 1-10 by SN Andrea said 6-7. Andrea was able (via sticker prescription) to give clinician bolus of 2mg. The PCA pump seemed complex but she did not hesitate in her input of what looked to me a reasonably complicated series of events. I asked her why she was giving this and she replied, 'if the pain was not controlled – they can give clinician bolus – they are all trained' (referring to the nursing staff). She did write the time and 6-7 on the observation chart but did not check this patient again regarding pain. When I asked her about this she said, 'Well I gave the bolus, that should be enough, he needs to use it more. He will tell me if he is in pain'. (FN4 L64)*

There is a common assumption, widely held among all health care professionals, that if a patient has a PCA they are in control of their own pain (Chumbley *et al.* 1998). This appeared to be the case also for Newcastle

Ward, where patients with PCA seemed assumed to be pain free, because of its presence.

*In all the conversations that she had about him, there was little mention regarding the patients pain, beyond, 'he has a PCA doesn't he, he can have all the opioid he likes'. (SR Rene P7, FN15 L27)*

Epidurals were another relatively sophisticated pain management technique that was used in the ward, though less frequently than PCA. The nurses seemed to have less knowledge about epidural technique and were certainly less comfortable with them.

*Things like PCAs epidurals, the patient controlled epidural, they always throw me, I hate, don't ask me why I prefer PCAs to epidural because obviously with the blocks [patients get better pain relief] and that, [but it] worries me more, I'd rather have a PCA. (SN Tahlia P2, interview L5)*

Syringe drivers were also used on the ward, mostly for those patients who were seen as at the end of life. On one of the early observation days SN Tahlia (P2) was told a patient was in pain, with the time recorded as 1050. Tahlia said she would 'do it' after something else.

*I found her at 1115 getting the syringe driver for this patient done (cyclizine and haloperidol) which was due at 1100. She seemed to put a lot of emphasis on getting this done on time, (though it was already 15 minutes late, and presumably had run out earlier), and the analgesia (oramorph) at the same time ... she seemed to indicate the syringe*

*driver was somehow part of the analgesic regime. She knew the antiemetic, but was less clear when asked what the haloperidol was for, saying vaguely 'making her feel calmer and her pain better'. (FN2 L41)*

Field notes recorded at the time; *'maybe the machine (the syringe driver) was enough to make staff think that pain management was being done'. On another occasion it seemed that checking the pump was more critical than looking at the patient.*

*SR Rene (P7) went straight to check the driver, the patient was talking to her, but seemed largely to be disregarded. Rene was showing me the syringe driver and checking how much solution was left using a sterile dressing with a little ruler on the edge. Rene said to me 30mg diamorphine (I think this came from handover), but the prescription said diamorphine 5-10 (5mg given), midazolam 2.5-5, (2.5mg given) and haloperidol (which had not be given). She asked the patient 'Are you pain free? Are you comfortable?' The patient replied 'I think so', in a hesitant, spaced out sort of a way. Rene continued to fuss with the pump. (FN26 L35)*

Two things seemed to occur when a patient had a pain management device. Decisions nurses made about the pain management for patients with pain management pumps were mainly limited to caring for the pump, and there appeared to be the assumption the patients was in control of their own pain.

In this section findings relating to nurses knowledge and use of analgesics were presented. Findings were discussed relating to health care

professionals knowledge of the consequences of giving or withholding analgesics and how previous experience with pain or analgesics can influences their beliefs about the outcomes of giving or withholding drugs. Findings relating to the influence a pain management pump has on the pain management decisions of the nurses has been presented.

The next section will present findings associated with the subtheme inattention to pain cues, where nurses seem to disregard clear signs from patients that they were in pain.

#### **5.4.3 Inattention to pain cues**

There were occasions when pain cues patients gave the nurses both verbally and non verbally, were seemingly missed or minimised by nurses. These occasions could be very frustrating, and remarks recorded post observation reflected this.

*I am unsure if I noticed these cues because I am an expert pain management practitioner, though I could not be called an experienced ward nurse by any measure, having not worked on a ward since my general nurse training over 20 years ago. Maybe I was able to pick up the cues that the other nurses were not because I was watching; a person with a task that is only observation is perhaps more likely to attend to observed signals. (FN9 L114)*

Examples to demonstrate this theme comes from the observation data.

*During the washes and beds, there was no talk of pain, no questioning*

*if patients were able to get out of bed. On one occasion when a patient groaned while we were rolling her, there was a pause, the handling became more gentle, and kind soothing words were said, but no pain questions, only 'sorry, we are nearly finished, we will be as gentle as we can'. (HCA Kirsten P5, FN3 L16)*

SN Andrea (P24) was being observed as she did the morning drug round for the male end of the ward. A patient had been moved to a side room because, *'he was too disruptive overnight – asking for oramorph all night long, keeping the other patients awake'* (FN4 L85). The previous day his prescribed oramorph 10mg had been changed to OxyNorm® 5mg, a standard equianalgesic dose, however the patient was on a long standing fentanyl patch 50mcg which should have meant the patient having oramorph 30mg or OxyNorm® 15mg in order to be receiving an effective breakthrough dose, and there was guidance for this in the Pain Matters folder (Research Trust 2009). Andrea did not question the dose of the OxyNorm® or the fentanyl patch; in common with her colleagues and what was spoken about in handover, she seemed principally concerned that he had to be moved because he was disturbing other patients. Field notes demonstrate some frustration: *'Perhaps he was in pain and this was why he was asking for more oramorph'*. (FN4 L87)

Another afternoon SN Claire (P11) was discharging a gentleman following a head injury; he had sustained a laceration to his ear and this required cleaning prior to discharge. As Claire was cleaning the blood from the ear she asked the patient regarding his pain, though in the briefest possible way

saying simply, 'Pain?'

*The patient replied 'oh loads of pain'. Claire giggled. The subject of pain was not pursued. I asked her later to, 'tell me of the pain management advice you gave him?' Claire replied 'he was confused earlier so doctor said only paracetamol, he has been using only paracetamol so that is okay'. (FN10 L39)*

Claire seemed to disregard the comment from the patient, and when she was questioned about this she repeated the doctor's advice. Field notes recorded, '*I wondered if this meant she felt unable to do anything further*'. (FN10 L44)

The findings relating to inattention to pain management cues have been presented. Aligned somewhat to this finding is a subtheme of nurses performing a single pain management action; this is presented as a new finding.

#### **5.4.4 A single action following pain management decisions**

This section presents new evidence relating to nurses pain management decisions, which demonstrate nurses perform a single action following a pain management decision. They would make a decision and take an action, and then it seemed there was nothing further they could do. Nursing staff when presented with patients in pain gave medications, positioned patients, spoke to doctors, but were rarely seen to take any further action, even an evaluation of the first action, and seemed to disregard the patients further signals as if they did not know how to take any further pain management

measures.

This is a new finding which reveals a novel and so far unrecognised factor which influences nurses when they make pain management decisions. It seems as if one pain management action per situation is sufficient. This finding may also go some way to explain the finding 'inattention to pain cues', which earlier researchers who have demonstrated it, have explained it as an effect of the busyness of the ward (Manias *et al.* 2004b), or a lack of empathy in the nurses (Dihle *et al.* 2006). It seems decisions made by nurses were restricted to actions which they were more comfortable with.

*The patient is very distressed and is rolling around the bed, crying out in pain. SN Kay (P16) asks where pain is, patient says high in chest, through to back, shoulder and going up into the face. Kay asked a student nurse to ring the Outreach team, to do some observations and an ECG, and then left to get GTN. Kay returned with a GTN tablet which she gave along with 10mg oramorph. (FN22 L45)*

The field notes recorded further:

*Apart from the GTN, which would have been the right thing to do if it was angina, and 10mg oramorph, nothing else was discussed about the pain. There seemed to be an acceptance that they had done what they could and therefore it did not need to be worried about. (FN22 L59)*

About 30 minutes later Kay is discussing the patient with the student nurse

and said, *'The pain score is still 8 but she is much calmer, she seems a lot calmer now she has the oxygen on'*. (FN22 L125)

The field notes record:

*Again the focus seems to be on behaviour, does Kay think that the oxygen has made her pain better. And anyway now the patient is calm.*  
(FN22 L126)

SN Lorraine (P8) was observed one morning as she was doing the drug round. She went to a patient who had been spoken about at handover as having an anal wound that was being dressed twice daily with topical morphine added and was taking MST (long acting morphine) and oramorph.

The field notes record:

*Lorraine is preparing to give medications to the patient. The patient is trying to get Lorraine to engage in a discussion regarding the MacMillan Nurse instructions, but Lorraine is not listening ... The patient is told she had oramorph an hour ago, but that she is due her MST and Lorraine walked out of the bay. The patient called after her saying 'I am starting to climb the walls'.* (FN25 L118)

Lorraine did not acknowledge this remark from the patient, and when she was asked about this, she replied, *'she is not due any more oramorph, only the MST'* (FN25 L137). She continued the administration of the twice-daily controlled drugs, though she did not give this patient's MST for a further 25 minutes. This really minimised the engagement Lorraine had with the

patient, but also seemed to be as much as she could do; a single pain management action based it seemed on what was prescribed regularly, and what she had the time to do within the tasks she was undertaking.

There seemed to be no questioning of incidents, as evidenced by field notes which record comments made on a morning handover.

*SR Rene (P7) said about a patient, 'OD [overdose] on opioids yesterday so no morphine today'. There was no further information, what drug had she overdosed on, how much had she taken, was naloxone required (certainly there was no naloxone infusion), was she in pain now, had she been in pain, why had she taken the opioids (suicide or accidental); just a sentence – no opioids today because she overdosed yesterday. (FN3 L54)*

SR Alexandra (P8) a few minutes later at the sister's handover made a further comment about this case:

*'It was unlikely to be an opioid overdose as she had only had codeine'. This led me to think of even more questions, why did they think it was strong opioids, what had happened anyway, why does no one appear interested if the patient was in pain or required any opioids now. (FN3 L68)*

They seemed to be following instructions from the doctor; a single pain management action. The report below could be because of lack of knowledge or following orders without question.

*We were getting the oramorph for the patient. There was no discussion about the dose, only 10mg was prescribed. I noticed a fentanyl patch for 225mcg. SN Claire did know this but did not question the PRN dose, she did not ask the pain score, but simply gave the oramorph to the patient. She did not ask if it was enough, or if it had worked before. The documented pain score at 1430 was 6. (FN10 L61)*

*When asked about how nurses would know if an analgesic dose was effective SN Lesley was very clear, 'You need to check it, you need to go back in order to make sure your dose is effective', but I have never seen anyone do this. (FN9 L97)*

The field notes below demonstrate SN Kay (P16), assessing a patient for information she needs to make a pain management decision.

*SN Kay goes to the patient who appears to be sleeping, she wakes him. 'Good morning, how are you?' 'Not too good'. 'Are you in pain, where is your pain?' 'Mostly in my knee'. 'And on a score of 1-10?' 'A 5 I think'. 'Shall I give you some syrup to help you with the pain?' 'Yes please'. 'Is the pain constant?' 'Yes', says the patient. (FN 22 L177)*

She does give some PRN oramorph and then continues:

*SN Kay says, 'You can have syrup every 2 hours, don't hesitate to ask for it. The pain will stop you getting up otherwise and if you just lie still you will get sores'. 'I don't want to lie still but if I move around...' Kay interrupted the patient and said 'It is just difficult I know'.*

*I reflected that I would have thought it would be painful on movement rather than difficult. (FN 22 L201)*

The response from Kay, when it seemed the patient was saying he was unable to move because of pain, was deflected and therefore a further pain management response no longer required.

Another example below demonstrates how one pain management decision was normally felt to be sufficient. A patient was being observed and said she was in pain, so a nurse was informed.

*I found a nurse who said to me 'I gave her 60mg of codeine 2 hours ago, I know I did, because then I put the drug chart back, so she must be alright'. (SR Rene P7, FN15 L80)*

This next example again seems to demonstrate that one action, in this case distraction, is sufficient. Here SR Danielle and SR Rene are having a handover.

*A patient who was just back on the ward post ankle fracture repair is described as, 'in a lot of pain, agitated and itching ++, pain score of 12. He had 5mg in recovery, he is trying to distract himself with TV'. Nothing was mentioned about what else they would do. (FN5 L8)*

The inattention with which the nursing staff approached pain management opportunities, and the single pain management actions, was observed on every observation day, and seemed behaviours that were part of the culture of how pain management was performed on Newcastle Ward. It was seen in

pain assessment, analgesic administration and pain management actions. The nursing staff on Newcastle Ward said they were concerned about their patients' pain management, and really believed they were performing pain management as well, or as well as they could, however little observational evidence supports this.

In this section findings relating to pain assessment have been presented. It is demonstrated that 'how the patient looks' (Sjöström *et al.* 2000a) is the favoured method used to assess pain, though other factors also influence nurses, such as age, the patient condition, what medications the patients have had previously, and the nurses experience. The limited extent of nurses' pain management knowledge is revealed, and the inattention to pain cues observed in nurses on Newcastle Ward is demonstrated. It is uncertain if nurses heard or noticed these cues; they appeared to be mainly inattentive to any pain management issue that was out of the routine, only administering regularly prescribed analgesics, and performing inadequate pain assessments only at observation and less frequently at medication rounds. The evidence around the single pain management action is a new and novel finding, which along with a general inattention to pain management could explain many of the findings, for example inadequate pain assessment and inattention to pain cues. Patients are of course integral to any pain management in a clinical setting, and the next section explores findings relating to the third main theme of nurses' expectation of the role of the patient in pain management.

## **5.5 Nurses' expectation of patient behaviour and knowledge**

This section will present the findings relating the third main theme of the role the nursing staff believe the patient has in pain management within Newcastle Ward; how ward staff feel the patient should behave. There will be a data presented which demonstrates what factors are likely to make staff doubt the patient's voice, and what happens to these patients who can be labelled as non conforming. Data is presented to show how the patients' pain management can be affected by how ward staff perceive the patients' behaviour.

### **5.5.1 How the patient should look**

How the patient should look is an important aspect of how pain assessment is performed. Nurses in Newcastle Ward have been shown to make decisions regarding pain management using 'how the patient looked' as their principle decision-making tool.

*I will sometimes ask them what their pain score is, if I can't judge it by their face or if they won't ask for regular painkillers. (SN Tahlia P2, FN11 L1470)*

*It is how they look, because if they're in a lot of pain, you can tell from their face ... you can just tell, so I look at the patient as well. (SN Helena P18, FN16 L228)*

Sometimes nurses used this strategy when other evidence was available.

*She's still complaining of the same pain score [8] but I think she looked more comfortable. I did peek round there a little while ago, you know when there was no-one in there and she did seem, she was still and not kind of shifting about, she was just laying there. (SR Danielle P1, FN 13 L220)*

When asked a question at interview SN Tracey demonstrated how she thought she would use how the patient looked to make pain management decisions.

