BEING SAFE & TAKING RISKS:

HOW A GROUP OF NURSES MANAGED CHILDREN'S PAIN

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

Master of Philosophy in Nursing

at Massey University

by

Anne Coup

1998

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ABSTRACT

A small, grounded theory study was conducted in a children's surgical ward in a large, urban teaching hospital involving registered nurse volunteers. The purpose of the study was to investigate how nurses' deal with children's acute pain. Ten unstructured, but focused in-depth, taped interviews were conducted with five nurses. The constant comparative method as proposed by Glaser and Strauss (1967) and Glaser (1978) was used to generate substantive theoretical categories, a core category and basic social process.

Analysis revealed that what nurses may want to do and what they can do when managing children's pain is not necessarily the same thing. A number of structural barriers to prompt and effective pain management were identified, such as doctors not always being available to write prescriptions, under prescribing or doctors even refusing to prescribe opioids for children at times. Lack of equipment for delivering continuous analgesic infusions meant that optimal methods could not always be used. The predominant method used was intermittent incremental intravenous doses of morphine, which appeared to provide poor pain control in many cases. The analgesic protocols the nurses were expected to follow were time consuming and impractical when they had several children needing analgesia at once. The nurses' solution to such dilemmas was to still act to relieve pain even when this involved some risk because the nurses' believed that the risk-taking was done responsibly, and that it was more important to promote the child's wellbeing.

The types of risks they took included administering several doses of morphine in quick succession without always monitoring for respiratory depression, and altering prescriptions (but not in writing).

Being Safe and Taking Risks emerged as a paradoxical core category, which reflected the pattern for the nurses' pain management decision-making and practice. It also emerged that a moral interest (*Being Ethical*) appeared to direct and connect the nurse's thinking and practice; they tended to do what they considered was in the child's best interests and believed that the benefits outweighed potential harms.

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ACKNOWLEDGMENTS

I wish to thank the following people and organisations that contributed to this study in a variety of ways:

- Special thanks to the nurses who willingly and frankly shared their experiences and insights of working with children experiencing pain;
- Dr. Judith Christensen, my supervisor, for her constructive comments, for believing in me and her continual support;
- The Otago Polytechnic Research and Development Committee for their financial support;
- The Nursing and Midwifery Department for some financial assistance and leave to write up this thesis;
- Barbara for offering to read the first draft and providing helpful comments;
- Cathy and Linda, my office colleagues, for their support and consideration throughout;
- Denise on the Help Desk who was always patient and helpful in sorting out computer problems;
- Jenny for relieving me of teaching and administrative responsibilities so that I could go on leave as well as for her continual encouragement, support and grounded theory insights;
- Mary and Bronwyn for checking the science, pharmacology and drug calculations;
- Pamela for her helpful comments and suggestions; and,
- Other colleagues for their encouragement and support.

- Finally, thank you to my family for their continual support and forbearance – my daughters Jessica and Liz and especially my husband Daryl.

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INTRODUCTION

Despite considerable advances in knowledge about children's pain experience, its assessment and management, research continues to demonstrate that some nurses still tend to under medicate children experiencing pain, or not to medicate at all, even when analgesics have been prescribed (e.g. Altimier, Norwood, Dick, Holditch-Davis & Lawless 1994; Asprey, 1994; Eland 1974; Eland & Anderson 1977; Mather & Mackie 1983; Schecter 1989). Some of the children in these studies had no prescription for an analgesic, and whether nurses tried to obtain analgesic prescriptions for those children is not known. Researchers have suggested that nurses lack education in pain management and efforts to improve pain management have not been very successful. Other reasons for ineffective management of children's pain have been suggested, including the persistence of misconceptions about children's pain, especially in relation to use of opioid analgesics (e.g. Eland & Anderson, 1977; Lloyd & McLauchlan, 1994); lack of assessment skills and failure to use pain assessment tools (Price, 1992; McCaffery & Ferrell, 1994); and situational barriers (Ferrell, Eberts, McCaffery & Grant, 1991). No published research was found that examined how New Zealand nurses deal with children's pain.

To date, the research methods used to investigate the problem have tended to be either surveys involving the use of questionnaires which have provided information about nurses knowledge, beliefs, attitudes, opinions, and perceptions of their pain management or retrospective chart reviews to determine patterns of analgesic prescription and administration. A major criticism of surveys is that they tend to yield rather superficial information, and confusing or unclear responses that cannot be clarified later. Chart reviews may demonstrate only whether an analgesic was given, other strategies directed at relieving pain and the effectiveness of the analgesic may not be recorded.

Researchers have inferred some reasons for poor or no treatment for pain, but few of these have been confirmed. Consequently, not only are nurses' reasons for particular medication decisions relating to children's pain unclear but also little is known about the process of making such decisions. There is also little information about other strategies nurses may use to relieve pain. Thus, research is needed that aims to discover more about what is going on when nurses deal with children's pain.

A qualitative research method, such as grounded theory, is useful for discovering more about a little known phenomenon, or for gaining new insights into an already familiar problem area, such as children's pain management. Unlike surveys, qualitative methods allow in-depth exploration and clarification of ideas expressed by participants.

The Problem of Pain

Pain is a common human experience which most of us would claim to know, to some extent. Yet, it is also a very puzzling phenomenon because peoples perceptions of pain can differ; pain can develop and persist with, or without, physical injury; pain may be felt in a body site distant from the location where it originates; pain may be felt in a limb which has been amputated; and sometimes pain is not felt despite major injury. However, the most difficult aspect is that only the person experiencing pain knows what it is like. There is no direct means for measuring their pain.

