

School of Nursing & Midwifery

**Indonesian Nurses Management of Pain in Children: A Grounded
Theory Study**

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**This thesis is presented for the Degree of
Doctor of Philosophy
of
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DECLARATION

To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgement has been made.

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university

Signature:.....

Date:

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ABSTRACT

Hospitalised children continue to experience significant levels of pain during hospitalisation despite proliferation of pain research, advances in pain management knowledge and treatments, and improved methods to relieve pain. Effective pain management remains an elusive goal in Indonesia. There is little research in Indonesia regarding pain management in children. The purpose of this study was to explore Indonesian nurses' perceptions of and experiences with pain management of hospitalised children, with a view to discovering the factors that impact on nurses' ability to provide pain management; and to develop a substantive theory that explain how Indonesian nurses attempt to resolve the main concern experienced by them when caring for such children.

A Glaserian Grounded Theory approach was used to conduct the study, allowing a substantive theory to be developed. Data were collected from a sample of 37 nurses through semi-structured, in-depth interviews. Audio-recordings of interviews and hand-written field notes were transcribed verbatim. Data were managed by using manual thematic analysis procedures to identify themes, patterns and essential elements contained within the text, while constant comparative analysis using open, theoretical and selective coding (Glaser & Strauss, 1967; Glaser, 1978, 1992, 1998) was performed.

The core concern/problem of experiencing professional role tensions was found to be a central shared concern that the majority of nurse participants in this study experienced when caring for hospitalised children in pain. The participants felt that they were unable to provide effective pain care and as a result they experienced professional role tensions. They found themselves internally conflicted because, although they had the desire to provide effective pain care, they were in the main unable to accomplish this objective. The core concern/problem of being caught between tensions comprised two core categories, namely, 1) barriers to pain management and 2) carrying out the pain management role. The majority of the

participants in this current study articulated that various factors impacted on and directly contributed to their experience of professional role tensions.

The nurses in this current study understood that in order to provide effective paediatric pain care they were required to regulate their own emotions and manage or minimise their professional role tensions. The substantive theory of the process of managing professional role tension explains how nurses used four strategies in response to varied and complicated conditions that existed in their workplaces: accommodating professional role tensions, seeking support, responding action, and reconciling moral distress. These strategies provided the nurses with both immediate and long-term resolution where the nurse made a conscious decision to actively manage and reduce his or her professional role tensions. In this way the nurses could protect themselves and maintain their emotional wellbeing when working and caring for hospitalised children in pain. These strategies helped nurses to reduce their professional role tensions by enabling them to reconcile themselves with the fact that they were unable to do much to relieve paediatric patients' pain. Therefore, they adapted to the limitations imposed on them by the workplace.

Throughout this thesis relevant scientific literature has been merged into the research findings to illustrate the relevance of the newly developed theory, and to place the substantive theory within the context of other findings and related theories. The findings detailed in the substantive theory contribute to the knowledge and understanding of Indonesian nurses' experiences when caring for hospitalised children in pain. This has relevance both nationally in Indonesia and internationally, to the provision of nursing care related to paediatric pain management.

TABLE OF CONTENTS

DECLARATION	i
ACKNOWLEDGEMENTS	ii
ABSTRACT	iv
LIST OF TABLES	xi
LIST OF FIGURES	xii
CHAPTER 1	1
INTRODUCTION AND BACKGROUND TO STUDY	1
1.1 Introduction	1
1.2 Background of the study.....	2
1.3 Problem statement and justification of the study	3
1.4 Purpose of the study	5
1.4.1 Objectives of the study	6
1.5 Significance of the study	7
1.6 Organisation of the thesis	8
1.7 Conclusion.....	10
CHAPTER 2	11
LITERATURE REVIEW.....	11
2.1 Introduction	11
2.2 The role of the literature review in a grounded theory approach	12
2.3 Parameters of the literature search	14
2.3.1 Aim of the review	14
2.3.2 Search criteria	14
2.3.3 Data sources	16
2.4 The consequences of unresolved pain for children	17
2.5 Nurses' responsibilities for and roles in pain management in children.....	18
2.6 Current pain management practice in hospitalised children.	20
2.6.1 Putting pain assessment in children into practice	20
2.6.2 How to provide pain management practice in children	24
2.6.3 Pain documentation.....	28

2.7 Obstacles to adequate pain assessment and management practice in children	30
2.7.1 Children’s age-related factors	30
2.7.2 Myths and misconceptions about pain in children and its treatment	33
2.7.3 Nurses’ attitudes and beliefs about children’s pain	35
2.7.4 Lack of knowledge about pain and its management	37
2.7.5 Lack of education/preparation for, and/or training about pain	39
management	39
2.7.6 Context of organisational influences	42
2. 8 Implications of this review for this study	47
2.9 Chapter 2 summary	48
CHAPTER 3	51
METHODOLOGY: THE GROUNDED THEORY METHOD	51
3.1 Introduction	51
3.2 The choice of a qualitative paradigm	52
3.3 Grounded Theory: the methodology	56
3.3.1 The origin of Grounded Theory	56
3.3.2. Philosophical roots of Grounded Theory	61
3.3.3 Evolution of Grounded Theory	64
3.3.4 When is Grounded Theory an appropriate approach?	65
3.3.5 Grounded Theory and nursing research	66
3.3.6 Differences in approach between Glaserian and Straussian Grounded Theory	67
3.3.7 Glaserian Grounded Theory	72
3.3.8 Key elements of Glaserian Grounded Theory	73
3.4 Chapter 3 summary	92
CHAPTER 4	93
RESEARCH METHOD AND PROCESSES	93
4.1 Introduction	93
4.2. The settings of the study	93
4.2.1. Research settings	94
4.3 Sample description	95
4.4 Sampling strategies	96
4.5 Participant recruitment	97
4.6 Data collection	98

4.6.1 Interviews as the source of data.....	98
4.7 The interview process.....	99
4.8 Data management and analysis process	102
4.9 The constant comparative method of analysis	103
4.9.1 Coding and conceptualising data	104
4.10 Memoing	112
4.11 Diagramming.....	114
4.12 Writing theory	114
4.13 Theoretical sensitivity	115
4.14 Criteria for evaluating the rigour of the emergent theory, or the proof of product.....	116
4.15 Ethical consideration	118
4.16 Chapter 4 summary	120
CHAPTER 5	122
FINDINGS: THE CORE PROBLEM.....	122
5.1 Introduction.....	122
5.2 Core Category—Barriers to pain management	124
5.2.1 Structure of the organisation.....	126
5.2.2 Culture of organisation	140
5.3 Core category—Carrying out the pain management role.....	152
5.3.1 Nurses’ values and attitudes towards pain management	153
5.3.2 Nursing care related to pain management.....	158
5.3.3 Suggestions for improving nursing pain management	169
5.4 Core concern/problem—Experiencing professional role tensions.....	178
CHAPTER 6	182
A GROUNDED THEORY OF THE PROCESS OF MANAGING PROFESSIONAL ROLE TENSIONS	182
6.1 Introduction	182
6.1.1 Overview of the theory	182
6.2 Resolving the core problem—the process of managing professional role tensions	186
6.2.1 The context	187
6.2.2 Accommodating professional role tensions.....	190
6.2.3 Seeking support.....	194

6.2.4 Responding action.....	198
6.2.5 Reconciling moral distress.....	201
6.3 Chapter 6 summary	205
CHAPTER 7	207
DISCUSSIONS, RECOMMENDATIONS AND CONCLUSIONS.....	207
7.1 Introduction	207
7.2 Discussion	208
7.2.1 Barriers to pain management	208
7.2.2 Carrying out the pain management role.....	225
7.2.3 The substantive theory of the process of managing professional role tensions	232
7.3 Implications of the study findings for clinical practice	240
7.4 Recommendations of this study	245
7.4.1 Recommendations for clinical practice.....	245
7.4.2 Recommendations for nursing education	246
7.4.3 Recommendations for future research	247
7.5 Strengths and limitations of this study	247
7.6 Concluding statement	249
LIST OF REFERENCES	251
LIST OF APPENDICES	291
Appendix 1: Information for Directors of Dr Hasan Sadikin General Teaching Hospital	291
Appendix 1a: Information for Director of Gunung Jati Hospital Cirebon	292
Appendix 2: Information sheet for potential participants	293
Appendix 3: Indication of intention to participate in the study.....	295
Appendix 4: Consent form for participants	296
Appendix 5: Demographic questionnaire for participants.....	297
Appendix 6: Interview guides	298
Appendix 7: Information for Directors of Dr Hasan Sadikin General Teaching Hospital in Bahasa Indonesia	299
Appendix 8: Information for Director Gunung Jati Hospital Cirebon in Bahasa Indonesia	300
Appendix 9: Information sheet for potential participants in Bahasa Indonesia. ..	301
Appendix 10: Indication of intention to participate in the study in Bahasa Indonesia	303

Appendix 11: Consent form for participants in Bahasa Indonesia.....	304
Appendix 12: Interview guides in Bahasa Indonesia	305
Appendix 13: Demographic questionnaire for participants in Bahasa Indonesia	306
Appendix 14: Ethic Approval from Curtin University.....	307
Appendix 15: Renewal Ethic Approval from Curtin University.....	308
Appendix 16: Ethic Approval from Dr Hasan Sadikin General Teaching Hospital	309
Appendix 17: Letter permission for conducting research in Dr Hasan Sadikin Hospital	310
Appendix 18: Letter permission for conducting research in Gunung Jati hospital Cirebon	311
ABBREVIATION USED IN THIS STUDY	312

LIST OF TABLES

Table 2.1 Myths and misconceptions about pain in children.....	34
Table 4.1 Demographic statistics of nurses.....	94
Table 4.2 Demographic statistics of nurses in the second setting.....	95
Table 5.1 Core Concern/problem- Experiencing professional role tensions	123
Table 5.2 Summary of the profile of the nurse participants.....	124
Table 5.3 Core Category-Barriers to pain management.....	125
Table 5.4 Structure of the organisation.....	127
Table 5.5 Culture of the organisation.....	141
Table 5.6 Core Category-Carrying out the pain management role.....	153
Table 5.7 Sub-category-Nurses'values and attitudes towards pain management....	155
Table 5.8 Sub-category-Nursing care related to pain management	159
Table 5.9 Sub-category-Suggestions for improving nursing pain management.....	169

LIST OF FIGURES

Figure 4.1 Sample of interview transcript.....	105
Figure 5.1 Core concern/problem- Experiencing professional role tensions	178
Figure 6.1 The process of managing professional role tensions	185
Figure 6.2 Accommodating professional role tensions.....	191
Figure 6.3 Seeking support	195
Figure 6.4 Responding action	199
Figure 6.5 Reconciling moral distress.....	203

CHAPTER 1

INTRODUCTION AND BACKGROUND TO STUDY

1.1 Introduction

As in all countries, children in Indonesia require pain relief during hospital admissions. According to a declaration by the special interest group of the International Association for the Study of Pain (IASP, 2005), the relief of pain in children is a necessary and humane aspect of paediatric and adolescent health care; indeed, it is a basic human right (Brennan & Cousins, 2004). In addition, effective pain management has the potential to improve recovery, reduce morbidity, mortality, patient fear, anxiety, parents' and nursing staff's distress, and reduce cost related to health care (Dowden, McCarthy, & Chalkiadis, 2008; Duff, 2003). Nurses play a pivotal role in relieving children's pain in hospital (Kortessluoma, Nikkonen, & Serlo, 2008; Schechter, Berde, & Yaster, 2003; Vincent, 2005; Vincent & Denyes, 2004) and are most likely to be the ones who recognise and administer pain relief in the first instance.

Geographically, Indonesia is the world's sixteenth largest country in terms of land area (World Health Organisation [WHO], 2012), and is located between two continents, Asia and Australia, and two oceans; the Indian and the Pacific (Ministry of Health, Indonesia, 2012). Indonesia is the largest archipelagic country in the world, consisting of more than 17,000 islands. With over 240 million inhabitants, it is the fourth most populated country in the world (National Central Bureau of Statistics [BPS], 2010). The public health profile in Indonesia has improved significantly over the last few decades, and the average life expectancy in 2013 was 71.9 years (Index Mundi, 2013).

In Indonesia the health of children is improving, as shown by indicators such as the under-five mortality rate (U5MR) and the infant mortality rate (IMR) (WHO, 2012). Indonesia has made good progress and is on track to achieving the Millennium Development Goal (MDG) of reducing child mortality (WHO South-East Asia Region [SEARO], 2011). The under-five mortality rate has decreased from 97 to 44 per 1,000 between 1991 and 2007 (Badan Perencanaan Pembangunan Nasional

[BAPPENAS], 2011). Infant and neonatal mortality are also declining significantly. Infant mortality has decreased from 68 to 34 per 1,000 live births between 1991 and 2007 and the neonatal mortality rate from 32 to 19 per 1,000 live births in the same period (BAPPENAS, 2011).

Even with all of these improvements in health care, Mediani (2002) found that nurses still did not give adequate pain relief to paediatric patients [children]. Many paediatric patients experience unrelieved and unnecessary pain after procedures and surgery during hospitalisation (Mediani, 2002). It is therefore vital to identify the factors that influence Indonesian nurses' pain management of hospitalised children's pain. As such, the aim of this study was to explore nurses' experience with and perceptions of providing pain relief to hospitalised children in Indonesia. It is important for Indonesian nurses to examine their pain management practice in order to determine whether their practice contributes to inadequate pain relief in hospitalised children.

1.2 Background of the study

Pain is a significant factor in children's illness, and its treatment remains a major concern for hospitalised children (Kortessluoma & Nikkonen, 2006). In addition, pain is a common experience and distressing for children (Gold et al., 2006; Kortessluoma et al., 2008; Taddio et al., 2009). Numerous sources of pain have been identified when children are admitted to hospital, including surgical trauma, invasive procedures, and the disease process itself (Gold, Kim, Kant, Joseph, & Rizzo, 2006; Kortessluoma et al., 2008; Puntillo et al., 2004; Taddio et al., 2009; Vincent & Denyes, 2004). Pain is also one of the most feared experiences for hospitalised children and their families. Children of all ages feel intense fear when they perceive a threat to body integrity and physical wellbeing (Taddio et al., 2009). All children, including infants, have the ability to feel pain, and a healthy outcome for a child may be compromised when pain is not managed adequately (Kortessluoma et al., 2008; Schechter et al., 2003; Taddio et al., 2009).

The consequences of unrelieved pain are well documented. Unrelieved pain has adverse physiological effects, negative emotional and psychological implications and also inhibits children's participation in therapy (Duff, 2003; Llewellyn, 2003; Taddio

et al., 2009). Unrelieved pain can slow recovery, create burdens for patients and their families, and increase the cost of care (Llewellyn, 2003; Taddio et al., 2009). For instance, children with surgical pain are known to experience difficulty coughing, deep breathing and ambulating, leading to their experiencing increased post-operative complications, longer hospital stays and increased health expenditures (Schechter et al., 2003; Taddio et al., 2009). Psychological consequences of unrelieved pain may include increased anxiety, decreased cooperation with future procedures, and nightmares about pain and surgery (Taddio et al., 2009). Pain also impacts on quality of life, increases vulnerability in an already vulnerable population such as children, and promotes dependence on health care providers for access to adequate pain management (Hockenberry, 2004). Untreated pain in early childhood produces immediate consequences and impacts upon the child later in life (Taddio et al., 2009). This can result in long-term effects such as post-traumatic stress disorder (PTSD), often causing decreased intellectual and social capacities and decreased immune function (Zengerle-Levy, 2006). It is therefore important to ensure that pain is managed effectively.

Every day, an unknown number of children in Indonesia endure pain from surgery, illness, trauma, nursing interventions and other medical procedures during hospitalisation (Mediani, 2002). These children are dependent on nurses for the assessment and management of their pain. This dependence is even greater for children who are unable to describe their pain: for example infants, young children, those who are intellectually disabled, critically ill or unconscious (Trudeau, Lamb, Gowans, & Lauder, 2009). In Indonesia, hospitalised children are under-treated for pain, not just from a lack of physicians' prescriptions, but also because of inadequate nursing assessment and management (Mediani, 2002). Findings like this suggest that nurses are not adequately prioritising children's pain and this may have a considerable impact on paediatric patients as it is the nursing profession with whom they have the greatest contact during a hospital admission (Johnston et al., 2007).

1.3 Problem statement and justification of the study

Despite the reduction in mortality in children, care practices such as effective pain management remain an elusive goal in Indonesia. The proliferation of research, advances in the pain treatment field, and improved methods to relieve pain (Gordon

et al., 2005) have only brought about a minimal change in nursing practice; many patients continue to suffer unnecessarily. This phenomenon is not specific to Indonesia; around the world, effective pain management continues to be a health care problem, especially for children (Finley, Forgeron, & Arnaout, 2008; IASP, 2010; Size, Soyannwo, & Justins, 2007; Stinson et al., 2008; Taddio et al., 2009; Taylor, Boyer, & Campbell, 2008). Many authors have identified that children are particularly vulnerable to sub-optimal treatment of pain and children continue to have their symptoms of acute and chronic pain under-treated (Ellis et al., 2002; Johnston et al., 2007; Twycross, 2007; Vincent & Denyes, 2004) and the relief of their pain remains problematic. Previous reports have found that children receive less analgesia than adults in comparable situations (Schechter et al., 2003; Vincent & Denyes, 2004; Vincent, 2005) and that children hospitalised after surgery continue to experience moderate to severe pain (Broome & Huth, 2003; Buscemi, Vandermeer, & Curtis, 2008; Griffin, Polit, & Byrne, 2007; Pop, Manworren, Guzzetta, & Hynan, 2007; Vincent, 2005; Vincent & Denyes, 2004). The findings of these studies are alarming. However, the real reasons behind sub-optimal treatment of pain in children are still unknown. Therefore the issue of under-treatment in children needs to be explored further; in particular, the contextual issues influencing nurses' pain management practice. Greater research efforts are needed to identify the factors that affect nurses' perceptions of pain management and their pain management practice for hospitalised children in pain (Griffin, Polit, & Byrne, 2008). Existing literature has clearly identified that despite the fact that a variety of research and clinical studies on all aspects of pain have been conducted in many countries, the factors affecting pain management and its implementation have not been well identified (Czarnecki et al., 2011; Twycross & Collins, 2013).

Particular reasons for inadequate pain assessment and pain management practices in hospitalised children have been postulated. These include insufficient basic training programs for health care providers, nurses' lack of knowledge or inaccurate knowledge regarding pain management, difficulty in making decisions about pain management, and nurses' fear or misconceptions regarding the use of opioid analgesics (Ely, 2001; Shrestha-Ranjit, & Manias, 2010). All of these matters contribute to the problem of under-treatment of children in pain (Buscemi et al., 2008; Probst, Lyons, Leonard, & Esposito, 2005; Simons, van Dijk, Anand,

Roofthoof & van Lingen, 2003; Shrestha-Ranjit, & Manias, 2010; Sutters et al., 2004; Vincent & Denyes, 2004). According to a number of authors, another barrier to optimal pain management in children occurs because children are less able to communicate their pain to nurses and doctors and as such are less likely to expect pain relief from them (Cheng, Foster, & Hester, 2003; Taddio, Shah, Gilbert-Macleod, & Latz, 2002). In practice, other factors such as the relationship with the patient, age, diagnosis, and patterns of behaviour also influence nurses' pain management (Gimbley-Berglund, Ljusegren, & Enskar, 2008; Simons & Roberson, 2002).

A majority of studies dealing with issues of pain management in children have utilised a quantitative research approach (Finley, Kristjansdottir & Forgeron, 2009; Malviya, Voepel-Lewis, Merkel, & Tait, 2005; Pud, 2004; Rieman & Gordon, 2007; Simon & Roberson, 2002; Simpson, Kautzman, & Dodd, 2002; Vincent & Denyes, 2004). These studies have used descriptive or correlational research designs to establish a number of possible factors that influence nurses' pain management practice with hospitalised children experiencing pain. These factors include the following characteristics of the nurse: level of education (Malviya et al., 2005; Simpson et al., 2002; Vincent & Denyes, 2004); personal experience (Pud, 2004); belief system, and knowledge of pain and pain management (Rieman, Gordon & Marvin, 2007; Simon & Roberson, 2002; Simpson et al., 2002; Vincent & Denyes, 2004), as well as the cultural background of both the nurse and the patient (Finley et al., 2009). Although these studies are valuable in developing a foundation for future research, there are gaps in existing knowledge that require examination using qualitative methods. A qualitative approach is valuable for exploring work demands in clinical areas and levels of accountability related to pain management (Richards & Hubbert, 2007). There is limited qualitative research on pain management for hospitalised children in Indonesia.

1.4 Purpose of the study

Even with all of the above research, paediatric pain care research and knowledge building is still at the inception stage in Indonesia. The purpose of this study was to describe what influences Indonesian nurses' pain management practice with regard to relieving hospitalised children's pain. The process of identifying the factors that

influence nursing practice allows for further efforts to improve paediatric pain management and health care for hospitalised children within the Indonesian context. In doing so the study has explored how nurses' knowledge, attitude, beliefs, structures and organisational cultures affect their pain management practices.

This study is one of the first to explore Indonesian nurses' perceptions of and experiences with pain management of hospitalised children, with a view to discovering factors that influence nurses' ability to provide pain management. It was important to understand the process that Indonesian nurses utilise when managing pain in hospitalised children, and using a Grounded Theory (GT) approach was seen as the most appropriate way to obtain this understanding. A Glaserian GT approach (Glaser & Strauss, 1967; Glaser, 1978; 1992; 1998) allowed the researcher to explore Indonesian nurses' perceptions of and experiences with pain management when caring for hospitalised children. The researcher was able to explore and discover the main concern of the Indonesian nurse participants when caring for paediatric patients in pain, which proved to be their experience of professional role tensions. In addition, the researcher developed a substantive theory explaining how these nurses attempted to manage these professional role tensions (their main concern) and continue to provide care in the context of Indonesian paediatric wards. The theory explains how they managed these role tensions in order to protect themselves from distress and maintain their emotional wellbeing, accept their complex working environments and remain working and practising so that they could deliver paediatric patient care effectively.

1.4.1 Objectives of the study

The objectives of this study were to:

- (1) Explore Indonesian nurses' experience of managing pain in hospitalised children
- (2) Identify factors that affect Indonesian nurses' provision of pain management to hospitalised children
- (3) Explore the main concerns of Indonesian nurses when caring for children in pain on paediatric wards

- (4) Develop a substantive theory that explains how Indonesian nurses attempt to manage the main concern experienced by them when caring for children experiencing pain in paediatric wards

1.5 Significance of the study

Managing hospitalised children's pain is an important element of paediatric care (Rieman et al., 2007). Nurses spend more time with hospitalised children than any other health care providers and they play a vital role in the assessment and management of the children's pain. Clinical decisions made by nurses in pain management include determining when a patient is experiencing pain, whether or not medication should be administered, how much, how often, and by what route (Brockopp et al., 2004; Ely, 2001). The nurse's decisions when managing children's pain directly affect the care that patients receive (Brockopp et al., 2004). Good pain management practice greatly influences the quality of care given to affected hospitalised children and their families.

The significance of this study is that to date, only one study (Mediani, 2002) has explored Indonesian nurses' experiences of pain management in paediatric patients. As such, this new study provides readers with insight into the experiences of Indonesian nurses working in paediatric settings, relative to the provision of pain management. This study highlights the problems these nurses face and the ways they try to overcome the situations in which they find themselves. It shows that despite their best efforts, pain management by nurses is still not well done and requires attention. The study adds to the current body of knowledge and identifies where efforts should be focused to assist these nurses to strengthen their skills and develop their knowledge base regarding pain management in children. The study's findings have identified that providing paediatric patient pain care in Indonesian clinical settings is an increasingly demanding, difficult and complicated undertaking. This stems from the challenges and dilemmas that participants face when caring for hospitalised children in pain. It is also a consequence of complex working environments and the increasing expectations and demands of the hospital organisation. These situations were found to have created role tensions for nurses. The results of this study are timely in addressing the need to emphasise a healthy and positive work culture, and in demonstrating that learning how to effectively manage

role tensions is an important and necessary tool with which to equip all paediatric nurses in Indonesia.

It is anticipated that the substantive theory developed in this study will increase our understanding of the complex phenomenon of nursing pain management in hospitalised children in Indonesia. It highlights how Indonesian nurses have attempted to manage the role tensions experienced as a consequence of being unable to provide effective pain care for hospitalised children experiencing pain in paediatric clinical settings. The process of managing professional role tensions was found to be affected by several interrelated factors such as working environment, professional factors, nurses' values, and personal characteristics. A comprehensive understanding of contextual issues that affect Indonesian nurses' pain management practice enables a more comprehensive and targeted approach to supporting these nurses to provide better pain care. In addition, the emerging substantive theory will provide information and a foundation for future research on nursing pain management in paediatric patients in the West Java Province, and across Indonesia in general.

1.6 Organisation of the thesis

This thesis consists of seven chapters.

Chapter One presents the introduction to the study, its significance, and an overview of children's health in Indonesia. The background to the study and the reasons for undertaking this research and for using Grounded Theory (GT) are explained. The study objectives are also presented in this first chapter.

Chapter Two presents a review of the literature, critiquing and summarising the known information about pain management in children. The literature review provides justification for the study by identifying a knowledge gap concerning nurses' pain management for hospitalised children in Indonesia.

Chapter Three presents the methodology used in this study. This chapter details an overview of GT methodology, and the methodological framework chosen for the study. An historical summary of the methodology is presented, followed by an examination of the components of GT method: constant comparative analysis, open,

theoretical and selective coding, theoretical sampling, category saturation, memoing and theoretical sorting (Glaser & Strauss, 1967; Glaser, 1998; Glaser, 1978).

Chapter Four presents a description of the methods used. It gives a detailed account of how the participants were recruited and how ethical considerations were addressed. The particular GT methods used in this research are presented. These include semi-structured interviews and coding procedures. Finally, the methodological issues that have emerged during the conduct of the study are discussed.

Chapter Five presents the findings of the study: importantly, the core problem that was generated from the data. More specifically, the chapter discusses two core categories: barriers to pain management and carrying out the pain management role. The main conditions affecting the problem, including contextual and causal factors, are then described, and illustrated with examples from the data. Sub-categories and properties of the core categories are also illustrated with examples from the data. Existing literature is used as data to support the emerging picture of these nurses' experiences with providing pain management to hospitalised children.

Chapter Six sets out the substantive theory of the process of managing the professional role tensions that emerge from this study. The theory explains how nurse participants manage their role tensions through the use of four strategies when caring for hospitalised children in pain. This theoretical framework explains the way in which they process this concern. The chapter begins with an overview of the process of managing professional role tensions and then explains each strategy in detail. Existing literature is used to support the emerging theory.

The final chapter, Chapter Seven, presents the discussion of the findings in this study, implications for clinical practice, recommendations and conclusions. This chapter begins with a discussion of the findings presented in Chapter Five and this is followed by a discussion of the theory presented in Chapter Six. Existing literature is used to strengthen the discussion. In Chapter Seven, the conclusions reached from the findings, a discussion of study limitations and the implications of this study, are presented. Finally, recommendations are made on how the findings can be used for

improvements or changes that need to be made within the Indonesian context, and for further research required to improve the nursing sector's pain assessment and pain management for children hospitalised in Indonesia.

1.7 Conclusion

Paediatric nurses' pain management practices continue to fall short, with hospitalised children still experiencing moderate to severe pain. Untreated pain may have significant consequences for children. The physical, psychological, and emotional effects of pain for paediatric patients are serious. Nurses play a significant role in pain management through their recognition of the need for intervention and advocacy for hospitalised children in pain; therefore they have the potential to make a difference in relation to pain management. This is as true for the Indonesian setting of this study, as for any other country or culture. It was necessary to conduct research in the Indonesia clinical setting in order to attempt to uncover the reasons for pain management in hospitalised children still remaining inadequate. There was a need to understand the factors affecting Indonesian nurses' pain management practices when caring for hospitalised children.

The specific aim of this study was to implement a Glaserian GT method to explore Indonesian nurses' perceptions of and experiences with pain management when caring for hospitalised children. It was important to uncover the main concern for nurse participants and to understand the factors that affect their pain management practice as well as how they manage their main concern. The use of a qualitative method for this study was supported by the gaps in the existing knowledge, the conflicting findings of existing knowledge, and the lack of application of existing knowledge to clinical practice. The following chapter will review the existing literature on the study topic and highlight the gaps in knowledge that supported the need for this study.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

Pain management in children has become a focus of attention for health care professionals, researchers, health educators and policy makers globally. Children's pain and its management are important issues, and adequate and appropriate pain management is a major clinical problem confronting health care professionals in paediatric clinical settings. This chapter presents a critical review of the current literature that addresses the under-treatment of pain in children, factors affecting pain management in hospitalised children, and the complex issues entailed in pain management within the paediatric population. This literature review focuses on what is currently understood about nurses' pain management practice in the case of hospitalised children.

The literature on health care professionals' (in particular nurses') pain management practices identified in this review presents both qualitative and quantitative research. Studies have suggested that nurses' pain management practice in hospitalised patients is influenced by several factors, such as nurses' beliefs, attitudes, knowledge base, and experience, as well as factors associated with the patient, with the organisational structure, and with nurses' collaboration with doctors. These factors, which have been identified as influencing pain management practice in hospitalised children, have been reviewed.

In general, this review of the relevant literature examined the results of related studies, identified gaps in the current literature and provided a framework for establishing the importance of the study (Creswell, 2013). However, the use of literature in a Glaserian GT study causes confusion for many researchers as it differs from the traditional approach where literature is examined to provide background. This chapter begins with a discussion of the role of the literature review in a GT approach, and how it was used in this study. This discussion is followed by a critical review of the evidence that shapes nurses' pain management practice in hospitalised children.

2.2 The role of the literature review in a grounded theory approach

In quantitative studies, researchers thoroughly review the literature on the topic of interest before conducting the study. Conducting a literature review prior to commencement of a GT study is sometimes viewed as controversial and debatable. These perceptions have arisen because many researchers consider that the substantive theory generated in a GT study should emerge from the participants involved. In GT, salient issues and concepts are unknown until they emerge in the data (Glaser & Strauss, 1967; Glaser, 1992, 1998). Glaser and Strauss (1967) argued that conducting an initial literature review was unnecessary. Glaser (1978, 1992) was strongly against any type of literature review before the study is undertaken. Instead, it is proposed that research data be dealt with first, as the literature may influence the researcher unduly and predispose him/her to force data into pre-existing codes and categories (Glaser & Strauss, 1967). In addition, Glaser and Strauss (1967) argued that the researcher has no control over what he or she already knows when entering the research field, but can exercise control over what is added to that knowledge base. Glaser (1978, 1992) was of the view that in order to have the “freedom to discover” (Glaser, 1998, p. 68) the literature should not be examined until the researcher is in the field and codes and categories have begun to emerge. This was necessary to prevent generating a focus from the literature rather than from the emerging data. Reviewing the literature prior to this step can contaminate or impede the generation of theory (Glaser, 1978, 1992). According to Glaser (1998) researchers should read generally in other fields to extend their theoretical sensitivity. Only when the grounded theory is nearly completed can a literature search be accomplished and ‘woven into the theory as more data for constant comparative analysis’ (Glaser 1998, p. 67), clearly supporting the emerging concept or findings.

In contrast, McCallin (2003), and Schreiber (2001), argue that in order to identify the knowledge gaps in the literature it is necessary to undertake a review prior to the commencement of data collection and analysis in a GT study. Giske and Artinian (2009) suggest that perusal of existing literature is required during the planning phase of the study, to examine gaps in knowledge for proposal development. This suggestion is plausible, as the most significant reasons for undertaking research are to develop a strong knowledge base in the field being studied, to critique previous

research related to the area of interest, to identify a specific area that requires further study, to generate hypotheses or research questions, and to determine an appropriate design and suitable methodology for undertaking the new study under consideration (Schneider, Elliot, LoBiondo-Wood, & Haber, 2003). Therefore, if a review is not undertaken, it is difficult to know whether or not there are deficits in the literature that warrant exploration. It is acknowledged that researchers bring their belief systems, perceptions, ideas, theoretical frameworks and experiences to their chosen area of study, a factor that ultimately influences data collection and analysis (McCann & Clark, 2003). Researchers typically study areas and topics of which they already have some previous experience and knowledge. There is therefore a need to balance the risk of existing literature biasing data collection and interpretation (Backman & Kyngas, 1999). It is important that the researcher be aware of the potential for bias, identifying what he or she already knows, and take measures to ensure that the study findings emerge from the data, as opposed to trying to force the data to fit the researcher's own preconceptions and ideas (Backman & Kyngas, 1999; McCann & Clark, 2003). According to Heath and Cowley (2004) it is impossible to expect the researcher to enter a field of study completely devoid of the influence of previous reading. Reading the literature usually assists the researcher to clarify his/her thoughts and to narrow down the topic of study (Backman & Kyngas, 1999). In GT research, a literature review is used to determine how much is known about the subject (Backman & Kyngas, 1999; McCann & Clark, 2003).