*PvR: If you were told a patient's pain is 8, what things about the patient would change or shape your decision?*

*How the patient was sitting up in a chair uncomfortably. Sometimes you just go to a patient and you can see it in their face, they are in agony. Sometimes you go there and they, yes they are in pain but they're not showing any severe signs of it, you know, they might be on the phone. You know if someone's come in with a very acute cholecystitis they are in the bed, rolling around, you know, they are in agony. (SN Tracey P37, interview L224)*

An HCA at interview had a similar view, though added in patient behaviour to help her make the decision of what to tell the staff nurse about the patient:

*By their face really, by their expressions, and then there are two sorts of people, there's the people that go very, very quiet and then there's the rowdy ones, you have to be careful of the ones that are very, very*

*quiet because they tend not to ask for any painkillers or anything like that so you have to ask them, you know because you can see on their face that they are in pain. Then you get the rowdy ones, that keep on and on and on. I would tend to trust the ones that are quiet really, rather than the rowdy ones, especially ones like that are on entonox and things like that, they tend to, you don't know whether they just want to take the entonox. (HCA Kate P30, interview L23)*

These findings were evident throughout the formal interviews, informal conversations, and the observations. Nurses and health care assistants believed how the patient looked and how they behaved was able to be used to verify their report of pain, and to assist nurses in making decisions regarding pain management. Newcastle Ward staff were also influenced by what the patient said.

### **5.5.2 What the patient should say**

Margo McCaffery's well known expression 'Pain is what the patient says it is, existing whenever the patient says it does' (McCaffery 1972 p. 8) could suggest that the patient has a role to play in their own pain management.

Patients were asked to make decisions about their analgesia.

*SN Lesley asked the patient 'do you think the paracetamol and the meptazinol is enough for your pain? If you want some stronger one, let me know because you can have it every 4 hours, you know the liquid one?' (SN Lesley P10, FN9 L36)*

Many nurses felt the patient had a big role to play in their pain management.

*I think the patients' role is to say that they are in pain, to make sure that they tell the nurses that they are in pain. ... so I think yes they have got a role to play as well.* (SR Jana P31, interview L99)

*They should let us know.* (SN Jennifer P35, interview L144)

There was a notion that patients knew quite a lot about pain management.

*I think they are quite clued up, I think sometimes they are more clued up than I am, although I think they are more focused on certain drugs.*  
(SN Karen P3, interview L287)

Often throughout the observations questions regarding patients and analgesia doses were met with comments like;

*I mean, obviously that patient needs to let us know that they are in pain.* (SN Emma P27, interview L31)

*If they were in pain they would say something.* (SN Claire P11, FN8 L36)

Patients were told to inform the nurses if they were in any pain.

*I'll always say if you need any, get back to me.* (SN Michaela P12, interview L101)

This was frequently seen on observation.

*If they don't work, let me know, I'll give you something else.* (SN Louise P22, FN21 L27)

*If you have any pain you will let me know won't you?* (SN Kay P16, FN22 L152)

These observations seems to be positive behaviour, with nurses involving patients in decisions about their care, an indication of best practice latterly set out by the Department of Health (2010b), although no discussion between nursing staff or patients about shared decision-making was observed.

Findings have been presented which indicate the expectations nurses have of what patient should say: they should tell if they are in pain, and they should ask for analgesics when they want them. The next section explores what nurses think patients should know about pain management.

### **5.5.3 What the patient should know**

There were indications of an expectation that patients would know as much as the nurses did, but this seemed to be mainly with regard to pain management.

SN Michaela (P12) asked a patient:

*'Would you like some painkillers?' As she was asking she gave the Ferrous and the Ranitidine without any question. I asked her to 'tell me more about the decision to ask about painkillers and nebulisers but not iron and ranitidine?' She replied, 'The patient can tell me about her*

*pain but will know nothing about her iron or if she needs her stomach acid neutralised'. (SN Michaela P12, FN10 L100)*

Field notes recorded further:

*I thought this was very interesting. Is this about the patient always knowing about pain? It assumes that patients know enough to treat themselves. Is this about everyone knowing about pain, that it is okay, expected, that nurses have enough knowledge and that patients have the same knowledge? (FN10 L103)*

Below Michaela is explaining discharge medications to a patient post appendectomy and demonstrates the level of knowledge she expects the patient to have.

*'This is paracetamol, take two four times a day, don't take any other flu tablets. Diclofenac, this is for pain relief and anti inflammatory, take one tablet three times a day. This is codeine, which are strong, take one or two, 4 to 6 hourly'. The patient asked 'What is the maximum of the codeine? So these are the main two, and use the codeine if needed'. Michaela said simply 'you can use them all at once'. (FN17 L31)*

The field notes added:

*I wondered if she felt her advice regarding discharge medications had been enough, and why advice regarding decreasing doses was not given. When I asked her she seemed to think that it was okay, that this*

*was quite normal, and that she had done it very well. She did not feel that patients needed more advice than she had given saying, 'I wouldn't take anything stronger if I didn't need it'. (FN17 L38)*

It seemed that if she knew about how to take a combination of three analgesic medications in the effective and appropriate manner, then it was certain the patient knew as well.

It could be patients did not feel they were able to ask any further questions. When discussing reasons that patients may not feel they can ask for pain relief a number of explanations were stated.

*They don't want to bother you and they don't. They all leave it for maybe hours until their pain gets to the maximum level rather than letting us know. We will have told them you're allowed your pain relief again in two hours if you need it let us know, so even if we come back they might say oh I'm not really in any pain, but their pain score might be 5 or 6. They'll wait until it gets to 10 and then tell you they're in pain, so in a way I think they should have a little bit of responsibility. (SN Emma P27, interview L37)*

It can be seen from the remarks and observations above, nurses on Newcastle Ward believed patients had a part of play in their own pain management. Patients were expected to ensure the nursing staff knew when they were in pain. This seemed to be more than simply being involved in the pain assessment, or part of a shared decision-making process (Department of Health 2010b). They were also expected to have a degree of

knowledge about analgesics, and to be actively involved in the pain management decisions. However nurses were also observed, on occasion, to be suspicious of patients. The following section will explain further what occurs if the patient seems to know too much, or is too involved in their medications.

#### **5.5.4 Patients who do not conform to expectations**

While the staff did not use the terms 'good' or 'bad' patient, it seemed apparent there were patients whose behaviour did not meet with nurses expectations. There were those patients who left the ward; this field note was made during a morning handover.

*A 16 year old man with a pelvic fracture, dislocated elbow and various grazes following a motorcycle accident, was talked about at some length regarding his behaviour, going of the ward when on bed rest, maybe smoking cannabis, but no mention of pain. (FN10 L14)*

At interview many nurses had a view regarding patients who left the ward to have a cigarette.

*Especially with the mobile patients that smoke, they ask you for pain relief and then walk of the ward and you go back with the painkillers and they've gone and when they come back they say 'I'm in pain and I've been waiting over an hour for pain relief', but they have been off the ward for 45 minutes. (SN Lorraine P8, interview L69)*

*It is a bit difficult, I think we all probably feel a bit miffed about the patients that go off for a cigarette although they are in lots of pain, they say can I have it when I come back. (SR Danielle P1, interview L126)*

There was the feeling that if patients could leave the ward for a cigarette then they were not in pain.

*Sometimes it can be frustrating if they have a cigarette and if they give them something for pain and then they have a cigarette. You try to think that they are in pain and you try to give them what they want but you know one time they are in pain and then another time they go down straight away for a cigarette. (SN Andrea P24, interview L72)*

*I don't understand ... they'll walk about, have a cigarette downstairs, and then come up and they'll be in pain, so 2 seconds ago they were running round the ward and they weren't in pain, and now they are. (SN Helena P18, interview P41)*

Patients who asked regularly for painkillers are treated with some suspicion. The gentleman mentioned earlier who was moved from a bay to a side room because he kept asking for morphine overnight serves as a good example, (FN4 L85). SN Janine (P23) shows her concern about patients who ask for painkillers.

*I had an experience with a patient, when I was doing the drug round, about half past nine, and I got to him and he said, I need to get my*

*morphine at 10 o'clock. And I said, if you are in pain, just ask me when you are in pain, I'll give you morphine, but he said I need my morphine at ten o'clock. I said that means that you say you will get pain at 2200.*  
(FN22 L25)

SR Rene was also reflecting on previous 'difficult' patients.

*I had three last week, one's in pain, then the other's in pain, then the other's one was in pain, they're all clock watching and they're all just winding each other up and asking for painkillers all the time.* (SR Rene P7, FN27 L13)

There is some concern about patients knowing their own drug schedules.

*There's some you don't know if they just making it because they can have the morphine and they go down for cigarette and come back, [and] as soon as they come back, the pain is there and they say can we have the morphine. They always know the time, they know exactly what time they can have the next one.* (HCA Ceri P36, interview L25)

*Last weekend [a patient] he was just asking for pethidine and every two hours, and its pethidine, you know what that means.* (SR Rene P7, FN27 L18)

Field notes reflected:

*Rene feels the patient is just in hospital because he wants pethidine. While this is not an unknown situation, she has said to me she does not*

*considered the patient to be in pain. This is a worry as he may be and is apparently being dismissed'. (FN27 L18)*

When SN Andrea (P24, interview L51) was asked if there were challenges to giving good pain management replied, *'It is more difficult if patients ask for pain relief every two hours'*.

Patients asking for pain relief when their signs of acute illness have subsided or when they are getting some analgesia are seen as uncooperative.

*She is on 10mg MST now and is still asking for it every hour, but her pancreatitis is much better. (SN Lorraine P8, FN25 L96)*

*But it is the ones that come in and they have all these tests done and then they come back with nothing, NAD [no abnormally detected]. (SR Rene P7, FN20 L99)*

Some patients were seen as attention seeking.

*Somebody will say oh nurse I'm really in pain, I'm really in pain. But when you look, ok you should always believe, but a lot of them you know ... they're not really in pain it's just attention seeking. (HCA Isabelle P28, interview L147)*

Some patients are seen as drug seeking, while others are seen as seeking both drugs and attention. The field notes recorded:

*Just following handover during the safety briefing there was a lady who was howling in pain, shouting, calling, crying, rolling around the bed.*

*Immediately SR Alexandra reported that a doctor had said this was 'drug seeking behaviour'. (FN19 L5)*

The patient had some analgesics and approximately sixty minutes later SR Alexandra said spontaneously to me:

*'All that noise, just nonsense'. I asked her if it did not upset her, that calling and crying? She replied, 'No, I feel nothing, nothing'. I wonder what this is about, bravado, unable to do anything so shutting off, genuine not caring. I get a sense that it is about people making that sort of noise, they must be just making it up, other people don't make that sort of noise. SR Alexandra said, 'The doctor said it was drug seeking behaviour, I say attention seeking'. (FN19 L29)*

Field notes reported at the time:

*Is it easier for the nurses (and doctors) to call this behaviour drug seeking or attention seeking, or to have an illness or symptoms that they have no explanation for? There seems a lot of it going on, though maybe that is my frustration. (FN19 L34)*

Many of these patients were seen to the nursing staff as people who are taking advantage of the NHS.

*What worries me is there are some patients who abuse the system.*  
(SR Rene P7, interview L66)

And it seems that this suspected misuse of the health system changes pain management care.

*I do think that there are a subsection of patients that know how to use the system ... you get somebody lying on the bed screaming that they are in pain and you respond, and the next minute they are downstairs having a cigarette and I think when you get that type of patient it doesn't take long to change the attitude of nursing staff to think no I'm going to give it to them in a few minutes, they are going to go down for a fag anyway, so they drag their heels, they maybe don't respond as quickly as they should. (SR Alexandra P32, interview L74)*

HCA Isabelle (P28) was also concerned about this patient group.

*Nightmare, absolute nightmare, pancreatitis, alcoholics, druggies, yeah, they want their PCAs, they want all their other bits and then they clear off the ward and then as soon as they come back they're in agony. They are the ones that you sometimes hold back on a bit because you think you can't be in pain because if you've been off the ward for all this time you couldn't do it if you was in absolute agony. So I think some of them they just come up for another shot and then they are off again and to me that's wrong. (HCA Isabelle P28, interview L137)*

It should be noted that not all nurses said they would alter their pain management for patients perceived as difficult.

*You can hear other people just thinking, oh my god, he's just gone off the ward and he only come back for his morphine. I always tell them don't judge them because we don't know how are they feeling. I don't want to judge them at all, if they are in pain, especially the pancreatitis*

*patients; some men are just really hiding it. I don't know maybe they are desperate for the medication but it is not for me to decide really.*

(SN Kay P16, interview L128)

It must have been difficult for patients to negotiate the middle ground between asking for analgesia as the nurses have requested, being aware of their own analgesic requirement having taken it outside of hospital, and the assumption nurses have of the patient both knowing their analgesic requirement, but not being allowed to insist on it.

But by far the biggest concern nurses had was about those patients who they saw as illicit drug users. It appeared nursing staff had some misunderstandings about the physiological consequences of taking illicit opioids.

*The methadone obviously affects their pain more than the average person, because their pain threshold is a lot lower than the likes of me so that were to be ... they don't feel pain as much.* (SN Tahlia P2, interview L86)

*He would not have a good pain threshold because he is a heroin addict.* (FN16 L148)

The young gentleman described below was severely injured by a person unknown and required emergency abdominal surgery. He came to the ward post operatively, in the presence of two policemen, there to protect him from

further injury. HCA Cheryl (P26) came to the clinical room and said to SR Rene (P7).

*'He is in so much pain, he is unable to pee and is really kicking off in there'. Rene said 'he is a cocaine, cannabis and alcohol user', she closed the door and whispered to me, 'he is a drug addict, you know what they are like, they metabolise it differently, it affects them differently'. (FN15 L10)*

Two days later when back on the ward this gentleman still seemed to be causing some concern as evidenced from the field notes.

*At the nurses' station SN Karen (P3) asked, 'is he withdrawing?' The doctor replied that the patient had been up front about what he takes and he said a little cannabis and alcohol. SN Lorraine (P8) and Karen appeared to disregard this information and both said they had lots of experience of people withdrawing from cocaine, while working outside the acute setting. (FN16 L119)*

In any hospital there will be a proportion of patients who were drug users; being an intravenous drug user is a high risk way of life. Many of these patients are on methadone as part of a treatment program, though some also use illicit drugs, relying on the daily methadone dose to stop withdrawal symptoms (Day & Strang 2011). A number of these patients were seen in Newcastle Ward during the observations. The healthcare professionals seemed not to wholly understand the needs of these patients. This patient

was seen on a routine morning drug round with SN Tahlia (P2) at about 0800.