Elaine Scarry (1985) suggested that pain creates powerful double binds in the minds of those involved. Because pain is an inner experience, even those closest to the patient can never truly observe its progress or share its suffering. As such, she argued, patients have no means for establishing its validity as an 'objective' part of the world for health professionals or society at large. Although pain may be an absolute private certainty to the sufferer, it may also be an absolute public doubt to the observer. *The upshot is often a pervasive distrust that undermines family as well as clinical relationships* (Good et al., 1992, p. 7).

The parents of very young children presumably know their children well including how they react to stress and pain. Thus, parents can provide valuable information to assist nurses in their assessment of children. Even though the parent may be absolutely convinced that their child is in pain, some health professionals may doubt this, leading to distrust between the family and health professionals caring for their child. Children can experience difficulty, even when supported by the parents, in both communicating their pain, and getting adequate relief.

Schecter (1989) has suggested that lack of appreciation of the subjectivity of pain experience has been the main cause of under treatment. If health professionals adopted McCaffery's dictum that pain *is whatever the person experiencing it says it is, existing whenever the experiencing person says it does* (McCaffery & Beebe, 1994, p. 15) whether they are adults or children, then a significant aspect of the problem of under treatment for pain would surely disappear.

The researcher's interest in children's pain experience

My interest in how nurses deal with children's pain arose from personal experience. When she was nine years old, my daughter spent some time in hospital with a painful, undiagnosed orthopaedic condition that severely limited her mobility. At home her pain had been managed with a regimen of paracetamol every four hours and twelve hourly diclofenac. Following admission to hospital she had difficulty convincing some of the nurses that she was experiencing pain and obtaining an analgesic, despite the fact that there was one prescribed. Later, as a clinical lecturer working with nursing students in the same paediatric ward, I became aware that some of the nurses at times were reluctant to give analgesics to children who said they were in pain. Thus, this clinical issue challenged and interested me as a parent, a nurse and an educational professional. I believe that parents ought to be able to have confidence in the practice of nurses caring for their children and nurses ought to demonstrate current knowledge for the specialty they work in. The profession also expects this as described in the Code of Practice for Nurses and Midwives (Nursing Council, 1996).

In summary, various studies have shown that dealing with children's pain is problematic for some nurses and doctors. Thus, as a researcher, I was interested in the problem relating to: *What happens when nurses provide care for children experiencing pain*?

The aim of this study was to approach the problem area with an open mind and attempt to discover from nurses their perspective on this; that is, the form of research was to be one of discovery. The research approach, which advocates discovery as its modus operandi, is 'grounded theory.' Glaser and Strauss, two sociologists, developed this method in the 1960s during their study of dying patients in hospital. The grounded theory researcher attempts to discover the nature of the problem, whether there are any patterns in the problem and how it is processed, and if so how these patterns may be related (Artinian, In Chenitz & Swanson, 1986; Glaser & Strauss, 1967).

In their original formulation Glaser and Strauss (1967) recommended putting aside one's pre-conceived ideas, values and beliefs in order to be open to what is going on in relation to the problem being studied. However, Glaser (1992) later acknowledged that professional and personal experience and in-depth knowledge of the area being studied may contribute to the researcher's ability to be theoretically sensitive; to generate categories, their properties and relationships. "This is particularly true for generating *in vivo* categories- those using the terminology of the area under study" (Glaser, 1992, p. 28). Thus, the researcher's knowledge and experience of the substantive area being studied can contribute to the research enterprise when used judiciously.

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Structure of the thesis:

Chapter 1 - is a critical review and discussion of selected research, and other literature relating to children's pain assessment and treatment

Chapter 2 - provides an overview of the research approach used in this study; grounded theory. Methodological issues of concern to the grounded theory researcher are identified and discussed. The research process used in this study is then described including the area of concern, study purpose, study setting, access to, and recruitment of participants, and sources of data. Ethical considerations and procedures used to enhance rigour in this qualitative study are also discussed. Finally, issues and problems associated with doing research in a familiar culture, and subjectivity are discussed. Any difficulties encountered during the actual research are identified and explained throughout.

Chapter 3 - describes the process of data analysis and generation of theory. This follows Glaser and Strauss' strategies for discovering grounded theory as described in their book The Discovery of Grounded Theory first published in 1967 and later publications (Glaser, 1978; Glaser, 1992, Glaser, 1998).

Chapter 4 - describes the *core process* that emerged from the data: *managing pain.* The five stages of the *managing pain* process: *assessing*, *checking and interpreting*, *choosing*, *giving*, and *monitoring and responding* are also described. Excerpts from the data are used to illustrate each stage and its properties, and there is a brief discussion with reference to nursing and other relevant literature.

Chapter 5 - describes one dimension of the *core category*, which emerged from the data: *being safe.* The category *being safe* has four properties*: following rules, right responding, being cautious* and, *managing risk.* Excerpts from the data are used to illustrate *being safe* and its properties, followed by a brief discussion with reference to nursing and other relevant literature.

Chapter 6 - describes the other dimension of the core category that emerged from the data: *taking risks. Taking risks*, as used here, refers to exposing the patient to some

inherent danger related to administering pain medication. Excerpts from the data are used to illustrate *taking risks* followed by a brief discussion with reference to nursing and other relevant literature.

Chapter 7 - describes a pervasive and significant category: *being ethical,* that underpinned the core category of *Being Safe and Taking Risks.* The category *being ethical* contains the properties of '*doing good*' (and its corollary *preventing harm*); *being trustworthy*; *being an advocate*. When the nurses felt unable to achieve their ethical ideal when managing pain they reported feeling distressed. Each of the properties of *being ethical* is critically discussed in relation to selected ethics literature.

Chapter 8 - The tentative theoretical relationships between *Being Safe and Taking Risks* while *Being Ethical,* and the process of *Managing Pain* are described. The implications of these findings for nursing education, and practice are discussed. The limitations of the study and recommendations for future research are also discussed.

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