In keeping with this concept, a preliminary literature review was conducted to provide justification for this qualitative study; to assist with proposal development and articulation of the research problem; to meet the university's requirements for candidacy and ethics approval; to uncover knowledge related to the phenomenon of interest; to identify gaps in research related to pain management in children, and to assess whether GT was an appropriate methodology. The literature review that follows focuses on substantive literature and identifies previously established concepts that pertain to the phenomena of interest. The literature presented in this chapter also served at a later stage in the study as an additional source of data, and was used to compare, differentiate, and validate concepts emerging from the collected data (Chenitz, 1986; Glaser & Strauss, 1967; Strauss & Corbin, 1998). The literature search and review was ongoing throughout this study. Literature was

reviewed as the researcher conducted data analysis and concepts began to emerge from the data. Moreover, once the developing theory began to emerge and was sufficiently stable to accommodate comparison with existing studies and theories, an additional search was conducted to identify literature pertinent to the findings. This is the point at which the researcher can determine which literature is relevant, and integrate it, using constant comparison to define new theoretical properties in the emergent theory (Glaser, 1978, 1992, 1998). Furthermore, literature has also been interwoven into the findings (Chapter 5) and the theory (Chapter 6), and used to support the discussion (Chapter 7). The findings of the various literature reviews have been arranged in this thesis to support the flow of the work and prevent repetition (irrespective of when in the process it was reviewed).

To sum up, in this GT study, the literature review presented in this chapter was used to provide a background for this current study. Thus, the information provided is meant to frame the problem, highlighting what is known and what is missing, and to identify knowledge gaps. Further information derived from subsequent literature reviews that informed the development of a substantive theory in this GT study, is woven into discussions throughout the thesis.

2.3 Parameters of the literature search

A comprehensive search of the literature was used in this study, the parameters of which will be discussed in the following section.

2.3.1 Aim of the review

This review of the literature critiques and provides an overview of the available contemporary research literature on pain management in children, in order to identify possible issues or problems that influence pain management practice in children.

2.3.2 Search criteria

To be included in this review of literature, the articles had to meet the following criteria:

- The material should be written and/or published between 2001 and 2013.
Normally, a contemporary review would only include the literature from the

past 10 years. However, in this study, as there were relevant research papers relating to pain management in children that had been written in 2001, the time frame for the literature review was extended by two years. This time frame extension allowed for an expansion of the literature available for review, which was useful in view of the fact that there was likely to be a paucity of relevant previous qualitative evidence for a qualitative study such as this one.

- Research articles were sought, not anecdotal literature. All information sourced from research articles was included in the literature review for critique. The review consisted of literature written in English, as no literature written in the Indonesian language could be located that met the multiple criteria of being a peer-reviewed research article, addressing aspects of pain management in children, and being published between 2001 and 2013.
- The key words, terms or phrases used in the literature search were those commonly used in the area of pain management in children. Both Australian and American spelling, and combinations of the two, were used. These included the following examples: acute pain in infants and children; chronic pain in children; pain in hospitalised children, pain in hospitalized children; paediatric patients' pain, pediatric patients' pain; nurses' role in pain assessment in paediatric patients; nurses' role in managing paediatric patients' pain during hospitalization, nurses' role in managing pediatric patients' pain during hospitalisation; pain measurement in children; pain measurement in infants; pain assessment in infants and children; pain management in infants and children; pharmacological and/or non-pharmacological pain management strategies; pain documentation; effects of unrelieved pain for infants and children; nurses' knowledge, beliefs and attitudes about pain management; pain management practice in infants and children; factors influencing pain assessment and its management in children; organisational influences; barriers to pain assessment in infants and children and barriers to pain management in infants and children. Relevant articles that explored pain management practice in children, including both qualitative and quantitative studies, were included.

The subsequent literature reviewed for this current study was dictated by the concepts that arose as the grounded theory emerged, and as such do not conform to traditional inclusion and exclusion parameters found in other studies.

2.3.3 Data sources

The following electronic databases were searched: CINAHL, Ovid, Science Direct, MedScape, PubMed, Cochrane Library, Blackwell Synergy and Google Scholar. Several themes were identified: pain in infants and children; pain assessment and measurement in children; misconceptions about pain in children; pharmacological pain management strategies; non-pharmacological pain management strategies; nurses' role in pain management; nurses' knowledge about pain and its management; nurses' attitudes and beliefs about pain in children, and barriers to pain management in children.

In the following sections, relevant themes, including the consequences of unresolved pain for children; nurses' responsibility for, and/or roles in, pain management in children; the effectiveness of current pain assessment and management practices, and obstacles to adequate pain assessment and management practice in children, will be discussed.

The literature highlighted the complexities of pain care across paediatric populations and contexts. Understanding of the issues entailed in pain management, and the barriers that prevent nurses' provision of optimal pain management for paediatric patients, is imperative in order to improve pain management practice. There was a paucity of literature that focused on developing countries such as Indonesia, with only one study (Mediani, 2002) that has examined this in any way. However, extrapolating from the reported experience of developed countries, it is certain that most children in countries in the developing world, such as Indonesia, receive inadequate pain care. Important factors to be considered are the inherent differences that may exist between the developed and non-developed world. For example, most developing countries lack infrastructure in terms of availability of trained nursing staff, or lack drugs and equipment for even simple procedures (IASP, 2010; Size et al., 2007). There is limited information available within the Indonesian context regarding the issues entailed in pain management practices in children. Due to this

significant gap there was a need to explore the factors that influenced Indonesian nurses' pain management practice when caring for hospitalised children within the Indonesian context. The following sections discuss the issues entailed in pain management in children.

2.4 The consequences of unresolved pain for children

Although painful experiences are part of life for every child, unrelieved pain can have both short- and long-term undesirable consequences (Buscemi et al., 2008; Kortessluoma & Nikkonen, 2006; McGrath & Hiller, 2003; Perquin et al., 2000; Vincent, 2007). Some of these consequences are physical, and some psychological, and they manifest across all age groups (Grunau et al., 2006; Taddio et al., 2002; Twycross, 2009; Walker, 2008). Twycross (2009) suggested that physiologically, unrelieved pain can lead to decreased ambulation, and to respiratory problems such as lack of deep breathing, and coughing, which may lead to atelectasis and pneumonia. Other consequences include increased heart rate, blood pressure and myocardial oxygen requirements, which can lead to cardiac morbidity and ischaemia. Untreated pain also can increase stress hormones such as cortisone, adrenalin, and catecholamines, which will increase the metabolic rate, and impede healing and immune functions. Under-treated pain can cause slowing or stasis of gut and urinary systems, which leads to nausea, vomiting, ileus and urinary retention. Unrelieved pain can result in muscle tension, spasm and fatigue, which can make patients reluctant to move, further delaying recovery (Twycross, 2009; Walker, 2008). These physiological responses can lengthen paediatric patients' stay in hospital and increase health care costs (Simons & Roberson, 2002). Unrelieved pain can result in increased pain sensitivity later in life (Mitchell & Boss, 2002). In addition, the failure to properly administer analgesia to children when needed can add to the risk of complications, takes energy away from the process of recovery, and can even lead to death (Simons & Roberson, 2002; Walker, 2008).

Psychological consequences of unrelieved pain in paediatric patients may include increased anxiety, distress, lessening of cooperation with future procedures, sleep disturbances, nightmares about pain and surgery, reduced coping, and developmental regression (Twycross, 2009; Walker, 2008). The combined physical and psychological consequences of long-term pain may have a negative impact on the

child's overall health. Several authors reported long-term effects of pain in early life, such as alteration in behavioural responses (Grunau, Holsti, & Peters, 2006); change in baseline sensory function (Schmelzle-Lubiecki, Campbell, Howard, Franck, & Fitzgerald, 2007); enhanced responses to future pain (Taddio et al., 2009; Hermann, Hohmeister, Demirakca, Zohsel, & Flor, 2006), and increased analgesic requirements (Taddio et al., 2009). In addition, unmanaged acute pain can lead to the development of chronic pain (Fortier, Chou, Maurer, & Kain, 2011). When these consequences are considered, the need to manage children's pain becomes obvious.

2.5 Nurses' responsibilities for and roles in pain management in children

Consensus guidelines by several organisations such as the IASP and WHO have delineated the rights of children to have their pain relieved (IASP, 2010; WHO, 2008). Relieving children's suffering and pain is a vital responsibility of all health professionals. Nurses have a central role in pain management in children because they provide care 24 hours a day to hospitalised children experiencing acute and chronic pain, and have more frequent contact with paediatric patients than any other health care professionals (Mediani, 2002). Nurses are considered to be the most important players in pain management, compared to other health care professionals. As the health care professionals involved in giving bedside care around the clock, nurses are in a unique position and have a considerable amount of responsibility and power in relation to the actions and strategies used to relieve hospitalised patients' pain (Czarnecki et al., 2011). This expectation is most evident when the patient comes from a vulnerable population such as children.

Nurses play an important role in the assessment and management of paediatric patients and are usually responsible for the administration of all medication, often according to a doctor's prescription (American Academy of Paediatrics [AAP] & American Pain Society [APS], 2001; Ellis et al., 2007; Simons & Roberson, 2002). Their involvement in medication management extends beyond the simple administration of a drug, particularly when a medication is prescribed on a *pro re nata* (PRN) basis (as needed/ requested), which is currently still the predominant order for analgesics in clinical settings such as on surgical wards (Smyth, Toombes, & Usher, 2011). Nursing pain management involves a number of activities. These include assessing pain, deciding whether to administer analgesics, determining the

routes of administration, monitoring the effects of medications, and ideally, evaluating the outcome of such interventions (AAP & APS, 2001). Nurses need to report promptly and accurately to the doctor when a change of analgesia is needed. In some situations, nurses help to coordinate the care by referring patients to doctors (WHO, 2008). If nurses do not evaluate the effectiveness of the analgesia given, then patients could suffer unnecessary pain. However, for those nurses who care for paediatric patients, this particular aspect of the role—evaluation of effectiveness—may become problematic, especially if the patient is too young and cannot understand the nurse’s explanation. In these cases it will be the family or the principle caregiver whom the nurses will advise.

Advocacy is integral to nursing practice. Nurses play a key role as advocates for children in decisions about their health (McClearly, Ellis, & Rowley, 2004; Twycross, 2008). Paediatric patients and their parents may not understand what is available to them, or their rights to pain management (Vaartio, Leino-Klipi, Salantera, & Suominen, 2006). Therefore, they often need nurses to advocate on their behalf for the best possible pain management (Ware, Bruckenthal, Davis, & O’Conner-Von, 2011). Nurses play an essential role in advocating for the patient (Baldwin, 2003), and this includes recognition of their role in pain management (Vaartio et al., 2006). In some situations, nurses may need to speak up for the paediatric patient needing better pain management, whereas in others there is a need for a partnership between the patient and the nurses to achieve pain management goals (Vaartio et al., 2006). McClearly et al. (2004) recognised advocacy as an integral role within good professional practice, placing advocacy squarely within the realm of nursing practice. This is consistent with the American Nurses’ Association (ANA) (2001) Code of Ethics for Nurses, which suggests that the nurse proactively advocate for patients and strive to protect patients’ health, safety and rights. However, the advocacy role can be achieved only if the nurses have sufficient knowledge of patient advocacy, and also of pain itself and its management in infants and children (McClearly et al, 2004). Effective treatment modalities for alleviating pain and several valid and reliable pain measures for assessing pain in infants and children have been developed (IASP, 2010). However, nurses do not always make effective pain management decisions. As a result, pain management practices continue to be less than optimal, with hospitalised children experiencing moderate to

severe unresolved pain (Twycross & Collins, 2013). To improve the quality of paediatric patients' pain care, it is important to have an understanding of the issues entailed in nurses' roles in pain assessment and management within specific settings. There is a paucity of information regarding this topic in the Indonesian context, and therefore this study has explored the factors that affect nurses' pain management practice in children in Indonesia.

2.6 Current pain management practice in hospitalised children.

The following section will present the literature on current pain management practice in hospitalised children. This will be divided into three areas: pain assessment, pain management, and pain documentation.

2.6.1 Putting pain assessment in children into practice

Conducting pain assessment and documenting pain on a regular basis is as important as performing routine tests for any other vital signs (Royal College of Nursing [RCN], 2009). Accurate pain assessment is the key determinant for pain management in infants and children. Assessment of children's pain can play a vital role in contributing to the early recognition of pain, providing information as a basis for making subsequent pain intervention decisions and providing effective management of pain in children (AAP & APS, 2001; Carlson, 2009; Finley, Franck, Grunau, & von Baeyer, 2005; Howard, 2003; McCaffery & Pasero, 2001; Young, 2005). Systematic, routine pain assessment using standardised, validated measures is known to be the basis of effective pain management for all patients, regardless of age, condition and setting (Franck & Bruce, 2009). Evaluating behavioural and physiological factors using appropriate pain assessment tools, in conjunction with children's self-reporting of pain, is important for achieving accurate pain measurement (National Health & Medical Research Council, Australia [NHMRC], 2005; Nilsson, Finnstrom, & Kokinsky, 2008). Regular assessment leads to improved pain management and results in overall patient, parent, and health care providers' satisfaction with pain assessment and management (Treadwell, Franck, & Vichinsky, 2002). However, little progress has been made towards integration of pain assessment into routine hospital care of children (Howard et al., 2008). Pain assessment has not become the pattern of routine care foreseen 10 years ago (Joint Commission on Accreditation of Healthcare Organizations, [JCAHO], 2009), with

some researchers suggesting poor compliance with local pain assessment protocols, and inappropriate pain assessment and pain management decisions in paediatric care as the main reasons for this failure (Franck & Bruce, 2009; Simons & MacDonald, 2006). In addition, Franck and Bruce (2009) stated that after developing and validating pain measurements, producing standards and guidelines, and educating and auditing health care professionals for more than 30 years, pain assessment is still inadequate, with poor pain care of children. This indicates gaps in translating theory and research into practice, which supports the introduction and use of valid and reliable pain assessment tools (Simons & MacDonald, 2006). This situation may indicate that children's pain is perceived as low-priority (Simons & MacDonald, 2006). The lack of prioritisation for pain assessment in children could be an obstacle to the implementation of emerging evidence that substantial changes to pain management practice are required (Simons & MacDonald, 2006).

The use of a standardised pain assessment tool is essential for effective pain management (JCAHO, 2009). The literature suggests that the child's self-report or verbal report of pain is considered as the gold standard of pain assessment (IASP, 2005; JCAHO, 2009). However, previous research has shown that nurses mainly consider patients' facial expressions to be the primary indicator of pain (Chambers, Hardial, Craig, Court, & Montgomery, 2005; Howell, Butler, Vincent, Watt-Watson, & Stearn, 2000). For instance, Simons and MacDonald (2004) conducted a descriptive survey of 100 nurses in a tertiary referral centre in the United Kingdom (UK) to explore nurses' views on pain assessment tools. The researchers found that almost two-thirds of the nurses surveyed did not have a preference for a pain assessment tool. The researchers suggested that nurses did not view pain assessment or using the pain tools as part of the nurse's role, and finally that nurses do not have sufficient knowledge of pain assessment tools. Similar results were found in an earlier UK study conducted by Simons and Roberson (2002). The authors found that all 20 nurses in their study did not view standardised pain assessment tools as being necessary for effective pain management, although the children cared for by nurses at the time of the study were assessed at moderate to severe levels of pain. These participants suggested that if the paediatric patients were in pain, they would complain to nurses. This assumption would not be valid in the case of infants or preverbal children as they would not be able to complain, at least not specifically.

This study too had a small sample size but provided insight into how nurses conducted pain assessment in paediatric patients.

A number of studies have demonstrated that pain assessment in paediatric patients is not conducted and recorded regularly, nor is formal reassessment routinely undertaken (Johnston et al., 2007; Simon & Moseley, 2008; Taylor et al., 2008; Shrestha-Ranjit & Manias, 2010; Twycross, 2007; Twycross, Finley, & Latimer, 2013). Some of these studies used retrospective chart audits to obtain a picture of pain assessment in children (Johnston et al., 2007; Simon & Moseley, 2008; Shrestha-Ranjit & Manias, 2010). For instance, Shrestha-Ranjit and Manias (2010) conducted a two-year retrospective clinical audit of all medical records of 106 children aged 5–15 years who were admitted to a paediatric hospital in Australia for surgical procedures to treat a fractured lower limb. The aim of this study was to examine paediatric nurses' pain assessment and management practices using evidence-based guidelines. An audit tool was created to collect data regarding children's post-operative pain assessment and management from the day of the operation to the third post-operative day. The results of the audit showed that the pain assessment of children post-surgery was inadequate. Nurses conducted pain assessment less frequently compared to the number of times they were expected to assess paediatric patients' pain post-operatively. As nurses in this study did not assess patients' pain regularly, it may be possible that paediatric patients might have had episodes of breakthrough pain between pain assessment intervals that were not effectively managed (Shrestha-Ranjit & Manias, 2010). However, there were limitations to this study because it used a retrospective audit of medical records rather than a prospective examination of actual pain assessment practice. In addition to the lack of regular pain assessments, it has also been shown that nurses do not conduct routine evaluations following the implementation of pain management strategies (Shrestha-Ranjit & Manias, 2010).

In order to obtain a real and more complete portrait of pain assessment in children, several studies have included observational data (Smyth, Toombes, & Usher, 2011; Twycross, 2007; Twycross et al., 2013). For example, Twycross (2007) conducted an observational study of registered nurses (n=13) in a teaching hospital in the UK, to explore how nurses managed post-operative pain in children and whether pain

management practices adhered to current best practice guidelines. Each nurse participant was observed continuously for a period of five hours per shift, for two to four shifts each. The researcher found that nurses did not routinely collect pain histories when children were admitted to the ward. Pain was not observed consistently. Nurses did not use assessment tools with any regularity, nor did they seem to take account of behavioural or psychological indicators of pain. The researcher showed that nurses did not use pain assessment tools when assessing preverbal children post-operatively, but pain scores were recorded in patient notes for the immediate post-operative period. It seems nurses used their perceptions or intuition to determine how much pain children were experiencing (Twycross, 2007). This study found that there were no formal pain assessment tools for neonates/infants and preverbal children on the ward, an obvious reason for pain assessment tools not being used. However, exactly what parameters nurses were using to identify the intensity of children's pain was unclear. Nevertheless, the results of this study provided a picture of what nurses actually do when assessing pain in children and whether pain management practices follow current best practice guidelines.

When these findings are compared with those of recent studies, there are many similarities (Taylor et al., 2008; Twycross et al., 2013). For example, a recent observational study in a Canadian tertiary children's hospital conducted by Twycross et al. (2013) also identified that pain assessment in paediatric patients was not conducted frequently and formal reassessment was not routinely undertaken. This study showed that although pain scores were recorded, they were not used to guide choices about pain management strategies. Nurses in this study did not continuously reassess their patient's pain if the patient had a pain score ≥ 5 . Of the 27 occasions when a pain score ≥ 5 was recorded, a reassessment was conducted only six times (22%). Moreover, patients' self-reported pain was not the main factor considered when choosing which pain management intervention to be used. Another piece of evidence of the complexity of pain assessment practice found by Twycross et al. (2013) was the difficulty nurses had when trying to reconcile paediatric patients' behaviour with reported pain scores. It seemed nurses did not believe the children's self-reports. This has also been suggested in other studies (Ljusegren, Johansson, Gimbler-Berglund, & Enskar, 2012; Twycross & Collins, 2013; Vincent & Gaddy, 2009). Often, behavioural indicators are the main factors taken into account by

nurses (Vincent & Denyes, 2004; Vincent & Gaddy, 2011; Vincent, Wilkie, & Szalacha, 2010).

Such findings raise important questions about the quality, source, and adequacy of the clinical knowledge used by nurses to assess pain (Blondal & Halldorsdottir, 2012; Twycross & Dowden, 2009; Twycross, 2007). Lack of knowledge among nurses about pain in children can be an obstacle to proper assessment of pain (Simons & Roberson, 2002; Simons & Moseley, 2009; Twycross, 2007). Failure to adequately assess and manage pain effectively in children constitutes poor quality of pain care (Miaskowski, 2003; Simons & Moseley, 2009; Twycross, 2007). One of the fundamental barriers impeding effective pain management in infants and children is the failure on the part of nurses to incorporate into clinical practice valid and reliable pain assessment tools for children, especially for infants and preverbal children (Miaskowski, 2003). Although valid and reliable tools for assessing pain in infants and children are available now, evidence exists that nurses do not use pain assessment tools consistently in clinical settings. From these studies it clearly emerges that there are still gaps in terms of translating theory and research into practice. Due to these gaps, and in order to improve the quality of pain care for children in Indonesian hospitals, it was essential that this issue be explored within an Indonesian context. Additionally, this study has also explored factors that influence nurses' pain assessment behaviour. An understanding of the factors that influence Indonesian nurses in their assessment of hospitalised children's pain was deemed important in relation to understanding what factors affected the nurses' pain care and pain management practice.

2.6.2 How to provide pain management practice in children

A number of studies have focused on how health care professionals provide pain management to paediatric patients in clinical settings. Some practices conform to current guidelines or standards of pain management (RCN, 2009), but in some cases, practice may not always correspond to current best practice guidelines (Twycross, 2008). The literature has highlighted that paediatric patients on PRN analgesics receive lower doses of analgesics and have significantly higher pain intensity scores than those on regularly administered analgesics (Cimpello, Khine, & Avner, 2004; Probst, Lyons, Leonard, & Esposito, 2005; Simons et al., 2003; Simons & Moseley,

2008; Sutter et al., 2004; Taylor et al., 2008; Vincent & Denyes, 2004). In another study by Twycross (2007), the researcher found that nurses chose not to administer analgesics regularly, even when analgesic drugs were prescribed to be given at regular intervals. Nurses tended to postpone giving the drug, or waited until the children complained of their pain. Only 32% of 95 analgesia prescriptions were administered regularly. In addition, nurse participants tended to give analgesics at lower doses than those prescribed (Twycross, 2007).

Similarly, Shrestha-Ranjit and Manias (2010) used a retrospective audit to examine paediatric nurses' pain management practice regarding post-operative care for hospitalised children following surgery for a fractured lower limb, and compared this practice with evidence-based guidelines. This study found that pain management of children post-surgery was sub-optimal. On average, 75% of paediatric patients experienced some degree of pain and 50% had moderate to severe pain. Paediatric patients received a higher proportion of the ordered amounts of analgesics via parenteral infusions rather than by oral preparations. Opioid infusions were stopped in the majority of paediatric patients by the second and third post-operative days. In contrast, general analgesics administered either by the oral or rectal route were ordered for the paediatric patients throughout the post-operative period, but paediatric patients received lower amounts of analgesics than the ordered amounts. The findings of the study indicated that the amounts of analgesic administered by oral or rectal routes may not have been effective in alleviating children's pain, particularly during the time following the discontinuation of opioid infusions. Moreover, this study found that analgesics were usually ordered and administered on a PRN basis, and this may have contributed to ineffective pain treatment in paediatric patients (Shrestha-Ranjit & Manias, 2010). The results of Shrestha-Ranjit and Manias' study (2010) are congruent with other current research, which shows that nurses often administer inadequate analgesics. Smyth et al. (2011) conducted a sequential mixed methods study in a regional hospital in Australia to explore nursing practices associated with the administration of PRN post-operative analgesia to children. In Phase 1, the researchers conducted a retrospective audit of existing documentation with a convenience sample of 95 hospitalised children, to examine the patterns of administration of PRN analgesia. In Phase 2 the researchers used participant observations and interviews with 18 nurses to answer questions about the

decision-making process related to the administration of post-operative PRN analgesia to children. They found that several nurses attempted to delay administering PRN analgesia to paediatric patients, although the patients were in pain. There were some limitations found in this study: for example, retrospective chart audits are problematic in general (Geffen et al., 2002). Although the technique of participant observation was employed, there was only minimal explanation given for the differences in nurses' experiences in relation to post-operative pain.

Alternatively, in a recent study, Twycross et al. (2013) demonstrated that nurses provided regular medication. This study aimed to gain an in-depth picture of post-operative pain care, and to obtain a full description of nurses' pain management practice. The main aim was to examine the nurses' care practice when a pain score of five or greater was recorded, and the relationship between pain scores and administration of analgesics. The results show that nurses tried to administer analgesics round-the-clock. Giving analgesics round-the-clock and treating anticipated pain is best practice (Pasero, 2010). This finding was not congruent with other earlier studies that found PRN analgesics were not given as often as they could be (Simons & Moseley, 2008; Sutter et al., 2004; Taylor et al., 2008; Vincent & Denyes, 2004). However, Twycross et al. (2013) showed that although nurses tried to apply the round-the-clock approach to relieve paediatric patients during the immediate post-operative period, those patients continued to experience moderate to severe pain. There were some limitations found in this study. For instance, one researcher conducted all of the data collection, but this researcher was not a nurse in this setting, and thus was not a true insider; thus there may have been some bias, and the researcher's attendance may have influenced nurses' pain care practices on the ward. Another limitation of this study was that data were collected in only one setting, and the demographic data of the nurse participants were not collected, so the characteristics of the participants in this study were unknown (Twycross et al., 2013). However, the portrait of pain management practice in this study was similar to that emerging from previous studies (Twycross, 2007; Vincent & Denyes, 2004).

The literature has highlighted deficiencies in pain treatment for paediatric patients and has indicated that hospitalised children are likely to have inadequate prescriptions for post-operative pain and are much less likely to receive analgesics

during their post-operative recovery (Drendel, Brousseau, & Gorelic 2006; Simons & Moseley, 2008; Taylor et al., 2008; Vincent, 2005). Such results are alarming. The recognition that paediatric patients may not be given adequate pain medication after significant injuries, or prior to conducting painful procedures, is a cause for concern. However, the reasons behind the inadequate administration of pain medication and analgesia are unknown. These findings show that although the International Association for the Study of Pain (IASP, 2005) advocates the effective use of analgesic medication for paediatric patients to prevent and treat their pain, nurses have not administered analgesics appropriately to relieve hospitalised children's pain (Johnson et al., 2007; Twycross, 2007; Vincent & Denyes, 2004). Nurses have a responsibility to assess and administer the appropriate prescribed analgesia for children on a PRN or 'as needed' basis (Karimi, Parsa, Mehran, & Nik, 2002). These studies have raised concerns about the under-treatment of children's pain, but have provided little detailed information about the administration of analgesics, such as the dosages and timing of the analgesics given.

Non-pharmacological methods provide complementary pain relief in paediatric patients by reducing emotional perceptions of pain, strengthening the coping abilities of children and increasing comfort (Nahit et al., 2003; Van Epps, Schechter, Zempsy, Pescatello, & Lerer, 2007). However, the literature has shown that, despite the advantages of using non-drug methods to manage paediatric patients' pain, these strategies have not been regularly used by nurses in practice. In addition, when nurses do use non-pharmacological approaches, they do not report or document the use of these strategies as often as they do pharmacological approaches to pain management (Pölkki, Vehvilainen-Jukunen, & Pietila, 2001; Twycross, 2007). For instance, Pölkki et al. (2001) conducted a survey in Finland to examine nurses' attitudes to and knowledge of non-pharmacological interventions to relieve post-operative pain in children. Pölkki et al. (2001) found that only 57% of respondents routinely applied non-pharmacological methods to relieve children's pain. This reluctance to use non-drug methods was also found in another study conducted in Canada by Twycross et al. (2013). Findings showed that it was parents who tended to use non-pharmacological methods. A reluctance to use non-pharmacological approaches could indicate that such approaches are not considered to be part of the nursing role (Twycross et al., 2013).

It has been well demonstrated that even in developed countries such as the USA, the UK and Canada, pain management practice for children continues to be problematic; even more so in developing countries, where pain management practice for children is inadequate (IASP, 2011). However, the research has not identified nurses' views on why this gap is still present or on what could be done to address the gap. The issue of inadequate pain management practice needs to be explored further. It was important for this study to examine the pain management practices of Indonesian nurses and identify factors that may have affected these practices, in order to determine whether their practice contributes to the inadequate pain relief for hospitalised children. Additional research was needed to explore the issue of inadequate pain relief in hospitalised children within a specific setting in Indonesia, and also the underlying causes of ineffective treatment of children's pain.

2.6.3 Pain documentation

Systematic pain management requires documentation of the entire pain management process from assessment to intervention (Halimaa, 2003). Successful and effective pain management includes each of the following key components: (1) accurate pain assessment, (2) pain alleviation methods such as administering analgesics and non-pharmacological interventions, and (3) documentation in the medical record of the pain assessment and methods used to alleviate pain (Halimaa, 2003). It is difficult to separate these components since pain management is a process that incorporates all three. Accurate and routine documentation of pain assessment and management, including patient responses regarding improvement in pain scores, is important for improving patient care (DeRemer, Katsanevas, & Ustun, 2011; Pölkki et al., 2010; Reyes, 2003). Some research has been conducted on a clinical audit of documentation of pain assessment and its management in the paediatric context (Shrestha-Ranjit & Manias, 2010; Twycross et al., 2013). For instance, Reyes (2003) conducted an exploratory descriptive design to examine nurses' beliefs and documentation practices related to pain assessment in infants in a Neonatal Intensive Care Unit (NICU) at a regional paediatric medical centre in the USA. A survey was distributed to 51 nurses, of whom 24 (47%) responded. Results demonstrated that 75% of the nurses reported that they documented pain assessment every four hours. However, 25% of the nurses said that they documented pain assessment just once

during the shift. The researchers also conducted a retrospective audit of 100 patient records, which indicated that pain assessment was documented only 37% of the time on day shift, and 44% of the time on night shift. In addition, of the 289 procedures performed, such as arterial puncture, venipuncture, heel lance, chest tube, peripherally inserted central catheter (PICC), and lumbar puncture, only 1% had a documented follow-up pain assessment (Reyes, 2003). This finding of a lack of documentation of pain assessment was consistent with other studies (Johnston et al., 2007; Shrestha-Ranjit & Manias, 2010; Simons & Moseley, 2008; Taylor et al., 2008).

Inadequate documentation of pain and its management was an issue in Shrestha-Ranjit & Manias' study (2010). When paediatric patients received few, or low doses of PRN analgesia, nurses did not document their reasons for giving lower amounts of analgesia than those ordered, or for not giving any analgesia at all. Moreover, this study found that there was no documented evidence of nurses' collaboration or consultation with other health care professionals. Lack of documentation of pain management practices can be a barrier to effective communication between health care professionals, patients and parents or families, which may compromise the quality of pain management in children (Shrestha-Ranjit & Manias, 2010). Such documentation is essential for delivering effective pain management (Idvall & Ehrenberg, 2002). However, there were limitations found in the Shrestha-Ranjit & Manias study (2010). The findings were based on a retrospective audit of medical records rather than asking nurses about their actual pain assessment and management practice. Thus, the pain documentation alone may not have fully reflected how nurses practised pain assessment and management in the clinical setting, and the reasons for the inadequate pain documentation cannot be examined. Therefore, asking nurses about their pain management practice is necessary in order to gain a deeper understanding of how they assess, manage and document pain in the practice environment.

This review has identified that gaps still exist in nurses' pain management practice. It is important to explore further the issues entailed in nurses' pain management practice, in order to gain in-depth knowledge about how nurses deliver pain management in clinical settings. A qualitative exploration, with interviews of nurses

is needed in order to identify their perceptions about caring for children in pain. Although the literature has provided an understanding of factors in Western countries that affect nurses' pain management practice, little is known about practice in developing countries such as Indonesia. Therefore, it was deemed essential to conduct a GT study to explore Indonesian nurses' perceptions and experiences when caring for hospitalised children in pain and, specifically, factors that may influence the nurses when caring for paediatric patients in pain, in the Indonesian context.

2.7 Obstacles to adequate pain assessment and management practice in children

Several factors have been identified in the literature that may contribute to barriers to providing adequate pain management to children (Czarnecki et al., 2011). The following section will discuss these factors, including children's age-related factors; myths and misconceptions about pain in children and the treatment of children's pain; nurses' attitudes to and beliefs about children's pain; lack of knowledge about pain and its management; lack of education or preparation for, and/or training in, pain management, and the context of organisational influences.

2.7.1 Children's age-related factors

Age-related factors are probably the major reason children are at risk of inadequate pain management (AAP & APS, 2001; Simon & Roberson, 2002). Health care professionals experience difficulties when trying to evaluate or measure the amount of pain that a child is suffering (AAP & APS, 2001). This is especially the case in children who lack the cognitive ability or vocabulary to describe their pain verbally, such as those who are preverbal or developmentally delayed (AAP & APS, 2001; IASP, 2005; Treadwell et al., 2002). If pain cannot be clearly communicated, it remains an isolated experience, easily ignored or misinterpreted by others (AAP & APS, 2001; O'Rourke, 2004). Children have limited experience and may be unable to use words that adequately express their discomfort. Therefore, determining just how much pain a child is experiencing can be difficult, and as a result children may be at risk of under-treatment (AAP & APS, 2001; Cheng et al., 2003; Malviya et al., 2005).

With regard to the age of the child, young age has been shown to be a consistent barrier associated with the assessment and documentation of a child's pain score

(Brockkopp, Ryan, & Warden, 2003; Gimbler-Berglund et al., 2008; Pawar & Garten, 2010; Probst et al., 2005). For instance, Gimbler-Berglund et al. (2008) conducted a qualitative study to identify factors that affected nurses' pain management in children in Sweden. The study interviewed 21 nurses working in a paediatric department and found that the child's age affected nurses' pain assessment in children. Nurses mentioned that assessing pain in young children was difficult because they found it difficult to interpret their pain behaviour. The researchers concluded that one obstacle to effective pain management in children was nurses' inability to identify children's expressions of pain, especially in infants and young children. There were limitations to this study. The study was conducted in one paediatric department in Sweden, hence while the study's findings reflected the situation there, they did not give a clear picture of universal problems that could be used to change practice.