*The patient says he has not had his regular medications for 3 days, I wonder if anyone has spoken to his doctor? He wants methadone, diazepam, zopiclon and mirtazepine, none of which are prescribed. The patient said 'I am starting to withdraw from methadone'. Tahlia did not appear to be listening to this, simply handed him the tablets that he was prescribed (diclofenac). The patient asked, 'Are they strong painkillers, because my leg was agony last night. I can't lift my leg it is excruciating'. Tahlia appeared to ignore this and said, 'I have given you diclofenac, it works really well with the other things you have had' (paracetamol & codeine at 0500). She appeared not to notice the issue of his methadone or diazepam which he had not had, and was asking for, or that he was saying he was in excruciating pain. She did not do a pain score, or asked him any questions about his pain, injuries, or drug addiction. (FN11 L30)*

This patient (PT1) was an addict who took 50mg of methadone daily though admitted he used illicit drugs as well.

*He says oramorph is stopping him from withdrawing but is not helping his pain. The paracetamol and diclofenac are helpful. His pain score is 8/10 on movement, 2 at rest. A doctor came and when the patient asked about methadone, the doctor said he was not certain he was allowed to prescribe methadone. (FN11 L81)*

Field notes recorded:

*I was a starting to get a little upset at the apparent lack of caring/knowledge about this patient's needs. Is it because it is methadone and the assumption (correctly mostly) that these patients are addicts that makes it okay for healthcare professionals not to meet their needs? (FN11 L85)*

Another patient had not been receiving daily methadone following his admission two days previously. This was discussed with SN Tahlia.

*Tahlia said 'it was the first time meeting him myself. [Whispering] He come in with a stab wound and he's a methadone user. [Methadone is used] 'to come off drugs. I had a placement at a drug unit that's the only reason I know it quite well. [If he does not get his methadone] 'he will get withdrawal symptoms. So I mean obviously he will become more anxious, it could affect his blood pressure, his recovery, so obviously we need to get that sorted out quite quick, I will bleep the doctors and say can you come and prescribe his regular medications, [the] patient is on methadone and hasn't prescribed it for a couple of days and he hasn't had it, so he needs sorting out NOW. So I will go and do that in a minute before I do anything else. (FN11 L113)*

Field notes recorded, 'It seems that once a medical reason (possible increased BP) for needing the methadone was found, then it became urgent'. (FN11 L142)

This attitude seemed pervasive; if the patient was a drug addict, or perceived to be one, the nurses and medical staff were less likely to respond to their medication or pain management needs.

Findings are presented which demonstrate the role nurses think the patient should play in their own pain management. Patients should ensure nurses are kept informed of the pain they are having, and they should know about their analgesia to the extent to be able to decide when to have them or not. Conversely it appears that if patients ask too specifically for analgesics, or in a too emotive way, they are treated with suspicion and their pain management can be disregarded.

## **5.6 Summary**

This chapter has presented the findings of this ethnography. Newcastle Ward has been described and the ward processes which underpin and inform pain management have been demonstrated. The culture of the ward has begun to be revealed through the views ward staff have about both the ward, and performing pain management within it. A new finding of the silence of routine pain management communication is presented. Pain is not mentioned at any handover for routine patients, only for those few who are seen as difficult patients. Pain management roles and tasks have been described, including the role clinical leadership has in both establishing and maintaining the set duties.

Pain assessment is seen to be performed predominantly without the patient's self report, mainly relying on how the patient looks, supported by what the ward staff expect the pain to be. The pain management knowledge ward staff have is demonstrated; the ease and familiarity they have with common analgesics, accompanied by their relative lack of understanding of strong opioids. It is shown nursing staff are using their own experience as an influencing factor for pain management decisions, rather than any education they have had, or the evidenced based guidelines available to them.

There is a new finding demonstrating the ward was inattentive to pain management which led to ward staff performing largely single pain management actions. Inattention to pain cues which is seen in these findings, and has been described in the literature, could come from the general inattention to pain. Many decision-making opportunities for dealing or engaging with a patient's pain were not acknowledged and consequently missed. When nurses started a pain management process they would largely stop after a single action, seemingly doing only those things easily accessible to them.

The final section of this chapter presented the findings related to the role the ward staff thought the patient should have in the decisions made about their pain. Findings show ward staff thought patients should look like they are in pain, should say when they are in pain, and know what medication they require. Nurses were seen to involve patients in decisions about their pain management care, however conversely, and probably confusingly to the patient, findings have also been presented which highlight what happens

when patients act in ways which do not conform to these expectations. The following chapter will discuss these findings, leading to an explication of what factors influence Newcastle Ward nurses when they make pain management decisions.

## **Chapter 6      Discussion and conclusions**

*“Our beliefs do not sit passively in our brains waiting to be confirmed or contradicted by incoming information. Instead they play a key role in shaping how we see the world.” (Wiseman 2011 p. 8)*

### **6.1            Introduction**

In this chapter the findings from this ethnography are discussed. The discussion is structured by the aims of the study, within the context of the wider literature including social psychology, national health policy, and clinical leadership. The factors influencing nurses when they make pain management decisions in a clinical setting are multifarious and can be complex, though these factors are largely integrated into the culture of the clinical environment, which affects pain management practice.

In summary, this study found that ward staff, both registered nurses and healthcare assistants, have a clear understanding of both what pain management means for them and patients, and their responsibility towards pain management. All ward staff, described Newcastle Ward as a busy, short-staff ward, with complex patients. Pain was not a priority, and a resulting inattention to pain management by ward staff was observed. The silence of routine pain management communication, and nurses performing a single pain management action are presented as new findings.

Using social psychology as a framework, how this culture of inattention to pain management may have developed is explored. The social identity perspective (Hogg & Reid 2006) explains Newcastle Ward as an in-group,

and demonstrates how pain management behaviours are maintained as part of in-group norms. Social cognitive theory (Bandura 1989) and cognitive dissonance theory (Festinger & Carlsmith 1959), further informs how these in-group behaviours are learnt and maintained. The implications of in-groups, and the ways of influencing their behaviour are discussed. A summary framework model to facilitate understanding of how the findings as discussed fit together, is presented.

The limitations of this study are considered, and a conclusion summarising the contribution this study has made to the pain management knowledge is presented. Using the conclusions, the section which follows make recommendations for practice and research.

## **6.2 Pain management culture on Newcastle Ward**

This section will discuss the findings associated with the pain management culture on Newcastle Ward, and how this affected the pain management decisions made by nurses. The processes which underpin pain management on the ward are discussed, while demonstrating how the ward staff work within Newcastle Ward, and how they define the ward. A heuristic, used by ward staff is presented as a motif central to ward culture, and how this has consequences for pain management is discussed. How national and local health performance targets have influenced the working practices on Newcastle Ward are explored, concluding that because of competing considerations, pain management is not a priority.

### 6.2.1 Pain management within a ward environment

The physical environment of a setting will have an impact on how nurses work occurs within that setting (Thompson *et al.* 2008c). The ward however, is in many ways, a typical surgical ward in a District General Hospital (DGH) in the UK. Thirty bedded wards are not uncommon and the layout of four six-bedded bays and six side rooms, based along a single corridor is fairly typical (Dr Foster 2012). Delivering same sex accommodation, latterly developed into Eliminating Mixed Sex Accommodation (EMSA), a Department of Health (2010a) initiative aimed at ensuring patient privacy and dignity, meant the bathrooms on the ward were no longer shared by members of the opposite sex, though the bays had always been strictly divided into two male and two female bays. The client mix is again typical of a surgical ward in a DGH; there would always be surgical and medical outliers; patients who did not sit within the ward speciality.

The NHS Operating Framework sets out annually “*the planning, performance and financial requirements for NHS organisations in 2012/13 and the basis on which they will be held to account*” (Department of Health 2011 p. 7), prescribing how NHS Trusts are performance managed against targets.

There would be few who would argue against a focus on dementia, heart disease, diabetes, cancer, mental health (these are mentioned most often), or that attention was needed around patient safety, falls, pressure ulcers and infections, however there is no mention of pain. Similarly a joint report from the NHS Institute of Innovation and Improvement (NHSI) and the NMC, High Impact Actions (NHSI 2009) set out directives to all nurses to improve care

with eight specific conditions, and again pain and pain management are not included. These national documents provide the focus for performance at Trust and subsequently ward level around specific targets, and pain is not mentioned.

There was an Essence of Care document published in the second round of this series of documents, entitled 'Benchmark for the prevention and management of pain' (Department of Health 2010c). This is a comprehensive document, developed with input from pain management Clinical Nurse Specialists, setting out excellent standards of care for pain management, however there is no evidence in literature to confirm it is being used, or has impacted on pain management care.

Pain is mentioned as part of recent NICE guidelines (NICE 2012), designed to provide evidence for the required cultural shift to truly patient centred care through a focus on the patient experience. It does deliver clear instructions to not assume the patient is pain free, to ask patients regularly about their pain using a pain scale, and provide analgesic measures.

These documents aside, pain management is rarely mentioned at a national healthcare level except at specialist conferences and meetings, where professional colleges and specialist societies provide guidance for pain management. As pain is not mentioned in the large group of performance targets or aspirations, it is left to local Trusts to decide to commission pain management teams according to British Pain Society guidelines (Faculty of Pain Medicine 2010). It is these pain management teams which provide the

focus for pain management within the Trust, providing expert knowledge, policy and procedure development, but in many cases are not able to ensure the Trust prioritises pain management (McDonnell *et al.* 2003, Powell *et al.* 2009b).

The Trust did have a pain management team based on a common model, as advised by the BPS (2010), and shared with the large majority of NHS Trusts in England (Powell *et al.* 2004). Newcastle Ward staff saw the pain management team as a valuable resource and as providing an excellent service, however the pain management team said they struggled to improve pain management practices within the Trust. Powell *et al.* (2004) stated 52% of the hospitals surveyed, described their postoperative pain management services as 'struggling to manage', stating lack of resources and commitment from management and commissioners, as barriers to developing acute pain services. A later study suggested this would not change until sufficient local organisational change occurred which addressed attitudes, beliefs and assumptions of staff groups (Powell *et al.* 2009b).

### **6.2.2 Local pain management policies and procedures**

Extensive evidenced-based pain management policies and procedures were present on Newcastle Ward (appendix 6). While there was awareness among the Newcastle Ward staff that these policies and procedures existed, no one described accessing them either via the intranet or the Pain Folder. Manias and Street (2000b) reported nurses having a good knowledge of department policies and guidelines and using them to inform their decisions;

this was not seen on Newcastle Ward, where findings demonstrated nurses using their own experience over pain management guidelines to inform their pain management decisions. This is supported by Rycroft-Malone *et al.* (2009) who found nurses preferred to use their own 'mental flowcharts', referring rarely to written protocols. Nonetheless there remains a requirement for multidisciplinary pain management policy development to encourage standardisation of care (Rycroft-Malone *et al.* 2009), and effective decision-making (Subramanian *et al.* 2011).

### **6.2.3 Pain management link nurses**

Link nurses, aligned to a specialist subject, have been used to disseminate knowledge from clinical nurses specialists to the ward based nurses for many years (Tinley 2000), though there are a number of barriers to its effective use (Hasson *et al.* 2008). The Pain Control Lead initiative used on Newcastle Ward comes out of a perceived local failure of this model. The requirements within the process of becoming a Pain Control Lead were designed to give the nurse increased knowledge and some ownership of pain management. Social psychology suggests that this approach should have had an effect as it offers recognition and reward and an obligation to reciprocate (Redelmeier & Cialdini 2002). Hasson *et al.* (2008) however, suggest link nurses work more effectively in clinical areas with strong management support for the subject, and Newcastle Ward could not demonstrate this commitment. Newcastle Ward senior nursing staff did not know who the Pain Control Lead was for the ward. The ward was not able to supply a registered nurse for the programme, sponsoring a Health Care

Assistant instead (HCA Denise). Ward staff were not seen to value her input, and in many ways she was left to assume the responsibility of pain management, albeit at an HCA level. Ideally she would have had meetings with Newcastle Ward clinical leaders to establish what projects should be concentrated on, and provided with sufficient resources to undertake them (normally time) (Hasson *et al.* 2008). Denise reported never discussing the Pain Control Lead role with the sisters, and she undertook any project work in her own time. The lack of support with resources and little or no input to ensure any projects proposed matched Trust or ward priorities, meant the Pain Control Lead, while enthusiastic, would struggle to be effective in this role (Cotterell *et al.* 2007).

#### **6.2.4 How Newcastle Ward was defined by the staff**

What nurses' thought about Newcastle Ward was important; it guided how they perform their nursing role (Laschinger *et al.* 2009). Nurses saw the ward as a busy, short-staffed ward with many complex patients. This image of the ward was maintained by daily reference to some part of this image. This could be described as a heuristic, a mental shortcut allowing people to make judgements quickly and without effort. While heuristics are usually used as a device for decision-making (Cioffi 1997, Gigerenzer & Gaissmaier 2011), in this case it describes a shared culturally determined picture of Newcastle Ward. This heuristic was available to all staff, and they were seen to use it frequently whenever they required a description of what it was like to work on Newcastle Ward.

When nurses were describing the ward, or their day, the most common word used was busy, followed by short-staffed and then complex patients. Senior Sister Alexandra used these terms many times in the study; when interviewed, during informal conversations, and she was observed to speak in these terms to the staff during the shift. It is true Newcastle Ward often had a diverse group of patients, and as such nursing tasks often had to be re-prioritised, in common with findings by Thompson *et al.* (2008c). There is no question there was a lot to do on Newcastle Ward; the patients often had complex surgery, complications or conditions, which meant frequent and close observations were important.

Thompson *et al.* (2008b) defined busyness as, “*An individual perception of internalized pressure created by a situation where there is a shortage of time to accomplish valued work*” (p. 542). They continue this definition to say it is characterized by “*much action or motion*”. This definition describes very clearly the situation on Newcastle Ward as evidenced by this field note, ‘*there seemed to be a lot of activity, lots of tasks, bed making, observations, washes, drug rounds*’ (FN2 L28). Scott and Pollack (2008) suggested being busy meant nurses were fulfilling their role, while Manias and Street (2000a) described this phenomenon as the tyranny of busyness; the level of activity which needed to be maintained otherwise staff felt undervalued.

This interpretation of being busy as having value was not evident in data from Newcastle Ward. Busy was a word used to describe the ward, to illustrate their activity, part of the label for Newcastle Ward. This heuristic of being ‘busy, short-staffed and working with complex patients’, did have an

effect on the ward however. It appeared to obstruct Newcastle Ward staff from reflecting on the tasks and duties they were performing, and certainly impacted on how they prioritised pain management.

Within the context of being busy, short-staffed, and looking after a complex patient group, and within the wider healthcare environment which values innovation to provide efficiency and effectiveness (Department of Health 2011, Monitor 2012), concentrating on specific patient issues such as pressure ulcers, patient dignity, nutrition, patient safety, with plans to realign and reform the whole NHS, it could be said pain management is not a priority. Not for the healthcare economy, and perhaps as a result not for Newcastle Ward. This conclusion, that pain management is not a priority, has been identified previously in the literature (Goldberg & McGee 2011, Nielsen *et al.* 1994), though this is largely been discussed in the context of chronic pain. The consequences of not prioritising pain for inpatients are discussed in the next section.