However, the findings of Gimbler-Berglund et al. (2008) in their Swedish study were congruent with a study conducted in the Indonesian context (Mediani, 2002). Mediani (2002) conducted an interpretive qualitative study to examine Indonesian nurses' beliefs and perceptions regarding pain management in children, using in-depth interviews (n=5). The findings of this study indicated that most participants perceived that the child's age influenced nurses' pain assessment. Nurses in this study perceived that identifying pain in young children such as infants was difficult, because they could not differentiate between a cry expressing pain and one communicating a response to another sensation, such as hunger or being wet. The nurses in the study had difficulty assessing pain in preverbal children, because pain perception in this group is complex and highly subjective (Mediani, 2002). Thus, children may have been at high risk of receiving inadequate pain management from nurses. Therefore, in order to be able to provide appropriate pain management for children of all ages it is essential that nurses know and understand children's developmental stages and their responses to pain. Mediani's (2002) study was the only one found that investigated nurses' management of paediatric pain in the Indonesian context. The study was conducted in only one setting and with only five participants. Therefore, in order to gain a more in-depth understanding of how the age of the child may influence the pain assessment and management practices of

paediatric nurses in Indonesia, it is necessary to conduct further exploration into this phenomenon.

The age of the child has been shown not only to influence nurses' pain assessment, but also the administration of analgesic drugs. For example, Probst et al. (2005) conducted a survey in a hospital emergency department in the USA to evaluate assessment and management of pain in paediatric patients. The results of the study showed that children between birth and five years of age were offered opioids less frequently than children between the ages of six and 16 years. The findings of this study were congruent with a previous study conducted by Alexander and Manno (2003), who used a retrospective chart review of patients seen between 1999 and 2000 at a paediatric emergency centre in the USA, to compare the use of analgesic agents in very young children with that in older children with isolated painful injuries. Paediatric patients aged six months to 10 years old who had sustained isolated long bone fractures, or second- and third-degree burns, were included in this study. A total of 180 cases met the inclusion criteria; 96 paediatric patients were included in the very young group (ages six to 24 months) and 84 in the school-age group (ages six to 10 years). The study showed that, for painful injuries, children younger than two years of age received disproportionately less analgesia than school-age children. The very young children received no analgesia more often than the school-age group for all injuries (64.6% versus 47.6%, respectively). Moreover, this study finding showed that only 16.7% of the very young group was administered opioid analgesia, which is considerably less than the 44% of the school-age group that received opioids. The very young children were given over-the-counter medications more often than the school-age group (18% versus 7% respectively). The findings from this study demonstrate how pain management for very young children remains inadequate (Alexander & Manno, 2003).

From the findings of these studies it would appear that nurses were better able to choose the appropriate dose for older children than for infants and young children such as toddlers and preschool-age children. This suggests that pain management was less effective for young children, and the age of the child does have a significant effect on pain assessment and management. However, the reasons for nurses administering fewer, or lower, doses to young children than those recommended

continues to be unknown, but it may explain why pain management is not as effective in young children when compared to older ones. It is important that an understanding of nurses' perceptions regarding the need to conduct pain assessment should be sensitive to, and should examine the individual paediatric patients' ages and developmental levels. In addition, due to the paucity of such research conducted in the developing world, it is essential that this issue be explored within a developing country such as Indonesia.

2.7.2 Myths and misconceptions about pain in children and its treatment

Myths and misconceptions about children's pain held by health professionals may be another reason for children in pain not getting the attention they need. Some key misconceptions about children's pain have been identified (AAP & APS, 2001; IASP, 2005; Twycross, 2009; WHO, 2003). A summary of such myths can be seen in Table 2.1 below. These misconceptions have been shown to have no scientific rationale (IASP, 2005; Twycross, 2009). They are presented in a table because they are easier to describe in this way.

Table 2.1 Myths and misconceptions about pain in children

Myths/misconceptions	Evidence/ Truth
Infants do not feel as much pain as adults. This means infants do not need as much medicine to stop their pain as adults.	Research has identified that the central nervous system of a 26-week-old foetus possesses the anatomical and neurochemical capability to experience pain (Anand, 1998). Other research has shown that pain pathways (although immature) are formed before birth, and pain impulses are able to travel to and from the pain centres in the brain (Coskun & Anand, 2000; Fitzgerald, 2000). Moreover, neonates exhibit behavioural, physiological and hormonal responses to pain (Abu-Saad et al., 1998; Stevens, 1999).
Infants cannot feel pain because their nervous system is immature.	Several studies have found that complete myelination is not necessary for pain to be felt (Volpe, 1981). Painful stimuli are transmitted by both myelinated and unmyelinated fibres (Craig & Grunau, 1993; Volpe, 1981). Incomplete myelination means only a slower conduction speed in the nerves, which is offset by the shorter distances the impulse has to travel (Anand & Hickey, 1987). Noxious stimuli have been shown to produce a cortical pain response in pre-term babies (Bartoli et al, 2006; Slater et al., 2006).
Young children cannot indicate where pain is located.	Studies have shown that children as young as four years old can demonstrate on a body chart where they hurt, without knowing the names of body parts (Van Cleve & Savendra, 1993). Children are able to report the intensity of pain by the age of 3–4 years (Harbeck & Peterson, 1992).
Active children are not in pain.	Research has shown that increased activity is often a sign of pain (Eland, 1985).
A child engaged in play activity cannot be in pain.	Several studies have identified that children are particularly gifted in the use of distraction, and use play as a diversion and as a coping mechanism (Eland, 1985; McCaffery & Beebe, 1989).
Sleeping children cannot be in pain.	A study has shown that sleep may be the result of exhaustion because of persistent pain (Hawley, 1984).

It is clear from this review that children are still needlessly experiencing pain, partly because of myths and misconceptions. Nurses should be aware of these

misconceptions, which may influence pain management. However, the reasons behind existing myths and misconceptions are unknown. Therefore, the issue of myths and misconceptions about children's pain needs to be explored further. It is important for Indonesian nurses to examine their perceptions regarding pain in children in order to determine whether their perceptions contribute to inadequate pain relief in hospitalised children. Additional research is needed to explore the issue of inadequate pain relief in hospitalised children within a specific setting in Indonesia.

2.7.3 Nurses' attitudes and beliefs about children's pain

Attitudes are unconscious motivations for action and reaction in life that can be either reinforced or altered by experience (Bell, 2000). Attitude change is influenced by the person's beliefs system, and people hold positive or negative beliefs and objects that determine their attitudes (Bell, 2000). However, changing beliefs and attitudes is never easy, which perhaps explains why, in spite of compelling evidence, health care professionals continue to have misconceptions about pain and its relief (Twycross, 2007). Beliefs are the assumptions that a person holds as being true (Lasch, 2000). Health care professionals bring their own beliefs and attitudes to the interpretation of the patient's pain experience (Watt-Watson, Stevens, Garfinkel, Streiner, & Gallop, 2001).

Exploring nurses' attitudes to and beliefs about pain management in children has been shown to be a complex task (Melhuish & Payne, 2006). In addition, the actual behaviour of nurses does not automatically concur with their reported beliefs about pain management (Visentin, Trentin, & DeMarco, 2001). There are a number of prevalent incorrect beliefs that influence nurses' pain management practice (Gunnarsdottir, Donovan, & Ward, 2003). The first set of beliefs is that children's pain does not really matter. Either children are not really in pain, or they will not remember the experience once it is over; or it is good for children to learn to tolerate pain and they should not be 'spoiled' by others protecting them from pain (Visentin et al., 2001). The second set of beliefs suggests that negative effects and risks associated with analgesic drugs, particularly opioid analgesics, are far worse for children than adults (Ellis et al., 2007; Gunnarsdottir et al., 2003). The literature recognises that due to the subjective nature of pain, health care professionals' attitudes and beliefs can contribute to under-treatment of pain. This can happen when

health care professionals make pain management decisions for patients based on their own beliefs and do not accept patients' self-reporting as the 'gold standard' (McCaffery & Pasero, 2001).

Nurses' personal beliefs and attitudes regarding pain and its management in children have been shown to influence pain management practice in hospitalised children (Broome & Huth, 2003; Twycross & Dowden, 2009). A number of studies have identified that nurses hold misconceptions regarding the administration of opioid medications post-surgery including drug dosing, effects, respiratory depression, sedation and addiction reduction (Ellis et al., 2007; Manworren, 2000; Rieman & Gordon, 2007; Vincent, 2005; Vincent & Denyes, 2004; Watt-Watson et al., 2001). For instance, Watt-Watson et al. (2001) conducted a descriptive, correlational study in a Canadian hospital to examine adult patients' post-operative analgesic administration and found that those patients who reported moderate to severe pain received only 47% of the analgesia that could have been administered.

Misconceptions regarding pain existed, and many nurses were reluctant to medicate adequately for pain relief (Watt-Watson et al., 2001). Nurses' mistaken beliefs about opioid analgesics may occur because of their lack of knowledge about the pharmacokinetic and pharmacodynamic effects of opioids (Vincent et al., 2012). Patients recovering from surgery may be left in pain because nurses hold misconceptions and doubts about both the severity of patients' pain and their need for analgesic medication (Vincent et al., 2012; Watt-Watson et al., 2001). The personal beliefs and values of nurses about the treatment of pain may hinder effective pain management in children (Subhashini, Vatsa, & Lodha, 2009).

It is evident that pain management appears to be influenced by nurses' beliefs, and/or perceptions. However, how these beliefs or misconceptions influence nurses' assessment and administration of analgesics is unknown. Further research on nurses' attitudes towards pain and its management in children is needed, and in particular, in a context outside developed countries that have well-resourced health care systems. Hence, it is necessary to explore the issue further within the Indonesian context.

2.7.4 Lack of knowledge about pain and its management

Lack of theoretical knowledge about pain, pain assessment and its management in children has been suggested as one reason paediatric nurses may not provide effective pain management (Blondal & Halldorsdottir, 2012; Simons & Roberson, 2002; Simons & MacDonald, 2004; Twycross & Powls, 2006; Vincent & Denyes, 2004). Health professionals' lack of pain management knowledge has emerged as one of the most significant problems related to adequate pain management in many countries (Enskar et al., 2007; Kuuppelomaki, 2002 ; Simons & Roberson, 2002; Simons & MacDonald, 2004; Taylor, 2010; Twycross & Powls, 2006; Twycross, 2007; Van Niekerk & Martin, 2002; Vincent & Denyes, 2004).

When investigating the knowledge base of nurses, several studies found that there were gaps in their knowledge with regard to pain assessment and both pharmacological and non-pharmacological pain management in children (Simons & Roberson, 2002; Simons & MacDonald, 2004; Taylor, 2010; Twycross & Powls, 2006; Twycross, 2007; Vincent & Denyes, 2004). For instance, Simons and Roberson (2002) conducted a phenomenological study to explore nurses' perceptions of post-operative pain management in children (n=20) in the UK. The authors found that nurses demonstrated limited knowledge of many aspects of pain management in children, which resulted in ineffective pain management practices. Other studies also found limitations in nurses' knowledge of pain and its assessment and management (Manworren, 2000; Malviya et al., 2005; Salantera & Lauri, 2000; Twycross, 2007; Vincent & Denyes, 2004). For instance, Twycross (2007) conducted an exploratory study to explore the impact of theoretical knowledge on paediatric nurses' management of post-operative pain in a children's hospital in the UK (n=13). Twycross (2007) found that only four (31%) of the 13 nurses tested had good theoretical knowledge of pain. However, even when nurses had a good level of theoretical knowledge of pain assessment and management, they did not routinely apply their theoretical knowledge in practice. Unfortunately, because of the small sample used, and the fact that the study collected data from only one ward, it is not possible to generalise from this study's findings. In a larger study, Vincent (2005) examined the knowledge and attitudes of 67 nurses about relieving children's pain. This study found that there were gaps in nurses' knowledge of analgesic and non-drug methods of pain relief, and the incidence of respiratory depression from opioids.

The author suggested that nurses required more knowledge about analgesic drugs, about the value of patients' self-reporting, and about respiratory depression in paediatric patients receiving opioid analgesia.

Congruent with these studies cited above, other authors have also shown that nurses still have limited theoretical knowledge of pain and its management (Ellis et al., 2007; Rieman & Gordon, 2007; Stanley & Pollard, 2013). For instance, a recent study conducted by Stanley and Pollard (2013) examined the level of knowledge among nurses of paediatric pain management, their attitudes towards pain management, and the level of paediatric nurses' self-efficacy in an acute care setting in the USA (n=25). The Paediatric Nurses' Knowledge and Attitude Survey (PNKAS) was used to examine the level of knowledge of the paediatric nurses. Results from this study indicated that the nurses' level of knowledge was low, with only 66% of participants answering the questions correctly. This level of knowledge was lower than deemed acceptable by most nursing standards described by the authors, who cited 85% as the desired level of accuracy in answering the questions. The researchers emphasised the need for increased education for paediatric nurses (Stanley & Pollard, 2013). There were limitations to this study, including the small sample size (n=25), and there was no description of the education on pain management protocols provided to nurses. Additionally, the PNKAS did not represent actual clinical practice and consequently may not have identified nurses' actual clinical abilities (Manworren, 2000; Rieman & Gordon, 2007). The results of these studies have reported that gaps remain in nurses' knowledge of pain in children, particularly about pain assessment, and about analgesic and non-drug methods. These gaps in knowledge may be the reason for inadequate paediatric pain management practice. Additionally, Wilson (2007) conducted a survey of 72 nurses (35 hospice/oncology nurses [specialist] and 37 general nurses) in the UK, to examine nurses' knowledge of pain. This survey's findings showed that the specialist nurses had a greater knowledge base than general nurses. However, their knowledge scores did not appear to be correlated to their experience in terms of years spent within the nursing profession. In addition, the results also suggested that nurses may be incapable of managing patients' pain, despite knowledge of the existence of the patient's pain. The findings of this study and others have identified that gaps continue to remain in nurses' knowledge of pain. Limitations were found in this

study, such as the small study sample, which was limited to a specific group of nurses who were self-selecting. In addition, there was no correlational relationship between the special nurses' knowledge scores and their nursing experience. It is therefore necessary to search for other explanations for inadequacies in nurses' pain management.

This literature review identified that nurses lack knowledge regarding pain and pain management strategies in a variety of settings. This deficiency is not limited to pharmacological knowledge, but extends to non-pharmacological techniques as well. Insufficient knowledge is one reason paediatric nurses do not manage hospitalised children effectively, and is a factor that may hinder nurses' pain management practices. Although these studies were valuable in developing a basis for future research, there were still gaps in the existing knowledge that require qualitative methods to fill. In addition, there is need for a more comprehensive study focusing on how nurses acquire knowledge about pain, how they assess pain, and what strategies they use to relieve pain in children. Hence, future research should elucidate more fully how Indonesian nurses provide pain management practice to paediatric patients. The discovery of answers to questions about nurses managing hospitalised children's pain may help researchers better understand what factors influence nurses' pain management practices when caring for children in pain. There is little information about how Indonesian nurses' knowledge of pain and pain management is applied in practice. Therefore, this issue needs to be explored within the Indonesian context.

2.7.5 Lack of education/preparation for, and/or training about pain management

Education and in-service training are essential to enable nurses to gain the appropriate knowledge and skills to manage pain in the clinical setting. It is generally assumed that education increases clinical performance and expertise (Benner, 2001). However, hospitalised children still experience unresolved pain following surgery and medical and nursing procedures despite extensive education available to health professionals. Research has identified that one of the major reasons for inadequate paediatric pain management is the lack of educational preparation or basic training programmes about pain management for nurses (Namnabati, Abazari, & Talakoub,

2012; Malviya et al., 2005; Simpson et al., 2002; Twycross, 2000). Polomano, Rathmell, Dunwoody and Krenzischek (2008) found that acute pain management was not a prescribed component of the basic education of health professionals, including nurses, in the USA. Consequently, nurses lack adequate educational preparation to assess and manage pain in the clinical setting. When examining the extent of pain content provided in nursing curricula in England, Twycross (2000) found that limited time was allocated to specific instruction on pain management. Many health care professionals have often received very little formal training in paediatric pain management but are expected to prescribe and administer analgesia to paediatric patients (Morton, 2007). As a result of deficiencies in training in pain assessment and treatment, nursing staff tend to use inadequate doses of analgesic drugs (Simpson et al., 2002).

The effect of educational preparation on knowledge of pain management has been examined in several studies. A number of researchers have reported that nurses who are better educated regarding pain are more skilled in making decisions on pain management for their paediatric patients (Chiang, Chen, & Huang, 2006; Manworren, 2000; Vincent, 2005; Vincent & Denyes, 2004). Other studies have indicated that nurses with high levels of professional development and education are knowledgeable about pain (McCaffery & Robinson, 2002). Christenson (2000) conducted a study in a hospital in the USA and found that nurses with advanced degrees chose higher opioid doses, and had greater confidence in their pain assessment and management. This perhaps shows a need for better education of health professionals about pain and its management, in order to improve pain management practice in clinical settings.

On the contrary, Wilson and McSherry (2006) found a different result regarding the effect of nurses' education on practice. They conducted a study in the UK to examine whether post-registration education and clinical experience influenced nurses' inferences of paediatric and adult patients' physical pain. A series of vignettes was employed to examine nurses' inferences of physical pain for six hypothetical patients. These vignettes were used within a self-administered questionnaire that also addressed lifestyle factors among patients in pain, as well as nurses' general attitudes to and beliefs about pain management, and general knowledge of pain control. The

study distributed 100 questionnaires; 86 nurses returned the questionnaire, giving a response rate of 86%. Quantitative data were then analysed using the SPSS statistics analysis software, with qualitative analysis of the written responses. However, instrument reliability was not discussed. Findings of this study showed that there was a significant difference between the generalist and specialist nurses' inferences of physical pain. The differences in the results among the nurses' inferences of pain based on the hypothetical vignettes were scored using the Mann Whitney U-test (observed $U=176$, $Z=-5.345$, $p\leq 0.01$; based on all vignettes scored together). Surprisingly, the findings of this study showed that the specialist nurses tended to perceive lower levels of physical pain than the general nurses when considering the patients in the vignettes. The researchers concluded that education and clinical experience influence nurses' knowledge, attitudes to and beliefs about pain. However, it would appear that nurse specialists were not able to transfer their knowledge and experience into practice, resulting in desensitisation to the patients' physical pain (Wilson & McSherry, 2006).

According to Quinn (2000), effective education or training programmes should be able to change nurses' behaviour as a result of what has been learnt. However, research has failed to prove the effectiveness of pain management programmes (Mackintosh & Bowles, 2000; Watt-Watson et al., 2001). For example, Mackintosh and Bowles (2000) conducted a study to examine the impact of an acute pain training service program on nurses' knowledge and beliefs in clinical settings in the UK. The results of this study demonstrated a consistent but mainly statistically non-significant trend in all areas towards an improved knowledge base, and more appropriate beliefs about pain following implementation of the dedicated service (Mackintosh & Bowles, 2000).

It is evident from these studies that the relationship between nurses' education and professional experience and their decision-making about pain assessment and management remains uncertain. Twycross (2002) found that nurses' education does not appear to prepare nurses to manage pain in clinical practice. Furthermore, developing a sound knowledge base during education is important and helps the nurses to proceed from beginner status to expert status in nursing (Salantera & Lauri, 2000). There will always be a need to educate nurses about pain assessment and

management. However, there is evidence that nurses are not using their theoretical knowledge in practice (Twycross, 2007; Vincent & Denyes, 2004; Watt-Watson, et al., 2001; Wilson & McSherry, 2006). Attempts to improve knowledge have also not produced corresponding changes in pain management (Twycross, 2002). From this review, it can be concluded that internationally, nursing curricula contain limited education in pain management. However, currently there is no available information on whether nurses' education preparation affects Indonesian nurses' management of paediatric patients experiencing pain. Hence, exploration of this phenomenon within Indonesia is needed.

2.7.6 Context of organisational influences

In addition to education, the context in which the nurse works has also been shown to influence pain management practice. Context is the environment or setting where individuals receive health care services, and can include organisational culture, leadership, and evaluation (McCormack et al., 2002). The dynamic and uncertain nature of health care environments requires nurses to be competent in making decisions about pain management, in order to achieve effective pain management practice. In other words, nurses should be able to identify patients' pain problems, plan relevant care effectively, and appropriately implement these plans, in order to solve paediatric patients' pain problems in the context of the multidisciplinary team.

Context has been shown to play an essential role in nurses' pain management practice. However, context—the environment where practice occurs—has been cited as a barrier to achieving effective pain management practice in children (Twycross & Collins, 2013). Understanding how contextual issues affect pain management practice will enhance a more comprehensive and targeted approach to better care (Manias, Bucknall, & Botti, 2005; Schafheutle, Cantrill, & Noyce, 2001). The following section discusses further the elements of the inner contexts of structure and organisational culture that may affect nurses' pain management practice in hospitalised children.

2.7.6.1 Organisational structure

One important aspect of the work environment is the organisational structure (Campbell et al., 2004). Research has identified that organisational structure factors

affect nurses' pain management practice (Bucknall, Manias, & Botti, 2007; Ely, 2001; Treadwell et al., 2002). Some elements of organisational structure will be discussed further in the following sections.

2.7.6.1. 1 Nurses' workload

Nurses' workloads have been shown to figure in ineffective clinical decision-making and patient safety (Lang, Berbaum, & Baum, 2006), and a heavy nursing workload is known to produce sub-optimal patient care (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002). Studies have shown that workload affects nurses' pain management practice. Simons and MacDonald (2004) conducted a descriptive survey to explore the views of nurses using a pain assessment tool in a hospital in London.

Questionnaires were sent to 100 nurses, bringing a response rate of 51%. This study found that nurses' workload was an obstacle to achieving optimal pain assessment in children, and nurses consequently were not able to assess and record children's pain adequately.

Similarly, Rejeh, Ahmadi, Mohammadi, Anoosheh and Kazemnejad (2009) conducted a qualitative study to identify nurses' experiences and perceptions about the barriers to post-operative pain management in three teaching hospitals in Tehran (n=26). The results showed that nurses' workload affected their pain management. Nurses perceived that as a result of heavy workloads they experienced difficulties when conducting pain assessment and in implementing interventions among their patients. They had to take on extra responsibilities, especially on night shifts, because of a lack of nursing staff. Nurses in this study perceived that they did not manage their patients very well. Their results were congruent with earlier studies.

Kaasalainen et al. (2007) explored the decision-making process of physicians and nurses in pain management for older adults with cognitive impairment in four long-term-care (LCT) facilities in a region within south western Ontario, Canada. Nurses were constantly working under immense pressure to meet the demands of their workload, and had difficulty in adequately assessing patients' pain, or providing psychosocial support. Kuuppelomaki (2002) found that because of heavy workloads on the ward, nurses were not able to use non-pharmacological interventions for alleviating patients' pain, while Simon and MacDonald's study (2004) indicated that

increased workloads in the ward were an obstacle to assessing and recording children's pain.

Twycross and Collins (2013) also identified nurses' workload as an influence on nurses' pain management practices. They conducted a qualitative study using focus groups in a hospital in the south of England. A total of 30 nurses participated and were asked questions regarding their views about barriers and facilitators to effective pain management in the hospital. The study found that nurses' workload was one of the barriers to effective pain management practice in children. Nurses in this study felt that a heavy workload and staff shortages impeded the quality of the care they knew they should provide. Limitations in this study included the use of focus groups, rather than private, individual interviews, which meant it was not possible to explore the issue in depth. However, the results of this study concur with other studies in this area and provide insight into what nurses see and experience as the barriers to effective pain management in hospitalised children.

Studies in this review provide evidence about how workloads affect pain management practice in children. However, whether this issue may influence Indonesian nurses' pain management practice still is unknown. Therefore, this issue should be explored further in Indonesia.

2.7.6.1.2 Time constraints

Other organisational factors such as time constraints have also been argued to be one of the most common barriers to effective pain management (Blondal & Halldorsdottir, 2009; Czarnecki et al., 2011; Ely, 2001; Gimbler-Berglund et al., 2008; Johnston et al., 2007; Kaasalainen et al., 2007; Manias, Bucknall, Botti, 2005; Rejeh et al., 2009; Rejeh, Ahmadi, Mohamadi, Anoosheh, & Kazemnejad, 2008; Twycross & Collins, 2013; Vincent, 2005). Rejeh et al. (2008) conducted a study examining Iranian nurses' perceptions of the barriers and facilitators influencing their management of post-operative pain. Nurses in this study noted that time constraints forced them to revise work patterns so that they could complete many tasks in a limited time, and time constraints were a barrier to managing post-operative patients effectively. Similarly, Czarnecki et al. (2010) conducted a study to identify the perceived barriers to optimal pain management reported by Registered

Nurses in a paediatric hospital in Wisconsin, USA. A survey was used to examine how nurses described optimal pain management, and how many nurses perceived barriers that interfered with their ability to provide an optimal level of care. Of the 970 surveys distributed, 272 (28%) were returned. This study identified that there was a lack of time allowed for pre-medication before procedures that influenced pain management, and insufficient time was one of the five most significant barriers to optimal pain management practice. Lack of time to properly prepare children for painful procedures was one of the difficult organisational barriers that needed to be overcome.

It is clear from this review that lack of time has been identified as a major barrier to optimal pain management practice in paediatric clinical settings. However, this issue remains unexplored in an Indonesian setting, and it is not known whether it may influence nurses' pain management practice with Indonesian children. Therefore, it is essential to explore this issue within the context of Indonesia.

2.7.6.2 Organisational culture

'Organisational culture' refers to the unique pattern of shared values, attitudes, beliefs, rituals, principles, socialisation, norms and rules (both written and unwritten), expectations, and assumptions of the employees in the organisation (McCormack et al., 2002; Stanley & Swann, 2005). A study by Clabo (2008) provided evidence of the impact of organisational culture on pain assessment and management practices. This ethnographical study examined nursing pain assessment practice across two adult post-operative units in the USA. Bourdieu's theory of practice approach to ethnography was employed in the belief that nursing practice is shaped by the specific field of practice (Bourdieu, 1977). The results of this study show that a predominant pattern of pain assessment existed on each unit. Nurses used criteria of pain assessment from three spheres: the patient's narrative, existing evidential criteria, and a reference typology of assessment findings. Each of these spheres is based on a specific belief about the nature of pain. For instance, using evidential criteria is rooted in the belief that patients in pain exhibit expected behaviour. The researcher concluded that nursing practice, including pain assessment practice, was socially embedded, and nurses working on the same unit display similar orientations toward pain assessment practice. The pain assessment practices

of an individual nurse are deeply shaped by the social context of the unit in which practice occurs.

Other studies also described organisational culture as one barrier to effective pain management practice. Rejeh et al. (2008) conducted a qualitative study of 26 nurses in three educational hospitals in Tehran city to explore Iranian nurses' perceptions of the barriers and facilitators influencing their management of post-operative pain. This study's findings identified organisational culture elements as barriers to optimal post-operative pain management practices. Rejeh et al. (2008) found several factors that contributed to ineffective post-operative pain management, such as powerlessness, the policies and rules of an organisation, physician-led care, and limited communication. All participants experienced powerlessness in practical pain management as they were dependent on physicians' prescriptions. Moreover, Iranian nurses felt subordinate to physicians and therefore could not take independent action in relation to analgesic medication. Nurses in this study felt that they did not relieve patients' pain effectively due to a lack of prescriptions. Nurses perceived that physicians had strong authority, as physicians lead practice in Iran. Rejeh et al. (2008) suggested that medical dominance could be seen as one of the major difficulties regarding the implementation of effective pain management. This study indicated that the policy and rules of the hospital organisation did not prioritise pain management compared to other activities such as wound dressing, conducting vital signs, observations and checking wound sites. Even with these extensive findings, there were limitations to this study: for example, the data provided a rich description of the factors that hindered post-operative pain management from the nurse participants' perceptions, but the potential to generalise the study's findings to the larger population of nurses is limited. Similarly, Ely (2001) found that organisational culture factors affected nurses' pain management practices, and nurses felt their lack of power, falling morale and job insecurity.

The appropriate assessment and treatment of pain is highly dependent upon collegial working relationships between doctors and nurses. The role of the doctor is to assess and provide pharmacological interventions, whereas the role of the nurse is to assess a patient's status and serve as an advocate for the patient by promoting understanding of the patients' problems among the members of the health care team (Van Niekerk

& Martin, 2002). Therefore, optimal pain management is dependent on adequate and accurate communication between the nurse and the doctor regarding their respective assessments. Nurses in the study by Gimbler-Berglund et al. (2008) talked about the importance of good cooperation with doctors in providing children with optimal pain relief. The way nurses managed pain in children in this study was influenced by the cooperation between nurses and doctors, and among nurses, patients and parents. Some nurses had good cooperation with doctors, but some did not. The authors concluded that pain management in children could be improved through increased cooperation among nurses, doctors and parents. How far there is cooperation between nurses and doctors in managing pain in children in a particular clinical setting in Indonesia is still unknown. Hence, it is time to explore this issue in this present study within an Indonesian context.

From this review, clearly organisational culture affects nurses' pain assessment and management practice. However, the impact of organisational culture on pain assessment and management practices needs further exploration (Twycross & Dowden, 2010). How the ward setting may affect an individual nurse's pain management practice needs investigation. There is no information about how this issue may influence Indonesian nurses' pain management practice. Therefore, it is necessary to explore further the impact of organisational culture on nurses' pain management practice in the context of Indonesia. An understanding of the contextual factors that may influence nurses' pain management practices is essential to enhance effective paediatric pain care.

2. 8 Implications of this review for this study

The primary motivation for choosing nursing as a profession is to provide effective care for people (Watson, 2001). However, it is well known that children continue to experience moderate to severe pain during hospitalisation. Despite the fact that current knowledge has been developed into the form of clinical guidelines to guide nurses' pain management practices, paediatric patients continue to receive inadequate pain management in the clinical setting (Twycross, 2010; Vincent, 2005; Vincent & Denyes, 2004). To some extent it has been established that inadequate pain management practice is a product of nurses' knowledge deficits, as well as their inappropriate attitudes and beliefs regarding pain, pain assessment and pain relief.

Moreover, previous research has explored variations in the knowledge, attitudes to and beliefs about pain management related to nurses' individual characteristics, such as their education, professional experience and personal pain experience.

Unfortunately, the results of many of these studies have been inconclusive and contradictory. Similarly, mixed findings have been reported from studies that have examined the manner and extent of variation in nurses' pain management practice. It may be accepted that clinical decision-making is one of the nursing activities that may contribute to better pain management, and the goal of enabling nurses to engage in such decision-making will be to the benefit of the patient (Harbison, 2001). Therefore, the quality of nurses' pain management becomes important in clinical practice and research.

Although the literature has abundant information on this topic, the majority of the studies cited do not address the relative importance of different factors that influence nurses' pain management, and in some cases, lead to contradictory results. In addition, since there are very few studies that address the influence of context or organisational factors on nurses' provision of pain management in children, it is necessary for this area to receive more attention. Moreover, very little is known about the influence of nurses' autonomy in processes of pain management in children. Future research is needed to explore nurses' pain management practice in hospitalised children, and the factors that influence nurses' pain management practice within Indonesia should also be studied.

2.9 Chapter 2 summary

The literature reviewed in this chapter has highlighted that paediatric patients are continuing to experience unnecessary pain during hospitalisation, and the factors that are thought to influence nursing practice in paediatric pain management in clinical settings. The problems associated with ineffective pain management in children have been discussed in the literature, but recent research suggests that pain management practice is still less than optimal. The assessment of pain and its management remains one of the most significant cognitive tasks confronting a paediatric nurse in the clinical setting (Clabo, 2008). Adequate pain assessment and its management are important components of nursing care for children of all groups in hospitals (Ellis et

al., 2007). Much of the available literature suggests a failure on the part of the nurse to accurately assess a child's pain and to intervene appropriately, thus leading to inadequate pain relief. Nurses frequently underestimate patients' pain and provide inadequate pain management. Despite the advances in available methods for pain management, deficiencies remain in using them effectively (Twycross et al., 2013). This literature review has identified a multitude of factors that influence nurses' ability to provide effective pain management in children. These factors comprise barriers that nurses themselves identify and acknowledge, and can be categorised as health care system-, health care provider-, and patient-related. Changing practice is not easy, but nurses need to be accountable for making appropriate decisions regarding pain management when caring for children.

The gaps in knowledge have been identified in this literature review. Lack of knowledge, together with the beliefs and attitudes of health care professionals, and organisational barriers, continue to deter paediatric nurses from providing adequate pain management to paediatric patients. Nurses need to be aware of possible influences on their perceptions, beliefs and negative attitudes towards pain in children. Assessments of nurses' knowledge, attitudes and beliefs have failed to explain completely the forces that facilitate or hinder nurses when providing adequate pain management in hospitalised children. The literature also indicated that there are inconsistencies between nurses' knowledge and attitudes regarding pain management, and actual clinical practice. It is perhaps not surprising that these factors were found to vary in different research reports, and the nature of the problem requires further exploration. Perhaps there are other significant factors that have not yet been identified, as a result of the methods used in the majority of pain management research. More research is needed to identify other factors that affect paediatric pain management practice and the impact on the quality of paediatric pain care. A better understanding of how these factors, as well as nurses' experience, influence processes of pain management in children, is essential to achieve effective pain management practice in children. The findings from this research will be used to develop interventions to improve pain management practice. The multiple aspects of paediatric pain management can be further explored through a qualitative approach to better understand the practices of pain management used by nurses when caring for hospitalised children in pain, and those factors that facilitate or hinder nurses in

managing children's pain. There is also a need for nurses, doctors, children, parents and all members of the multidisciplinary team to work in partnership to ensure that hospitalised children no longer experience unnecessary pain (Twycross, Dowden, & Bruce, 2009).