### **6.3 Consequences of not prioritising pain management**

The consequences of non-prioritisation both for pain management culture, and subsequent practice is explored initially through an examination of pain management roles and tasks. The silence of routine pain management communication is new knowledge regarding the factors influencing nurses when they make pain management decisions in a clinical setting, and this is discussed, followed by a brief examination of the role of clinical leadership in maintaining culture.

Nurses are required to constantly reprioritise their tasks due to competing demands on their time (Thompson *et al.* 2008a). Priorities mandated nationally are important to the healthcare organisation and the emphasis on specific targets will be apparent when ward staff decide in what order to perform nursing tasks. If pain is not a priority, as was seen on Newcastle Ward, there will be an inattention to pain management as ward staff concentrate their efforts on duties with a greater priority to them. This inattention in pain management on Newcastle Ward was demonstrated in the low status of pain management tasks, and with a new finding of silence of routine pain management communication.

### **6.3.1 Pain management roles and tasks**

Roles and tasks of pain management within Newcastle Ward were performed by specific staff groups. While there was some overlap in tasks allocated to the different roles, a member of one group performing a task of another group was rarely observed. It is difficult to find any support for this model with such rigid boundaries in the literature. Much of the evidence suggests collaborative models of nursing care, with both HCAs and RNs working closely together (Butler-Williams *et al.* 2010, Spilsbury & Meyer 2004). This did not occur on Newcastle Ward where the lines between different roles appeared inflexible.

Manias *et al.* (2006) suggested pain assessment was performed at times convenient to nurses; the start of day, at patients' observations, or at nursing handovers. In Newcastle Ward, pain assessment was performed by HCAs,

as a component of patient observations, and less frequently by RNs, at medication rounds. This separation of pain management roles is not discussed in other pain management observational studies. Brown and McCormack (2006) suggest registered nurses thought of the medication round as a necessary evil, a task to get finished quickly, and said nurses could have missed the opportunity to assess the patients pain in a meaningful way. In common with Brown and McCormack (2006), the emphasis on Newcastle Ward was to complete the medication round, rather than to use the occasion to engage with patient about their pain or pain management.

### **6.3.2 Pain management communication**

If something is spoken of often within an environment, it has a likelihood of being seen as important or even defining (Cialdini 2007 p. 57, Redelmeier & Cialdini 2002). The heuristic describing Newcastle Ward is a good example of this, it was reiterated frequently and became the defining image of the ward. Pain management however, was rarely discussed on Newcastle Ward, either at formal shift handover or other more informal conversations. The extent of the silence of routine pain management communication which was observed in Newcastle Ward is not apparent in the literature, and is presented here as a new finding; a contribution to the explication of factors which influence nurses pain management decisions in a clinical setting.

Whenever nurses were asked about pain management, they replied pain management was very important to them for a number of reasons: patient

recovery, patient comfort, shorter length of stay, less complaints. This however was not evidenced in the observations of communication, when a mention of pain within ward staff communication was infrequent, including at shift handovers. Brown and McCormack (2006) suggest a similar pattern in the handovers observed in their study, with pain not mentioned routinely, and in a later work identified interruptions to handover as having a significant impact on communication (Brown & McCormack 2011). Manias and Street (2000a) suggest nursing handovers take different forms and serve different purposes, which is supported by findings from Newcastle Ward. The formal shift handover was also about task allocation, team building (Mayor *et al.* 2011), censure if an error or complaint had occurred; in fact many of the elements as discussed by Chaboyer *et al.* (2010) as important components of shift handover: passing on clinical information, mentoring, teaching, forward planning. It appeared pain management however, was not one of the clinical information elements considered relevant.

Despite the predominance of silence, pain was discussed for two small groups of patients. Nurses discussing pain management differently for different groups of patients, has been demonstrated for many years (Blomqvist 2003, Wiener 1975). These were typically the only conversations observed about pain management, at handovers, informal conversations, and observations. Davitz and Davitz (1981 p. 165) perhaps summarised it best when they said, "*Most nurses' report a clear distinction between those patients 'who have a right to complain', and those who are merely*

*'complainers'. These patients tend to elicit irritation, anger, and rejection on the part of the nurse".*

On Newcastle Ward some patients were described as difficult or frustrating, and along with a few patients who pain was believed to be 'real', nurses found their pain difficult to manage. If at a handover, staff were discussing a 'frustrating' patient as defined by Blomqvist (2003), with an element of disbelief about the stated level of pain, sisters failed to take the opportunity to stifle this behaviour, choosing mostly to join and contribute to the conversation. If clinical leaders role model behaviours, this makes these behaviours acceptable and routine (Redelmeier & Cialdini 2002, Stanley 2006).

Fagerhaugh and Strauss (1977 p. 278) suggested organisations should ensure responsibility and accountability regarding pain; the same suggestion has most latterly been made by Powell *et al.* (2009a). However as no censure from the clinical leaders around any aspects of poor pain management practice was observed on Newcastle Ward, it seems this organisational or clinical accountability has not been assigned. Pain management was said by the Newcastle Ward staff at interview to be everyone's responsibility; however no one was held accountable for breaches in pain management care. Potential or actual rebuke from the CNS in Pain Management was mentioned by some ward staff, but as the pain management team was outside of the ward, with an admonishment which could be seen as discouraging ward staff (Brown & McCormack 2011), and with no comment or guidance from inside the ward line management

structure, this was unlikely to affect anything except the relationship between the CNS and the staff member (Cialdini 2007 p. 212).

### **6.3.3 Clinical leadership**

Clinical leadership on Newcastle Ward was usually transactional, largely responsive, and focused on the day to day of getting necessary tasks completed. Any incident was dealt with by stressing corrective actions to improve performance, relying on staff being motivated by their own self interest of not getting into trouble. The Senior Sister Alexandra, was a committed and experienced nurse, who typically worked in a supervisory role as is suggested by the RCN (2009). However she was observed to use a transactional leadership style, with the key intention to create harmony in situations, to remedy team disagreements, or to encourage staff during stressful circumstances. In terms of her influence on the pain management culture of Newcastle Ward, by using this transactional leadership style, she reinforced the inattention with which the ward staff interacted with pain management opportunities (Cummings *et al.* 2010). In this way she was role modelling this behaviour (Salmela *et al.* 2012). Gifford (2007) suggested behavioural change is unlikely to occur or be sustained without managerial support, which is integrated with organisational objectives and policies, and there was no evidence of this support for Alexandra on Newcastle Ward.

### **6.3.4 Summary**

This section has discussed Newcastle Ward, and how the day to day work of healthcare provision is undertaken. NHS policy can be seen to mandate

clinical and healthcare process with important priorities becoming part of NHS performance management (Department of Health 2011, NHSI 2009). That pain management is not part of this focus goes some way to ensuring pain is not a priority at a Trust or ward level. The new finding of silence of routine pain management communications is demonstrated to be a factor which influences Newcastle Ward nurse's pain management decisions by ensuring the inattention to pain management caused by the lack of prioritisation of pain continues. The next section explores nurses understanding of pain management and their responsibility for it.

#### **6.4 Nurses' understanding of pain management responsibilities**

This section discusses how nurses understand their responsibilities regarding pain management, and their responses to this responsibility with regard to clinical pain management decisions in Newcastle Ward. Within this section where the nature of ward staffs' pain management decisions is explored a new finding emerged; staff were seen to make a single pain management action following a decision. This finding is aligned with the silence of pain management communication discussed earlier, as silence and this single pain management action, while different functions, could arise from the same culture of not prioritising pain. Other aspects of nurses' pain management are examined as part of the shared culturally determined strategies available to them; ineffective pain assessment, poor pain management knowledge and inattention to pain cues. These are considered

in the context of being part of a culture that does not prioritise pain management.

#### **6.4.1 A single pain management action following a decision**

Nurses on Newcastle Ward appeared to use pattern recognition to make decisions. They seemed to have an immediate heuristic to deal with all pain management situations. Pain management strategies which were too challenging appeared to have a culturally shared heuristic of avoidance or resignation. Hansson (2006) asserts decision-making is a contextual complex process, including personal and cultural factors. By the homogeneity of the types of decisions made, and the similarity of the actions, it seems the culture of Newcastle Ward largely provides the context to the pain management decision-making process.

A new finding emerged from the data demonstrating nurses' pain management decision-making and subsequent actions. It was observed when nurses performed a pain management action, only a single action was performed. It could be argued that one pain management action would be enough if it were the appropriate one, however unless a further action is taken to assess the effectiveness of the first, one action cannot be considered sufficient (Department of Health 2010c).

Some elements of this finding have been reported previously in pain management literature. Manias *et al.* (2005) found no further pain assessment questions were asked of patients if they had a pain management device. Brown and McCormack (2006) described nurses as

being competent with pain management to a certain degree, but if the situation was too complicated nurses had scarce options accessible to them. In common with Bucknall *et al.* (2007) nurses on Newcastle Ward failed to reassess patients after administration of analgesics.

Bucknall *et al.* (2007) suggest it is because of the busyness of nursing work, lack of nursing knowledge around pain management, lack of patient knowledge, and no pain management decision-making tools readily available in busy clinical environments. These conclusions do not readily fit with what was observed in Newcastle Ward; the nurses were being educated, and pain assessment scores were mandated, though not always used. It was as if a patient could only receive one pain management action; nurses did not appear to consider there was anything else they could do. The findings from Newcastle Ward seemed more around a culture of only performing single pain management actions, at medications rounds, observation rounds, and less frequently if a patient asked for extra analgesia.

Bucknall *et al.* (2007) suggested actions were performed only on external decision-making triggers. While pain management actions on Newcastle Ward were largely performed at these same external decision-making triggers (observation rounds, medication rounds), an alternative explanation could be that pain management was not a priority, enabling a culture which is inattentive to pain management ensuring decision-making triggers continue to be the only points of action.

So while Manias *et al.* (2005), Bucknall *et al.* (2007), and Brown and McCormack (2006), have reported on one aspect of this lack of pain management follow-up, on Newcastle Ward it was observed to be a part of every facet of pain management. Nurses would only perform those pain management actions the ward culture expected of them, inadequate pain assessment at an observation round, administration of regularly prescribed analgesics, the occasional PRN medication after a patient request. Following these and any other pain management action, nothing further was observed. This is presented as a new finding of nurses performing a single pain management action. It is suggested this finding is a function of the pain management culture within Newcastle Ward; a shared culturally mediated strategy for pain management. There are other shared culturally determined pain management strategies used by Newcastle Ward staff. These are grouped around pain assessment, pain management knowledge and inattention to pain cues.

#### **6.4.2 Culturally shared pain management strategies**

Many of the elements of the pain management behaviour appeared to culturally shared. Lauzon Clabo (2008) found different models of pain assessment on the two units studied, asserting it was the culture of the unit which enabled the pain assessment behaviours, with nurses who could not work in the culturally shared way leaving. Within Newcastle Ward as well as the performing of a single pain management action, the areas of pain assessment, nursing use of pain knowledge, and nurses' inattention to pain cues seemed to be shared behaviours.

### 6.4.3 Inadequate pain assessment

Pain assessment is the first step in pain management (van Dijk *et al.* 2012), and the findings from Newcastle Ward show nurses did not perform pain assessment to the standard indicated by Trust policy. Nurses used an element of 'how the patient looked', what operation the patient had, and their own experience, as indicators of the patient's pain.

A verbal rating scale (0-10 on movement) was part of the Trust policy on pain management, indicated on the patient observation chart, and taught both formally at yearly training, and informally at ward visits by the Trust pain management team. The pain assessment policy was available to all staff on the Trust Intranet, and as a hard copy on the ward. Findings however demonstrated nurses rarely used this pain assessment tool to measure patients' pain. Many nurses, in common with findings from other studies which have investigated pain assessment, depended on the typology of the patient to inform their pain assessment (Hirsh *et al.* 2011, Hirsh *et al.* 2009, Klopper *et al.* 2006, Sjöström *et al.* 2000a).

Pain assessment in Newcastle Ward was often performed by the use of simple questions, for example '*Pain?*' Brown and McCormack (2006) also found nurses using simple questions to assess pain, like '*You ok?*', and suggested the use of these very basic, general questions were particularly directed at the older patient. On Newcastle Ward these types of questions were observed to be used with all ages of patients, while Manias *et al.* (2004b) also found nurses preferred to use simple questions to evaluate the

patients pain, without any hint this truncated pain assessment was being directed at any age group. Whether directed at any specific group of patients or not, these basic questions, asked without the context of a full query or a formal pain assessment, can easily be misunderstood (Manias *et al.* 2004b).

Nurses on Newcastle Ward were comfortable using facial expressions, body language and the typology of the patient to assess pain, being confident in their ability to correctly assess the patient's pain using these methods. A nurse's pain assessment which used the combination of '*How the patient looked/I have learnt the typology of patients*' was found by Sjöström *et al.* (2000b) to result in less accurate pain assessment. On Newcastle Ward the patient's operation or condition was often also used as a way of determining or confirming the patients report of pain, supporting findings by Manias *et al.* (2002) where nurses are reported as associating specific conditions with a predetermined severity of pain.

Newcastle Ward nurses were being educated and instructed to perform pain assessment in a prescribed evidenced based way, however they were observed to value their own experience and opinions above other sources of knowledge. Willson (2000) suggested nurses had their own model of pain assessment, which was based in their experience. This experiential model is further supported by Lauzon Clabo (2008) who found nurses in the same unit used pain assessment practices which were remarkably similar to each other. Sjöström *et al.* (2000a) suggests this experientially learnt behaviour

with the resultant use of the strategy 'I have learnt a typology of patients/How the patient looks', is sufficient in itself to explain poor pain assessment.

If nurses did perform a pain assessment, using the prescribed tool, a simple question, or their experience with facial expressions and body language, it was not always documented on the observation chart. This picture of pain assessment documentation is echoed in literature. Willson (2000) found nurses did not feel they had the time to document pain scores. This is supported by Manias *et al.* (2004b) who found nurses documented a verbal pain assessment on only half of the appropriate occasions. Nash *et al.* (1999) suggests nurses are more likely to report pain verbally than document it, however evidence of this was not seen in Newcastle Ward, where nurses would rarely speak about pain, either at handover supporting Brown and McCormack's (2006) similar findings, or during any routine observations of care.

How nurses performed pain assessment has been discussed within the context of the wider literature. The factors which influence Newcastle Ward staff's decisions around pain assessment are: the value staff place on their own experience and, their confidence in their ability to see if the patient is in pain, or to anticipate when they will be. Pain assessment on Newcastle Ward was performed in a largely nonparticipative way, with little evidence of shared decision-making supporting Manias and Williams' findings (2008), maintained by a inattentive pain management culture. A nurse's lack of pain management and analgesic knowledge is often cited as a barrier to effective

pain management. The findings from Newcastle Ward about pain management knowledge are discussed in the next section.