While this literature review is not exhaustive in its exploration of these factors, it has described the challenges that paediatric nurses face, that may affect their ability to examine barriers to pain relief in their own practice. The literature presented in this chapter has framed the problem, highlighting what is known and what is missing and, therefore, has identified gaps in the current knowledge of pain management in children. Although previous studies have documented a number of barriers encountered by nurses when providing pain management practice for paediatric patients' pain, these issues have not been studied in any sample from Indonesia, indicating a need for this present study. Therefore, using a sample of Indonesian nurses, this GT study has explored the understanding and processes of pain management deployed by Indonesian nurses when caring for paediatric patients, and factors that influence nurses' pain management practice. In keeping with the methodological principles of GT, further literature was reviewed during the sampling, data collection and analysis phases of the study. This literature was used as data and to support the analysis and presentation of the findings (Chapter 5) and the emergent theory (Chapter 6), and to discuss the study outcome within the context of existing knowledge (Chapter 7).

CHAPTER 3

METHODOLOGY: THE GROUNDED THEORY METHOD

3.1 Introduction

All research is based on underlying philosophical assumptions about what constitutes valid research and which research method is appropriate for the development of knowledge in a given study. This chapter describes the Grounded Theory (GT) methodology used in this study to explore Indonesian nurses' perception of and experience with pain management of hospitalised children, with a view to discovering the factors that influence nurses' ability in providing pain management, and to develop a substantive theory that explains how Indonesian nurses attempt to resolve the main concern experienced by them when caring for children experiencing pain in paediatric wards. This approach has allowed for inductive exploration and analysis of the pain management practice used by Indonesian paediatric nurses. It has resulted in the development of a substantive theory that explains how Indonesian nurses manage professional role tensions when caring for hospitalised children in pain. The inquiry required a research methodology that would capture the meaning of human interaction and phenomena through the participants' own perspectives and would also clearly identify their definitions, meanings, values, and understandings of this particular social phenomenon. Therefore, grounded theory (GT) was chosen as an appropriate methodology for this research inquiry. To this end, the Glaserian version of GT methodology (Glaser & Strauss, 1967; Glaser, 1978, 1992, 1998) was used to explore in detail Indonesian nurses' experience of managing pain in paediatric patients, and to identify the contextual factors that affect their engagement with the paediatric pain management processes.

The purpose of this chapter is to critically examine GT and to demonstrate its suitability for use in this study. The opening section of this chapter begins with a brief description of qualitative research, in an effort to position the researcher's choice of a GT methodology. The next section provides a discussion of GT with respect to the methodology and the method used to achieve the objectives of this study. The historical development of GT methodology, including the issue of

methodological split, is discussed. The Glaserian version of GT is then explained in detail.

3.2 The choice of a qualitative paradigm

Qualitative research can be broadly defined as any type of research that produces results not arrived at by using statistical analysis, mathematics, measurement, experiments or any of the other fundamentals of quantitative research (Glaser & Strauss, 1967; Neuman, 2006; Strauss & Corbin, 1990). According to Creswell (2013) qualitative research is the process of understanding a social or human phenomenon, based on methodological traditions. The term ‘qualitative’ implies an emphasis on examination of processes and meanings, but not their measurement in terms of quantity, amount, or frequency (Labuschagne, 2003). Qualitative inquiry aims to discover the experience of the situation from the participant’s point of view, finding answers to questions that revolve around social experience, how it is created and how this gives meaning to human life (Denzin & Lincoln, 2003). A study based upon a qualitative inquiry has the goal of providing an in-depth understanding of the world as seen through the eyes of the people being studied (Burns & Grove, 2007). In addition, qualitative research provides the researcher with multiple choices and means to explore the depth, richness, and complexity inherent in the phenomena being studied, and also to understand a social or human problem from multiple perspectives (Creswell, 2013).

Qualitative research methodologies were developed in the social sciences to provide researchers with a scientific method to interpret data that emphasised meaning and the understanding of human actions and behaviour, explaining phenomena from a more personal, subjective, and emic (insider) viewpoint rather than from the separated, etic (outsider) or impersonal and rigid, scientific perspective of positivist thought (Denzin & Lincoln, 2003; Holloway & Wheeler, 2002; Speziale & Carpenter, 2007). These methodological approaches focus on describing the in-depth experiences of people’s lives and the social context that strengthens, supports, or diminishes those experiences (Munhall, 2011; Speziale & Carpenter, 2007). Qualitative research is a method of inquiry appropriate to many different academic disciplines. Traditionally, the method has been used in the social sciences and has increased in popularity over the last two decades; it has become widely accepted

across most disciplines, including sociology, psychology, anthropology, political science, communication studies, business and economics, and in health-related disciplines such as nursing (Burns & Grove, 2007; Denzin & Lincoln, 2003; Huberman & Miles, 2002). Qualitative research is popular in nursing because it focuses on understanding the whole experience, a concept that is central to the philosophy of nursing (Burns & Grove, 2007). Qualitative researchers study things in their natural settings, attempting to make sense of, or interpret phenomena in terms of the meanings people bring to them (Denzin & Lincoln, 2003). Therefore, a qualitative methodology was seen as the most appropriate for the purposes of this study. This decision was made because the study sought to discover meaning and gather an in-depth understanding of the phenomenon of Indonesian nurses' pain management experiences within a paediatric setting, rather than seeking causal determination, prediction, and generalisation of findings. When applied more broadly, this will provide a guide for nursing practice and further theory development within the Indonesian context.

There are different types of qualitative methodologies that sit under the qualitative umbrella. Denzin and Lincoln (2003) divided qualitative research into six main research strategies including hermeneutic and phenomenological research, naturalistic inquiry, ethnography, qualitative case study research, participatory action research, and GT. However, each methodological approach has a different philosophical stance that guides the questions asked and the procedure used for data collection and analysis (Morse, 1999). Although the terminology and the procedures used are determined by the philosophical orientation of the identified approach, for instance, ethnography, GT, or phenomenology, there are two commonalities across all qualitative methodologies (Munhall & Boyd, 1993). Firstly, all approaches acknowledge that reality changes over time and is based on the individual's perception, making reality different for each person (Munhall & Boyd, 1993). Secondly, an individual's knowledge only has meaning within a given situation or context, and as each individual's perception differs, many distinct meanings are possible (Munhall & Boyd, 1993). The qualitative researcher's goal is try to understand the ways in which different individuals make sense of their lives, and to describe those meanings. Qualitative researchers seek to discover the meanings that

participants attach to their behaviour, how they interpret situations, and what their perspectives are on particular issues (Wood, 2006).

Why use a qualitative research methodology in this study? The goal of this study, in common with other forms of qualitative inquiry, was to add insight and seek to arrive at an understanding of a particular phenomenon from the perspective of those experiencing the phenomenon, and to create theory (Richards & Morse, 2007; Speziale & Carpenter, 2007). Despite significant knowledge development during the last two decades and the extensive empirical evidence that exists regarding paediatric pain research, which shows that paediatric patients in pain are often inadequately managed during hospitalisation (Buscemi et al., 2008; Stinson, et al., 2008; Twycross, 2010), effective pain management continues to be a health care problem globally, especially for paediatric patients (IASP, 2005; Finley & Forgeron, 2008) and it is certain that most children in the developing world, such as in Indonesia, receive inadequate pain care. A significant gap continues to exist between the research evidence on adequate pain management in children and what is reflected in clinical practice (Simons & MacDonald, 2004; Twycross, 2010; Vincent, 2005). By this, the researcher means that factors that influence nurses' engagement in managing paediatric patients in pain could not be identified easily and required further exploration. In addition, it was not clear whether Indonesian nurses faced barriers when managing pain management in children. This area of interest has not been previously investigated in Indonesia. Therefore, qualitative research was necessary to conduct an exploration of Indonesian nurses' understanding, experiences, and interpretations of pain management practice in hospitalised children. These reasons made a qualitative approach to the exploration the best option, rather than using predetermined information from the literature or relying on results from other studies in other contexts.

A qualitative research methodology enabled the researcher to explore depths and complexity in the phenomena being studied, through the viewpoint of the participants. This detail could only be established by talking directly with the participants, going to participants' places of work, and allowing them to tell their stories, and hearing their voices about the phenomena under study. This study aimed to achieve a theoretical understanding and required a qualitative methodology that

could embrace the complexity of factors affecting Indonesian nurses' role in managing paediatric patients' pain, such as organisational, cultural and personal factors. Therefore, a qualitative method was considered appropriate for an analysis of concepts and themes derived from an exploration of Indonesian nurses' perceptions of and experiences with engaging in pain management practices when caring for hospitalised children in pain.

The researcher was aware that an exploratory, qualitative design was needed to investigate this subject area, because the intent of the study was to make the phenomenon (Indonesian nurses' perceptions of and experience with pain management in hospitalised children experiencing pain) comprehensible. There is a need to understand the attitudes upon which nurses rely when caring for children in pain, and the factors that influence nurses' pain assessment and management. A clear understanding of the processes of managing pain in hospitalised children can best be derived through GT research. Exploratory studies are undertaken when a new area is being investigated or when little is known about an area of interest (Polit, Beck, & Hungler, 2001).

A GT approach was most suited to the study's purposes, considering the complex, subjective nature of nurses' perceptions, beliefs and experiences of pain management practice in children. As stated earlier, little was known about Indonesian nurses' perceptions and experiences related to pain management in children or about the factors that may influence nurses' ability to provide pain management practice to hospitalised children experiencing pain. It was determined that a GT approach would best facilitate an in-depth understanding of the pain management practices used by Indonesian nurses when caring for hospitalised children in pain. Moreover, the use of GT was intended to facilitate the exploration and discovery of the main concern of Indonesian nurses when caring for paediatric patients experiencing pain. A GT approach provided an understanding of the social processes used by Indonesian nurses to resolve their main concern in order to provide better pain care. GT research investigates human experiences to identify shared meaning and patterns of behaviour in the development of a substantive theory. Further, by exploration and analysis of these nurses' experiences and social processes, the researcher was able to develop a substantive theory explaining the phenomenon of Indonesian nurses' pain

management practice when caring for children in pain within an Indonesian health context, as seen through the eyes of the nursing participants. Given these considerations, this study required a research methodology underpinned by the interpretivist paradigm, suitable for the exploration and explanation of a process. Grounded Theory is one of the qualitative approaches suited to the purpose of generating theory to aid in explaining human behaviour (Glaser & Strauss, 1967; Morse & Field, 1995; Strauss & Corbin, 1990). As such, this method facilitated the generation of rich, complex and dense theory and was used to generate new theory and understanding about a phenomenon, rather than test existing theory (Speziale & Carpenter, 2007). A classic or Glaserian GT methodology in the form described by Glaser and Strauss (1967) and Glaser (1978, 1992, 1998) best matched the qualitative criteria set for this study, hence Glaserian GT was selected as the research methodology, and will be explained in this chapter. The following section will provide an explanation of the GT method.

3.3 Grounded Theory: the methodology

3.3.1 The origin of Grounded Theory

3.3.1.1 Historical overview of the origin of Grounded Theory

Grounded Theory or GT was first developed during the 1960s by American sociologists Barney Glaser and Anselm Strauss (Artinian, 2009; Glaser, 1992; Strauss & Corbin, 1990). At that time, grand theory (logic-deductive theorising) and theory testing (verification) were the predominant approaches to knowledge development (Glaser & Strauss, 1967). As sociologists, Glaser and Strauss felt driven by the lack of rigour and theoretical grounding in social science studies, and by the criticisms directed to qualitative research by those who considered quantitative studies to be the only viable means of enquiry (Hallberg, 2006). The two theorists came from different philosophical and research backgrounds and had made equally important contributions towards the creation of the grounded theory (Glaser, 1992; Wuest, 2012). Anselm Strauss graduated from the University of Chicago, which specialised in qualitative research and symbolic interactionism, and he was influenced by pragmatist writings. His training and fields of interest contributed to the GT method. He was trained in symbolic interactionism by Herbert Blumer and Everett Hughes, a school of thought where strong tradition emphasised the importance of interaction between human behaviour and social roles (Blumer,

1969; Hallberg, 2006; Walker & Myrick, 2006). On the other hand, Barney Glaser came from a tradition of quantitative research at Columbia University, where he developed an inductive perspective that combined both quantitative and qualitative research (Hallberg, 2006; McCann & Clark, 2003; Walker & Myrick, 2006). This perspective embraced the importance of theory generation from the perspective of participants (Creswell, 2013). Glaser was influenced by Paul Lazarsfeld, an innovator in the field of quantitative methods (Glaser, 1992; Hallberg, 2006; Walker & Myrick, 2006) and also Glaser's teacher when he was studying quantitative and qualitative mathematics at Columbia University. Paul Lazarsfeld and his work on qualitative analysis influenced Glaser's conceptual ideas of GT (Glaser & Strauss, 1967; Glaser, 1998, 2005). Lazarsfeld's research strategies were similar to those used in the GT process (Martin & Gynnild, 2011). According to Glaser (2005), Lazarsfeld influenced him with four important methodological contributions to the development of GT: the index formation model to generate concepts; the interchangeability of indicators to generate concepts; constant comparative analysis, and the core variable analysis model. The first two originated directly from Lazarsfeld's work, while the constant comparative analysis technique was discovered and developed by Glaser (Glaser, 2005).

In 1965, Glaser and Strauss worked together on a study of the sociology of illness that resulted in an article entitled "Awareness of Dying" (Glaser & Strauss, 1965), in which they sought to develop an abstract theory of the interactions between patients and staff in hospitals at the end of life, rather than to provide a descriptive analysis of events or attitudes (Glaser & Strauss, 1967). The approach they developed was a systematic method of discovering theory from data involving inductive processes (Glaser & Strauss, 1967). During this study Glaser and Strauss became aware that the methodology they used was original. "The Awareness of Dying" article provided the first account of GT the grounded theory and marked the introduction of this research approach as an alternative to other more established research methodologies (Elliot & Lazenbatt, 2005). This article was highly acclaimed, and as such the authors received a lot of attention from the scientific community, which led to their decision to present GT more formally by publishing a book on it (Glaser, 1992).

Two years later, Glaser and Strauss published the methodology for qualitative research that they had developed during the Awareness of Dying study, in the book, *Discovery of Grounded Theory: Strategies for qualitative research* (Glaser & Strauss, 1967). They named their new method 'Grounded Theory' and presented this as a new approach to research, developed during their study of dying (Glaser & Strauss, 1967). This discovery resulted from their attempts to improve the theory-research gap that had not been bridged by studies using logical deductive reasoning as the method of inquiry (Eaves, 2001; Jeon, 2004). Grounded Theory was therefore designed to provide an alternative to the verificational research tradition prevalent in sociology at that time (Glaser & Strauss, 1967). In addition, Glaser and Strauss developed the GT approach in response to the then prevalent view of quantitative research as the predominant model for social science research (Charmaz, 2000).

Glaser and Strauss (1967) found that qualitative research consisted of detailed description, mostly giving background to quantitative studies but generating little theory. At the same time, quantitative researchers were developing rigorous methods for testing and reproducing facts (Glaser & Strauss, 1967). Glaser and Strauss (1967) explained that the rationale for GT was to generate and develop theory through interplay with data collected during research projects. They demonstrated how to generate a substantive theory from data originating from reality by using an inductive research method. Consequently, GT has been presented as an inductive research method that aims at generating theory through the emergence of that theory from substantive data (Glaser & Strauss, 1967). This was the beginning of the classical Grounded Theory methodology (Schreiber & Stern, 2001).

3.3.1.2 What is Grounded Theory?

Grounded Theory is defined by Glaser and Strauss (1967) as a general research method that provides for the systematic generation of theory from data acquired by a rigorous research method. As a general methodology, GT can use either qualitative or quantitative data, or a combination of these (Glaser, 1978, 1992). However, it has mainly been used with qualitative research data and it is for this use that it is best known (Speziale & Carpenter, 2007). Grounded Theory was developed for the purpose of studying social phenomena from the perspective of symbolic interactionism, to generate new theory. The new theory that is generated accounts for

a pattern of behaviour that is relevant and also problematic for those involved who have an understanding of the phenomenon, rather than testing existing theory (Chenitz & Swanson, 1986; Eaves, 2001; Glaser & Strauss, 1967; Glaser, 1978, 1992, 1998; 2002, 2005). The method is termed ‘grounded’ because the theory is systematically obtained from a broad array of data through a rigorous process of constant comparison (Glaser & Strauss, 1967; Glaser, 1978, 1992; Stern, 1994; Strauss & Corbin, 1990).

The generation of a new theory using this method is an evolutionary process that occurs as the research is being conducted (Speziale & Carpenter, 2007). This research method does not start out from the circumstance of predefined concepts or an existing theory; the concept and properties emerge as the researcher gathers, codes and analyses data (Backman & Kyngas, 1999; Glaser & Strauss, 1967; Heath & Cowley, 2004; McCallin, 2003). The methodology is based on a systematic set of data collection and constant comparative analysis among or between groups of participants in the area of research interest (Glaser & Strauss, 1967; Glaser, 1978, 1992). This comparative analysis is a central feature of GT and is often referred to as the constant comparative method (Glaser & Strauss, 1967; Glaser, 1978, 1992). By using comparative analysis, allowing for the systematic discovery of theory by the careful and in-depth examination of the data in the study, theory grounded in the data can be scientifically derived (Glaser & Strauss, 1967; Glaser, 1978, 1992; Newman, 1997; Speziale & Carpenter 2007). The method makes a study of abstract problems and the processes occurring within social frameworks (Glaser, 1992).

Grounded Theory is a combination of both inductive and deductive approaches (Heath & Cowley, 2004). In order to identify the emerging substantive theory and gain an understanding of the phenomena under scrutiny, the primary approach taken in GT is inductive, as the researcher is continually guided by the data and its subsequent patterns, codes and categories (Glaser & Holton, 2004; Glaser & Strauss, 1967; Glaser, 1978, 1992; Speziale & Carpenter 2007; Strauss & Corbin, 1990). GT researchers do not formulate their hypotheses in advance since preformed hypotheses are prohibited (Glaser & Strauss, 1967). Thus the researcher investigates and tries to get an in-depth understanding of a particular phenomenon by examining the similarities and differences that exist in the data collected in the field. The researcher

analyses the data and tries to look for links that exist within the data, and hypothesises about the data's relationship with the phenomenon, to generate a draft theory. The researcher aims also to discover the participants' main concern and how they continually try to solve it (Glaser, 1992, 2002). However, there is also a deductive element to the method. Once initial data have been collected and analysed, the researcher follows a process of theoretical sampling, using the initial analysis to deduce where to go next to further data collection and enhance the developing theory (Glaser, 1978, 1992, 1998).

Grounded Theory is a research approach that results in the development of middle-range theory at a substantive or formal level (Glaser, 1978, 1992). This explicit goal of theory generation makes GT unique and different from other qualitative research methods (Glaser, 1992; Strauss & Corbin, 1990; Wuest, 2012). In their original text, Glaser and Strauss (1967) differentiated 'substantive theory' from formal theory. Substantive theory is developed from research conducted in one specific area or contextual situation, such as patient care. Formal theory development is more conceptual. An example of the substantive theory approach would be research into pain or violence (Glaser & Strauss, 1967). This researcher's study is based on the issues of Indonesian nurses' perceptions and experiences related to pain management in children and the factors that may influence their ability to provide pain management. The study has resulted in the development of a substantive theory explaining how these nurses manage professional role tensions when caring for hospitalised children experiencing pain within an Indonesian health context. This insight has been provided from the perspective of the nurses concerned. Hence the study was focused on a specific contextual situation, and suited the development of a substantive theory.

3.3.1.3 The Grounded Theory approach

The procedures in a GT study incorporate several steps and processes. These steps include data selection and collection; open coding; theoretical sampling; constant comparative analysis; generating memos, and theory development, which includes the consideration of relevant literature (Glaser & Strauss, 1967; Glaser, 1978, 1992; Speziale & Carpenter, 2007). Data collection, coding and analysis occur concurrently throughout the study (Glaser, 1978, 1992). The process is not impeded by the

development of research problems, theoretical understanding, or literature review. Instead the researcher is granted the freedom to enter the field and discover the main concern of participants, and to identify participant approaches to resolving the problems experienced (Glaser, 1978, 1992). Through analysis, data—mainly in the form of transcripts, field-note observations, written data or literature—are sorted into conceptual codes. Then, a process of comparison, these individual codes are compared, and arranged to form meaningful categories. Finally, through a process of abstraction, these categories build, and are refined until they are able to lead the researcher toward the development of substantive theory or conceptual hypotheses (Glaser & Strauss, 1967; Glaser, 1978, 1992).

Throughout the analysis process, memos are written to capture emerging ideas about concepts and their relationships (Glaser, 1978, 1992). This process of collecting data to develop the hypotheses and further identify properties and relationships among concepts is called theoretical sampling (Glaser & Strauss, 1967; Glaser, 1978). The emerging theory is further integrated by theoretical coding, a process of examining the data in theoretical rather than descriptive terms (Glaser, 1978). Diagramming relationships among concepts increases the level of abstraction. As data collection and analysis proceed, a core category that explains the main concern for the participants is identified (Glaser, 1978, 1992). A core category becomes the central phenomenon around which all other categories are integrated into a conceptual framework (Glaser & Strauss, 1978; Glaser, 1978; Strauss & Corbin, 1990). A core category can be theoretically modelled as a basic social process that accounts for most of the variation over time, in context and in behaviour, in the studied area (Glaser, 1978, 1992). When the core category is identified, researchers conduct a literature review to learn what has been published about the emerging concepts (Stern, 1994); the literature is theoretically sampled for what it can contribute to the developing theory (Wuest, 2012). An important characteristic of GT is modifiability as new data are generated (Glaser, 1978, 1992; Wuest, 2012).

3.3.2. Philosophical roots of Grounded Theory

Grounded Theory, as described earlier, has its roots in the social sciences. Specifically, it is rooted within the symbolic interaction tradition of social psychology and sociology (Chenitz & Swanson, 1986; Crook, 2001; Cutcliffe, 2000;

Eaves, 2001; Goulding, 1999; Hutchinson & Wilson, 2001; Milliken & Schreiber, 2001). An assumption of GT is that people actively shape the worlds they live in through the process of symbolic interaction, and that life is characterised by variability, complexity, change and process (Glaser, 1992). Symbolic interactionism was developed by Mead (1934) and advanced by Blumer (1969), and represents not only a theory of human behaviour but also an approach to studying the lives, conduct, actions and interactions of humans within societal groups (Annells, 1996; Chenitz & Swanson, 1986; Blumer, 1969). Symbolic interactionism is concerned with the meaning of events to people and the symbols they use to convey those meanings (Baker, Wuest, & Stern, 1992). It focuses on the experiential aspects of human behaviour or on how people define events and reality, and on how they act according to their beliefs (Chenitz & Swanson, 1986). Symbolic interactionism holds that people are in a continual process of interpretation and definition as they move from one situation to another (Eaves, 2001).

Blumer (1969) identified three assumptions that underpin symbolic interactionism: firstly, people act and react to things and people on the basis of meanings that these have for them; secondly, meanings stem from interaction with others, and finally, people's meanings are modified through an interpretive process that they use to make sense of and manage their social worlds. Blumer (1969, p. 3) emphasises that meaning is central to symbolic interactionism and argues that to ignore the 'meaning of things toward which people act is seen as falsifying the behaviour under study.' Thus, human behaviour is the result of an interpretive process in which people assign meaning to the events and situations that they encounter (Baker et al., 1992). Meaning is one of the major elements in understanding human behaviour, interactions and social process (Goulding, 1999; Jeon, 2004). According to this paradigm, individuals engage in a world which requires reflexive interaction instead of an environmental response (Goulding, 1999). People are purposive in their actions and will act and react to environmental cues, objects and other factors, according to the meaning these hold for them. These meanings evolve from social interaction which is itself symbolic because of the interpretation attached to various forms of communication such as language, gesture, and significant objects (Goulding, 1999). These meanings are modified, suspended or regrouped in the light of changing situations (Schwandt, 1994). Symbolic interactionism emphasises that individuals

and groups are active participants in creating meaning within situations (Chenitz & Swanson, 1986). This is because people, individually and within groups, construct their realities from the symbols around them, through interaction (Bowers, 1989; Cutcliffe, 2000). Through social interactions, human beings become aware of what others are doing or of what they are willing to do (Aldiabat & Le Navenec, 2011). Using the perspective of symbolic interactionism, GT therefore, provides a means of studying human behaviour and interaction, creating a new perspective and understanding of common behaviour at both an interactional and symbolic level (Chenitz & Swanson, 1986).

The symbolic interactionism perspective has implications for research because the meaning of the event must be understood from the participants' perspective, and behaviour must be understood at the symbolic and behavioural levels, and examined in interaction (Chenitz & Swanson, 1986). In addition, Chenitz and Swanson (1986) suggest that this perspective is useful in complex situations, to examine emerging or unresolved social problems. Methodologically, the researcher is required to enter the world of the participants under study to observe and examine the human interactions and interpretations that occur in order to fully understand them (Goulding, 1999). The researcher examines behaviour in the setting in which it occurs, in terms of social interaction and shared meanings (Chenitz & Swanson, 1986). In order to understand the phenomenon under study the researcher must be both an observer and a participant (at least in imagination) in the participants' world and further must be a translator of this understanding into the language of the researcher's discipline (Chenitz & Swanson, 1986). Using these principles as the basic foundation, Glaser and Strauss developed a more defined and systematic procedure for collecting and analysing qualitative data (Glaser, 1998, 2004; Goulding, 1999). Thus, symbolic interactionism provides a guiding framework for the collection of data about meanings, and how they change through social and physical time and space (Aldiabat & Le Navenec, 2011; Chenitz & Swanson, 1986; Glaser, 1978, 1992, 1998).

Grounded Theory is based upon assumptions that both knowledge and people are dynamic, and the context facilitates, hinders, or influences human goals and the psychosocial process (Benoliel, 1996). Based on this assumption, GT's main aim is developing and understanding the knowledge of human behaviour—how individuals

construct and reconstruct their lives in the light of their experiences, and the meanings they assign to these—in order to discover the basic social process (Glaser, 1978; MacDonald & Schreiber, 2001; Milliken & Schreiber, 2001). Grounded Theory has the potential to provide insight into a complex phenomenon, like nurses' pain management practice when caring for hospitalised children experiencing pain. Thus, in GT the researcher needs to comprehend participants' behaviours as they understand them. This can be achieved by learning about participants' interpretation of self in the interaction, and sharing their definition. Symbolic interactionism directs grounded theorists to assume that meaning is made and constantly changed through interaction, and to become embedded in social context (Wuest, 2012). To sum up, symbolic interactionism is the source of GT's foundational assumptions (Chenitz & Swanson, 1986; Wuest, 2012) and has contributed to the philosophy guiding the development of GT methodology (Annels, 1996; Blumer, 1969; Chenitz & Swanson, 1986; Schwandt, 1994).

3.3.3 Evolution of Grounded Theory

After the publication of *The Discovery of Grounded Theory* (1967), Glaser and Strauss continued to work together to conduct many collaborative research projects, and wrote four more books from their study on dying: *Time for dying* (Glaser & Strauss, 1968); *Anguish: Case study of a dying patient* (Glaser & Strauss, 1970); *Status passage* (Glaser & Strauss, 1971), and *Chronic illness and the quality of life* (Glaser & Strauss, 1975).

In 1978, Glaser published the advances in GT methodology as *Theoretical sensitivity*, the purpose of which was to provide practical insights into the methodological processes involved in generating a grounded theory. Glaser (1978) provided step-by-step guidance for conducting the GT process, and for theoretical coding, basic social processes, and theoretical sorting. Nine years later, Strauss published his own text, *Qualitative analysis for social sciences* (Strauss, 1987), which was intended to make GT more accessible because there was still criticism about Glaser's use of 'abstract terms and dense writing' in *Theoretical sensitivity* (Charmaz, 2000). However, other writers disagreed with this criticism and continued to recommend *Theoretical sensitivity* as a good resource for the GT student (MacDonald & Schreiber, 2001).

In 1990 Strauss and Glaser parted ways when Strauss published *Basics of qualitative research: Grounded theory procedures and techniques* with Juliet Corbin (Strauss & Corbin, 1990). Glaser argued that this book misrepresented GT. Moreover, Glaser disagreed with many of the stances taken by the book, criticising Strauss and Corbin's method for producing description rather than theory, and for imposing preconceived codes on data (Glaser, 1992). Glaser responded with the book *Basics of grounded theory: Emergence vs. forcing* (Glaser, 1992). Since 1992, Glaser has developed GT alone. The method elaborated by Glaser is often called Classic Grounded Theory (CGT) or Glaserian Grounded Theory. This method will be explained later, in the next section.

3.3.4 When is Grounded Theory an appropriate approach?

Because the GT method captures social process in social context, this research approach is most useful when the goal is a framework or theory that explains human behaviour in context (Glaser & Strauss, 1967; Glaser, 1978). Grounded Theory offers a useful approach for nursing researchers who wish to investigate social-psychological processes and generate theoretical explanations for them (Chenitz & Swanson, 1986). Grounded theorists support the view that each member experiences a basic social psychological problem not usually made explicit or articulated by the group (Wilson & Hutchinson, 1991). Grounded Theory is known as an effective way of discovering the participants' primary concern, the core category or core concern/problem; and how the participants handle their life circumstances, the core process (Crooks, 2001; Glaser & Strauss, 1967; Morse & Richards, 2002; Schreiber & Stern, 2001; Speziale & Carpenter, 2007). Thus, GT provides tools to discover the participants' core problem and to generate a theoretical conceptualisation derived from living phenomena. By developing theory, researchers seek to understand the problem situation as experienced by a group of participants and how they deal with this problem (Glaser, 1992, 1998).

One major problem not readily understood or described in the literature is Indonesian nurses' perceptions of and experiences with providing pain management in hospitalised children, and the factors that may influence their ability to provide pain management. The literature has long indicated that the management of children's

pain remains inadequate in the health care clinical setting. The nursing management of children's pain continues to be sub-optimal and it is certain that most children in the developing world such as Indonesia receive inadequate pain management (Finley et al., 2008; IASP, 2010; Stinson et al., 2008; Taddio et al., 2009; Taylor et al., 2008). Therefore, gaining an understanding of the experience of Indonesian nurses dealing with and providing pain management practice in hospitalised children experiencing pain is necessary. This understanding is critical to help improve the Indonesians nurses' paediatric pain management practice. The investigation of human behaviour related to health care issues in nursing is well suited to GT research (Wuest, 2012).

3.3.5 Grounded Theory and nursing research

Grounded Theory has been embraced by nurses since the early 1970s (Burns & Grove, 2007; Elliott & Lanzenbatt, 2005; Speziale & Carpenter, 2007; Stern & Covan, 2001). Grounded Theory is useful for directing nursing practice because it is an explanatory theory of human behaviour within a social context (Burns & Grove, 2007; Wuest, 2012). A GT approach provides nursing with a feasible means of generating theory about dominant psychosocial processes that present within human interactions, theory that is grounded in the realities of everyday clinical practice (Speziale & Carpenter, 2007). Grounded Theory has been used to study a wide range of issues in practice settings such as the quality of nursing care in acute-care hospitals (Irurita, 1996); managing depression among black West Indian Canadian women (Schreiber et al., 1998), and restructuring life for fire victims (Stern, 1996). Grounded Theory is applicable to a wide variety of issues relevant to clinical practice and can make an important contribution to the development of a theoretical base for clinical nursing and midwifery practice (Elliott & Lanzenbatt, 2005).

Grounded Theory is well suited to nursing inquiry because it explains what is actually occurring in a situation at a certain time, rather than simply describing what is predicted to occur (Schreiber & Stern, 2001). It is the method of choice when knowledge about how people organise their lives within the framework of nursing in the contemporary health care system is sought (McCallin, 2003). Moreover, GT is recognised as a desirable research method when examining the field of nursing, because it produces a substantive or formal theory (Field & Morse, 1985). Grounded

Theory is also suited to this study because the issue of Indonesian nurses' perceptions and experiences related to pain management in children and the factors that may influence nurses' ability in providing pain management practice when caring for children in pain have not been clearly identified. The identification of factors influencing nurses' pain management practice allows for further efforts to improve paediatric pain management and health care for hospitalised children within the Indonesian context.

3.3.6 Differences in approach between Glaserian and Straussian Grounded Theory

The originators of GT, Glaser and Strauss, differ on how to apply the GT method. This difference of opinion has resulted in a fracture within GT ideology. There is general acknowledgment that Glaser has remained more faithful to the original form of GT. Strauss on the other hand, has pointed out that both he and the method, through time and experience, have evolved and that such change is only natural (Heath & Cowley, 2003; McCann & Clark, 2003; Stern, 1994; Walker & Myrick, 2006). From this point on, the GT originators have continued independently to build up the method over the years. Their separated pathways have led to what is now known as 'Classic Grounded Theory' (CGT) or 'Glaserian Grounded Theory,' and 'Straussian Grounded Theory' (SGT). It is commonly accepted that there are two major GT approaches, each with different epistemological underpinning.

Given the differences in the two approaches to the method, it is important that researchers undertaking a GT approach choose either CGT or SGT (Heath & Cowley, 2004; Stern, 1994). The choice will influence the way data is collected and analysed, the motivations of the research and the final theoretical outcome (Heath & Cowley, 2004). For this study, the CGT or Glaserian approach was selected as the more suitable method on account of its adherence to 'classical' GT methods. An explanation for the decision to use this particular approach will be detailed in the next section.

The differences between the two approaches are largely subtle (Heath & Cowley, 2003; McCann & Clark, 2003; Walker & Myrick, 2006). At the surface level, there are no recognisable differences, because both use the same language and similar

processes (McCann & Clark, 2003). Glaser, as well as Strauss and Corbin, defines the GT approach as a qualitative research method that uses a systematic set of procedures to develop a theory about a substantive area. The theory emerges from the data, and is therefore grounded in the data. In addition, both Glaser's and Strauss' versions of GT use common elements, such as theoretical sampling; theoretical sensitivity; constant comparative analysis; coding and categorising the data; literature as a source of data, and theoretical memos, in the process of generating theory (Heath & Cowley, 2003; McCann & Clark, 2003; Walker & Myrick, 2006). However, the differences lie not in the language or general processes but rather in the disconnect between Glaser's and Strauss' different perspectives regarding the data analysis process, specifically the procedures used, while differences are also found in the interventions and activities by means of which the researcher engages with the data (Heath & Cowley, 2003; Walker & Myrick, 2006). Nevertheless, it is possible to outline the key points of controversy, as demonstrated below.

3.3.6.1 Paradigmatic differences

Both GT approaches have different epistemological underpinnings (McCann & Clark, 2003). Annells (1996) and, McCann and Clark (2003) have pointed out that CGT adopts a critical realist stance, and argue that CGT reflects the post-positivist inquiry paradigm. This paradigm is broadly allied to the realist ontology and objectivist epistemology of positivism, but assumes a more subtle reality (Denzin & Lincoln, 2003). This ontology is sometimes referred to as 'critical realism' (Denzin & Lincoln, 2003). Critical realism is prominent in symbolic interactionism ontology, which is concerned with the nature of a 'real' reality (Annells, 1996, p. 384). Glaser (1992) pointed out that the CGT mode focuses on 'concepts of reality' (p. 14), looking 'for what is, not what might be' (p. 67), while searching for 'true meaning' (p. 55), and that the generated grounded theory 'really exists in the data' (p. 53). Whereas, the approach developed by Strauss and Corbin draws on social constructionism ontology and the post-structuralist paradigm or relativism, where reality cannot be known but can be interpreted (Annells, 1996; McCann & Clark, 2003; Strauss & Corbin, 1990). Post-structuralism is a way of viewing the world that challenges prevailing beliefs and established truth (Kellner, 1988; Wright, 2003). Strauss and Corbin (2008) have rejected the label 'post-positivist' and seem to prefer 'constructivist'. The work of Strauss and Corbin has taken shape as relativist,

ontologically speaking, and subjectivist, epistemologically speaking; however, in its methodology it recognises the interactive nature of the inquirer and the participants, placing the GT approach under the constructivist paradigm of inquiry (McCann & Clark, 2003). In addition, Strauss' and Corbin's approach also has a broader field of focus, with consideration being given to both the cultural scene and the participants' socially constructed reality; meanwhile, Glaser's approach emphasises the socially constructed world of the participants (McCann & Clark, 2003).

3.3.6.2 Emergence versus Forcing of data

Glaser (1992) used the 'emergence' metaphor to characterise the strict emergence of theory from data in the Glaserian approach. Glaser (1992) believed that the GT-based researcher should allow the theory to emerge as he or she observes codes and analyses data. Hence, Glaser leads with the principle that theory should emerge. Strauss and Corbin (1990) on the other hand believed that the researcher should do more than just wait for the theory to emerge. Strauss and Corbin (1990) felt that there was a need to develop a more structured approach to observing coding, and to analysing and recording data. They developed the concept of the coding paradigm to help the researcher generate a theory. However, Glaser (1992) criticised this approach, on the grounds that using concepts such as axial coding and coding paradigms results in the forcing of categories from the data instead of allowing the categories to emerge. Glaser (1992) believed that using a coding paradigm involving condition, context, action/interactional strategies and consequences would lead to the development of hypotheses for verification rather than theory development. Verification is not a goal for GT (Glaser, 1992). Glaser argues that GT is not about forcing preconceived ideas from data, but rather about systematically allowing the discovery of concepts and models as the study evolves (Glaser, 1992). The conflict between the two methodologies is thus often referred to as the 'Emergence versus Forcing' debate.

3.3.6.3 Formulation of research questions

Another visible difference between the two approaches is that CGT methodology requires one to enter the research setting without any research question (Glaser & Strauss, 1967). According to the Straussian perspective, entering the field with some research questions is allowed, and when formulating the research problems and

questions, the researcher can use his or her experience and knowledge, and even literature too if needed (Strauss & Corbin, 1990, 1998). According to Strauss and Corbin (1990) the purpose of the questions is to guide the research. Moreover, Strauss and Corbin (1990) indicated that the way one asks the research questions is of crucial importance, as that largely determines the research method used. This presents a dilemma, according to Strauss and Corbin (1990). The dilemma is whether the problem area and questions asked by the researcher cause him or her to choose the GT method. On the other hand, Strauss and Corbin also wondered whether the decision to use GT methodology should precede the framing of the question. Strauss and Corbin (1990) suggested that another important aspect of the research question is the setting of boundaries on what to study. They thought it was impossible for the researcher to cover all aspects of a problem. They indicated that the research questions help to narrow down the problem to a workable size.

Glaser (1992) on the other hand, identified the need to clarify the distinction between being interested in an area of study and having an interest in a specific problem. Glaser (1992) suggested that a researcher could have an interest, which then yields a research problem, and then look for a substantive area or population in which to study it. Glaser (1992) believed that starting research with an identified problem would bring the researcher's preconceptions into the study and this might lead to forcing theory from data rather than letting it emerge naturally from the data. It might also mean that the researcher could miss what participants in the chosen area under study consider, from their perspective, to be the true problem that they face (Glaser, 1992). Grounded Theory researchers move into an area of interest with no problem articulated (Glaser, 1992). The researcher is required to enter the field with abstract wonderment about what is going on and how individuals in that context handle it (Glaser, 1992). Therefore, the grounded theorist keeps his or her mind open to the true problems in the area. Furthermore, the research questions in GT study are not statements that identify the phenomena for research. The problem emerges, and so do questions regarding the problem that serve to guide theoretical sampling. A focus emerges for the research out of open coding, collection, theoretical sampling and analysis (Glaser, 1992).

3.3.6.4 Analysis coding procedures

Further essential disconnect between Glaser and Strauss lies in their different perspectives regarding process analysis data, particularly the procedures that are carried out (Heath & Cowley, 2003; Walker & Myrick, 2006). The differences are found in the way they engage in data analysis (Walker & Myrick, 2006). Glaser (1992) commented that Strauss and Corbin's (1990) method is not only a different version of GT but, rather, a totally separate and different method that results in a full conceptual description of the relationship between categories and concepts, as opposed to GT (Walker & Myrick, 2006). Both Glaser and Strauss employ the word 'coding' in analysing the data, but they present the process differently (Heath & Cowley, 2003; Walker & Myrick, 2006).

The Glaserian coding method tends towards more simple, quite focused, openness and flexibility in the elaboration of necessary analytical steps, and is more in keeping with the original version of GT (Locke 2001; Walker & Myrick, 2006). Glaser (1992, p. 38) defined coding as 'conceptualising data by constant comparison of incident with incident, and incident with concept.' Glaser (1978) has divided the coding process into two procedures: substantive and theoretical coding. Substantive coding consists of two sub-phases—open, and selective coding—and is focused on producing categories and properties. Theoretical coding arises at the conceptual level, merging the substantive codes into a hypothesis and theory (Glaser, 1978). In the initial phase of the coding process, the researcher makes comparisons between incident and incident to generate categories, and then compares new incidents to the categories. In the second phase, the researcher making the comparisons is required to examine the data by using neutral questions: for instance, 'What category does this incident indicate?' (Glaser, 1978, p. 57). According to Glaser (1978), by using the constant comparison method, the researcher can conceptualise data more quickly and easily. Both categories and properties emerge from the comparison process.

On the other hand, Strauss and Corbin (1990) defined coding as 'the process of analysing data' (p. 61). The Straussian coding process contains three major coding phases, labelling them 'open', 'axial' and 'selective' coding (Strauss & Corbin, 1990, 1998). In the coding process, Strauss and Corbin (1990) also used constant comparison methods, and posed questions within these phases, with each having

specific procedures to achieve distinct purposes. According to Walker and Myrick (2006), although Strauss and Corbin have confessed that the lines between the three phases might be carried out concurrently, in fact, each phase requires different interventions on the part of the researcher. However, the coding process appears complex. Initially, the coding process tends to be simple but as one moves deeper into the method, the process that the researcher must utilise becomes more detailed and complex. Regarding the coding phases, according to Strauss and Corbin (1990), during open coding, categories are developed by grouping similar concepts together into more abstract explanatory terms. Discrete concepts may then become properties or characteristics of a category, or may provide suggestions for such characteristics. The rationale for this higher-order grouping is that categories are easier to remember, think about, and develop in terms of properties and dimensions, and can be further differentiated by breaking them down into sub-categories if necessary (Strauss & Corbin, 1990, 1998). Meanwhile, Glaser (1978, 1992) has a slightly different view on this process, arguing that first identifying discrete concepts and then grouping them into higher-order categories is unnecessarily tedious and laborious. Rather, he suggests, through constant comparative analysis, broad-based categories should emerge, and then further comparative analysis will yield the properties and dimensions of these categories.

In the case of the selective coding, Glaser and Strauss differ more obviously. Strauss and Corbin (1990) defined this as, ‘the process by which all categories are unified around a core category, and categories that need further explication are filled-in with descriptive details’ (p. 14). Glaser provided a critique of this definition, saying that, ‘... the selective coding starts after and only when the analyst is sure that she has found a core variable’ (Glaser, 1992, p. 75). According to Glaser (1992), the core category simply emerges from the constant comparison coding that then becomes a guide for further data collection and theoretical sampling.

3.3.7 Glaserian Grounded Theory

Glaser (1992) formally defined GT as a general inductive research method that uses a systematic set of methods to generate an inductive theory about a substantive area. The central goal of Glaserian GT is to capture the core category or main concern of participants in their social context (Glaser, 1992). A good grounded theory should be

understandable to all, should fit the data, and be relevant to the behaviour being studied; it should also work by explaining, predicting and interpreting what is happening, and it must be modifiable by subsequently collected data (Glaser & Strauss, 1967; Glaser, 1978, 1992, 2005). Meaning, action and interaction are central to GT research; however a grounded theory is conceptual, not interactional (Giske & Artinian, 2009).

The central issue in a GT study is to know what the participants' main concern is and how the participants solve the problem (Glaser, 1978, 1992, 1998, 2001). A grounded theory gives a conceptual account of how the participants resolve their main concern (Glaser, 1992). Thus, in a GT study, participants provide data that reflect their concerns. It is important that the researcher understand, and ask questions about, what is happening. In GT the researcher must continually ask, 'What is going on?' and, 'What is the main problem of the participants and how are they trying to solve it?' (Glaser, 1978, 1992, 1998). These questions will be answered by discovering the core category and its sub-categories, and the properties of the data. A core category is the highest-level concept of the theory, relating to other categories and properties of the grounded theory; however it does not indicate how the different categories are related to each other (Glaser, 1978, 1992, 1998).

Glaserian GT or CGT is better equipped than other forms of GT to produce a clear, accurate understanding of what is actually happening in the data and what is really going on (Glaser, 1978, 1998, 2001). Grounded Theory does not aim for 'truth' but to conceptualise what is going on by using empirical data (Glaser & Strauss, 1967; Glaser, 1978, 1992). Thus the researcher must be immersed in the data in order to understand the events described and proceed from data collection to analysis, and on to organising concepts and relationships into a theory (Glaser, 1992). The theory gathered by this approach can be clarified and refined by asking questions which can provide more in-depth knowledge about categories. Implicit in this process is the practice of constantly comparing data (Chenitz & Swanson, 1986).

3.3.8 Key elements of Glaserian Grounded Theory

This section outlines the fundamental elements of CGT and by doing so attempts to provide a fuller explanation of the methodology for this approach. The elements of

this approach are: ‘all is data’; the use of the literature review; theory emergence from data; theoretical sensitivity; theoretical sampling; theoretical saturation; constant comparative analysis; coding; conceptualisation of latent patterns; memoing; developing a core category, and a social process analysis (Annells, 1997; Glaser & Strauss, 1967; Glaser, 1978, 1992; Glaser & Holton, 2005). These elements will now be discussed.

3.3.8.1 ‘All is data’

For the grounded theorist, the world is empirical and his or her task is to consider exactly what is occurring, not what he or she wishes would occur (Glaser, 1998). The dictum ‘All is data’ is a fundamental property of GT (Glaser, 1992, 1998, 2001). It means that everything encountered in the field should be considered for examination: not only interviews and observations, but anything that helps the researcher generate concepts for the emerging theory can be considered and used as data (Glaser, 1992, 1998, 2001). Everything encountered in the field related to the topic is used for building the theory and deriving concepts (Glaser, 1998, 2001). According to Glaser (2001) the researcher must always consider what is occurring, what is socially produced and what the participants are engaged in. Most importantly, the researcher must always be aware of what is going on in front of him/her as well as the intrinsic meanings attached. In GT, it does not matter what type of data the researcher obtains, or even if there are mixed or different types of data, because ‘the data is the data’ (Glaser, 2001, p. 145). The researcher’s task is to let themes emerge in their own right, and deduce the meaning implied by data (Glaser, 1998, 2001).

3.3.8.2 Theoretical sampling

A further feature of the GT method relates to the sampling of participants. Sampling is a critical part of the study and identification of data sources is a crucial part of a GT study (Glaser, 1978; Speziale & Carpenter, 2007). Unlike the quantitative researchers, the grounded theorist does not decide on the size of the sample population before the study begins (Cutcliffe, 2000; Glaser & Strauss, 1967). A GT sample is not entirely predetermined; participants are selected because of their expert knowledge of the phenomenon under inquiry (Green, 2005; Smith & Biley, 1997; Speziale & Carpenter, 2007). The sample size is not fixed, rather it ideally relies on ‘theoretical sampling’ (Glaser, 1978). Theoretical sampling is a process whereby

concepts, categories, and conceptual ideas are elicited from raw data through constant comparison and used to direct further data generation in order to develop the theory as it emerges (Glaser, 1978; Glaser & Holton, 2004). This process of data collection is ‘controlled by the emerging theory’ (Glaser, 1978, p. 36), with sampling being directed by the emerging theory (Goulding, 1999). Initially, the researcher will go to the most likely participants in search of information. However, as concepts are identified and the theory starts to develop, further individuals, situations and places may need to be incorporated in order to further explore, clarify, verify, and strengthen the findings (Glaser, 1978, 1998; Goulding, 1999; Morse & Field, 1995). Theoretical sampling is the means by which a researcher develops categories and builds theories.

Grounded Theory uses non-probability sampling. The aim of non-probability sampling is to describe and promote understanding, and obtain meaning (Morse, 1991). However, theoretical sampling differs from other non-probability sampling strategies commonly used in qualitative research, such as purposive and selective sampling (Glaser, 1992).

Purposive or selective sampling methods are usually used at the beginning of qualitative research to recruit informants to provide data about experiences or phenomena of interest to the researcher (Morse, 1991; Speziale & Carpenter, 2007). The research question determines who or what is of interest (Speziale & Carpenter, 2007). The intention of purposive sampling is to get the best data possible to enable a rich or thick description of phenomena (Speziale & Carpenter, 2003) which can be studied in depth (Patton, 2002). In a GT study theoretical sampling goes beyond purposive or selective sampling (Jeon, 2004).

The GT researcher initially enters into a process of purposeful sampling, which is gradually replaced by theoretical sampling once the data and or hypotheses identify the direction that future sampling will follow (Backman & Kyngas, 1999; Cutcliffe, 2000). The two most important questions in theoretical sampling are: what groups or subgroups does one turn to next in data collection?, and for what theoretical purpose or relevance? The selected participants should be determined by the emerging data, and data analysis will offer further participants for further interviews (Glaser, 1978).

These participants are chosen because they are deemed to be relevant sources of data, and this relevance is determined by what is necessary to generate and define the theoretical codes (Glaser & Strauss, 1967; Glaser, 1978, 1998). At this stage of the research the process of ongoing data collection is controlled by the emerging theory. Therefore, only data that is relevant and able to add density to the emergent theory is sought (Glaser, 1978). This process of sampling continues as categories emerge. The researcher targets particular groups, firstly to test and refine emerging categories, and later to expand, develop and saturate these categories (Schreiber, 2001). The particular groups are not recruited before the research begins but only as they are needed for their theoretical relevance to the development of further emerging categories. Categories are saturated when new data do not reveal any new concepts that could be incorporated into the theory (Cutcliffe, 2000).

3.3.8.3 The use of a literature review

Issues concerning reading and using literature in a GT process are the most debated among the theory's users. In the early stages of a GT study, the literature review serves the purpose of supporting the emergence of a theory and thus is a product of, and not a precursor to, the process of analysis. Glaser and Strauss (1967) recommended that GT researchers omit the usual traditional literature review in favour of investigation of the main concern, or disregard any prior knowledge held about the area being researched. Reading relevant literature too early in the study leads the researcher into a deductive approach that contaminates the generation of concepts from field data (Glaser, 1978). This position was also taken by Stern (1980), who stated that the usual literature search undertaken at the beginning of a verificational research study was considered inappropriate when using the GT method. Reviewing the literature prior to data collection leads to prejudgment and a premature closure of ideas, and to possible misdirection or inaccuracy of the data collection and analysis process, based on the review (Stern, 1985). The literature is reviewed after the core variable is generated (Glaser, 1992). The rationale for not conducting an extensive literature review earlier is to ensure that the researcher's efforts to generate concepts from the data are not contaminated, or constrained by preconceived ideas, which may hinder the emerging theory from truly being grounded in the data (Cutcliffe, 2000; Glaser & Strauss, 1967; Glaser, 1978, 1992; Stern, 1994).

However, some authors have argued that it is impossible and unfeasible to expect researchers to enter a field of study completely devoid of the influence of previous reading and experience (Heath & Cowley, 2004; McCallin, 2003; Schreiber, 2001). General reading of the literature may be conducted to serve two goals: acquiring a feel for the issues at work in the subject area, and identifying any gaps to be filled by one's GT study (Smith & Biley, 1997). Other authors have suggested that it is important, for the novice GT researcher at least, to explore the literature, in order to identify knowledge gaps or aspects of the area of interest that warrant study (McCann & Clark, 2003). A preliminary brief literature review is done before data collection and analysis to justify the need for the study, develop sensitising concepts and provide a background to the study (McCann & Clark, 2003; Schreiber & Stern, 2001). According to Wuest (2012) an initial literature review is needed in GT research in order to justify to the thesis committee or research funding agency that a GT study is needed. In addition, knowledge of what is known in the domain under study allows the researcher to understand how the generated theory is similar to or different from what is known (Morse & Richards, 2002). Through a literature review, the researcher demonstrates a broad grasp of the strengths and limitations of the theoretical and empirical knowledge in the domain under study (Schreiber & Stern, 2001; Wuest, 2012). If little is known, if the literature review is fairly straightforward and if the broad domain has been well studied, a case must be developed as to why existing theoretical perspectives are inadequate, and why a GT approach is needed (Wuest, 2012).

There are methodological reasons for undertaking a review of the literature (Glaser (1978, 1992, 1998). Firstly, reading related technical and popular literature effectively expands the researcher's ideas about the phenomenon under study, aiding the development of theoretical sensitivity (Glaser, 1978, 1992, 1998; McCallin, 2003; Schreiber, 2001). Secondly, the researcher can clarify many of the existing conceptualisations, ideas, and understanding of the phenomenon being studied by subjecting them to ongoing comparison with data (Glaser, 1978, 1992, 1998; McCallin, 2003; Schreiber, 2001). The salient point is that reading literature has a place in contemporary GT research because 'all is data', including literature, and the literature review contributes another perspective to the understanding of observed

social processes (Backman & Kyngas, 1999; Glaser, 1978, 1992, 1998; Heath & Cowley, 2004; McCallin, 2003; Schreiber, 2001). Previous knowledge can be integrated into a study by using constant comparative analysis to refine emerging concepts and categories (Backman & Kyngas, 1999; McCallin, 2003; Schreiber, 2001). As theory begins to emerge, researchers conduct a literature review to learn what has been published about the emerging concepts (Stern, 1980). By conducting a formal literature review, the researcher can fully explicate many of his or her existing conceptualisations and sensitising concepts regarding the phenomenon under study (Schreiber & Stern, 2001). Therefore, the researcher uses constant comparison to scrutinise the literature for its fit with emerging concepts and theory (Schreiber & Stern, 2001). There can be no doubt that a literature review undertaken just prior to a study clarifies the researcher's thoughts and defines the area of a study. This was the position adopted in this study where a literature review was used to verify the study's purpose, background and significance in response to candidacy requirements as part of the higher degree-by-research process.

3.3.8.4 Data collection methods

In a GT study, data collection is shaped by analytical interpretations and discoveries that continue until the theorist is able to substantiate fully the theoretical explanations of the phenomenon under investigation (Sandelowski, 1995; Rice & Ezzy, 1999; Cutcliffe, 2000). The procedural steps of data collection and analysis occur simultaneously, along with constructing the emerging theory, which is driven by the mechanics of the constant comparative method (Glaser & Strauss, 1967; Glaser, 1978, 1992). Through simultaneous data collection and analysis, the grounded theorist discovers patterns and concepts underlying the phenomena (Glaser & Strauss, 1967; Glaser, 1978, 1992).

Most GT studies have used interviews for a significant part of data collection. These interviews are described as formal or informal, semi-structured or unstructured, and have been conducted with one person or with a group of people (Artinian, 2009; Chenitz & Swanson, 1986; Morse & Richards, 2002). Kvale (1996) stated that an interview is a conversation that has a structure and a purpose. It is flexible, dynamic and directed towards understanding the participants' perspectives on their experiences, expressed in their own words (Taylor & Bogdan, 1998), and explore

how they deal with their situation and continually resolve their main concern (Christiansen, 2008). Interviews are particularly suited for studying people's experiences and elaborating their perspective on the world (Kvale, 1996). The interview is viewed as a reproduction of the participant's reality (Hall & Callery, 2001). As data collection and analysis proceed, the interview process shifts in the light of the emerging theory (Wuest, 2012). The following section will provide details on the scope and process of data collection and analysis.

3.3.8.5 Data analysis

3.3.8.5.1 Constant comparative analysis

Data analysis in the GT method is aimed at discovering a core category (Glaser, 1978, 1992). Constant comparative analysis is a cyclical analysis of data, whereby new data are compared and analysed against previously collected data to enable conceptual richness as the theory develops, and is a fundamental technique of the GT method (Glaser & Strauss, 1967; Glaser, 1978; Strauss & Corbin, 1998). This process is repetitive and data-centred and is conducted throughout the course of the GT study (Glaser & Strauss, 1967; Glaser, 1978). The aim is to ensure that the researcher remains open and sensitive to the participants' interpretations and meanings of the situation under study, within their social world and context (Heath & Cowley, 2004). When using the constant comparative method of analysis, the data collection, coding and analysis occur simultaneously and continue until a grounded theory is fully integrated and generated (Glaser & Strauss, 1967; Glaser, 1978). The process is not linear, as the analyst is perpetually moving back and forth from the substantive line-by-line coding, to theoretical consideration, to memoing, and then back to the substantive data (Glaser & Strauss, 1967; Wuest, 2012). This process ensures that the theory is a correct representation of the data (Glaser & Strauss, 1967; Smith & Biley, 1997).

There are four stages of the constant comparative analysis: (1) comparing incidents applicable to each category; (2) integrating categories and their properties; (3) delimiting the theory, and (4) writing up the theory (Glaser & Strauss, 1967). Two first stages are fundamental to the constant comparative method of coding and ensure the generation of categories and their properties from the data (Glaser & Strauss, 1967; Glaser, 1978, 1992). This method of constant comparison leads to a modifiable

theory that keeps up with what is going on as change occurs (Glaser, 1978). During constant comparative analysis, each section of the data is compared with every datum throughout the study for similarities, differences, and connections, and this is the principal approach to data analysis in the development of a grounded theory (Glaser & Strauss, 1967; Glaser, 1978, 1992). In line with the principle of emergence, researchers should suspend any preconceived ideas and notions about the phenomenon under investigation, in order to allow the data ‘to speak for itself’ (Glaser, 2001, p. 195). Constant comparative analysis continues for the duration of the research. It begins with the coding of incidents (elements of data) that in turn lead to the emergence of categories and their properties, and finishes with the theoretical codes that connect the categories with each other and the core category (Glaser, 1978, 1992, 2001). This process of constant comparison continues until the core category, the one that accounts for most of the variation in the patterns of behaviour, is identified, and a theory with sufficient detail is generated from the data (Glaser, 1978, 1992, 2001). This means that all the data collected over the course of the research has been compared and analysed and that the theory that emerges is a true reflection not only of the data that has been collected but also of the participants involved in the study (Glaser, 1978, 1992). The application of this process to this current study is described in Chapter 4, Research Methods and Processes.

3.3.8.5.2 Coding in Grounded Theory

Coding is the fundamental analytic process in the constant comparative method. Coding in GT methodology means conceptualising data by constantly comparing incident with incident and incident with concept, to facilitate the emergence of more categories and their properties (Glaser & Strauss, 1967; Glaser, 1978, 1992). The process of conceptual coding enables the researcher to transform raw data into theory (Backman & Kyngas, 1999; Schreiber, 2001). Coding is concerned with opening up the text to expose thoughts, ideas, meanings, similarities and differences contained within the events, actions and interactions by conducting a word, line or sentence analysis (Coffey, Holbrook & Atkinson, 1996). Incidents articulated in the data are analysed and coded using the constant comparative analysis method to generate initially substantive and later theoretical categories (Glaser, 1978, 1992; Glaser & Holton, 2004). An incident, a phrase or a sentence or paragraph from an interview transcript, such as behaviour (specific acts), events, activities, strategies, states, and

meanings (Glaser, 1978, 1992, 1998) is a key item of data that can be coded. Joint coding and analysis lift the data from an empirical or descriptive level to a conceptual or theoretical level (Glaser, 1978, 1992). This path from the empirical to the conceptual level is not linear but creative in nature (Schreiber, 2001). The coding process in Glaser's approach comprises open coding, theoretical coding and selective coding. These components are discussed in more depth in the following sections.

3.3.8.5.2.1 Open coding (Level I coding)

Open coding is the first step in GT analysis of transcribed data, the one that leads to the discovery of categories and properties (Glaser, 1978, 1992). This is an inductive process whereby unique characteristics of the data are identified (Glaser, 1978, 1992). Open coding is conceptualisation at the first level of abstraction (Glaser & Strauss, 1967; Glaser, 1978, 1992). Open coding, also referred to as substantive coding, consists of categories and their properties relevant to the substantive area or to the actual behaviour of participants (Glaser & Strauss, 1967; Glaser, 1978, 1992, 1998).

In this step, the analyst begins with no preconceived concepts and organises data which were obtained from, for instance, interviews or fieldwork observations, which have been transcribed verbatim into incidents. These incidents form the basis of analysis and are examined and constantly compared against one another, looking for similarities and differences (Glaser & Strauss, 1967; Glaser, 1978, 1992). In this phase the data is coded in as many ways as possible (Glaser, 1978). Examining the data word-by-word, line-by-line, or in even larger sections such as paragraphs or pages, can achieve this outcome. The researcher looks for emerging patterns, beginning with no preconceived conceptual thoughts or ideas. During open coding, the researcher must consider questions, since these are important in maintaining a research focus; these are questions such as, 'What are the data a study of?' 'What category or property of a category does this incident indicate?' 'What category or property of a category, of what part of the emerging theory, does this incident indicate?' 'What is actually happening in the data? That is, what is the participant's main concern?' (Glaser, 1978, p. 57). These questions and open coding are the foundational grounding approaches to the data, and lead to emergent discoveries (Glaser, 1978, 1992, 1998).

During open coding, many codes may emerge and as the process continues, these codes are grouped together to form sub-categories and categories (Glaser, 1978, 1992). This stage of data analysis should be used to identify the category or property of a category to which data being analysed belongs (Glaser, 1992). A category is a set of codes or concepts that are similar, and therefore, by definition, grouped together (Schreiber, 2001). It is at this stage of analysis that there may be some indication or evidence of a core category (Glaser, 1978, 1992; Schreiber, 2001). A core category is the main category that explains the variations in the data and therefore the behaviour or actions of the participants in the research (Glaser, 1978, 1992).

3.3.8.5.2.2 Theoretical coding (Level II coding)

The second stage of constant comparative analysis is theoretical coding (Glaser & Strauss, 1967; Glaser, 1978, 1992, 1998). In this stage the constant comparative units change from comparison of incident to comparison of incidents with properties of the categories (Glaser & Strauss, 1967; Glaser, 1978, 1992, 1998). The focus at this level is on examining the relationships between and among categories (Glaser & Strauss, 1967; Glaser, 1978; Schreiber, 2001). This leads to categories and their properties becoming integrated in many different ways, resulting in a unified whole; connections or links between the categories and the core category emerge from the data (Glaser & Strauss, 1967, Glaser, 1978, 1992, 1998). Theoretical coding deals with conceptual codes, which are derived from the open codes, and forms the link between the data and the theoretical findings (Glaser, 1978, 1998). Categories emerging as Level I codes are compared and collapsed. By having to compare concepts and determine what is going on in the data, 'like' concepts get grouped and the researcher is in effect putting the fractured data back together but in a different way, which contributes to the developing theory (Glaser, 1998, p. 163).

Theoretical coding is the conceptualisation of how substantive codes potentially interrelate as hypotheses, facilitating their theoretical integration (Glaser; 1978, 1998). Theoretical coding is also the stage where descriptive links between the categories are changed to more theoretical links (Chenitz & Swanson, 1986).

Theoretical codes are the conceptual connectors linking the categories to one another

and to the core category (Glaser, 1978, 1992, 1998). Therefore, it is these theoretical connectors that enable and guide the process of theory generation, development and integration (Chenitz & Swanson, 1986; Glaser, 1978, 1992, 1998).

Glaser provided guidance on theoretical coding, the basic social process, theoretical sorting, and on how to pace the research work. There are a number of ‘families’ of theoretical codes that can guide data analysis and theory development (Glaser, 1978). For instance, the theoretical codes known as ‘the Six Cs’—causes, contexts, contingencies, consequences, covariances and conditions is the family that a beginner grounded theorist should use, because most studies fit into a causal, consequence or conditions model (Glaser, 1978). The Six Cs family, like the other coding families, is used to assist the researcher to identify the theoretical connectors between various categories and the core category (Glaser, 1978). As the analysis evolves, one coding family may trigger the use of another coding family (Glaser, 1978). To do this, a series of questions are asked when analysing the data. For example, is this category a condition of some other category? Is it a cause, context or a contingency of another category? Does this category co-vary with other categories? Is the category a strategy? (Glaser, 1978, p. 76).

During theoretical coding, the researcher will find that there are unanswered questions that need to be explored (Chenitz & Swanson, 1986; Glaser, 1978). In order to address this, more data are collected in the specific area of deficit, facilitating the saturation of the properties, categories or core category, and enabling theory development to continue (Glaser, 1978). This is achieved by ‘theoretical sampling’ (Glaser, 1978) which will be explained later in this chapter.

3.3.8.5.2.3 Selective coding (Level III coding)

The third stage is selective coding, which relates to delimiting the theory. Selective coding is more analytical and uses conceptual and theoretical codes that become the foundation of the developing theory (Glaser, 1978, 1992, 1998). This step is sometimes called ‘theoretical constructs’ (Hutchinson & Wilson, 2001). Unlike open coding, which uses substantive codes (in the participants’ own words), selective coding is more analytical and abstract, leading to conceptual names of categories. Selective coding delimits the study, moving it forward. This is encouraged when

undertaking GT as it is not concerned with data accuracy as in descriptive research, but is about generating concepts that are abstracts of time, place and people (Glaser, 1978, 1992, 1998).

This stage involves reducing the number of categories and their properties into a smaller set of higher-level concepts and is done after having found the core variable or what is thought to be core (Glaser & Strauss, 1967; Glaser, 1978, 1992, 1998). Selective coding is the strategy used to code for the core (Glaser, 1978, 1992, 1998). The core explains the behaviour of the participants in resolving their main concern (Glaser, 1978, 1992, 1991, 2001). In this phase the focus usually is on limited numbers of categories that best represent the major aspects of the data (Glaser, 1978). The researcher examines and collapses codes into higher-level relational concepts or categories (Glaser & Strauss, 1967; Glaser, 1978, 1992; Heath & Cowley, 2004; Speziale & Carpenter, 2007). As in open coding, the researcher continues searching for a core category, and once this has been discovered, it guides ongoing data collection and theoretical sampling (Glaser, 1978, 1992, 1998). A core category will be explained below.