#### **6.4.4 Pain management behaviours arising from knowledge**

Nurses were uncertain about their knowledge of pain management, though when questioned they all limited this lack of certainty to knowledge of analgesics. The confidence nurses on Newcastle Ward had with weak opioids and simple analgesics may have less to do with those particular drugs, and more to do with their uneasiness with stronger opioids. This apprehension with opioids has been widely discussed in the literature, with findings demonstrating nurses would prefer to administer a non opioid analgesic (Edwards *et al.* 2001), would give a less than effective dose even in the face of severe pain and minimal side effects (Gordon *et al.* 2008), and that addiction was seen as a very real problem with the use of opioids for postoperative pain (Broekmans *et al.* 2004).

Findings from observational studies have given more detailed information about this behaviour. Willson (2000) found nurses were more confident with weak opioids and simple analgesics. Bucknall *et al.* (2007) suggested neither nurses nor patients have enough clinical knowledge about pain management, while Manias *et al.* (2002) suggested nurses do not have opportunity to be skilled at pain assessment and management as they are too busy. Observations in Newcastle Ward, and transcripts of mandatory teaching sessions, show nurses were being informed about strong opioids, so it would be incorrect to suggest this information was not available; it is

perhaps more interesting to examine why this education is not used by nurses.

As Newcastle Ward was a postoperative ward, patients frequently had either patient controlled analgesia device (PCA) or an epidural for a number of days postoperatively, a picture that reflects national trends (McDonnell *et al.* 2003). There were also patients, who were given painkillers and other medications via a syringe driver. The data show patients with pain management devices were treated differently from other patients; the device added a different dimension to the patient. While Brown and McCormack (2006) described pain assessment improving with this patient group, the current study found patients with pain management devices were considered to be in charge of their own pain management, and had little pain management nursing input. This is supported by King and Walsh (2007), who described nurses feeling the control the patient had over their own pain as the most important feature of a PCA. King and Walsh (2007) also articulated how a PCA was seen by nurses to free up scarce nursing time, though they acknowledge there was seldom enough time to do all the observations a PCA required, in support of findings by Thompson *et al.* (2008c).

The nurses on Newcastle Ward were skilled at using the pain management devices, however were observed to be somewhat perfunctory in their management of patients with these devices. If a patient had a PCA and was complaining of pain, they were told to 'press the button more often', as if this was the only option available to either the patient or the nurse; a single pain

management action. This observation supports earlier findings that suggested nursing staff valued the control the patient had with pain devices (Chumbley *et al.* 1998, 1999, King & Walsh 2007, Taylor *et al.* 1996). These more sophisticated medical devices delivering analgesia were seen as moving the responsibility of pain management to the patient (King & Walsh 2007), though in common with findings from Newcastle Ward, no education or explication of this responsibility to the patient was observed; the nurses appeared to make the assumption patients knew this.

This section has discussed the pain management knowledge nurses have and the behaviours which can arise from this knowledge. The nurses' pain management decisions were influenced by their attitudes and understanding of analgesics, including the fear of side effects of opioids. The use of more sophisticated devices to administer analgesics showed nurses limiting their pain management involvement and decisions to the pain management pump. These factors were part of the inattentive pain management culture.

#### **6.4.5 Inattention to pain cues**

Inattention to pain cues could be considered part of the general inattention to pain management on Newcastle Ward, caused by not prioritising pain.

Nurses were often observed to not attend to cues that the patient was in pain or required pain management. Patients would say to nurses they were in pain, or that their movement or activity was restricted by pain in some way, yet nurses were often observed, at best, to acknowledge the comment with a kind remark but with no following action. There were occasions where a

patient was observed to request painkillers and analgesics were promptly administered. However on many other occasions, equally well defined verbal prompts and behaviours appeared to be disregarded. These findings are supported by Manias *et al.* (2005 p. 27) who described nurses as '*paying little attention to pain cues*'. They suggested this was because nurses and patients believed some pain was bearable and inevitable, a finding not supported by findings from Newcastle Ward. Inattention to pain cues is also discussed briefly by Dihle *et al.* (2006), however they proposed this was because of a deficit in nurses' empathy and recommended empathy should be taught through nursing education. Manias *et al.* (2005) suggested the inattention to pain cues was simply they were not being prioritised; they were considered less important in comparison to other nursing activities. It seems in the light of the Newcastle Ward data, inattention to pain cues is a part of the inattentive pain management culture.

The culture of a healthcare organisation is influenced by the wider political and legislative culture of healthcare, including the wider culture of nursing within the UK. The culture of a clinical ward is influenced by the culture of the hospital but also by that same wider culture of nursing. Nursing priorities have latterly been given higher importance within healthcare (Department of Health 2010c), however these nursing priorities do not include pain, which goes some way to ensuring nursing culture remains inattentive to pain management.

## 6.5 The patient's role in pain management

This section discusses the findings around the role the nurses on Newcastle Ward expected the patients to play in their own pain management. There is a tension arising from the nurses' expectations of patients' behaviour and what occurs if these expectations are not met. A set of rules for patients, from a nurse's perspective, emerged from the findings. A similar set of unwritten rules for nurses with regard to pain management, did not immediately suggest itself from the data. The inattention to pain management demonstrated by nurses discussed throughout this chapter can also be seen in this section.

Patient centred care has been firmly established by Equity and Excellence: Liberating the NHS, the White Paper for NHS reform (Department of Health 2010b) with the phrase "*No decision about me, without me*". While this could be said to be a political slogan, rather than a true value statement, it is branded by the Department of Health as a firm commitment to ensuring the involvement of patients as partners in their care as described by Edwards and Elwyn (2009). Patients should be at the centre of healthcare (Staniszewska & Henderson 2005), with patient centred care being defined by Pelzang (2010) as, "*considering the patient's point of view and circumstances in the decision-making process*", adding it went beyond goal setting exercises with the patient. The Code (NMC 2008), the standards of conduct and performance for nurses and midwives in the United Kingdom, says specifically in paragraph 8, "*You must listen to the people in your care*

*and respond to their concerns and preferences*". It is established nurses are required to listen to their patients; this is the cornerstone of patient centred care. Patient centred pain management care would encourage the patient to be an equal partner in their care, an active participant in pain assessment, involved in the decision about what pain management strategy to use (Manias & Williams 2008).

On Newcastle Ward the patient's own pain assessment was distrusted if it failed to meet the nurses' expectations of the situation. This is not a new finding; over four decades ago Wiener (1975) identified nurses who were labelling patients as difficult and clock-watchers because of nursing staffs' difficulties in dealing with their pain. Lauzon Clabo (2008) reported nurses readily informing her of patients who they perceived overestimated their pain to receive more analgesics. Patients with pain in the category described by Blomqvist (2003) as 'exaggerated', were described by participants in some detail. Blomqvist (2003) suggested this term was being used for patients whose diagnosis or clinical path was unclear, and where this uncertainty made the staff doubt the patient's self report. Healthcare professionals felt frustration and irritation with patients who did not have 'real' pain, describing them as 'demanding'. Data from Newcastle Ward were in accordance with Blomqvist's (2003) findings; the small group of patients who were felt to be exaggerating their pain were quickly identified and discussed at great length in handovers, formal and informal, and were described as demanding.

The treatments and sanctions imposed on patients seen as difficult and demanding was highlighted in an early report by Stockwell (1972). Though

this report was designed to investigate the general treatment of the unpopular patient rather than a specific aspect like pain management, some parallel findings one can be seen, for example unpopular patients' requests could be ignored.

Nurses thought the patient should know what to do about their pain. Not only what to do, but specifically what analgesics to ask for. As presented earlier it was common practice on Newcastle Ward for the nurse to tell the patient to call if they required any further analgesics, thus making pain management the patients responsibility; 'she will tell us if she needs more' (FN7 L72). Although this may have demonstrated nurses were working in partnership (Pelzang 2010), other studies have shown patients expect nurses to know when they will be in pain and what analgesia they should have (Rustoen *et al.* 2009).

Manias *et al.* (2005) suggested the perceived busyness of the nurses by the patients prevented the patients asking nurses for help. This is somewhat supported by Dawson (2005) who found patients wanted to be 'good patients' who did not speak about their pain, and findings from Newcastle Ward corroborated these. However there may be other reasons which prevent patients from requesting analgesics, or communicating to nursing staff about their pain, and to simply accept busyness as a single, or even principle reason for this, could prevent further investigation for alternative explanations.

Data from Newcastle Ward showed patients as passive receivers of pain management. Manias *et al.* (2006) found 60% of patients were completely passive in terms of their pain management; they simply took what medications they were given. This led in their study to patients having poorer patient outcomes in terms of pain management. In Newcastle Ward there were very few patients observed who took an active role in their own pain management. Although nurses frequently said patients should say if they were in pain and to ask for analgesics; patients who did ask for analgesics was often treated with doubt and wariness. Similar findings were described by Lauzon Clabo (2008); when nurses were described as feeling as if they could reflect on the patients' pain assessment credibility. There were occasions on Newcastle Ward when pain was seen as legitimate; renal colic for example was seen as a 'real' pain though preoperative pain from appendicitis was treated as if it was 'trivial' as described by Blomqvist (2003), because it was going to be fixed soon.

#### **6.5.1 Nurses' rules for patients regarding pain management**

From the findings from Newcastle Ward and supported by the literature, a set of unwritten patient rules are proposed. These are derived from the observations and interview data and suggest the way nurses enacted pain management on this ward. These rules demonstrate the culture of Newcastle Ward and are meant to illustrate the complex and complicated role of the patient with regard to pain management.

- Patients must behave consistently with regard to their pain; they may not be stoic at one time, and less so at another. It is better if they are stoic all the time, because being less stoic will be in violation of a later rule.
- Patients' pain management behaviour must be consistent with the nurse's expectation of how much pain a patient might have with the condition.
- The nurse's expectations of how painful a condition can be, is based on either previous knowledge of the individual patient, or her previous experience with this condition.
- The pain score given by the patient must be consistent with how the patient looks and the nurse's expectation of how much pain a patient might have with the condition.
- Renal colic and cardiac pain are 'real' and pain behaviours such as crying and yelling can be made, provided these conditions are proven. These pain behaviours at other times are not consistent with nurses' expectations and are seen as exaggerated behaviours.
- It is the patient's role to tell the nurse if they are in pain, provided it is consistent with the nurse's expectation of how much pain a patient might have with the condition.
- Patients must not know too much about their condition or their pain, or ask for strong analgesics even if they have been on strong analgesics for some time.

- If a patient has a pain management pump they should know how best to use it to optimize their pain. They will not require the ward staff to help them with their pain management.

There are a further two rules less identified in the existing literature, but taken from the Newcastle Ward data.

- The patient should not leave the clinical area for a cigarette, as this is seen as not behaving consistently with their pain. If they were in so much pain they would not be able to leave for a cigarette.
- The patient should not be a drug addict. Patients are classified as a drug addict, if they are known to be on a drug rehabilitation program, if they have been drug addict in the past, or if there is any hint of improper drug use.

Patients are unlikely to be aware of this list of nurses' expectations of patients, though it is possible long-term patients developed some understanding of them. A violation of these rules in Newcastle Ward meant the patient could be seen by the nurses as a 'difficult' pain management patient. According to the culture of Newcastle Ward difficult patients could be safely ignored, in support of Brown and McCormack's (2006) findings, which suggested nurses were using avoidance strategies if they felt the patient's pain was problematic.

There seemed a circular logic occurring; a patient was a good and compliant patient if they did not ask for analgesics or complain of pain, although this is

what the nurses asked them to do. As soon as the patient complained of pain or the need for analgesics there was a tension between the nurse and the patient, which often resulted in the patient being distrusted. The patient had to balance the need for analgesia, and nurses' request they ask for analgesia, with their own internal wish to be a 'good patient' and not complain about pain, and their own and the nurses' misconceptions about analgesic drugs, supporting the findings of Dawson *et al.* (2005), and Brown and McCormack (2006).

The role of the patient can be seen to be a complex one. It would be difficult for a patient to find an area of compromise between making enough of a request to get the analgesia they required, having to know what was required to relieve their pain, but not asking for it too often, or in a too assured manner, so as not to allow the nurses to doubt the legitimacy of the request. Patients appeared to need to balance their requirement for analgesia with nurse's routine, supporting Manias *et al.* (2002), and the nurses' rules for patients, of which they almost certainly will not be aware.

## **6.6 Summary of findings**

The findings from the study have been discussed and two new findings are presented: the silence of routine pain management communication, and nurses performing a single pain management action. These behaviours originate from pain not being prioritised, and arise from a pain management culture which is inattentive to pain management. There are many studies which have shown pain management is poor and all have offered some

recommendations to improve this situation (Cason *et al.* 1999, van Dijk *et al.* 2012, Young *et al.* 2006). Typically they have suggested more education, or more innovative education, to furnish nurses with more pain management knowledge. While this approach has been said to be effective (Gordon *et al.* 2008), clinical pain management has not improved (Subramanian *et al.* 2011), with some saying education does not appear to be the solution to poor decision-making (Thompson & Stapley 2011).

The PARIHS model of evidence-based practice cites culture, with leadership and evaluation, as a sub element of the context dimension, asserting a strong culture in terms of clear values which promotes learning, is crucial for the implementation of evidenced based practice (Kitson *et al.* 2008, Rycroft-Malone 2004). The evidence for the utility of this model comes from the study of organisations (Newhouse 2010), and it has been used to facilitate change in ward setting from ward staffs' point of view (Perry *et al.* 2011). How ward cultures become strong, so evidence-based change can be more readily facilitated there, remains less clear. What this study adds is an in-depth look at a specific part of a clinical culture – pain management. The next section begins to explore elements which cause a particular pain management culture to manifest itself and what factors maintain or allow change within this culture. Social psychology investigates human behaviour, and while it has been relatively little used in nursing research, can offer an approach to understanding why pain management behaviours have been so resistant to change.

## 6.7 Social psychology and pain management culture

Nurses on Newcastle Ward said they take pain management very seriously and that poorly treated postoperative pain has negative consequences for the patient. However this ethnography demonstrated their actual behaviour when faced with a pain management opportunity or problem did not reflect what they said. That there is a gap between what nurses say they do and what they are actually doing has been established both in this study and in others (Dihle *et al.* 2006). People may speak in such a way as to ensure they sound professional or credible, they may tell you what they wish happened, or what they think the interviewer wants to hear (Manias *et al.* 2004b). It is not necessarily the establishment of the gap which is interesting, but the exploration of why the gap between beliefs and knowledge about pain management, and the performance of it, actually exists.

This evidence practice gap has been said to be caused by a lack of pain management knowledge and more education is widely expressed, over five decades, as an answer to this problem (Fothergill-Bourbonnais & Wilson-Barnett 1992, Graffam 1979, McMillan *et al.* 2005, Subramanian *et al.* 2011, Taylor *et al.* 1984). However this may not be the only answer, as Newcastle Ward staff were being educated; they were not consistently using the knowledge they have gained. Over the last fifteen years there is an increasing acceptance that the theory practice gap which leads to ineffective pain management is caused by a number of factors, of which education is

only one aspect. Clinical leadership, seen to effect patient outcomes (Cummings *et al.* 2010, Gifford *et al.* 2007), and the culture of the clinical area shown to effect the context of pain management (Lauzon Clabo 2008), are central to this.

Clinical leadership has been shown to set the culture within the clinical setting (Cummings *et al.* 2010); the clinical leaders set the standards for acceptable behaviour within a unit, through role modelling and expectation setting. The culture in Newcastle Ward has been established as inattentive to pain management, though nurses are educated about pain management techniques and provided information about analgesics. If a nurse knew she had the knowledge to perform excellent pain management, and yet the social norms of the clinical setting discouraged her to use it, she may experience a discord; it might make her feel uncomfortable (Wilson 2007). This discomfort felt when one has conflicting or inconsistent, thoughts, beliefs, or behaviours, though people may not recognise the cause of the uncomfortable feeling, has been described as cognitive dissonance. Cognitive dissonance theory argues a person will neutralise this uncomfortable feeling by changing their attitude towards one of the inconsistencies (Miller 2008), though they may not be aware of the process (Festinger & Carlsmith 1959). Cognitive dissonance has been often explored in the context of mistakes (Crigger & Meek 2007, Tavis & Aronson 2007 p. 2). People who must acknowledge they have made a mistake (an uncomfortable state), have a natural tendency to deny the error and construct a self deception to assist with that denial (uncomfortable feeling reduces) (Miller 2008). Blomqvist (2003) suggested

nurses who had to inflict pain during routine nursing care, felt helpless and powerless. This feeling of inadequacy feels uncomfortable, so rather than admit their kind, caring nursing is causing the pain, they interpret the pain as procedural and unavoidable, therefore there is nothing else they can do.

Miller (2008) continues with the suggestion that recognising cognitive dissonance when it occurs, before the self-deception necessitates the need for change can assist nurses in learning from errors or misjudgements by changing future behaviour (Gruber 2003). This aspect will be discussed further under recommendations for practice.

Social identity theory has been explored in conjunction with cognitive dissonance theory (McKimmie *et al.* 2003). Social identity theory (Tajfel 1978) asserts a person's concept of self is in part derived from the social groups or organisations they belong to (Brown 2000b). It has been demonstrated even if a person is allocated randomly to a group, they will favour their in-group, and feel prejudice against the out-group (Tajfel *et al.* 1971) as they aspire to see their in-group in a positive light (Brown 2000b).

Professional groups, organisations, and work environments are cited as causing in-group identification (Burford 2012, Hogg & Reid 2006). The application of Social identity theory is little discussed within pain management literature, though has been explored within a wider healthcare context including leadership and change management (Bartunek 2011, Curry & Cole 2001, Forbes & Hallier 2006).

Self-categorization theory evolved from Social identity theory with increased emphasis on the processes involved with intragroup establishment and maintenance. These two theories combined again to become called the Social identity perspective. Self-categorization theory focuses on why people identify with groups and how group behaviours are manifested, and asserts this self-categorization into groups causes people's thoughts and behaviour to conform to the in-group prototype. The in-group prototype is a consensual view of the group which is constantly reinforced by group members and subsequently produces in-group behaviours. In this way Terry (1996) suggested prototypes prescribe how to behave to group members. People in groups will look to other members of the group as role models for the correct behaviour (Hogg & Reid 2006).

In-groups have norms which members of the group are expected to uphold. These norms are shared patterns of behaviour, either inferred through observation, or directly communicated through conversation (Hogg & Reid 2006). Deviant behaviours, those not established as 'how things are done in this in-group', are punished by loss of status within the group (Pinto *et al.* 2010).

As a means of understanding how culturally mediated behaviours develop, Social cognitive theory (Bandura 1989) asserts observational learning has evolved to enable humans to learn vicariously; to learn by watching other people's behaviour. This prevents people from being required to use trial and error as their main decision-making resource. Through observational learning people also learn vicarious emotional responses; they acquire

attitudes and values, and learn what to like and not like. People learn what is moral behaviour, what is considered right and wrong, by seeing other people rewarded or censured for acting in certain ways. Thompson *et al.* (2006) found on examination of knowledge utilisation literature an underlying assumption that more knowledge will change behaviour. An important aspect of Social cognitive theory is that peoples' acquisition of new knowledge will not necessarily change their behaviour, also claimed by Seers *et al.* (2006), in the same way a person's underlying attitude will not necessarily affect behaviour (Ajzen 2001). Bandura (1989) does not specifically discuss cognitive dissonance as a means of changing or not changing behaviour, but refers to the influence of social circumstances, and asserts moral justification is used to support any self-deception.

An important component of Social cognitive theory is the concept of self-efficacy, a person's belief in their ability to successfully complete a course or action. Wilson (2007) argues that a nurse's ability to complete a pain management action depends in some part to their degree of self-efficacy. Nurses may be asked to manage pain management situations which they will be unable to do successfully (Brown & McCormack 2006), and this will lower their self-efficacy. This can lead to a learned helplessness where nurses no longer try to succeed in areas where success is achievable. This learned helplessness can be role modelled by nursing colleagues until it becomes an in-group norm; a shared set of beliefs (Davitz & Davitz 1981 p. 170). The pressure to behave consistently with the in-group may mean

nurses do not use their pain management knowledge to act in a concordant in-group way, dismissing their knowledge and the patient's pain.

A CNS in pain management would be in a mixed position within a ward in-group. If the message given is positive (congratulations on a patient well managed), the group will embrace it as if she were an in-group member, however if the message is perceived as negative (some constructive criticism or suggestion to change behaviour), her position will be taken as being from an out-group and as such is discarded (Hogg & Reid 2006). This is suggested here as a potential reason for the failure of CNSs to really influence nurses pain management practice (Brown & McCormack 2011), the CNS is typically in an out-group position, trying to change in-group norms.

It can be seen that adherence to the norms incorporated within the in-group is an important part of the in-group identity, and failing to comply with these rules will create dissonance. Cognitive dissonance theory says this dissonance can be best resolved by changing one's attitude; by changing behaviour to bring it back in line with the group's social norms (McKimmie *et al.* 2003). Aspects of Social cognitive theory regarding learning from other peoples' behaviour, and the assertion from Self-categorisation theory which says social norms are developed in-group, clarify the in-group behaviour around pain management observed on Newcastle ward.

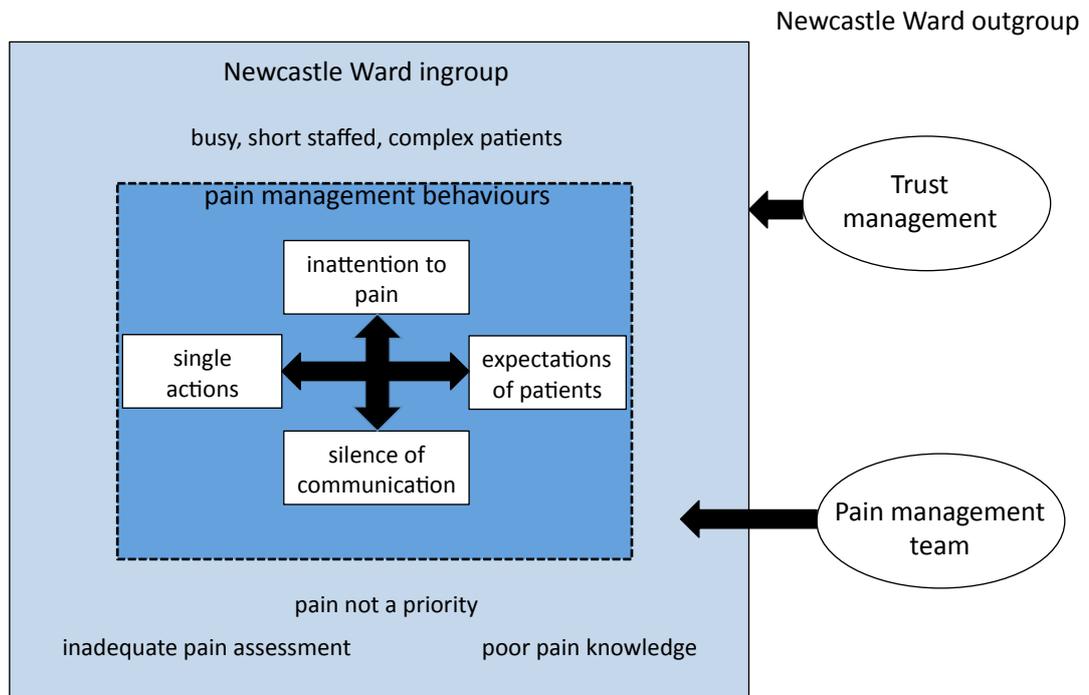
Newcastle Ward staff learn pain management behaviours through observation, with no censure for any failure to meet pain management

standards. The behaviours they learn, linked to a culture of inattention to pain management are, largely no communication around pain management, the custom of a single pain management action, and the maintenance of rules for patient behaviour around pain management. Cognitive dissonance suggests that any uncomfortable feelings which may arise by an conscious or unconscious awareness of discordant thoughts, new knowledge or poor behaviour, are ameliorated by a change in cognition to reduce the dissonance back to the in-group norm. In this way the pain management culture of Newcastle Ward which does not prioritise pain is maintained.

#### **6.7.1 Framework to summarise findings**

The framework below represents a summary of the findings of this study. The larger rectangle represents the wider culture of Newcastle Ward, with some pain management components within it, pain assessment, and knowledge of pain management. The understanding that pain is not a priority, while ward staff appear to have little awareness of this, sits within this general ward culture, as part of the way staff rank their nursing tasks. Within the wider culture is the pain management culture represented by the smaller rectangle.

*Figure 3. Summary framework for findings*



Within this are the findings of silence of communication, single pain management action, nurses' expectations of patients, and an inattention to pain. Each of these behaviours is maintained by the continuation of the other behaviours within the pain management culture. Trust management is represented as being an out-group and as such their influence on the pain management norms of the group is minimal. The pain management team though in a more advantageous position in terms of potential in-group status does not traditionally target the behaviours represented here within the pain management culture, concentrating only on improving pain assessment and increasing pain management knowledge, which may not have any real sustained effect on decision-making or pain management care (Hadjistavropoulos *et al.* 2009, Thompson & Stapley 2011).

## **6.8 Trustworthiness**

This study met the requirements of trustworthiness. Credibility is confirmed through using methods to provide triangulation of data collection; in this case observation of behaviour, with interviews and informal conversations to understand participants' beliefs and thoughts, and document analysis.

Credibility is further assured by an extended time in the field, with findings presented as thick descriptions to describe the culture of Newcastle Ward.

Dependability in this ethnography was satisfied by detailed explication of the research process, and through careful record keeping, with the use of reflexivity throughout the study. These aspects of the ethnography also fulfil the requirement of confirmability; assurance that the view of the participants is demonstrated. Transferability of the findings of this ethnography to other settings is within the judgement of the reader. The detailed contextual descriptions of the findings, with the other requirements of trustworthiness met, makes it possible these findings will resonate with experiences in other situations, allowing new knowledge from this study to be transferred to other clinical environments.

## **6.9 Limitations**

This study has a number of limitations. The study site was a single surgical postoperative ward in a district general hospital. This ward may not be representative of all surgical wards, and findings reported here might not have been found in other units. However a detailed and rich description of the setting and findings which emerges from ethnography allow the reader to

judge how the findings might apply to other settings, therefore ameliorating to some extent this limitation.

A senior nurse at the hospital chose the study site within the Trust. Further conversations as the study progressed suggested this choice might have been made because there were some concerns about pain management on Newcastle Ward. Different findings may have emerged from an area where pain management was perceived by senior management as excellent. This deliberate selection of a ward perceived by managers as providing less than ideal pain management may affect the transferability of the findings. The detailed descriptions of the ward are provided so resonance with other clinical environments can be judged.

Staff on Newcastle Ward knew a Clinical Nurse Specialist in Pain Management from a different Trust was conducting this observational study. It is possible this knowledge changed the way they interacted with patients and each other when they performed pain management action. However research has suggested staff quickly become accustomed to being observed and during sustained observation, practice is not changed (Manias *et al.* 2002).

This study was carried out by a neophyte ethnographer with some years of experience in positivist research. While this previous quantitative research experience assisted with ethical and research and development approval, study documentation, and literature review, the observational elements when starting the fieldwork were uncomfortable. This inexperience, and initial

discomfort, in the field may have led to less than comprehensive data collection particularly at the outset of the study. However this is part of a novice researcher's journey, to discover and practice new skills, and is countered by reflexivity.

Only one aspect of the ward culture was investigated in depth: pain management. Other aspects of nursing care within Newcastle Ward were not observed or explored in any detail, though clinical leadership related to pain became a part as the study progressed. A more comprehensive picture of the overall ward culture may have been seen if the scope of the study had been broadened.

Data collection was limited to the hours of 0700 – 2200. It is possible nurses were performing pain management differently at night.

While pain management information was collected from the observation charts, other data from the nursing care plans was not collected. This may have shown other aspects of pain related nursing care which are missing from this analysis.

The field notes and observations were annotated and reflected on close to the day of observation and themes arising from the data were identified, informally discussed, and had some impact on the study conduct. However the formal data analysis did not begin, as it arguably should have done, with the first data collected. Most ethnography texts suggest it is best for the analysis to occur in such a way as emergent themes from the data will inform questioning and observation in the field. In this study the data

collection began with observation over a period of nine months, then the interviews over a further five months, following which the data was formally analysed. In hindsight the observations and interviews may have been conducted differently, with more focused formal and informal queries, if some of the themes which were eventually revealed, had been evident as the observations were occurring.

### **6.10 Researcher reflection**

As this study progressed there were a number of changes in how I perceived pain management, ward culture, nursing staff and myself. That this change in perception occurs in a study as long, intense and reflexive as a PhD is perhaps not a surprise, however I believe my journey is worth reflecting on. I began this study as a passionate pain management clinical nurse specialist with a deep and often intuitive knowledge of pain management, and as an innovative and interesting speaker and communicator of knowledge. I was frustrated however by the inability to impart my knowledge and passion to the nursing staff in any meaningful way; in a way which changed practice behaviour and outcomes for patients. The early literature review in many ways only reinforced my frustration at how little progress had been made in postoperative pain management. When the observational component of the study began it demonstrated what I had seen in other hospital settings and again reinforced my frustration and disappointment in the nursing staffs' seemingly 'lack of caring' about patients pain. However I quickly became aware these hardworking and almost unfailingly cheerful nurses approached

their patients with genuine caring and often real affection. As I began more in depth reading around social psychology and culture, I began slowly to see it as something else. The incident highlighted earlier (page 225, FN22 L200), where SN Kay (P16) told me of what she would have told the patient regarding addiction when only a few minutes earlier she had not done so, made me realise nurses might not have been deliberately acting in defiance of pain management guidelines but were somehow unable to enact the guidelines with which they were very familiar. This epiphany led to much reflection and thought and then to a much better understanding of the role of culture in pain management practice. As a consequence of this, I noticed more discerning insights available from the data. This understanding continued throughout the data analysis and writing of the thesis, leading me to use these insights in my nursing practice. I feel I will now encourage changes in healthcare behaviours less through direction and instruction (my old style), but using leadership skills and an understanding of the role the ward culture has in developing and maintaining behaviours.