3.3.8.5.3 Core category

The core category is the main concern or central phenomenon for the participants, encasing the essential features of a consistently repetitive, recurring pattern of behaviour seen in the data, and summing up what is happening (Glaser & Strauss, 1967; Glaser, 1978, 1992; Schreiber, 2001). Core categories emerge from the constant comparison of categories and are broad in scope. They subsume and interrelate concepts and hypotheses and account for the majority of the variation found in the behaviour patterns of the research participants (Glaser & Strauss, 1967; Glaser, 1978, 1992; Speziale & Carpenter, 2007). The search for a core category begins from the outset of data analysis. As codes and categories emerge and are compared, the researcher looks for the core category that explains the main concern or problem for the participants. Glaser (1978, 1992) identifies the main criteria for core category selections as follows:

- The core category should be central to as many other categories as possible. It should account for most of the variation in the participants' behaviour.

- The core category is frequently seen in the data. It is a recurring theme. It must also become more relevant to other categories as the research progresses.
- The core category takes more time to saturate or expand than the other categories. Saturation is achieved when the data yields no new information for a category.
- The core category has meaningful links to the other categories and these links can be easily and quickly identified.
- The core category in a substantive theory must also have relevance in a formal theory. It means that the substantive theory can be used in larger and more diverse formal theory applications. It is important that the core category can be used to explain behaviour outside the parameters of the substantive area of research.
- The core category must have the capacity to explain behaviour for the duration of the research analysis. Therefore, it must be the central theme and offer a continuous explanation of participants' behaviour from the beginning to completion of the study. If the category fails to yield an ongoing explanation of the participants' behaviour, it is not a core category and a search for an alternative core category should begin.
- The core category must easily account for variations that occur as the relationships between the core category and other categories develop and expand. Therefore, a core category is open to easy modification if required.
- A core category should also be a part of the problem itself. Therefore, the core category should, in part, explain itself and its own variations.
- On occasions a core category may also be classified as a basic social process (BSP), which is explained below.

The core category is in essence the concept in the study that most commands the reader's attention and offers the greatest potential for an impactful study. As stated, it can be otherwise known as the basic social process (BSP) (Glaser, 1978).

3.3.8.5.4 Basic Social Process

A basic social process (BSP) is a type of core category or main concern, which is a fundamental behavioural pattern that research participants exhibit over time (Glaser, 1978, 1992). The distinction between BSPs and other categories is that BSP is procedural in nature (Schreiber, 2001). It has more than one state of being. For a BSP to exist, it must have two or more clear emergent stages or phases in development and these emergent stages should be able to distinguish between and provide an explanation for variations in the pattern of behaviour of interest (Glaser, 1978, 1992). Other core categories can use all other theoretical codes but do not have stages (Glaser, 1978, 1992). This is in contrast to a core category that has no procedural stages but is a stand-alone category (Glaser, 1978, 1992).

The BSP displays a number of defining properties other than emergent stages. These include pervasiveness, full variability and change over time (Glaser, 1978, 1992). The BSP theoretically reflects and summarises patterns of social behaviour that people go through (Glaser, 1978). They display durability and stability over time, achieving this through ‘accounting for change over time with a high degree of ease of meaning, fit and workability’ (Glaser, 1978, p.101). A core category can be any theoretical codes such as process or strategies and therefore, a BSP is always a core category, while not all categories are BSPs (Glaser, 1978). According to Glaser (1978) there are two BSPs in GT: firstly, a basic social psychological process (BSPP) which is useful in understanding behaviours: and secondly, a basic social structural process (BSSP) which is concerned with social structures in a process. Basic social processes are usually labelled with a gerund (‘-ing’) that reflects their evolving nature and a sense of motion—for example, ‘cultivating’, ‘influencing’, ‘engaging’, ‘communicating’, and ‘becoming’—, a format that embraces the sense of change over time, as well as embodying the participants’ actions (Glaser, 1978 p.135, Schreiber, 2001). Although Glaser (1978) made note that a core category may not always be a BSP, he stated that properties of a unit are more relevant to descriptive qualitative studies, while properties of a process are more relevant to studies aiming at theoretical conceptualisation (Glaser, 1978). Because this present study centres on properties of a process and not on properties of a unit, the main concern was found to be a BSP (as will be seen in Chapter 7).

3.3.8.6 Memoing

Memoing is the continual process used by the researcher of making notes and diagrams throughout the data collection, coding and analysis process, and is fundamental to a GT study (Backman & Kyngas, 1999; Schreiber, 2001; Smith & Biley, 1997). It is an integral component of the constant comparative method in that it allows the researcher to give shape to his/her thinking regarding the analysis of the data, and can assist in the development of theory in a number of ways (Glaser & Strauss, 1967; Glaser, 1978, 1992, 1998). According to a number of authors, memoing serves a number of purposes for the GT researcher (Backman & Kyngas, 1999; Glaser & Strauss, 1967; Glaser, 1978, 1992, 1998; Milliken & Schreiber, 2001; Schreiber, 2001; Smith & Biley, 1997; Speziale & Carpenter, 2007). Firstly, it makes clear the researcher's pre-existing assumptions, thereby opening them up for examination. Secondly, it records ideas, questions and thoughts generated at the various stages of data collection and analysis. Thirdly, it analyses and postulates about the data; this phase may encompass new codes and categories, relationships between categories or with existing theoretical models, analytical schemes, or hunches and abstractions. Lastly, it records methodological decisions made about the management of the research and acts as an audit trail of the researcher's decision-making process (Backman & Kyngas, 1999; Glaser & Strauss, 1967; Glaser, 1978, 1992; Milliken & Schreiber, 2001; Schreiber, 2001; Speziale & Carpenter, 2007).

Memoing commences in the planning stages of the study and continues during every phase of the research; it is sorted and used in an analytical process to write the final substantive theory (Glaser, 1978, 1992, 1998; Schreiber, 2001). Constant memoing throughout the study allows ideas to be recollected later during analysis and permits the expansion of the data with analytical ideas (Glaser, 1998). This aids in the development and integration of category characteristics and the generation of hypotheses and theory (Backman & Kyngas, 1999; Milliken & Schreiber, 2001; Schreiber, 2001). Memos are important tools to both refine and keep track of ideas that develop when the researcher compares incident to incident and then concept to concept in the evolving theory (Glaser, 1978, 1992; Schreiber, 2001). This in turn enables the researcher to keep track of the emerging theory (Glaser, 1978). In memos the researcher tries to comprehend the links between and among emerging categories, in diagrams or figures or whatever makes the ideas flow, and generates

comparative power (Schreiber & Stern, 2001). Undertaking the drawing and redrawing of diagrams gives the grounded theorist the opportunity to step back and gain an overall visual conceptualisation of the full theory (Schreiber, 2001).

According to Glaser (1978, 1998) memos are individual and private things and because of this, the GT researcher is not restricted by rules that specify what should and should not be included in them. Thus, memoing offers total creative freedom without rules of writing, grammar or style (Glaser, 1978, 1998). To achieve good results, the researcher is encouraged to register the ideas about the ongoing study that eventuate in everyday situations, using notes, pictures, diagrams, comments and hypotheses, from the beginning of data collection and coding until the completion of the final drafting of the thesis. Without memoing, the theory is superficial and the concepts generated not very original (Glaser, 1978, 1998). Most GT studies demonstrate the use of diagrams to facilitate analysis of data.

3.3.8.7 Theoretical sensitivity

Theoretical sensitivity is essential to GT and relates to comprehending the nature of and refinement of data. In the context of Glaser's approach to GT, theoretical sensitivity refers to the conceptual ability of the researcher to recognise the patterns of behaviour discovered in the data (Glaser & Strauss, 1967; Glaser, 1978, 1992). This insight facilitates the researcher's ability to recognise what is important in the data, helping to formulate theory that remains true to the reality of the sensory facts under study (Glaser & Strauss, 1967; Glaser, 1978). Theoretical sensitivity is the researcher's ability to think inductively, moving from specific data to general or abstract in order to assemble theory from the observation of particular incidents, and thinking in theoretical terms about what he or she knows (Glaser & Strauss, 1967). Theoretical sensitivity is something the researcher brings to the study and it is further developed throughout the research process (Glaser, 1978). Further, Glaser (1978) underscores the importance of the fact that the researcher using GT methodology needs to develop the necessary theoretical sensitivity to discover 'substantive, grounded categories' (p. 1). Theoretical sensitivity is important in the process of transcending from description to conceptual theory.

Theoretical sensitivity refers to a personal quality of the researcher and is necessary in order to conceptualise and formulate a theory as it emerges from data (Glaser & Strauss, 1967; Glaser, 1978, 1992). In being theoretically sensitive, a researcher has to be able to apply creativity and imagination when testing against data a range of possible explanations of what the data says (Heath & Cowley, 2004; Schreiber, 2001). In other words, the researcher in part shapes the data through his/her interpretation and in turn is shaped by the data, with validation occurring through constant comparison (Heath & Cowley, 2004; Schreiber, 2001).

There are two characteristics embodied in theoretical sensitivity. First, the concept involves the personality and temperament of the researcher (Glaser & Strauss, 1967). Second, it involves the researcher's ability to have theoretical insight into the area of research, the ability to give meaning to data, the capacity to understand, and the capability to separate the pertinent from the irrelevant (Glaser & Strauss, 1967; Glaser, 1992). All this develops conceptually rather than in concrete terms. Enhancement of theoretical sensitivity can be achieved through the researcher acknowledging and investigating all possible explanations for what is observable in the data (Heath & Cowley, 2004; Schreiber, 2001). This is particularly important when dealing with data that invalidate or challenge emerging hypotheses (Glaser, 1992; Heath & Cowley, 2004; Schreiber, 2001). Memoing, writing out one's preconceived ideas and theories and putting them away for later comparison against the data, is one technique the researcher can implement to promote theoretical sensitivity (Backman & Kyngas, 1999; Cutcliffe, 2000; Heath & Cowley, 2004). Another strategy helpful in promoting theoretical sensitivity is testing how the theory does or does not fit together by discussing with others the emerging theory, the categories and their characteristics (Glaser, 1978; Schreiber, 2001). This exercise assists in ensuring the analysis stays grounded in the data, as it helps the researcher to maintain perspective and not get lost in the analytical processes (Backman & Kyngas, 1999; Schreiber, 2001). The ongoing challenge for the researcher is to remain open to the theories in the data without getting lost in the process of theorising or becoming distracted by minor details contained in the data (Backman & Kyngas, 1999; McCallin, 2003; Schreiber, 2001).

3.3.8.8 Sorting and writing up

Theoretical sorting is the key component of theory generation and it begins toward the end of coding, when categories are nearing saturation (Glaser, 1978, 1992, 1998). The purpose of theoretical sorting is to sort the memos that the researcher has written over the course of the research in order to identify the emerging theory (Glaser, 1978, 1992, 1998). This is the act of arranging a huge pile of memos into an integrated theory—what Glaser labels as the epitome of the theory generation process—and it is an important step in the GT process (Glaser, 1992, 1998). Theoretical sorting generates a generalised, integrated, complex and dense theory outline, as it highlights the connections between the categories, core category and their properties (Glaser, 1992). This process provides the organisation for the first draft of the thesis and a sense of theory completeness (Glaser, 1992). This sorting process may also lead to the discovery of the core variable or BSP if it has not already been discovered. The major focus of the sorting process is to put back together the fractured data towards the end of the process of analysis, in an effort to provide a whole picture of the substantive area under scrutiny (Glaser, 2002).

3.3.8.9 The proof of product

In Glaserian GT the evaluation of GT is based on a stand-alone set of criteria comprising fit, workability, relevance and modifiability (Glaser & Strauss, 1967; Glaser, 1978, 1992, 1998). The four criteria that a grounded theory must satisfy in order to be considered useful are: ‘they would *fit* the real world; they would *work* across a range of contexts; they would be *relevant* to the people concerned; and they would be readily *modifiable*’ (Partington, 2000, p. 93).

‘Fit’ means that categories are derived from the data and Glaser (1978) explains that ‘fit’ happens automatically during the process of data analysis. The criterion of ‘fit’ demonstrates how the substantive GT is faithful to the realities of the substantive area under study through its ability to correspond closely with the data (Glaser, 1978). If a theory ‘fits’ the data, it means that the categories that make up the theory, as well as the structure of the theory, are not forced upon the data, but are allowed to emerge from the data itself (Glaser, 1978, 1992). The nature of emergence means that the categories will fit the data easily and well (Glaser, 1992).

Grounded theories 'work' when they can interpret, explain and predict what is happening in the substantive area under investigation (Glaser, 1978). According to Glaser (1978), 'workability' refers to whether or not the concepts and the way they are related to the hypotheses sufficiently accounts for how the main concern of participants in a substantive area is continually resolved. If a grounded theory works it can explain what happened, predict what will happen and interpret what is happening (Glaser, 1978). In terms of workability, it is not only academics that utilise the theory but also the people working in the field that use it themselves. Therefore, the theory must make sense and be readily understandable for anyone who may be concerned with this area (Glaser, 1978, 1992).

Closely linked to this criterion of 'workability' is the idea that a theory must be 'relevant' to the area under study. Relevance is whether or not the research deals with the main concerns of the participants involved, as opposed to the preconceived problem that is a researcher's professional interest (Glaser, 1978). Relevance also refers to whether the theory is meaningful for the participants and others whose behaviour can be explained by it (Glaser, 1992). To achieve this criterion, the researcher must allow core categories and the basic social process to emerge without other preconceived theories.

The final criterion for judging the quality of GT as a theory is modifiability. Modifiability is the potential for the theory's response to new data (Glaser, 1978). The emergent theory is never right or wrong, nor better or worse on the temporal scale of a study, but becomes modified by new data (Glaser, 2001). As long as it fits, works and is relevant, then it is an adequate explanation for a particular set of data (Glaser, 1978, 1992). In fact, in GT research, modification never ends (Glaser, 2001). However, if new data are compared to it and found to differ in some way, then the theory needs to be modified in order to account for the new data. Therefore, theories and categories must remain modifiable, and theorists need to maintain a 'nothing is sacred' attitude (Glaser, 1978, p. 5). According to Glaser (1998), the legitimacy of GT is the proof of the product.

3.4 Chapter 3 summary

This chapter provides the reader with an understanding of the methodology on which this study was based, and explains and describes the method used to gather and analyse the data. The foundational philosophical principles that underpin this study are identified, explained and justified. This includes the development of qualitative enquiry relating to symbolic interactionism. The chapter has also engaged with methodological issues relating to the Glaserian and Straussian approaches to GT. The methodological differences between the Glaserian and Straussian approaches to GT are explained. This chapter also provides a detailed discussion of the adopted approach of Glaserian GT which has informed the research design of this study. The discussion provides a rationale for the methodological concepts chosen for this study in regard to Indonesian nurses' perceptions of and experiences with pain management in hospitalised children. The Glaserian GT method was used in this current study with the objective of developing a substantive theory that would provide contributions to practice and research respectively. The following chapter presents a description of how the Glaserian GT approach was used in this study.

CHAPTER 4

RESEARCH METHOD AND PROCESSES

4.1 Introduction

The previous chapter explained Glaserian Grounded Theory (GT) methodology and its application to this study. Chapter Four focuses on the research method used in this study, commencing with a description of the setting of the study, the sample, and the sampling approaches utilised. The process of recruitment is discussed. The data collection methods and data collection procedures are also described, along with the data analysis method. The specific methods used to select and analyse the data and to develop the theory—open coding, theoretical coding, selective coding, memoing, identification of a core category, and theoretical sensitivity—are explained in detail. Finally, the criteria for evaluating the rigour of the emergent theory or the ‘proof of product’, and the ethical considerations involved in conducting the study, are outlined.

4.2. The settings of the study

This study was conducted in West Java Province, Indonesia, and data were collected from participants at two settings in that location. West Java Province was chosen for four reasons. Firstly, it is the third biggest province in Indonesia and is the public health centre of the western region in Java. Secondly, there are 104 hospitals in West Java Province, of which 43 are public and 61 are private. Thirdly, it is the researcher’s home region, and is where the Faculty of Nursing of Padjadjaran University in Bandung is located. As such, this location was an environment to which the researcher had access. Finally, in relation to hospitals and health settings, West Java Province is representative of all provinces in Java, by virtue of its size and the presence in the province of all levels of hospitals usually encountered in the Indonesian health care system. The clinical settings selected as sites for data collection were chosen on the basis of their status as government teaching hospitals. Two government teaching hospitals were used, being the referral-centre hospitals in West Java Province. These hospitals were chosen because of their reputations as being committed to both quality of patient care and research. Additionally, these

hospitals also offered in-patient paediatric care. This was a key reason for the choice of these particular settings.

4.2.1. Research settings

The first setting is a Type A¹ facility, a government-owned teaching hospital, and is a top referral hospital for West Java Province. The hospital has a bed capacity of approximately 1,400, providing a range of general, specialist and sub-specialist health care services, including paediatrics. A total of 1,176 nurses were working in the hospital at the time of the study. As demonstrated in Table 4.1 below, showing the demographic statistics of nurses in this setting, the majority of the nurses held a Diploma of Nursing.

Table 4.1 Demographic statistics of nurses

Qualifications	Number of nurses	%
Vocational (High School/SPK) ²	75	6.38
Diploma in Nursing	977	83.08
Bachelor of Nursing	115	9.78
Master of Nursing	4	0.34
Paediatrics-trained ³	5	0.42
Total	1,176	100

¹ Type A hospital (up to 1,500 beds), designed to provide national referral care (Thabrani, 2008).

² Some nurses in Indonesia are educated to senior high school health care certificate level only or Sekolah Perawat Kesehatan (SPK). However, currently this is changing, with the retirement of those trained at SPK level (Rokx, Satriawan, Marzoeki, & Harimurti, 2009; Shields & Hartati, 2003). The Indonesian Ministry of Health is closing down the SPK level, converting such schools to the higher diploma level (Ministry of Health, Indonesia, 2000).

³ These nurses hold Bachelor degrees and have done paediatric training such as paediatric wound care, neonatology care, paediatric emergency care.

The second setting is a hospital in North West Java Province. The hospital is a Type B⁴ hospital, also a government-owned teaching and referral hospital. This hospital is smaller than the hospital in the first setting. The total number of nurses in this hospital at the time of the study was approximately 311. Similar to the first setting, the majority of nurses held diplomas (Table 4.2). The following table illustrates the demographic statistics of nurses in this setting.

Table 4.2 Demographic statistics of nurses in the second setting

Qualifications	Number of nurses	%
Vocational (High School/SPK)	51	16.40
Diploma in Nursing	200	64.31
Bachelor of Nursing	56	18.01
Master of Nursing	2	0.64
Paediatrics-trained	2	0.64
Total	311	100

This study was conducted in six different paediatric care settings within the two hospitals: a paediatric surgical ward; a medical ward; a neurosurgical ward; an intensive care unit; an emergency department, and a neonatal intensive care unit.

4.3 Sample description

In keeping with the notion of purposeful sampling, the following criteria were developed to ensure the pool of participants allowed for the provision of rich descriptions of the phenomenon of interest. The sampling was targeted, and based on a set of predetermined criteria. The researcher made preliminary sampling decisions to select nurses with a minimum of three years' nursing experience in paediatric wards. This criterion was based on the consideration that the participants would have sufficient work experience to enable them to provide information-rich data regarding their perceptions of and experiences with pain management when caring for

⁴ Type B hospital (ranging in size from 300 to 800 beds), designed to provide local referral care (Thabrani, 2008).

paediatric patients in pain. To elicit a broad-based understanding of the phenomenon, participants were selected from the wards listed above.

4.4 Sampling strategies

Consistent with GT methodology, two sampling strategies were employed for this study: purposive, and theoretical sampling (Draucker, Martsof, Ross, & Rusk, 2007). Purposive sampling was used in conjunction with theoretical sampling, which was undertaken throughout the process of data collection and analysis (Glaser & Strauss, 1967; Glaser, 1978, 1992, 1998). Purposive sampling on the other hand was used during the initial stage of the study, on the basis that participants had experience of caring for paediatric patients in pain and could articulate this experience (Holloway & Wheeler, 2002; Morse & Richards, 2002). Furthermore, participants were familiar with the area of interest (paediatric pain management), and were willing to reflect on the phenomenon, serving the objectives of the study. In addition, purposive sampling was used to provide the best possible data to generate a rich or dense description of the phenomenon (Speziale & Carpenter, 2007). This initial sampling resulted in a total of 12 nurse participants.

Initially, during data collection and analysis, broad ideas, perceptions and concepts were sought from the data regarding the phenomena of nurses' perceptions and experiences of managing pain in paediatric patients within a paediatric setting. As the data were analysed, and the study developed, the researcher employed theoretical sampling to explore the emergent concepts and categories of paediatric pain management practice and to collect any additional data needed to enable full and complete construction of the theory. This method of sampling was used to increase the probability of describing the full scope of the studied phenomenon and to help the researcher to develop the theory (Creswell, 2013). In this study, theoretical sampling included the recruitment of further participants. Participants were invited on the basis of how their information added to the understanding of the study phenomenon, the development and refinement of the emerging categories, and the overall formulation of the grounded theory. After interviewing 12 staff nurse participants, questions arose that could be illuminated by senior nurses, such as clinical educators, and head nurses. The senior nurses were purposefully selected, and subsequent questions resulted in several other paediatric ward personnel being

interviewed as the study progressed. As data analysis continued, it seemed necessary to interview more senior staff, including nurse supervisors, heads of nursing divisions, and a head of a nursing department, in order to explore the full range of identified categories and thus further guide the emerging theory. Theoretical sampling resulted in a further 25 participants being interviewed, making a total of 37 participants from both sampling techniques. The process of theoretical sampling continued until the point of theoretical saturation was reached, where no additional data could be found (Glaser & Strauss, 1967). After completing 37 semi-structured, in-depth interviews, a reasonable degree of theoretical sufficiency had been achieved and there was no new information emerging from the data in the form of categories or themes. Therefore data collection ceased at this point. A description of the participants in this study is provided in Chapter Five.

4.5 Participant recruitment

To access participants initially, the researcher sent a letter to the directors of the two hospitals where the research was to be undertaken (see Appendix 1). This letter explained the purpose of the study and requested permission to conduct the research. Once the directors of the hospitals agreed to support the study, copies of the research proposal were sent to the ethics committees of the participating hospitals. Ethics approval was sought and gained from Curtin University's Human Research Ethics Committee, and from the general teaching hospitals in Indonesia. Following approval for the study, the researcher sought support from the relevant heads of nursing to assist with the recruitment processes.

A written request was sent to the heads of the nursing units requesting that they assist with facilitating participant recruitment by bringing the study to the attention of nurses employed in their areas. A letter of introduction, including a description of the study, was given to the heads of nursing units as a means of presenting the study to suitable individuals (see Appendix 2). The researcher then organised a time to speak with the nursing staff in the respective units about their participation in this study. At this presentation, the purpose and the benefit of the study were explained. In addition the researcher explained the commitment needed if the nurses decided to participate in the study. The nurses were given opportunities to ask questions. At this meeting the nurses were also given an information sheet that gave a brief overview

of the research and advised that participation was entirely voluntary. They were informed that, should they wish, they could withdraw at any time, and that total confidentiality would be assured (see Appendix 3).

Following the assurance of confidentiality, the potential nurse participants at this meeting were invited to be interviewed at a time and place convenient to them. The necessity for audio-recording of the interviews was also discussed. The researcher informed potential participants that further input of their time might be needed for the researcher to seek clarification of any aspect of the interview. Moreover, the researcher explained that once written consent was obtained, participants would be asked a series of open-ended questions exploring their perceptions and experiences of caring for paediatric patients in pain. Additionally, their perceptions regarding factors that enhanced or inhibited nurses' ability to provide pain management practice for paediatric patients experiencing pain during hospitalisation would be explored. The nurses were assured that to maintain confidentiality, any notes or audio-recorded would be coded and only the researcher would be able to identify the participant from whom the data came. Participants were also informed that the interviews would take approximately 50–60 minutes to complete.

4.6 Data collection

The credibility of a GT study depends on how data are collected, analysed, and developed into a conceptual theory (Giske & Artinian, 2009). In this GT study, data collection was shaped by analytical interpretations and discoveries that continued until the researcher was able fully to substantiate the theory explaining the phenomenon under investigation (Cutcliffe, 2000; Rice & Ezzy, 1999; Sandelowski, 1995). In this study data were collected in two rounds due to the researcher taking leave of absence for six months because of serious illness. The first round of the data was collected from August 2010 until February 2011; the second round of data collection continued from August 2011 up to December 2011.

4.6.1 Interviews as the source of data

Interviews were selected as the mode of data collection for this study because they facilitated in-depth exploration of the phenomena under study (Minichiello, Madison, Hays, Courtney, & St-John, 1999; Speziale & Carpenter, 2007) and assisted in

gathering rich, descriptive data, in the participants' own words (Hewitt-Taylor, 2002; Minichiello et al., 1999). The interviews were viewed as a reproduction of the participants' reality (Hall & Callery, 2001).

In this study, semi-structured, in-depth, audio-recorded interviews with individual participants were employed for data collection, a method commonly utilised in GT research (Creswell, 2013; Speziale & Carpenter, 2007; Wuest, 2012). In-depth interviews enabled the researcher to gain a detailed understanding of the research participants' perspectives on caring for children in pain (Minichiello et al., 1999). The researcher used semi-structured, in-depth interviews with nurse participants in order to ensure that a dense set of rich data was gathered. Informal short interviews or dialogues with nurse managers in the hospitals were also used to clarify evolving concepts. The following section will explain the interview process conducted in this study.

4.7 The interview process

The interviews in this current study were conducted face-to face, in the Indonesian language (*Bahasa Indonesia*). All of the interviews were carried out by the researcher and were held at the participants' work setting. To avoid interruption of the nurses' work, a mutually suitable time and location for each interview was negotiated. The interview settings in each paediatric ward were selected on the basis of safety and privacy, the need to use audio recording, and individual space requirements and preferences.

At the beginning of each initial interview, the nurse participants were greeted and thanked for their attendance and readiness to be involved in this current study. They were then requested to sign a consent form (see Appendix 4) to indicate their willingness to participate in the study. Each participant was requested to complete a demographic data sheet (see Appendix 5). Demographic data were relevant to this study, providing a description of participants' characteristics and helping to contextualise the findings. The nurse characteristics sought included age; gender; education; years of working experience; ethnicity, and marital status. The participants were encouraged to ask questions regarding the study. The expected duration of each interview was negotiated before the interview commenced. When

these formalities were finalised and the participant had no further questions about the study, the interview commenced.

Participants were informed of the researcher's role and that this research was part of the requirements for a doctoral degree. Moreover, the researcher explained that data would be collected and analysed simultaneously, to verify that the analysis captured their sense of the meaning and experience of paediatric pain management practice.

The researcher prepared a semi-structured interview guide (see Appendix 6) to provide direction if needed. The guide also assisted the researcher in maintaining her focus on the phenomenon of caring for children in pain in the clinical setting (Kvale & Brinkmann, 2009; Minichiello et al., 1999). The semi-structured interview guide consisted of a core set of open-ended questions designed to allow participants to explain their own viewpoints and experiences. The initial interview question, broadly posed and designed to encourage a conversation, was along the lines of: 'Please could you tell me of your experiences of working as a nurse in this hospital?' This broad question was consistent with GT principles, and allowed the participants to focus directly on the conversation that followed. In addition, follow-up questions were used to encourage elaboration of responses when necessary. Probing questions were used to ensure clarity. During these interviews, the participants were asked to explain their personal experiences and perceptions when caring for paediatric patients in pain, especially in relation to how they managed paediatric patients' pain. In addition, participants were asked to describe their understanding of their role in providing pain management practice; the importance of managing paediatric patients' pain; what factors enhanced or inhibited their ability to provide pain management; the strategies that they used, and the problems they encountered when caring for paediatric patients in pain, and how they dealt with those problems.

Interviews were recorded using a small audio-recorder. Although Glaser (1998) does not recommend recording, this strategy enabled the researcher to capture data more faithfully. Hand-written notes were not made during the interviews, but were written after the interview was completed, ensuring that the researcher's attention was focused on the conversations with the participants and not on note-taking. The length of the interviews ranged from 50–90 minutes.

Rapport-building with participants was essential to increase the researcher's chances of hearing their story (Berg, 2009). The quality of interview data is often influenced by the nature of the relationship between the researcher and the participants (Giske & Artinian, 2009). In this current study, rapport was established over time and through the use of several strategies. Firstly, the format of the interview was one of conversation rather than pursuing questions one-by-one in rapid succession. Secondly, the researcher used active listening skills such as an open posture and affirming what the participants said by nodding and making approving remarks. Finally, participants were reminded that there was no right or wrong answer and that any experience that they chose to share was of interest. None of the participants became visibly upset during the course of the interviews. Most of them, at the conclusion of the session, expressed gratitude to the researcher for the opportunity to talk about the issues, and made spontaneous comments about the importance of such research. For instance, one participant commented:

I am really happy to be able to get involved in this study because I can share and talk with you about my experiences caring for paediatric patients in pain. I do believe results of this study are useful and will have benefits for improving paediatric patient care in this hospital' (P#29).

Measures were taken to conduct the interview in a way that minimised any emotional discomfort that might occur as participants discussed issues related to the topic of the study.

Participants were advised that follow-up interviews, either face-to-face or via telephone, might be conducted at a later stage; therefore the researcher sought participants' willingness to make themselves available. Follow-up interviews were conducted with six participants, for data clarification. Follow-up interviews were shorter in duration than the initial interviews, with more focused questions. These interviews were not audio-recorded, although notes were taken during the interview. Finally, participants were asked not to discuss interviews with other potential participants, to avoid contamination of subsequent data. Memos were recorded on the completion of each interview and throughout the analysis stage, to act as an audit

trail of the researcher's decision-making process (Glaser, 1978; Glaser & Strauss, 1967).

4.8 Data management and analysis process

Data analysis for this study followed the principles of classical grounded theory (CGT) or Glaserian GT. The research process in this GT study used an iterative approach, which involved cycles of simultaneous data collection and analysis. Phases were interconnected continually from the beginning of the investigation to the end (Glaser & Strauss, 1967, Glaser, 1978, 1998). Data included demographic questionnaires, field notes, memos, audio-recorded interviews, and transcriptions of the audio interviews. Transcripts were considered the raw data of this qualitative study (Sandelowski, 1995). Data analysis was guided by the constant comparative method and theoretical sampling (Glaser & Strauss, 1967; Glaser, 1978; Giske & Artinian, 2009). An inductive method was used to analyse the data and to identify concepts, shared meanings, and linkages (Guba & Lincoln, 1994).

Following each interview, the interview data were transcribed verbatim by the researcher into a Microsoft Word document to allow the data to be read and organised. Transcribing was conducted by the researcher herself, to enhance the process of her immersion in the data (Schneider et al., 2003). The transcription was undertaken in *Bahasa Indonesia* in order to ensure that meaning was not lost and that the information provided by the nurse participants was not taken out of context. As Bahasa Indonesia is the researcher's primary language, this provided the researcher with an opportunity to interact with the details embedded in the data and thereby to sense the appropriate meaning behind the data. This process was performed to increase the researcher's sensitivity to the data and to add to the credibility of the findings. The research sensitivity was further enhanced by the coding process and interaction with the data transcripts. For all interviews the researcher (1) listened to the audio-recorded interviews several times; (2) transcribed the audio-recorded interviews; (3) read and re-read the transcribed manuscript while listening to the audio-recordings, making corrections as necessary; read and re-read the transcription several times to allow additional immersion in the data and to get a sense of the whole picture; and (4) made qualitative notes on aspects like participants' level of eye contact and tone of voice, next to the transcribed text.

Post transcription, all transcripts were translated from *Bahasa Indonesia* into English. To confirm the meaning of words and conversation, some transcripts were checked by an Indonesian nursing educator. The translation of data excerpts into English also provided an opportunity for the researcher to apply the inherent personal pacing that Glaser (1978) believed was a necessary part of applying GT. The intention of this subconscious pacing is to think deeply about the meaning of the data and to engage in searching interplay with it (Glaser, 1978, pp. 18–20). In this study, manual thematic analysis procedures were used to manage the data. The researcher also used the thematic analysis method to identify themes, essences or patterns within the text (Roberts & Taylor, 2002). In this way, the researcher made sense of the words and put them into some order for interpretation (Roberts & Taylor, 2002). The researcher followed the manual approaches of Roberts and Taylor (2002) to determine themes, ensuring that they followed the research aim and objectives. Thematic analysis is a method for identifying, analysing, and reporting patterns (themes) within data (Braun & Clarke, 2006). Braun and Clarke (2006) identify thematic analysis as the basis for qualitative analysis, since it fulfils most of the functions of GT and also other methods of analysing the meaning of interview transcripts. Thematic analysis allows for categories to emerge from data and enables researchers to construct theories that are grounded in the data themselves (Charmaz, 2006). Thematic analysis allows more hidden themes to be identified (Harper & Thompson, 2012).

4.9 The constant comparative method of analysis

This section describes the steps and processes that the researcher went through in the analysis process. Data analysis was a continuous process undertaken with varying degrees of intensity throughout the entire research project. In this study, the constant comparative method of analysis was the primary strategy in the integral coding and analysis stages of the grounded theory (Glaser & Strauss, 1967; Glaser, 1978, 1992, 1998). The study used comparative analysis as a strategic method to generate theory that is grounded in the data (Glaser & Strauss, 1967; Glaser, 1978, 1992, 1998). Constant comparison occurred throughout each of the coding stages, and involved three types of comparison: incident to incident; concept to incident; and concept to concept. In the constant comparative method, each piece of data is continually

compared with every other piece of data so as to generate theoretical concepts that encompass as much behavioural variation as possible (Glaser & Strauss, 1967). Concepts identified in the data were then compared with subsequent and prior data to generate their interrelationships and theoretical suppositions (Glaser & Strauss, 1967). This involved comparing various cases, events, phenomena, and behaviours that had emerged from each interview through purposeful questioning, in order to support the development and refinement of themes. Concepts were also compared in order to facilitate their integration into the emergent theory (Glaser & Strauss, 1967).

4.9.1 Coding and conceptualising data

The researcher employed open, theoretical and selective coding in order to conceptualise the data, identify the events and patterns embedded in the data, and to provide for the process of core category development (Glaser & Strauss, 1967: Glaser, 1978). The following section provides a description of the coding techniques used in analysing the data to arrive at a core category.

4.9.1.1 Open coding

Open coding was the first analytical process that the researcher undertook. The goal of open coding is to create as many conceptual codes as possible to fit the data (Wuest, 2012). In this study open coding was initially used in the coding process, as each transcribed interview was transcribed and printed. The researcher began to conceptualise the data. Coding began with exploration of all the different facets of the narrative that the researcher perceived as important or interesting. This meant re-reading the transcripts several times. In undertaking open coding, that is identifying, naming, categorising and describing phenomena, the researcher repeatedly asked, 'What is this all about?' 'What is being talked about here?' Two examples of open coding are provided below.

Open coding meant that the researcher conducted a 'line-by-line and 'word-by-word' analysis to identify key words, phrases and themes that had relevance to the phenomenon and to the participants' story. It was important to break down the participants' story so that important ideas were not missed. This involved comparing each incident in the data with other incidents, on a line-by-line basis. The researcher made 'line-by-line' notations in the margin. These notations picked up the

participants' own words (in-vivo codes), key words or phrases. Key words were underlined and then these key words were written in the right-hand margin of the transcripts. Line-by-line in- vivo coding was conducted on all transcripts that were considered to be 'thick' or dense in description. In the line-by-line, in-vivo coding, the researcher used key phrases in the participants' own words, such as, 'I have to know the child in pain and trying to contact the doctor'. Some notations were single words such as 'frustrated' or 'helpless'.

In the following excerpt from an interview, the left-hand column shows what the participant said, with relevant phrases underlined. First-level coding or open coding is shown in the right-hand column (Figure 4.1). In the transcript, hard returns were used to separate text units, and some sentences were broken up into several text units for coding purposes.

<p><i>I suppose <u>caring for child patients in pain is something challenging to conduct</u> and as a nurse I have responsibility to alleviate a patient's pain because it is a part of caring. In order to <u>provide effective pain management</u>.....uhmm....</i></p> <p><i>we <u>must know about a patient's condition such as how much their pain, whether it was severe, moderate or mild pain.</u></i></p> <p><i>For <u>knowing a patient's pain</u>hummm</i></p> <p><i>we must <u>conduct pain assessment adequately and correctly, but hum...</u></i></p> <p><i>it <u>needs more time to conduct pain assessment optimally.</u> However, because of some <u>circumstances present in this ward,</u> sometimes we <u>were not able to provide pain assessment effectively to my patients</u></i></p>	<p>Caring for children in pain Challenging Responsibility to alleviate patient's pain Providing effective pain management Knowing patient's condition Knowing severity of patient's pain</p> <p>Knowing the patient Conduct pain assessment adequately Correctly Need more time</p> <p>Circumstances in the ward We were not able to provide pain assessment effectively</p>
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Figure4.1 Sample of interview transcript

A second example follows, which shows identification of a concept from the narrative, or rather than from the participant using a specific word or phrase. This example identifies how a participant faced 'time constraints' in the working place:

I know we must conduct pain assessment regularly and use non-pharmacological techniques but sometimes we don't have a lot of time to do this routinely because many tasks have to be done including referral, transporting patients and paperwork, especially on the afternoon and night shift because there are only two nurses who are on duty' (P#2).

This statement revealed that the participant was aware that because there was a lack of time, she was unable to routinely conduct formal pain assessment and apply non-pharmacological interventions to relieve pain in the way she had been taught.

In open coding everything is coded so as to find as many codes as possible without consideration of relevance (Glaser, 1978). Open coding required that the researcher identified what was happening in the data. The researcher had to decide how each incident was labelled or coded (Glaser, 1978). Subsequently, the researcher compared an occurrence with another incident, and from here the concepts and categories emerged from the data. The unit analysis was conducted by words, phrases, and sentences. This was done to identify commonality with key words and phrases and was the commencement of the process of developing sub-categories, properties and dimensions. In order to analyse the data and identify concepts and their properties, the researcher continually asked the following three questions (Glaser, 1998, p. 140): 'What category does this incident indicate?' 'What category or property of a category does the incident indicate?' and 'What is the participant's main concern?' The process of asking these questions and seeking the answers from the data ensured that the open coding remained grounded and that relevant concepts emerged from the data that had been formed from the nurse participants' perspectives. Asking these questions helped to avoid forcing preconceptions about the data, encouraging a theory-driven approach that prioritised the analytic abstraction of theoretical categories and exploration of the relationships between them (Glaser, 1978).

Following the analysis of the first transcript, all other transcripts were dealt with in the same way. Particularly, each new piece of data was examined and broken down into concepts. Similar concepts were coded together and in this way each piece of data was compared with data already coded. During open coding many codes emerged and as the process continued, these codes were grouped together to form

sub-categories and categories (Glaser, 1978, 1992). When dissimilar data were identified, a new category was initiated, accompanied by a definition and an explanatory memo. During this phase it was important that the researcher remained aware of her own preconceived ideas, expectations or biases (Glaser, 1992, 1998). It was also necessary for the researcher to immerse herself in the data, to read it, think about it, and try to put herself in the position of the nurse participants. The researcher asked a series of questions of the data. Some of these questions follow: ‘What was going on in the data?’ ‘What does this mean to me?’ ‘What does this mean to the nurse participants?’ ‘Are these meanings the same?’ ‘What effects, if any, did these incidents have upon the decision-making process of pain management in paediatric patients?’ Eventually, all incidents from all interview transcripts were examined, compared, and coded for both similarities and differences. The codes provided the central point for the ongoing data collection and analysis. The researcher continually asked, ‘Where does this word, phrase or idea belong?’ The coding and analytical process required placing ‘codes’ into a sub-category, identifying them as properties or dimensions and identifying patterns of connection. Coding continued until there was a sense that no new concepts were being identified. At this point, theoretical coding occurred, and which will be discussed in the following section to maintain a sense of order in the process for the constant comparative method.

4.9.1.2 Theoretical coding

Theoretical coding was commenced concurrently during the study, as open coding of data continued. Theoretical coding began when many of the first-level codes had been collapsed into categories or higher-level concepts, with the focus on examining the relationships between and among categories (Glaser & Strauss, 1967; Glaser, 1978, 2003; Urquhart, 2013). The theoretical codes are the conceptual connectors linking the categories to each other, and to the core category (Glaser, 1992). These theoretical connectors enable and guide the process of theory generation, development and integration (Chenitz & Swanson, 1986; Glaser, 1978; Urquhart, 2013). The process of constant comparison assisted the researcher in theoretical coding. During this level of coding the researcher related the codes to each other and observed the relationships between those codes. Through having to compare concepts and determine what was going on in the data, the researcher was able to put the fractured data back together, but in a different way.

In this stage, the researcher identified the links between categories, such as cause and effect. For example, when a nurse participant admitted that she did not regularly conduct paediatric pain assessments, the researcher looked for explanatory reasons. There were several reasons identified in the data. For instance, pain assessment tools were not available in a paediatric ward. Another reason was that the nurse did not have enough time to conduct pain assessments routinely and adequately because of her heavy work load, which included non-nursing duties. Perhaps there was a combination of reasons as to why the nurse participant did not routinely assess the children's pain. The researcher also looked for other contextual factors that may have affected the nurse's pain management practice. As in all of the other stages of GT methodology the researcher allowed concepts to emerge from the data, from the participants' point of view. The nurse participants' stories were primary and it remained the researcher's responsibility to articulate these stories.

Theoretical coding, sometimes referred to as axial coding, facilitated more abstract or conceptual ways of looking at and linking the data (Holton, 2010). Theoretical coding helped the researcher to theorise the descriptive data (Stern, 1980). Furthermore, data linkages were made on the basis of knowledge gained throughout the research and through reading related literature, as well as on the basis of professional and experiential knowledge. Therefore, the researcher employed Glaser's (1978) 'Six Cs' to guide conceptual analysis. The Six Cs family, like the other coding families, was used to assist the researcher to identify the theoretical connectors between the various categories and the core category (Glaser, 1978). Where evident, the researcher analysed the data by identifying the causes, contexts, contingencies, consequences, covariances and conditions of each event (the Six Cs). In this way, linkages between categories were identified. Lastly, codes were collapsed and new categories developed, while others were expanded.

As more data were collected and compared, and newer insights confirmed, the researcher examined how and why concepts and categories occurred, how they were related, and the properties of these categories. In addition, the phases of the process were identified. The emerging core category was then discussed and verified by the researcher's supervisors. Further analysis and memo writing then led to the core

category, or the central conceptual category that helped to integrate the categories and processes found in the data (Glaser, 1978; Schreiber, 2001). Through this process categories were elevated to a more abstract level and the relationships between categories were integrated. This process led to the identification of the main concern or the basic psychosocial problem experienced by the nurse participants.

In this study, theoretical coding occurred when analyses and interpretations were written as memos. The codes were further compared in order to clarify and develop the meanings and linkages in the categories. Through data analysis two major categories emerged: 'Barriers to pain management' and 'Carrying out the pain management role'. These two categories indicated the main concern or the basic social problem (BSP) experienced by the nurse participants when caring for paediatric patients experiencing pain in the clinical setting. The concept of 'professional role tensions' emerged from the data as the participants' main concern or core problem. Further analysis then focused on identifying a core category and attempting to establish links between this and other categories. Memoing then led to the core category, or the central conceptual category that helped to integrate the categories and processes found in the data (Glaser, 1978; Schreiber, 2001; Speziale & Carpenter, 2007). Through coding and further analysis, a core category began to emerge and was conceptualised as 'Managing professional role tensions'. This category represented the way that Indonesian nurses utilised strategies to manage their professional role tensions in order to maintain their emotional wellbeing and have some control over their practice, as well as provide effective pain management for hospitalised paediatric patients to the best of their ability. The theoretical coding process provided the information needed to progress into selective coding.

4.9.1.3 Selective coding and theoretical saturation

Selective coding was conducted after having found the two major core categories. Once this stage was complete the researcher began to selectively code these categories and those that related to it. In the delimiting process, the large number of categories and their properties were reduced into a smaller set of those related to the core category only (Glaser & Strauss, 1967; Glaser, 1978). That is, any data that did not relate to the core were ignored. In line with the constant comparative method, as data chunks were being coded, questions were asked and hypotheses were

constructed; the researcher began to see links between larger codes. Eventually the core process or BSP, 'the process of managing professional role tensions', emerged as the core category. The researcher then moved to the identification of the relationship of this category to all other categories. To get to this point the researcher had to determine whether all other categories related to 'the process of managing professional role tensions' and whether this category had the most explanatory power. In the selective coding process all categories were examined and linked to the core. If evident, they were identified. Memos were written to keep track of how each code linked to the core category of 'the process of managing professional role tensions'. From this method used the core category of 'the process of managing professional role tensions' was verified from the data through determining its properties and relationships to other categories.

In this GT study the researcher continued collecting data until theoretical saturation was reached (Schreiber, 2001; Dey, 1999; Giske & Artinian, 2009). Theoretical saturation was achieved when completeness of all levels of coding occurred and when no further properties or relationships between codes and categories were identified (Glaser & Strauss, 1967; Giske & Artinian, 2009; Speziale & Carpenter, 2007). When the researcher recognised repetition amongst the data it was acknowledged that data had begun to saturate. This is the end point of theory-building and development. A theory is confirmed when new data do not contribute new concepts or categories. These concepts were 'saturated', and a substantive theory of 'the process of managing professional role tensions' was born. The generation of theory is considered completed when no new information about the core processes is forthcoming from ongoing data collection (Glaser & Strauss, 1967; Glaser, 1978). This process results in theoretical completeness (Glaser, 1998, 1978). In grounded theory, theoretical coverage is partial because a substantive theory can be modified as more data are compared (Glaser, 1978). However, Glaser (1978) explained some criteria for ensuring that the chosen core category is appropriate, and in turn provided guidance on when it can be recognised that theoretical saturation has been achieved. The core category must be central; that is, the other categories and variational aspects must be able to fit around the core category (Glaser, 1978). The core category must have occurred frequently within the data and it must account for patterns of behaviour seen in the data, and summing up what is happening in the

study setting (Glaser, 1978; Giske & Artinian, 2009; Schreiber, 2001). The saturation point thus indicates a level of theoretical stability where the core category accounts for as much empirical variation in the data as possible.

In Chapter Five, the researcher will describe the core concern/ problem of professional role tensions experienced by participants in this study when caring for hospitalised children in pain. This core concern emerged from the data through the coding process used in this current study. The core category is now discussed.

4.9.1.4 Identification of the core category

The end product of the process of developing theory is the core category (Glaser & Strauss, 1967; Glaser, 1978, 1992). The core category is integrated with the theoretical findings and describes how the participants resolve or process their main concern (Glaser, 1978). The identification of a core category in this study took time and required the analysis of a large amount of data. Sometimes a category emerged that appeared to be a core but which could not be linked to all other categories. Where this happened, it was because the researcher had identified an important, possibly sub-core, category. Therefore, the researcher continued with the analysis in order to find a category that had the power to integrate the whole theory. In this research the core category of ‘the process of managing professional role tensions’ emerged from the data. Codes and categories were examined and re-examined, and the researcher identified that the process of pain management practice used by Indonesian nurses when caring for paediatric patients in pain was often problematic. The overarching theme of every nurse participant’s story was the same. Every nurse participant in this study had experienced and tried to ‘manage professional role tensions’ to maintain their emotional wellbeing when working and caring for hospitalised children in pain. This core category was central to the overriding experience of nurse participants in this study when caring for hospitalised children in pain. Importantly it also provided a comprehensive array of sub-categories, properties and dimensions that accounted for the shared and individual variations in the experience of providing pain management for paediatric patients.

4.9.1.5 Basic Social Process

As stated in the previous chapter, a basic social process (BSP) theoretically reflects and summarises patterns of social behaviour that people go through (Glaser, 1978). In this study the core concern/problem that emerged from the data was the ‘professional role tensions’ that nurse participants experienced when they tried to manage paediatric patients’ pain. The BSP that emerged from the data was ‘the process of managing professional role tensions’. This core process explained how Indonesian nurses in this study utilised strategies to manage their professional role tensions when caring for hospitalised children in pain, and provided a theoretical framework that explained the way in which they processed this concern. The coding process and development of the emerging categories were facilitated by memoing and diagramming. These two processes are now discussed.

4.10 Memoing

Throughout all phases of this study the researcher maintained a series of reflective journals (Glaser & Strauss, 1967; Glaser, 1978, 1998). This process is called ‘memoing’ (Glaser, 1978). Memoing commenced in the planning stage of the study and continued until the study was concluded (Schreiber, 2001; Urquhart, 2013). Writing memos assisted the researcher to capture and document ideas, thoughts, questions, relationships between interviews, and specific themes that emerged, as well as aiding self-reflection (Giske & Artinian, 2009).

The purpose of a memo was to enable the researcher to explicate the conceptual process through abstract thought and visualisation. Memos consisted of sentences, paragraphs or a few pages, diagrams and preliminary ideas about the substantive theory. Memos were also written to define terms that were used to label categories, such as ‘powerless’ and ‘knowing the patient’. The initial memos were written prior to commencing the first interview with a participant. Each memo was given a title that included the name of the concept (or concepts) that it related to, together with a summary of participants’ perceptions about an issue concerning pain management. The initial open coding memos typically were used to record the properties of concepts as they emerged, identify links between concepts, and record thoughts about ‘best fit’ names. As the analysis progressed, the memos began to focus more

on the links between concepts and their respective boundaries. An example of a memo is shown below.

During coding, memos were written related to the concept 'knowing the paediatric patients':

Knowing the paediatric patients and their needs is an important aspect of nursing care. Knowing the paediatric patients and their needs is closely related to recognising when signs and symptoms are of concern. Knowing the patient is one of the facilitating factors that is an important motivating factor for the decision-making process on pain management, and requires that the nurse knows the patient as a person. That is, as an individual, which allows the nurse to interpret information and select individualised intervention. Nurses must be close and friendly to patients, taking an interest and making the patient feel important.

(Memo, October 2010).

Another example of a memo explored the participants' perceptions through their responses to questions on the factors that influenced their ability to provide pain management in paediatric patients (e.g. 'What are the factors that influence your pain management practice?'):

In general, nurses understand how pain management must be incorporated when caring for paediatric patients in pain. They were clear that time, or lack of it, was an important factor in creating the right environment for optimal pain management. Although heavy workloads is a difficulty to delivering optimal pain management, for the nurses in any setting, they recognised that patients needed extra time, which they endeavoured to take despite the potentially negative impact on the rest of their work. Nurses know they have to do the right thing and try to do as best as they can do. Nurses identified lack of knowledge, limited facilities, and heavy workload as key barriers to being able to 'provide good pain care' and 'to do the right thing'.

(Memo).

In this study, memoing assisted the researcher to identify and situate the researcher's thoughts as opposed to the participants' story, and as such allowed the emergent theory to be grounded in the data. Particularly when analysing data, the researcher made notes of what she herself was thinking about the concepts being identified and the context from which they had emerged.

4.11 Diagramming

The process of diagramming was an effective visual tool that assisted the researcher to return to and comprehend the link between and among emerging categories (Schreiber, 2001). Diagramming was used in this study to describe relationships amongst factors and categories or their properties. The researcher found diagramming very useful in terms of giving direction to her thoughts and helping the emergence of processes and relationships. For instance, diagramming was helpful in conceptualising the problems experienced by the nurse participants, in particular the components of each of the factors that led to their experiencing professional role tensions. At a later stage in the theory development, the properties and categories that made up the core variable were visualised, and ‘the process of managing professional role tensions’ was seen as occurring at points along these continuum (see Chapter Six, page 182).

As explained previously, stage four of the constant comparative method involved the drafting of the theory. Once the researcher considered that no new codes or concepts were developing and the data was saturated, and that the core concern/ problem and core process had been correctly identified, it was time to present the data as a substantive theory. This was done by bringing together the memos and the diagrams and developing a narrative describing and explaining the core category. This involved elaboration of the sub-categories, properties and dimensions, to explain what had emerged as the substantive theory. The theory developed to explain how Indonesian nurses in this study utilised strategies to manage their professional role tensions when caring for hospitalised children in pain, using ‘the process of managing professional role tensions’.

4.12 Writing theory

Once data were saturated and no new code or concepts were developing, and the researcher was sure that the basic socio-psychological problem and the basic socio-psychological process had been identified correctly, it was time to present the data as a substantive theory. In drafting the theory, a model was drawn to further illustrate the relationship between concepts. This model added to a written explanation of the concepts and their relationships (Glaser, 1998). The researcher read the existing literature while completing the step of writing the theory, and the current theory was

then compared to other theories (see Chapter 7). Concepts identified within the existing literature were used to support the core concern, ‘the process of managing professional role tensions’.

4.13 Theoretical sensitivity

Theoretical sensitivity means that the researcher can move beyond pure description to see theoretical possibilities in the data (Glaser, 1978). It guides the researcher to conceptualise a substantive theory as it emerges, thus ensuring that it faithfully reflects the true nature of the studied phenomenon (Glaser & Strauss, 1967). Theoretical sensitivity is the ability the researcher increasingly develops to conceptualise and formulate a substantive theory by using constant comparative method analysis (Giske & Artinian, 2009). As more data were collected and analysed, the researcher’s theoretical sensitivity increased, leading to more focused interviews. Thus the researcher began to use open questions to enhance the participants’ thoughts about their experiences, and to ask more specific questions in relation to certain events, behaviours, or experiences: for instance, questions about relationships with nursing staff, medical colleagues and patients, and about the nurse’s role in managing children’s pain. These were helpful in saturating concepts and their properties (Giske & Artinian, 2009). In addition, in this study, the researcher’s theoretical sensitivity consisted of having been educated as and working as a paediatric health nurse, and as a lecturer in nursing including paediatric health nursing. The researcher’s interest in the phenomenon was based on reading, and experience working for many years within paediatric surgical wards in a general teaching hospital in Indonesia. As Glaser and Strauss (1967) and Glaser (1992) suggested, the researcher’s personal inclinations, assumptions, experience and knowledge are useful in developing sensitivity to the research data. This experience increased the researcher’s self-awareness and theoretical sensitivity. The researcher believed that having a preliminary interest in and understanding of the phenomenon under study allowed her to engage in the interviews and analysis and to be sensitive to the need to allow the emergence of the nurses’ story without premature closure of analysis. However, the researcher realised that this also could have potentially biased the researcher’s view. Therefore, in order to reduce bias, the researcher discussed the results of her data analysis with the supervision teams. This was necessary and

helpful, to ensure that the researcher stayed true to the data and did not let her own experience impact on the emerging theory.

4.14 Criteria for evaluating the rigour of the emergent theory, or the proof of product

In the methodology chapter of this thesis, Glaser's (1978, 1992) criteria of 'fit, work, relevance and modifiability' were outlined and explained. The emergent grounded theory of 'the process of managing professional tensions' will now be evaluated based on these criteria.

The criterion of 'fit' was met when the substantive grounded theory demonstrated that it was faithful to the realities of the substantive area under investigation, through its ability to correspond closely with the data (Glaser & Strauss, 1967; Glaser, 1978, 1992). In other words, the final concepts or categories had emerged from the data and were not selected by means of any pre-established theoretical perspective. To meet this criterion, the researcher allowed the data to emerge, and did not force the data into pre-existing ideas, but remained open and sensitive to the data to discover what was really happening within the data, without bias (Glaser & Strauss, 1967; Glaser, 1978). With regard to the theory of 'the process of managing professional role tensions' the researcher has made the claim that it has 'fit'. The theory, developed sufficiently, explains the way in which the participants have processed their main concern.

The researcher considered that the criterion of 'work' was met by the substantive grounded theory's ability to be used to explain, predict and interpret the facts of the substantive area under investigation (Glaser & Strauss, 1967; Glaser, 1978, 1992). The theory was able to explain how the participants resolved their main concern (Thulesius, Hakansson, & Peterson, 2003). The main concern and the behaviours conceptualised in this thesis are, as a result of careful constant comparison, well grounded in the data. The 'workability' of the theory was also supported by the ability of the theory to summarise and synthesise findings from the literature. The term 'workability' means that the theory can be utilised by the nurses working in the clinical setting. That is, the theory of 'the process of managing professional role

tensions' makes sense and is readily understandable for every nurse who may work with and care for paediatric patients.

The researcher considers that this research is highly 'relevant' to nurse participants because it has explained, focused on and dealt with the main concerns of the participants involved (Glaser & Strauss, 1967; Glaser, 1978). 'Relevance' has been optimised in this study by ensuring the systematic and rigorous application of the constant comparison method and theoretical sampling, which progressively refine the emerging theory. In avoiding forcing preconceptions on the data by delaying the literature review and by engaging in continual memo writing, the researcher is confident that the main concern and core category identified are reflective of the data from which they were derived. The study has addressed the fact that the nurse participants experience professional role tensions when caring for hospitalised children in pain because they experience conflict between their desire to provide effective pain care, cannot achieve this objective in their practice owing to the contextual conditions of their workplace. The theory of 'the process of managing professional role tensions' is also 'relevant' to those in the substantive area who care for paediatric patients experiencing pain, as it gives them a new understanding of the experiences and challenges that their nursing colleagues face when caring for hospitalised children in pain.

Finally, 'modifiability' refers to the ability of this grounded theory to be altered in response to the comparison of new relevant data (Holton, 2008). New ideas increased its density and scope by adding further variation. Throughout the development of the theory, and up to a late point in the analysis intended to generate the theory, the researcher found the need to modify categories, and had to make a final decision with regard to two possible core categories. It was the data that drove these formulations, and it was new data that resulted in the need to modify further. While the researcher believed that the theory was well developed at this point, she knows that it can be modified at any time. The theory must be modifiable in order to ensure continuing 'fit, work and relevance'. The theory presented in this study is thus, quite appropriately modifiable. The theory of 'the process of managing professional role tensions' is thus presented as sufficiently theoretically complete, with demonstrated 'fit, relevance, and workability' within the substantive area and it remains open to

modification from further data. Its openness to future modification means that the theory will have lasting relevance and usefulness.

4.15 Ethical consideration

The research for this study conformed to the guidelines and principles of the Ethical Conduct in Research Involving Humans statement issued by the National Health and Medical Research Council (2007). Research on human subjects has many ethical considerations and within Australia it has been recommended that researchers adhere to set principles and guidelines (NHMRC, 2007). However, 'ethical conduct is more than simply doing the right thing. It involves acting in the right spirit, out of an abiding respect and concern for one's fellow creatures' (NHMRC, 2007, p. 3). Therefore, the human rights of the participants in this study were protected according to the guidelines set by the Human Research Ethics Committee (NHMRC, 2007).

Permission to conduct this study was obtained from both the Curtin University's Human Research Ethics Committee and the Research Ethics Committee at a general teaching hospital in Indonesia. Official permission was obtained from the Director of the Educational and Research Department at the two general teaching hospitals in Indonesia where the study participants were recruited. Ethical issues were considered as per the NHMRC statement (2007). Ethical issues are an important consideration for all researchers. These issues include: informed consent, participant-researcher relationships, gaining access, confidentiality, anonymity, sample size and data analysis (Speziale & Carpenter, 2007).

A particular issue that the researcher needed to be aware of in this study was the participant-researcher relationship. Embedded in qualitative research is the concept of relationships and power between researcher and participants (Orb, Eisenhauer & Wynaden, 2001). When seeking access to nurse participants in this study, the researcher was aware of the potential for an imbalance in her power relationship with the study participants because of the researcher's role as an educator in paediatric nursing care in Indonesia. There was a risk that some prospective participants might feel especially persuaded into accepting the invitation to be interviewed because they worked at the hospitals where the researcher had previously provided education services. Therefore, in order to reduce the risk of their feeling persuaded, prospective

participants were informed of the voluntary nature of their participation and told that they could withdraw at any time without penalty or disadvantage to themselves. Moreover, it was made clear to them that a decision to participate or not would in no way impact upon the work situation of a participant. All nurse participants confirmed that they understood this position and were willing to participate in the study.

The voluntary informed consent of research participants in this current study was important. Informed consent means that participants have adequate information regarding the research, are capable of comprehending the information and have the power of free choice, enabling them to consent voluntarily to participate in the research, or decline participation (Burns & Grove, 2007). As the participants were Indonesian, the information was written in the Indonesian language. Each prospective participant was sent a clear and understandable information sheet outlining the purpose of the study, with the assurance of confidentiality (Appendix 4), and written consent was obtained before data collection began. All prospective nurse participants had read the information sheet regarding this study and were provided with an opportunity to ask questions before data collection commenced.

The researcher ensured the confidentiality of every participant. Confidentiality is the right of an individual to have personal, identifiable information kept private (Burns & Grove, 2007; Speziale & Carpenter, 2007). Several steps were taken to ensure confidentiality. Interviews were conducted in a private space away from patients and staff. To ensure the confidentiality of the participants, their names were not used on the recording or on the transcribed data files. Instead, code names were used for the participants. Each participant was coded with a number, for example Participant #1 (P#1) and Participant #2 (P#2). The researcher used coded numbers rather than names for all participants in written reports, in order to ensure that no individual was identifiable to anyone in any publications associated with the project, other than possibly to the individuals themselves. In addition, no site details or identifying information have been included in any published material. All data were coded to ensure confidentiality but in such a manner as to allow recognition should follow-up be required. Audio-recorded interviews were transcribed verbatim and kept in a coded form. Finally, contact details for the researcher's thesis supervisor were provided to the participants. While conducting research all data were securely locked

at the researcher's office in Indonesia and returned to Australia, to the School of Nursing and Midwifery at Curtin University. On completion of the study, the researcher erased the audio-recordings to avoid identification and to ensure further anonymity of participants. De-identified transcripts have been saved on a secure share drive in the School of Nursing and Midwifery at Curtin University. All transcriptions will be stored in a secure place for seven years at the School of Nursing & Midwifery at Curtin University as per Curtin University policy (2014) regarding research data and primary material policy, and according to NHMRC (2007) guidelines. At the conclusion of this seven-year period the transcriptions will be destroyed as per NHMRC guidelines and according to Curtin University's policy on research data and primary material policy.

Finally, no physical risk to the participants was anticipated. However, it was possible that participants might have felt emotional or psychological discomfort in reflecting upon their experiences during or following interviews. Therefore, a plan for risk management included continuous assessment of a nurse participant's level of discomfort and anxiety throughout the interview, with the option of terminating the interview and rescheduling it for a later time if discomfort or anxiety occurred. In addition, nurse participants were informed that they could refuse to answer any question at any point in the interview. None of the nurse participants appeared to experience emotional distress or discomfort while participating in this study.

4.16 Chapter 4 summary

This chapter described the Grounded Theory method employed in this study. This method was chosen as the best approach to conceptualise the theoretical basis for comprehending the Indonesian nurses' perceptions and experience of managing hospitalised children's pain and to develop a theoretical explanation of the factors that influenced their pain management practice. The chapter outlined an overview of the processes of participant recruitment, data collection and data analysis that were used in this study. The setting for the study was described in order to situate the reader within the context from which the data came. The sample and the number of nurses who participated in the research were explained. The methods employed in participant recruitment were described and detailed. Data collection methods, such as semi-structured in-depth interview were discussed. The ethical implications

pertaining to this study were also discussed. The following chapter presents the findings of this grounded theory study.

CHAPTER 5

FINDINGS: THE CORE PROBLEM

5.1 Introduction

The aim of this study was firstly, to inductively explore Indonesian nurses' perceptions of and experiences with managing hospitalised children's pain, with a view to discovering factors that impacted on their ability to provide effective pain management; and secondly, to develop a substantive theory that would explain how Indonesian nurses attempted to manage the main concern experienced by them when caring for children experiencing pain in paediatric wards. A deeper understanding of the contextual issues influencing these nurses' pain management practices would enable a more comprehensive and targeted approach to better care. As such, the phenomenon of interest in this study was Indonesian nurses' experience of managing pain in hospitalised children.

In keeping with Glaserian (1978) Grounded Theory (GT), the researcher has attempted to identify the core concern/problem that the study participants experienced in their roles as paediatric nurses when caring for children in pain, and also the process that they used to resolve the problem. A total of 37 Indonesian nurses participated in this study and shared their experiences of caring for hospitalised children in pain (see Table 5.2). Nurse participants understood that an important responsibility of nurses who care for children is eliminating their pain and suffering as quickly and effectively as possible. They wished to provide effective pain care for their patients to the best of their ability. However, the reality of their practice was that nurse participants felt they were unable to provide effective pain care for their paediatric patients in the clinical setting, because of contextual conditions in their workplace. The organisational context of the hospitals impacted on nurses' pain assessment and pain management practices. This effect was juxtaposed with their need to provide effective pain care. Hence, the core concern/problem that emerged from the data was the nurses' experience of professional role tensions. The participants experienced inner conflict because although they had the desire to provide effective pain care, they were in the main unable to accomplish this objective. Their core concern/ problem of experiencing and managing role tensions

comprised two core categories: 1) barriers to pain management action, and 2) carrying out the pain management role as indicated in the following table (Table 5.1).

Table 5.1 Core Concern/Problem—Experiencing professional role tensions

Problem experienced by participants	Core categories
Experiencing professional role tensions	Barriers to pain management Carrying out the pain management role.

These two core categories that emerged from the data were causal conditions that led to the problem of professional role tensions. Nurse participants described barriers to providing effective pain management to hospitalised children, and they also described their desire to facilitate and engage in pain management, to alleviate paediatric patients' pain effectively and give maximum comfort to their patients, to the best of their ability.

The core categories were the main themes of the data that helped link the multiple sub-categories together and explained much of the data variation (Glaser, 1978). In this chapter the researcher describes both core categories, namely barriers to pain management, and carrying out the pain management role, as well as their sub-categories and properties, and these are illustrated with examples from the data. To relate each aspect of the findings to what is already known, relevant literature is incorporated throughout the chapter.

Table 5.2 Summary of the profiles of the nurse participants

Participant demographic information		
Category	Information	Number of participants
Gender	<i>Female</i>	30
	<i>Male</i>	7
Age group	<i>25–30 years</i>	6
	<i>31–40 years</i>	18
	<i>41–50 years</i>	9
	<i>51–60 years</i>	4
Highest qualification obtained	<i>Diploma in Nursing</i>	17
	<i>Bachelor of Nursing degree</i>	18
	<i>Masters of Nursing degree</i>	2
Years of experience	<i>0–5 years</i>	2
	<i>6–10 years</i>	10
	<i>11–20 years</i>	14
	<i>21–30 years</i>	9
	<i>More than 30 years</i>	2

Table 5.2 summarises the profile of the nurse participants. Most participants were female, with only seven male participants. Nursing in Indonesia is a predominantly female occupation. The age of the majority of participants ranged between 31 and 40 years old. Almost half of the participants held a Bachelor of Nursing degree, while only two had Masters of Nursing degrees. The length of time participants had been working in their present occupation varied; however, just under one-third of participants reported work experience that ranged between 11 and 20 years.