## **6.11 Conclusion**

The principal aims of this ethnography were to investigate what factors influence nurses' decisions about their pain management practice in a clinical setting, and how the culture of the clinical environment effects nurses' pain management practices. In order to understand the complete context of pain management in a clinical setting, further aims investigated:

- What did nurses, both trained and untrained, other healthcare professionals and the senior hospital team understand were their responsibilities regarding pain management?
- What was the meaning of pain management to nurses, other healthcare professionals and the senior hospital team?
- Were there shared culturally determined pain management strategies that influence nurse's decision-making?
- How did the patient influence the pain management strategies used by the nursing staff?

The aims of the ethnography were met. It was revealed that the pain management culture of Newcastle Ward was a crucial influencing factor. Within Newcastle Ward pain management appeared not to be a priority; this had at least in part arisen from a lack of national and local performance targets. As pain was not a priority on Newcastle Ward, there was an inattention to pain management within nursing practice. There was a silence of routine pain management communication; it was not part of the in-group norm to discuss patients' pain. Nurses routinely performed a single pain management action, appearing to believe this one action was sufficient. Because pain management information was rarely discussed, it was not part of the social norm on Newcastle Ward to discuss the outcome of pain management actions, nurses' behaviour suggested they believed that the single action performed was sufficient and routinely successful. The nurses' behaviour suggested there was a set of implicit rules which they expected

patients to follow although it seems unlikely many patients would be aware of them.

Culture can be described as the beliefs and behaviour of the group members (Atran *et al.* 2005). The culture of an environment is an important element of the context in which work within the space is enacted. The PARIHS framework (Kitson *et al.* 1998) asserts context has the sub elements of evaluation, leadership and culture, and that they need to be strong to be able to have a context amenable to the implementation of evidenced based practice. The culture on Newcastle Ward was observed to be 'weak' using this framework definition; there was not a strong learning culture and there appeared a focus on management of tasks. It was found pain management was not a priority on Newcastle Ward. Pain management was described by nurses as being very important, but this importance was rarely seen in the observations; pain management was seldom prioritised. There was a gap between saying and doing pain management similar to that described by Dihle *et al.* (2006). The theory of cognitive dissonance can help illuminate the processes around the gap between what nurses say they do and what they are observed doing. Nurses knew what was the correct (according to local policy) way to manage pain, and largely thought they met these standards, often explaining in detail how they did this. However the culture of Newcastle Ward did not enable them to easily perform pain management in this way, so the theory of cognitive dissonance can at least in part explain why they reported they met good pain management standards. Without the clinical leadership supporting and evaluating pain management, there were

no benchmarks set and no reprimand or learning identified from perceived failure of the standards. In this way ward staff on Newcastle Ward seemed assured they were continuing to perform pain management well, while being observed to give it little attention.

Clinical leadership is key to developing and maintaining a culture. The PARIHS framework (Kitson *et al.* 1998) proposes clinical leadership as one of the sub elements of context. It could be contended however that clinical leadership sets the culture and through evaluation maintains it. This may indicate clinical leadership has a more influential role than suggested for the implementation of change within a clinical setting.

The heuristic used to describe the ward by all staff (busy, short staffed, while looking after complex patients), was well developed, and was readily used to show a picture of what it was like to work on Newcastle Ward. It could be said to be a defining vision of nursing in this clinical setting. It meant however, that ward staff were largely unable to see the ward in any other way. Because the heuristic was constantly referred to by all ward staff, including the clinical leaders, it may be possible to begin to change the culture by changing the focus of the ward perception though an alteration of the heuristic; by talking about the ward in a different way.

Pain management has largely been studied in terms of attitude and knowledge, with few studies investigating culture. Pain assessment and pain management knowledge are the aspects most frequently investigated, and they are presented largely as being inadequate and producing ineffective

pain management (Bell & Duffy 2009, Carlson 2010). What this study has revealed are pain management behaviours which are culturally mediated; which form part of the culture of performing pain management in Newcastle Ward. The observations suggested pain was not systematically assessed, and pain management knowledge limited to non-opioid analgesics, with little awareness of the use of opioids. Pain was not a priority on the ward, and nurses were seen to be inattentive to pain cues, findings again seen in other studies, but with few focussing on how to bring about positive change to pain management in clinical practice (Allcock 1996b).

What is revealed from this study is on Newcastle Ward, while some aspects of pain management care supported the literature, the findings of other culturally mediated pain behaviours were new, and unexpected. What emerged is an impression of four linked and interacting behaviours.

While good practice would contest it should be otherwise, it is clear from the literature that the way a patient behaves influences nurses' pain management decisions. The nurses' set of rules for patients described earlier, represent a part of the culturally mediated strategies staff use to manage pain in Newcastle Ward. Nurses have expectations that patients will behave according to these rules; if a patient is not behaving in a compliant manner, it has been shown they can be quickly categorised as a 'difficult' patient. If they are classified in this way, they are largely thought to be exaggerating their pain, and as such do not really require any pain management actions beyond the routine. If however the patient meets the rules for patient behaviour, they will seldom require any pain management

actions, beyond the normal routine of regular medications at drug rounds. Which ever of the two scenarios are enacted the nurses' expectations of the patient will be met, and either way the nurse seemed to believe the patient will seldom require more than a single pain management action. In this way a single pain management action becomes a culturally determined behaviour on Newcastle Ward.

Nurses were seen to not discuss pain management routinely with either the patient or each other; the only pain management conversations observed were those which involved 'difficult' pain patients, where they were largely thought to be 'exaggerating'. As nurses do not discuss patients' pain management routinely, they have little mechanism to discover whether or not the single pain management action they performed was effective. While it is possible a single pain management action was effective, a second action of evaluation is almost always required to assure this, as set out in the Department of Health benchmark for pain management (Department of Health 2010c). This evaluation was very seldom observed to be done on Newcastle Ward. Without this confirmation nurses appeared to believe that it was effective, possibly because the feeling that it may not have been is uncomfortable, so will be ameliorated by a reduction in cognitive dissonance. This leads the nurses' behaviour to appear to an observer to be inattentive to pain management.

Each of these four behaviours, silence, a single action, the patient rules, and inattention to pain, are linked and influenced by each other, with each pain management action or inaction reinforcing the other. Owing to the

interaction between the behaviours, the use by nursing staff of any one of these behaviours is likely to contribute towards maintaining the strength and impact of the others.

These behaviours appear to be the most influential in nurses' pain management decision-making, and because of the constant validation these behaviours seem to be underpinned by strongly held beliefs. This cultural picture with these behaviours from strong beliefs have not been discussed as a barrier to effective pain management, nor targeted for any educational intervention.

For more than forty years it has been said pain management knowledge is insufficient, and attitudes to pain management poor. Over these five decades pain management education interventions have traditionally targeted poor knowledge and inadequate pain assessment. However it has been demonstrated that knowledge and attitude are not always useful predictors of behaviour (Ajzen 2001, Hogg & Reid 2006). Behaviour can be altered by increased knowledge or altered attitudes, but it is unlikely to occur if the culture of the group within which the behaviour occurs is not supportive of the change. If a member of a group persists in a behaviour change not supported by the group, she will soon be seen as a deviant member, and she will either leave the group or change her behaviour back to the group norm (Brown 2000b). To take any other position is too uncomfortable for most people to tolerate. Therefore without the in-group members being invested in changing their in-group social norms, any change management project is likely to be ineffective.

In-groups are unavoidable, they will occur naturally. There is much evidence for in-group behaviours being formed intragroup, forming in-group social norms, the beliefs and behaviours which make up the culture. In-group norms are designed to support the group, to demonstrate the socially acceptable way to behave in this group setting (Brown 2000a p. 43). The behaviours of silence, inattention, single action and expectations of patients' behaviour, are presented here as the in-group social norms for pain management behaviour on Newcastle Ward. They are resistant to change from outside the group, though there are processes, including restructuring of the boundaries of groups, which can change how group members see their out groups and so may look on outside information differently.

Over the last few decades education for pain management has largely been the responsibility of pain management nurses, and often focuses on the importance of pain assessment and on increasing nurses' knowledge.

However, this education has not resulted in widespread improvements in pain management. Findings from this study suggest there are other aspects of a pain management culture which exert an influence on nurses' decisions. It may be reasonable to suggest targeting interventions at one of the cultural aspects which seems more amenable to change, for example communication, with an acknowledgement of the impact the other in-group behaviours will have on this specifically directed intervention.

It seems likely however that a consideration of the whole pain management culture is important when trying to improve pain management. The significance of a culture of not prioritising pain on Newcastle Ward cannot be

overstated. This lack of prioritisation is reflected by, the general inattention to pain management, the silence of routine pain management communication, the use of single pain management actions, and nurses' expectations of the patients.

Pain is unlikely to become a national priority unless healthcare professionals and the public become more aware of the significance of poor pain management. However ensuring pain is a priority seems possible through targeted interventions, not at junior members of staff with little personal power to alter in-group norms, but at senior staff with authority and influence. Enabling clinical leaders within an organisation to acknowledge pain management as a priority for patient focused care, and supporting them to enable cultural change within their Trust or ward, may result in an improvement in the provision of effective pain management.

## **6.12 Recommendations**

This study has been successful in achieving its aims of determining which factors influence nurses when they make pain management decisions in a clinical setting. A previous section set out some of the limitations, but notwithstanding these limitations there are some important implications for practice, further research and education.

### **6.12.1 Recommendations for practice and education**

This study has suggested a number of reasons why pain management teams have not been as successful as they wished in effecting efficient pain

management practice in clinical environment. Educational interventions continue to be targeted at improving pain assessment and increasing knowledge, despite these not being successful in the past. Pain management teams should consider and challenge the extent of inattention to pain management, the lack of communication regarding routine pain management, and the single nature of any pain management actions, in their teaching and clinical practice. Specific in-group behaviours are an important consideration for pain management practice.

The finding that pain was not a priority at a ward level may be more difficult to change without a change in performance targets and priorities at a national level, however it is possible this can be challenged at a Trust level. The multidisciplinary pain management team should engage and assist the Medical Director, and Directors of Nursing and Operations to set clear standards for pain management, assign responsibility for delivery of the standards to clinical staff, and hold these staff to account for delivery of these standards. A measure of pain management could be included into Trust performance dashboards, commonly used as a performance reporting structure from the ward areas to the Trust Board. If local standards are implemented in an effective way, pain should become one of the priorities for ward staff.

Educational interventions should be designed which are specifically targeted at the in-group behaviours. The performance of a single pain management action intuitively seems more resistant to change without the context of an increased priority of pain. However inventions directed at increasing the

amount of pain communication at ward level, may have an impact on both the silence of pain management communication and effect an increase in planned individualised patient centred pain management care, with reassessment and further actions if required.

Facilitated clinical supervision with reflection, either individually or with a group, directed at bringing the process of cognitive dissonance to nurses' conscious awareness may help nurses challenge the less positive aspects of in-group culture.

The importance for ward level clinical leadership to affect the culture of pain management has been shown in this study. It is suggested to engage all staff in change management, but as the clinical leader will be an influential member of the in-group, it is suggested leadership in clinical settings be supported to become 'strong' as defined by Rycroft-Malone *et al.* (2004).

### **6.12.2 Recommendations for further research**

As this study is ethnography in a single ward, the findings are not generalisable. However their theoretical transferability could be explored through observation, in other wards, in other clinical settings. The identification of similar or dissimilar in-group norms in other units will begin to provide a qualitative database of pain management behaviours for pain management teams to target with specific interventions.

Findings from ethnographic studies can be difficult to translate into changes in practice (Brown & McCormack 2006). Brown and McCormack (2009) successfully used Emancipatory Action Research as an attempt to effect the

changes highlighted in their earlier study. Pain management research within this of type of framework may be able to provide interventions directed at in-group pain management behaviours.

The use of social identity perspective in pain management research is neophyte at best. In this study it has provided understanding of the group dynamics to human behaviour seen in studies with more traditional nursing theory viewpoints (Lauzon Clabo 2008). As social psychology is concerned with the study of human behaviour, studies informed by this perspective can add to nursing knowledge regarding how culture develops, and thus inform thinking on how to best facilitate changes within a specific culture.

### **6.13 Final words**

When Margo McCaffery wrote forty years ago, "*Pain is whatever the experiencing patient says it is, existing whenever he says it does*" (1972 p. 8), it is unlikely she would have envisaged what a mantra this sentence would become to nursing staff; nearly all nursing staff remember it (van Raders 2003). She may not have foreseen that after forty years of committed, increasingly innovative pain management education, and the extensive increase in pain management knowledge and available strategies, how little pain management had really changed (Subramanian *et al.* 2011). Pain has not become a priority for the public (Brown & McCormack 2006), healthcare organisations (Powell *et al.* 2009a), nor the majority of healthcare professionals (Hirsh *et al.* 2010, Rose *et al.* 2011).

Until pain becomes a priority within healthcare, where the culture of a clinical setting allows nurses to acknowledge pain exists, and ensure attention to pain management, the caring profession will not be able to “*provide for this right thing always to be done*” for pain management (Nightingale 1876 p. 24).

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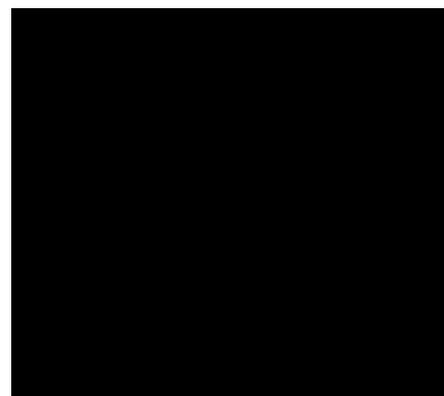
## Appendices

### Appendix 1 Search strategies

	<b>Search Terms Mesh (/) or Keyword (.mp)</b>	<b>OVID (Medline, Embase, AMED)</b>	<b>BNI Abstract (.ab)</b>	<b>CINAHL Abstract (.ab) or Title (.ti)</b>
1	Acute pain/ or acute pain .mp	3705		164449
2	Anthropology, Cultural/	3821		
3	Attitude/ or attitude .mp	191644	11472	9027
4	Attitude of Health Personnel/	78466		
5	Nurse Clinicians/	6849		
6	clinical nurse specialist .mp	1220	26	
7	Cognitive Dissonance/ or cognitive dissonance .mp	696		188
8	Culture/ or culture .mp	538134	3180	15723
9	Decision-making/ or decision-making .mp	103476	1362	21660
10	Decision Theory/ or decision theory .mp	1164		
11	Ethics/ or ethics .mp	79752	3380	9048
12	Ethnography .mp	939	.ab 69	.ti .ab 357
13	Inpatient*/ or inpatient* .mp	61775		
14	Interview/ or interview .mp	87110		
15	(knowledge and attitude) .mp	31756		.ti 389
16	Nociceptive Pain/ or nociceptive pain .mp	406		
17	Nurse-Patient Relations/	22423		
18	Nurse-patient relationships .mp	410		
19	Nurse's Role/ or nurse's role .mp	30009		
20	Nursing Care/ or nursing care .mp	29131		
21	Nursing Staff/ or nursing staff .mp	50364		
22	Nurses/	22808		
23	Nurs* .mp	427232		273389
24	Pain/ or pain .mp	358074	3539	40950
25	Pain assessment .mp	2493	194	.ab 1251
26	Pain Management/ or pain management .mp	20115	2697	.ab 4373
27	Pain Measurement/	50029	899	25969
28	Pain, Postoperative/ or pain, postoperative .mp	21057	473	

29	Pain Clinics/ or pain clinics .mp	1127		460
30	Psychology, Social/	3486		
31	Prevalence/ or prevalence .mp	343388		
32	Qualitative Research/ or qualitative research .mp	16991		
33	Social cognitive theory .mp	675		
34	Social identity theory .mp	118		
35	Social psychology .mp	828		
36	25 or 27 (pain assessment)	50835		
37	23 and 24 (nurs* and pain)	13115		
38	1 and 23	399		
39	12 and 24	78		
40	1 and 12	1		

## Appendix 2 Research Ethics Committee first response



3 April 2008

Ms Ella van Raders  
Part time PhD Student  
RCN/The University of Warwick  
9 Seymour Road  
Luton  
LU1 3NL

Dear Ms van Raders

**Full title of study:** A ethnographic study investigating the factors that influence nurses pain management decisions in the clinical setting  
**REC reference number:** 08/H0311/36

The Research Ethics Committee reviewed the above application at the meeting held on 26 March 2008. Thank you for attending to discuss the study.

### Documents reviewed

The documents reviewed at the meeting were:

<i>Document</i>	<i>Version</i>	<i>Date</i>	
Application		05 March 2008	
Investigator CV		01 March 2008	
Protocol	1	01 March 2008	
Covering Letter		05 March 2008	
Participant Information Sheet: Visitor	1	01 March 2008	
Participant Information Sheet: Professional	1	01 March 2008	
Participant Information Sheet: Patient	1	01 March 2008	

Participant Information Sheet: Ward Staff	1	01 March 2008	
Participant Consent Form: Visitor	1	01 March 2008	
Participant Consent Form: Professional	1	01 March 2008	
Participant Consent Form: Patient	1	01 March 2008	
Participant Consent Form: Ward Staff	1	01 March 2008	
Poster	1	01 March 2008	
Supervisor's CV - KS		01 March 2008	
Pamphlet	1	01 March 2008	

### **Provisional opinion**

The Committee would be content to give a favourable ethical opinion of the research, subject to receiving a complete response to the request for further information set out below.

The Committee delegated authority to confirm its final opinion on the application to a meeting of the sub-committee of the REC.

### **Further information or clarification required**

1. The research should be carried out in a different Trust to the one within which you work.
2. Consent should be reaffirmed upon each period of observation on the ward.
3. Only observational notes should be taken; recordings should be confined to formal interviews.
4. The participant information sheet (PIS) should include information on what will happen to the recordings once they have been transcribed and contact details for PALS or ICAS.
5. An interview schedule should be provided.
6. The deletion of the word 'having' in the pamphlet under the heading 'Interviews'.
7. The amendment of the "Who has reviewed the study?" paragraph in the participant information sheet to read, "All research in the NHS has to be approved by an Independent Research Ethics Committee. In order to protect ....".
8. The errors in the PIS should be corrected, including:
  - a) Patient PIS, page 1, paragraph 5, 1<sup>st</sup> line; paragraph 6, 2<sup>nd</sup> sentence.
  - b) Patient PIS, page 2, paragraph 1, 2<sup>nd</sup> sentence; paragraph 9, 2<sup>nd</sup> line.
  - c) Patient PIS, page 4, paragraph 5, last sentence.
  - d) Patient PIS, page 5, paragraph 7, last sentence.

When submitting your response to the Committee, please send revised documentation where appropriate underlining or otherwise highlighting the changes you have made and giving revised version numbers and dates.

The Committee will confirm the final ethical opinion within a maximum of 60 days from the date of initial receipt of the application, excluding the time taken by you to respond fully to the above points. A response should be submitted by no later than 25 July 2008.

### **Membership of the Committee**

The members of the Committee who were present at the meeting are listed on the attached sheet.

SE withdrew from the review of this application due to a working relationship with the applicant. SU took the Chair for this review.

### **Statement of compliance**

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

**08/H0311/36**

**Please quote this number on all correspondence**

Yours sincerely

[Redacted signature]

**Vice Chair**

Email:

[Redacted email address]

Enclosures:

List of names and professions of members who were present at the meeting and those who submitted written comments.

Copy to:

[Redacted copy list]

26 June 2008

Ella Van Raders  
Part time PhD Student  
RCN/The University of Warwick  
9 Seymour Road  
Luton  
LU1 3NL

Dear Ella

**Full title of study:** A ethnographic study investigating the factors that influence nurses pain management decisions in the clinical setting  
**REC reference number:** 08/H0311/36

Thank you for your letter of 27 May 2008, responding to the Committee's request for further information on the above research and submitting revised documentation, subject to the conditions specified below.

The further information was considered at the meeting of the Sub-Committee of the REC held on 13 June 2008. A list of the members who were present at the meeting is attached.

**Confirmation of ethical opinion**

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

**Ethical review of research sites**

The favourable opinion applies to the research sites listed on the attached form. Confirmation of approval for other sites listed in the application will be issued as soon as local assessors have confirmed they have no objection.

**Conditions of the favourable opinion**

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission at NHS sites ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

#### Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Application		05 March 2008
Investigator CV		01 March 2008
Protocol	2	27 May 2008
Covering Letter		05 March 2008
Letter from Sponsor		25 June 2008
Participant Information Sheet: Professionals	2	27 April 2008
Participant Information Sheet: Visitor	2	27 April 2008
Participant Information Sheet: Patient	2	27 April 2008
Participant Information Sheet: Ward Staff	2	27 April 2008
Participant Consent Form: Professionals	2	27 April 2008
Participant Consent Form: Visitor	2	27 April 2008
Participant Consent Form: Patient	2	27 April 2008
Participant Consent Form: Ward Staff	2	27 April 2008
Response to Request for Further Information		27 May 2008
Supervisor's CV - KS		01 March 2008
Pain Management Study Leaflet	2	27 April 2008
Poster	2	27 April 2008
Interview Schedule	1	27 May 2008

#### Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

#### After ethical review

Now that you have completed the application process please visit the National Research Ethics Website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email [referencegroup@nrcs.npsa.nhs.uk](mailto:referencegroup@nrcs.npsa.nhs.uk).

**08/H0311/36** **Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely

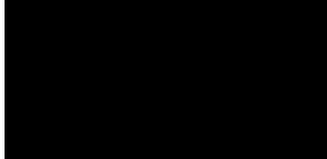
  
Vice Chair

Email: 

Enclosures: List of names and professions of members who were present at the meeting

"After ethical review – guidance for researchers "SL- AR2

Site approval form

Copy to: 

Hertfordshire REC					
LIST OF SITES WITH A FAVOURABLE ETHICAL OPINION					
<i>For all studies requiring site-specific assessment, this form is issued by the main REC to the Chief Investigator and sponsor with the favourable opinion letter and following subsequent notifications from site assessors. For issue 2 onwards, all sites with a favourable opinion are listed, adding the new sites approved.</i>					
<b>REC reference number:</b>	08/H0311/36	<b>Issue number:</b>	0	<b>Date of issue:</b>	26 June 2008
<b>Chief Investigator:</b>	Ms Ella van Raders				
<b>Full title of study:</b>	A ethnographic study investigating the factors that influence nurses pain management decisions in the clinical setting				
<i>This study was given a favourable ethical opinion by Hertfordshire REC on 13 June 2008. The favourable opinion is extended to each of the sites listed below. The research may commence at each NHS site when management approval from the relevant NHS care organisation has been confirmed.</i>					
<b>Principal Investigator</b>	<b>Post</b>	<b>Research site</b>	<b>Site assessor</b>	<b>Date of favourable opinion for this site</b>	<b>Notes <sup>(1)</sup></b>
Approved by the Chair on behalf of the REC:					
..... (Signature of Chair/Co-ordinator)					
(delete as applicable)					
..... (Name)					

(1) The notes column may be used by the main REC to record the early closure or withdrawal of a site (where notified by the Chief Investigator or sponsor), the suspension of termination of the favourable opinion for an individual site, or any other relevant development. The date should be recorded.

## **Appendix 4      Study code of conduct**

- I will stay in observation role unless someone was in danger of harm
- I will always act in a professional manner
- I will never disrespect any member of staff or patient to anyone
- I will act with a research nurse observer role
  - If in uniform, participant observation
  - If out of uniform, non participant observation
- I will consider carefully any request for me to do any task after I have considered
  - Is it within an HCA role?
  - Do I think it is more important than what I am doing?
- I will wait 2 seconds before replying to anyone.

## **Appendix 5 Interview schedule**

### **Factors influencing pain management - Interview schedule**

- Introduction to me
- Purpose of the study reiterated
- Purpose of interview – in order to gain a deeper understanding of how ‘you’ see pain management within the Trust.
- Consent for interview to continue and for audio recording
- Stating for the record ‘your’ job title, length of time in this employment, any other relevant demographic data.

I envisage some of the interview questions will arise from the observational data obtained during the first few months of the study; hence the planning of the formal interviews after approximately 6 months of data collection.

As the questions may differ for those participants who do not have an active clinical role, I have divided questions into two parts.

### **Questions – clinical staff (Ward Staff, Medical Staff, CNS’s, Pharmacists, Physiotherapists, Ward Managers)**

- Can you tell me what pain management means to you?
- Can you tell me what you think the Trust’s view is regarding pain management?
- Please could you describe to me how pain management is reflected in your role?
- Please could you describe to me how important pain management is within your role?
- Please could you describe to me who you think is responsible for patient pain management?
- How well do you think you manage pain?
- Could you tell me about the education you’ve had regarding pain management?
- Could you tell me about any barriers to effective pain management you encounter in your role? What might stop you from providing the pain management you wish to?
- Describe to me any factors that make pain management easier within your role?

- Can you tell me what you think about when you make pain management decisions? What factors do you consider?
- you please tell me how the patient influences your pain management decisions?

**Questions – non clinical staff (Executive Team, Matrons, Senior (non clinical) Physiotherapist, Pharmacists)**

- Can you tell me what pain management means to you?
- Can you tell me what you think the Trust's view is regarding pain management?
- Please could you describe to me how pain management is reflected in your role?
- Please could you describe to me how important pain management is within your role?
- Please could you describe to me who you think is responsible for patient pain management?
- Do you feel there are any barriers to pain management in this Trust
- Do you feel there are things that do or would help pain management in this Trust

## **Appendix 6      Pain control folder May 2009**

- Pain Management Team contact information
- Pain Control Leads from all the hospital wards
- Pain rating scales in Bengali, Chinese, Simple Chinese, Hindi, Greek, Gujarati, Polish, Punjabi, Somali, Urdu
- In Pain notice (this was a notice which all patients had above their beds suggesting if they were in pain they should tell the nursing staff)
- Epidural quick guide
- PCA quick guide
- Policies/Guidelines
  - Pain Assessment in Adults
  - Entonox
  - PCA Policy
  - Epidural Policy
  - Oral Analgesia in Adults
  - PGD Adult analgesia
  - Guidelines for administration of IV Opioids
  - Policy Administration of IV Opioids
  - Facio Iliac Compartment Block Policy
  - Acupuncture
- Assessment of pain in older people – national guideline
- Recognising Neuropathic pain
- Bandolier NNT page (no other explanation)
- Sickle Cell Trait fact sheet
- Sickle Cell disorder fact sheet
- Sickle Cell Disease instructions
- Sickle Cell Disease Article
- Durogesic Guide (from company)
- Alaris Pump quick guide

## Appendix 7 Handover sheet analysis

There are twenty five handover sheets for analysis from December 2008 to February 2010; of these nineteen have contemporaneous field notes marked on them, the majority (13) with handover notes for the whole ward, with six only noted for a team handover so only have half the ward.

The number of mentions of pain and pain related words (analgesia, specific analgesics, pain management pumps), in the diagnosis and in the notes column of each days nursing handover sheet where counted. The average shown is calculated from the daily totals, so would represent an image of what the nursing handover sheets communicated on any given day.

*Table 1. Pain management words on nursing handover sheets*

	Number of patients	Mentions in diagnosis (%)	Mentions in notes (%)	Diagnosis and notes (% of patients)	Diagnosis and notes (% of diagnosis)
Mean	27	8 (29)	6 (21)	2 (7)	2 (24)
Median	27	7 (25)	6 (21)	2 (7)	2 (22)
Range	21 - 30	4 - 13 (14 - 46)	3 - 10 (8 - 38)	0 - 5 (0 - 17)	0 - 5 (0 - 67)

On average 29% of patients had pain mentioned within their diagnosis or past medical history, but only 21% had pain management related words mentioned in the notes column.

It might be expected that if pain was mentioned as a diagnosis, a pain related note would be added. In this sample this is shown to be true in only 7% of patients. If investigated another way, using the number of mentions in diagnosis as denominator, if pain was mentioned in diagnosis an average of 24% of these patients would have a pain related mention in the notes section.

This data would indicate pain and pain related topics do not form a significant part of the written nursing handover; perhaps less than might be expected from a surgical ward, where it may be presumed that the majority of patients would have some pain management concerns.

The oral nursing handovers were always undertaken from the nursing handover sheet, so a similar pattern of pain management discussion might be expected.

The number of mentions of pain management in the oral handover was counted and linked to the mentions of pain in the diagnosis and in the notes column of each days nursing handover sheet. The average shown is calculated from the daily totals, so represents an image of what the nursing handover communicated on any given day.

Table 2 shows an analysis of the written nursing handover sheets with the oral handover field notes included.

*Table 2. Comparison of oral and written handovers*

	Mentions in oral (%)	Mention in diagnosis and oral (%)	Mention in notes and oral (%)	Mention in diagnosis, notes and oral (%)
Mean	7 (29)	1 (5)	2 (7)	1 (3)
Median	6 (27)	1 (4)	1 (7)	1 (0)
Range	1 - 15 (7 - 71)	0 - 4 (0 - 16)	0 - 4 (0 - 15)	0 - 3 (0 - 13)

As can be seen from Table 2, the range of patients who had pain management discussed at any level is very variable. An average of 29% of patients having pain management discussed as part of the handover process, though there appeared little correlation between pain mentioned in the diagnosis column, or if pain management was mentioned in the handover notes column.