5.2 Core Category—Barriers to pain management

The findings of this study showed that all nurse participants had the motivation and desire to provide effective pain care for their patients. This motivation drove their thoughts, feelings and actions throughout the care process, and guided all aspects of their patient care delivery. However, they identified several factors, found in the hospital setting, that they considered to be obstacles to their ability to provide effective pain care for hospitalised children. The context of the organisation was perceived by nurses as a barrier to providing effective pain care for children. Context is the environment or setting in which individuals receive health care services; it

encompasses organisational culture, leadership, and evaluation (McCormack et al., 2002). Twycross and Collins (2013) have highlighted the fact that context—the environment where nursing practice occurs—acts as a barrier to achieving effective pain management practice in paediatric patients. The first core category, barriers to pain management, emerged from the data analysis in this study, as illustrated in Table 5.3.

Table 5.3 Core Category—Barriers to pain management

Core category	Sub-categories	Properties
Barriers to pain management	Structure of organisation	<ul style="list-style-type: none"> • Imbalance in nurse-patient ratio • Lack of sufficient education and/or training • Lack of organisational support
	Culture of organisation	<ul style="list-style-type: none"> • Feeling powerless • Lack of professional autonomy • Inability to advocate for patient • Lack of a team approach to pain management.

The core category of barriers to pain management consisted of two sub-categories, which comprised two main organisational constraints: the structure of the organisation and the culture of the organisation. These constraints were identified as the reasons for nurses in this context being unable to provide effective pain care, and are described in the following sections.

Participants were aware that their actions at work were not always consistent with their desires and expectations regarding acting as carers and patient advocates. The main focus for all nurses when caring for hospitalised children experiencing pain, was their desire to provide effective pain care. Nurses wanted to provide the best care possible and facilitate the wellbeing of their patients by providing adequate pain relief. These expectations of themselves resulted in many nurses interpreting their failure to provide effective pain care as ineffective nursing practice. For example:

I am a professional nurse. I have responsibility to alleviate [the] patient's pain, giving comfort, and to provide optimal pain care for all my patients. I must facilitate the wellbeing of patients by alleviating their pain. If I am

unable to reduce the patient's suffering ... I feel ineffective in delivering pain care to the patient. I realise that sometimes I am unable to provide pain care effectively. (P#28)

Several nurses suggested that caring for children experiencing pain was challenging. However, in the Indonesian hospital context, nurse participants frequently felt unable to meet this challenge and provide the necessary care to keep their patients pain-free, because of the circumstances present in their work environment. This feeling occurred when the nurses were unable to or failed to effectively relieve their patients' pain. A nurse explained:

...caring for paediatric patients in pain is something challenging... and as a nurse I have a responsibility to alleviate the paediatric patients' pain because it is a part of caring. However, because of some circumstances present in this ward, occasionally, I am not able to alleviate paediatric patients' pain effectively. (P#15)

Conditions or circumstances within paediatric wards in the Indonesian hospital setting that participants identified as reasons they were often unable to provide effective pain care, included imbalanced nurse-patient ratios; an inability to apply knowledge to clinical practice; lack of organisational support; feeling powerless, and a lack of both professional autonomy and of a team approach to pain management. Therefore, being unable to provide effective pain care became a complex phenomenon influenced by many factors connected with the structure and culture of the organisation. The following section will discuss the sub-category of 'structure of the organisation'.

5.2.1 Structure of the organisation

For the nurses in this study the structure of the organisation was an important factor affecting the delivery of paediatric patient pain care and pain management in the clinical setting. The literature has also identified that organisational structure, practice, policies and procedures may affect effective pain management in paediatric patients and are important aspects of the work environment (Carr, 2008; Ely, 2001).

For the purposes of the present study, the concept of the structure of the hospital refers to the context of the clinical-practice work environment. These factors include

nurse-patient ratios, workloads, organisational support for nursing practice, and the nursing management structure within the hospital; and hospital health resources such as access to pain assessment tools and pain management guidelines. Issues relating to the organisational structure of the hospitals—such as imbalanced nurse-patient ratios, inadequate staffing, heavy workloads, lack of sufficient education and training, lack of organisational support, lack of pain assessment tools and of pain management guidelines—added to the problem of being unable to provide effective pain care. The organisational structure impacted on nurses’ job satisfaction. Nurses considered that they were unable to control these working conditions, which impacted on their practice; as a result they were unable to provide effective pain care.

Three properties emerged from the data as being related to the structure of the organisation. These were imbalance in nurse-patient ratios, lack of sufficient education and/or training, and lack of organisational support. The sub-category of structure of the organisation is illustrated in Table 5.4.

Table 5.4 Structure of the organisation

Structure of the organisation	
Properties	Elements
Imbalance in nurse-patient ratios	<ul style="list-style-type: none"> • Inadequate staffing • Heavy workloads • Time constraints • Task-oriented nursing
Lack of sufficient education and/or training	<ul style="list-style-type: none"> • Lack of knowledge • Lack of confidence
Lack of organisational support	<ul style="list-style-type: none"> • Lack of guidelines or standard patient care • Lack of evidence-based practice

5.2.1.1 Imbalance in nurse-patient ratios

Some nurses mentioned that factors such as imbalanced nurse-patient ratios exacerbated the problem of being unable to provide effective pain care and that this had implications for both the nurses and their patients. For the purposes of this study the notion of imbalanced nurse-patient ratios referred to the number of nurses available to care for patients across three nursing shifts in the hospitals studied. The nurse participants considered that there were too few staff to effectively care for the number of patients on the wards. They explained that this situation impacted on their ability to fulfil their role and deliver quality patient care. As a consequence of the imbalanced nurse-patient ratios they perceived that their relationship with patients was negatively impacted and that they were forced to adopt task-oriented ways of working. This process in turn acted as a barrier to applying their knowledge and skills. As a consequence this situation created conflict between their perceived professional role and the roles that the organisation had imposed on them. A nurse said:

As a professional nurse I have a responsibility to provide effective care, but in this situation of unbalanced nurse-patient ratios, how can we provide effective pain care to patients? I think it is a barrier to achieving optimal pain management. (P#31)

The imbalanced nurse-patient ratios affected the quality of pain care that nurses could deliver. The literature has identified that high patient to-nurse ratios cause negative outcomes for patients and nurses (Buchan, 2009; Erlen, 2001). To discuss this aspect of care further, there are four elements that will be presented: inadequate staffing, heavy workloads, time constraints, and task-oriented nursing.

The findings of this study indicated that an inadequate staffing level was one organisational structural factor that prevented nurses from providing effective pain care. They mentioned that despite the increase in patient numbers, nurse rostering and staff numbers remained unchanged. A nurse described the difficulty of caring for many paediatric patients with a small staff:

Normally there are seven to eight nurses on the morning shift including the head nurse; for the afternoon there are three nurses, and on the night shift only two to three nurses. Meanwhile we must care for more than thirty-five

patients daily. Sometimes, on the morning shift we have only six nurses. Nurses' rostering is never changed. It is difficult to work like this. (P#15)

Nurses considered that they did not have the time to provide individualised patient care because of the high number of patients they had to care for, and as a result they prioritised routine duties into tasks. Even adopting this approach, nurses stated that they were often behind time in completing routine duties due to the number of patients and the shortage of nurses. This outcome was compounded on the afternoon and night shifts because only two or three nurses were rostered on duty, even though they were caring for the same number of patients as on the morning shift.

Participants explained that the number of nurses rostered on duty was consistent regardless of the number of patients for whom they were expected to care:

There are 40 paediatric patients on this ward and there are only three nurses on the afternoon shift. How can we provide optimal pain care to all these patients in one working shift? We don't have time to do a lot of things, we are busy. (P# 5)

Some of the nurses claimed that they were required to perform extra duties—such as administration duties, coordination and referral, pharmacy and supplies, paperwork, meals service, and supervision of junior staff and nursing students—because of the lack of staff on the ward. Moreover, the findings of this study identified a lack of flexibility in the development of nursing rosters, with nurses themselves having little say in the shifts they worked. This inflexibility in the approach to rostering resulted in participants being tired and dissatisfied as a result of work demands and a work environment in which they could not effect change. As one nurse stated:

Actually, we don't like the situation, but we cannot do anything. We have to do all duties in a shift, and sometimes we work overtime to cover the minimum staff requirements per shift. Sometimes I feel so tired and stressed. (P#15)

Participants perceived that there were not enough nurses to cope with the demands of the wards and to meet all the needs of their patients, one of these being pain relief. This situation increased tensions, role conflict and moral distress for nurses because they felt that they were unable to provide effective pain care for their patients. It also

resulted in conflict amongst nurses, adding to the negative atmosphere within the work setting. An excessive number of paediatric patients, lack of staff, and obligatory overtime left nurses feeling dissatisfied, exhausted and distressed. Therefore, inadequate staffing levels impacted on Indonesian nurses' pain management in hospitalised children.

Imbalanced nurse-patient ratios, staff shortages, and the escalation of non-nursing duties, together meant that nurses experienced heavy workloads. This was a major problem for the participants in this study and was perceived to influence their delivery of nursing care. The relative severity of their patients' conditions, work system factors and hospital management expectations were the factors that most affected the nurses' workload. Nurses were expected to perform many tasks:

Nurses on the wards have so many things to do, not only nursing tasks but also non-nursing tasks such as delivering, transporting patients, ordering, coordinating, doing paperwork and sometimes housekeeping duties. We have to have a grasp on everything and we try our hardest to get through. I realise that it is difficult to provide effective pain management. (P#7)

Data analysis indicated that the quality of paediatric patient care was directly affected by nurses' workloads. The heavy workloads made it difficult for them to focus on caring for children in pain and attending to their patients' needs:

I can't focus on caring for paediatric patients...I have many tasks to complete on this shift...I am not able to deliver effective pain care. (P#23)

Some participants identified that as a consequence of the disproportionate nurse-patient ratios and heavy workloads on the ward, they were unable to conduct effective or routine pain assessment. As one nurse put it:

I know it is important to conduct frequent pain assessments but I cannot do it routinely and adequately during busy times because I have many routine tasks and work to finish before the shift is completed. (P#10)

The existing literature has demonstrated that heavy workloads can adversely affect nurses by threatening their physical safety, decreasing their job satisfaction and

causing burnout (Aiken et al., 2002; Hart, 2003). A number of nurses asserted that they felt dissatisfied with the effectiveness of the pain care they provided for their patients. The heavy workloads made them feel tired and inadequate. As a consequence they became stressed and felt guilty as they were not able to provide what they perceived to be the best care for their patients:

You know, I often feel tired after I finish the night shift because I have to care for many patients and do many things. I am not happy with this situation and I find it very hard not being able to do anything for the patients. Sometimes I feel inadequate, stressed and guilty because I can't provide optimal care.
(P#29)

These findings indicated that there was a relationship between nurses' working conditions and their dissatisfaction arising from being unable to provide adequate pain relief for their patients. Job stress resulting from inadequate staffing and higher workloads may have a negative impact on the health of nurses. The literature has identified a link between shortage of nurses, workload, and job stress (Hall & Doran, 2007). Similarly, the participants who found themselves in this situation experienced increased job pressure, job threat, and role tensions.

Besides heavy workloads and demanding work conditions, time constraints also hindered nurses from delivering what they perceived to be holistic professional care. According to the nurses, being short-staffed meant that they had insufficient time to provide effective pain care. The nurses constantly complained of not having the available time to deliver effective pain care for their patients:

Actually, I want to be a professional nurse but sometimes I cannot provide effective pain care for patients, especially if I must complete many tasks on the ward such as ...routine tasks including non-nursing duties. I don't have a whole lot of time. (P#25)

Time constraints, because of staff shortages and increased workloads, have been argued to be the most common barrier to effective pain management (Ely, 2001; Johnston et al., 2007). The nurses in this study perceived that time constraints had other professional ramifications. That is, they were unable to dedicate themselves to any one task for an extended period of time. In addition, the nurses were aware that because of time constraints they were often unable to conduct a formal pain

assessment and apply non-pharmacological interventions to relieve pain in the way they had been taught. This situation made them feel inadequate. For example:

I know we must conduct pain assessment regularly and use non-pharmacological techniques but sometimes we don't really have a lot of time to do this, especially on an afternoon and evening shift. It makes me feel inadequate. (P#3)

Another nurse participant who mentioned time constraints as a barrier to providing effective pain care also highlighted that this affected the nurses psychologically:

It would be good if we had plenty of time to assess every patient's needs and apply non-pharmacological interventions routinely, but as you can see for yourself the ward is always busy, there are many patients...So the demands are very high. We just do not have time to provide effective pain care, sometimes it is distressing. (P#22)

Several nurse participants mentioned that they had little time to sit and talk with patients to understand the child's pain experience or problem, and as a result they were unable to provide children and their parents with information about pain relief. Nurses explained that having time for patients was important to achieving optimal pain care:

If we are busy we cannot find the time to listen to the patient's complaints of pain, but instead, we just observe the patient in a hurry. We do not have much time to sit down and listen to our patients...especially on an afternoon and night shift, because we must care for many patients while there are only three nurses on duty. Actually, we need plenty of time to provide optimal pain care for our patients. (P#10)

The findings of this study indicated that time constraints appeared to affect the ability of nurses to think critically and reflect on their practice. A nurse explained:

I must care for many patients and perform many tasks during the shift. I feel that I could do this better, but because I am in a hurry to finish all my work, I do not have time to think, and just do it automatically. (P#2)

The quotes above show that in the context of this study, time constraints clearly influenced the nurses' perception that they were unable to provide effective pain care. Nurses did not seem to be able to alter their work situation and had little control

over their practice. Therefore, they were unable to find a balance between tasks and time, or focus on the individualised holistic nursing care that they felt was required to provide effective pain care.

Due to inadequate staffing and heavy workloads, nurses delivered task-oriented nursing rather than a patient-centred model of care delivery. Task-oriented nursing is defined as the act of focusing on an activity and procedure rather than the care of the total patient (Duffield et al., 2011; Tiedeman & Lookinland, 2004). Some participants expressed frustration with their work demands; their shifts were full of different nursing and non-nursing tasks. Nurses performed many procedures and treatments for paediatric patients, but they claimed they did not have enough time to adequately assess paediatric patients' pain:

I wish to spend time with my patients, to talk with, to assess paediatric patients adequately. However, when I must conduct many nursing procedures, treatment and other non-nursing duties, umm...I can't...and sometimes I feel frustration.” (P#31)

The literature notes that the greatest barrier for nurses caring for acutely ill patients was the lack of time to adequately assess and control pain (Dowden et al., 2008).

When a limited number of nurses were working with large numbers of patients, they were required to pay attention to the entire ward rather than to the individual patient. Therefore, in these instances, nurse-patient relationships were not strong. Nurses felt that they only had time to conduct routine tasks, which were not related to individual assessment and care planning:

Because of the lack of nursing staff and the high number of hospitalised children, nurses are more focused on routine work, which forces us to provide task-oriented care especially on the afternoon and evening shift. So it is difficult for us to provide optimal pain care. (P#28)

According to nurse participants the main routine tasks on the ward included medication administration; injections; wound care; chemotherapy; specimen collection; referrals, and paperwork. Nurses felt that it was very difficult to cover all these main routine tasks within their shift:

I realise I do not have the time to provide nursing care optimally. ...sometimes I take over two hours to give out the medications. Injections and wound dressings are also like that. Then I have to give chemotherapy, make referrals and do paperwork. There are so many routine tasks that I must cover during a seven-hour shift. (P#11)

Nurses accepted that they did not have enough time to provide patient-centred or individualised nursing care, because of the heavy workloads and inadequate number of nursing staff on the wards:

We must respond to work demands by performing many duties including non-nursing tasks ... ideally we should provide individualised nursing care or patient-centred care, but due to not having enough time, and inadequate staffing, we can't, especially on afternoon and night shifts. So we focus more on completing routine tasks. (P#13)

This situation caused role tensions and conflict between the nurses' perception of their professional role and the reality of their practice setting. Many nurses experienced role conflict, which caused them to feel ineffective and led to their experiencing job stress. One participant questioned her role:

How can I be a good nurse and be able to deliver optimal pain care for the patients if I must do all of these duties? I must care for many patients, doing routine work because of the limited nurses on this shift. Sometimes I feel inadequate and stressed. (P#15)

As demonstrated in the above comments, nurses considered that they were forced to adopt task-oriented nursing in order to finish their tasks quickly and efficiently. Time pressure has been shown to direct the mode of nursing care (patient-centred versus task-centred), or minimise the time available for nurses to spend with the patient or in discussion with other professionals (Duffield & O'Brien-Pallas, 2003). Although participants wanted to provide holistic care to their patients, the situation in their workplace forced them to provide task-oriented care. These circumstances caused participants to experience role conflict and tensions, where they considered that their professional voice was compromised, as the focus of their care was task-oriented and addressed goals that emphasised doctor-prescribed care. This situation impacted on their ability to provide effective pain care for paediatric patients. As a result, they felt

frustrated and dissatisfied with their role within the health care team, and experienced job stress.

All of the previously mentioned situations affected nurses' pain management practice with hospitalised children. Excessive work demands may result in an individual being unable to cope effectively and may lead to burnout (Maslach, 2003). In this study, it can be conceptualised that patient loads, imbalanced patient-nurse ratios, high workloads, inadequate staffing and shift rostering were the stress factors that affected participants' ability to provide effective pain care, and led to adverse physical and emotional outcomes for nurses.

5.2.1.2 Lack of sufficient education and/or training

Nurses make decisions related to the assessment of pain, the administration of prescribed analgesics and the provision of non-pharmacological interventions almost daily. Unfortunately, nurses in this study did not always feel that they possessed the knowledge to make effective decisions and provide this care. Lack of knowledge about pain and its assessment and management in children has been identified in the findings of this study as one of the barriers to providing effective pain care to hospitalised children. The literature has also suggested that lack of knowledge about pain, pain assessment and its management in children has been identified as one reason paediatric nurses are unable to provide effective pain management (Blondal & Halldorsdottir, 2012; Taylor, 2010).

The nurses in this study readily acknowledged that they had inadequate training and preparation to effectively manage their patients' pain, and this was the main reason for their being unable to provide effective pain care:

I suppose many nurses lack educational preparation about pain and its management. I think our academic education at diploma and degree level does not prepare students to conduct pain assessment and management adequately because we have only received the knowledge in brief. (P#31)

Nurses identified that there was a lack of focus on pain assessment during their nursing diploma course. Many participants mentioned that the content of the Indonesian nursing diploma curriculum was a barrier to their providing effective pain

care. This statement could suggest that because they had been trained for a general role, pain management was covered, but not in the detail required to take on this specialised role in paediatrics. As a result, nurses found it difficult to increase their knowledge of pain, pain assessment, pain care and pain management, and pharmacological interventions. One participant said:

As long as I have been working in this hospital I have never attended a course or training about pain management because the hospital has not provided training for pain management in children. I have only basic knowledge based on my education and experience and I am aware that my knowledge of pain assessment and pharmacological intervention is still limited. (P#12)

A nurse who had attended training related to palliative care explained that she had got some introductory knowledge about cancer and pain management but it was very limited. In addition, this training had focused on pain management in adult patients so she did not learn how to assess pain in the paediatric context, nor did this training session teach her about pain assessment tools. She noted that she needed more knowledge about pain assessment skills and the basic knowledge and principles of pharmacological pain management for children:

The training was useful for nurses in helping them to practise in the adult wards. Actually, we need more knowledge about pain assessment skills and basic knowledge and principles of pharmacological pain management for children. (P#9)

This lack of knowledge resulted in nurses lacking confidence to contribute to the discussions of pain management with doctors. According to participants, to provide effective pain relief, doctors and nurses need to work collaboratively in managing pain for their patients. However, in practice nurses just followed the doctor's orders because of their own perceived lack of authority:

I realise my knowledge about pain and pain therapy is still limited, especially about basic pharmacokinetic and analgesic agents, compared to the doctor's knowledge, because this information was not provided in detail when I undertook the diploma of nursing course. So I feel hesitant and lack confidence to discuss pain treatment with a doctor even when I know that the medication was not effective in reducing the patient's pain. I just follow the doctors' orders because I do not have authority. (P#1)

In most cases, the participants lacked self-confidence, a feeling brought on by a deficiency of knowledge about pain assessment skills and pharmacological pain management. These sentiments caused nurses to feel powerless and experience role conflict, and led them to consider that they were unable to collaborate with doctors and could only follow orders. This consequence further compounded their lack of collaboration with medical staff. In addition, the findings of this study have indicated that because of their lack of knowledge and understanding regarding pain management, the nurses were unable to perform effective pain assessment and management practices. From the findings there emerged a picture of nurses lacking knowledge regarding pain management in paediatric wards.

5.2.1.3 Lack of organisational support

Nurses in this study perceived that one barrier to providing adequate pain management for paediatric patients was the lack of support from the organisation. The participants characterised, 'support' mainly as managerial support. The nurses commented that they were not supported by the nursing and managerial system in the hospitals. Participants in this study considered unsupportive managers to be a barrier to their providing optimal pain assessment and to management of children's pain in the paediatric ward setting. One way this lack of support manifested itself was through the nurses' perception that organisational management did not provide them with the resources that could enable them to effectively manage children's pain. These resources included pain assessment tools, pain management guidelines, and standard operational procedures (SOPs). In addition, all nurse participants reported that no SOPs for pain management in paediatric and adult patients existed within the hospitals. Therefore, the nurses indicated that this lack of standardised patient pain care, including clinical guidelines for pain assessment and management, constituted a barrier. This belief influenced how they applied their knowledge in practice:

The tools for measuring pain are not available on the ward. Moreover, we do not have standard procedures for pain assessment and management. So that way, many nurses do not know how to do pain assessment theoretically. Many of us do pain assessment without using pain assessment tools for measuring pain. We are working without guidelines. Actually, the nursing manager must provide adequate facilities. (P#18)

This belief also meant that nurses in this study felt that they were not able to provide effective pain care because of the absence of official directives or reinforcements from the hospital organisation to help them perform this aspect of their role. It would appear from the findings that these participants had a strong sense of an external locus of control where they felt that the care they provided and any changes to care needed to be directed from higher up within the organisation. 'External locus of control' refers to the belief that chance, managers, organisations and other persons have greater power to make decisions and influence outcomes (Karimi & Alipour, 2011). According to Hsu (2011) people operating with a sense of external locus of control believe that their failures or successes are dependent on others and not on their own efforts.

This finding is potentially connected to the current absence of a regulatory body for nursing within the Indonesian context, and the absence of an official scope of practice. It would seem that, for nurses to work confidently within the clinical setting, their scope of practice needs to be clearly delineated. Similarly, the absence of SOPs and job descriptions within the hospital setting could conceivably affect how Indonesian nurses construe the limits of their role.

In developing countries such as Indonesia, where health care resources are scarce, the use of evidence-based practice is essential. The use of evidence-based practice is known to improve clinical care and patients' outcomes (Melnyk et al., 2004). Nurses in this study talked about the need to use evidence to support the provision of effective pain care. However, they emphasised that it was the role and responsibility of organisation managers to provide them with the evidence, rather than that they should discover it for themselves. The traditional nursing cultural value of 'doing' was still found to continue in this clinical practice setting (Makic, Martin, Burns, Philbrick, & Rauen, 2013). Study findings indicated that daily practice in nursing care was influenced more by tradition, intuition and experience than by scientific evidence. All nurse participants reported that they were unable to apply scientific evidence to their daily clinical practice, as they were time-poor owing to the demands of providing care and completing routine tasks. This left them no time during the work day to access published medical and nursing research reports to help

inform their care practices. In addition, the hospitals did not provide facilities for nurses to have access to free Internet services to assist with searching for evidence to support and guide practice. As one participant saw it:

Nurses are not influenced by evidence from research. Instead we are influenced by experiences, habits and basic knowledge that we got when we studied at nursing schools a few years ago. Ideally, to provide quality of pain care for paediatric patients we should use current research findings because knowledge and research is continually developed and managers must provide for all our needs. (P#19)

Again, as can be seen from the quote above, these participants felt that people higher in the organisation had a responsibility to assist with their lack of knowledge and to direct and sanction the care that they provided. Thus a lack of management support played a highly influential role in the development of frustration levels experienced by nurses. Not having access to resources or equipment necessary to do the job properly, or sufficient staff to cover a shift safely, created stress because it hampered the nurses in their ability to adequately and safely meet their responsibilities to provide effective pain care:

Sometimes I feel frustrated because I know what I have to do to assess and manage patients' pain effectively but because of the lack of facilities, such as pain assessment tools, I feel unable to fulfil my responsibility to provide optimal pain care. (P#31)

As demonstrated in the above comments, nurses emphasised that lack of support from nursing managers and the organisation was a reason they were unable to provide effective pain care. They stated that they had limited access to resources and they felt that pain assessment tools such as management guidelines would assist them in managing patients' pain. In addition, because they faced time constraints in their workplace, they felt unable to spend time locating evidence that might assist them to better manage their paediatric patients' pain. They considered the hospital organisation an important factor that prevented them from fulfilling their role in delivering patient pain care.

5.2.2 Culture of organisation

The findings of this study revealed that the culture of the hospital organisation was another important factor affecting nurses' participation in making clinical decisions on pain management. Organisational culture can be viewed as the unique pattern of shared values, attitudes, beliefs, rituals, principles, socialisation, norms and rules (both written and unwritten), expectations, and assumptions of the employees in an organisation (Hellriegel et al., 2004; McCormack et al., 2002). In this study 'organisational culture' referred to the shared values and expectations that influenced how nurses on paediatric wards performed their work, perceived their roles and interacted with each other. When the nurse participants considered the organisational culture in their workplace, they were thinking about the complex set of values, attitudes and ways of viewing the organisation.

The culture of the organisation emerged in the narratives as a barrier to providing effective pain care. One such organisational element was the hierarchical structure of nursing in the Indonesian context, historically derived from the medical model. In addition, the organisational culture was seen in the expectations that management had of the rituals and daily routines that were carried out by nurses. Nurses perceived the nature of 'task-oriented nursing' as a deterrent to the optimal delivery of paediatric patient care. They identified the culture of the organisation as the reason they lacked power and professional autonomy and nursing was not valued in the workplace. The nurses considered that they had no control over these conditions and that this impacted on their practice. As a consequence of this poor organisational culture they were unable to provide effective pain care.

There were four properties related to the culture of the organisation. These were being powerless, the lack of professional autonomy, being unable to be a patient advocate, and the lack of a team approach to pain management. The sub-category of culture of the organisation is illustrated in Table 5.5.

Table 5.5 Culture of the organisation

Culture of the organisation	
Properties	Elements
Feeling powerless	<ul style="list-style-type: none"> • Power imbalance between doctors and nurses • Lack of confidence • Lack of control
Lack of professional autonomy	<ul style="list-style-type: none"> • Not having a voice in decision-making • Lack of authority • Nurses' role is not visible • Physician-centred atmosphere
Being unable to be a patient advocate	<ul style="list-style-type: none"> • Medical dominance • Lack of managers' support
Lack of a team approach to pain management	<ul style="list-style-type: none"> • Medical-model dominance • Lack of collaboration with doctors

5.2.2.1 Feeling powerless

Feeling powerless was a property connected to the sub-category of culture of the organisation that was identified in the data. Although feeling powerless is presented here as a stand-alone category, it is important to note that all of the factors identified in the culture of the organisation contributed to the participants' perceptions of feeling powerless. This feeling was reported to affect the nurses' perceived ability to provide quality care, and contributed to moral dilemmas among nurses. When they sensed that they were unable to provide effective pain care, they also felt that they were letting the patient down, which led them to feel inadequate and powerless. Here a nurse explicitly expressed this feeling of powerlessness:

When I can't alleviate a paediatric patient's pain I feel that I am letting the patient down. I feel inadequate and powerless. (P#9)

Participants felt powerless because of their perceived lack of knowledge, authority and professional autonomy when making patient care decisions. This was due to

cultural organisational elements such as the medical dominance in delivering patient care, which contributed to nurses experiencing powerlessness (Manojlovich, 2007). Participants felt that working under medical direction oppressed nursing development and therefore contributed to their feelings of powerlessness.

The findings of this study identified that there was a power distance between nurses and doctors within the study context when delivering paediatric patient care. 'Power distance' in this context related to the way in which the nurses perceived that the power was distributed and the extent to which they (the less powerful) accepted that power was distributed unequally (Stanley & Swann, 2005). The power imbalance between doctors and nurses led to nurses feeling powerless and affected their ability to provide effective pain care. Doctors were perceived as having a major role in the hospital management system because they were the key people who made decisions within this system. Moreover, the nurses explained that the culture of the organisation relied on a hierarchical structure congruent with a medical model. They felt subordinate to doctors, and often considered that they were not heard and had no impact on decision-making, and they therefore considered that they had to follow the doctor's orders, as evidenced by the following participant's statement:

The doctor has power, while the nurse must obey and follow the doctor's decisions, including when caring for paediatric patients in pain. We can't control this situation; sometimes I feel undervalued and frustrated because we do not have power. (P#4)

According to a few nurses, they were so busy carrying out the doctor's orders that they were not seen as an equal professional in the care of patients:

Until now, many nurses only obey the doctor's orders, administer the drugs, do injections, monitor the patient's condition and write the nurses' notes, but we do not intervene independently. We are like robots. I know, the decision-making for drugs and non-drugs is not ours. We are restricted to what the doctors order, we can't discuss with them about pain relief. (P#18)

Their perceived inability to provide effective pain care resulted in their feeling frustrated, undervalued and powerless. Here a nurse explicitly expresses her feeling of powerlessness:

I had administered paracetamol as per the doctor's order to alleviate the patient's pain but the patient was still having pain. I knew the medication had not worked well so I reported that to the doctor and asked him to prescribe another analgesic which was more potent, but the doctor just said please follow my instructions, and I couldn't get any further. That makes me so powerless, and I felt guilty about my patient because I was not able to reduce their suffering of pain as well. (P#14)

The nurses felt that they worked in an environment that supported the culture of medical dominance. They believed that this situation impacted on their ability to fulfil their professional role, because they were directed by the medical profession's decisions in delivering paediatric patient care. Historically, hospital culture has been characterised by images of the nurse as a 'handmaiden' operating within a patriarchal environment (Kelly, 2006, p. 23). Organisations fashioned to be hierarchical do not foster a culture of professional collegiality (The Center for American Nurses 2008). This culture causes nurses to feel powerless (Kelly, 2006; The Center for American Nurses, 2008).

The findings of this study indicated that limited knowledge about pain medication, including doses, drug action and the side effects of analgesia, influenced nurses' actions in managing patients' pain and was one reason for nurses stating that they lacked confidence and felt powerless. According to Blondal and Halldorsdottir (2009) it is important for nurses to know their own potential and believe in themselves, since personal and professional knowledge, and experience, create a sense of self-confidence and increased empowerment, enabling nurses to follow their own convictions. The nurses in this study were reluctant to speak up during the decision-making process related to pain management because they felt that they lacked confidence and competence to discuss or argue with the doctor for or against, due to their limited knowledge of pain therapy:

Doctors never ask or discuss with us our opinions about pain therapy. Maybe they think our knowledge of pain therapy is not good. I know my knowledge is still limited compared to the doctor's knowledge, therefore I do not have enough capability to speak up, or make a comment. I lack competence to discuss or argue with doctors due to my limited knowledge about pain therapy. (P#9)

This situation of being unable to collaborate with medical staff to alleviate the paediatric patient's pain caused the nurses to feel powerless because they were unable to assist the child. When they were unable to do what was best for their patients they felt inadequate:

I feel inadequate when I cannot relieve the patient's pain because I am not able to discuss with the doctor and ask about pain therapy. I realise my knowledge about analgesia is still limited compared with the doctor's. I feel hesitant and lack confidence to discuss with the doctor. (P#31)

Furthermore, the nurses perceived that when they lacked knowledge in a particular situation or area, they were less confident about collaborating with doctors or other health professionals in clinical judgements and as a result were unable to provide effective pain care for their patients. This feeling was expressed by the head of a nursing department:

It is hard to make decisions if we have limited knowledge. This situation makes us feel helpless and powerless and of course this situation will influence our role. We cannot provide optimal care for the patient. If we have rich knowledge we can collaborate with other health professionals because we have confidence to do it, we have power. (P#36)

Nurses' knowledge deficit about pain and its management impacted on their ability to empower themselves and to take control of their practice; and it created a lack of confidence in their own ability to collaborate with doctors in order to make clinical judgements about pain management. This situation led them to feel powerless because of their limited knowledge. This set of circumstances resulted in their believing that they were not able to fulfil their professional role in providing effective pain care for paediatric patients.

Nurse participants perceived that the management structures within the hospitals remained unchanged due to the complex working environment. They mentioned that nurses continued to work in complex and unpleasant environments, dominated by medical views, with minimal acknowledgement of the value of nursing. As a result they were less satisfied with their jobs. One participant explained:

The management structure of the hospital, which is medical dominance and minimal acknowledgement of the value of nursing, is still unchanging. We

must work to fulfil the organisation's demands in a situation with inadequate staffing and facilities, lack of time, lack of support and lack of autonomy because we are working under medical direction. It is an unpleasant working environment. (P#18)

Nurses reported that their workplace was a reason explaining why they felt dissatisfied, inadequate, and undervalued. They experienced role conflict when they were expected to sacrifice their own plans and needs for the demands of work rosters. The nurses considered that they were unable to control these conditions. The nurses' perceptions of the lack of control over pain management practice led to decreased motivation and to feelings of tiredness and ineffectiveness. This in turn created a professional dilemma, as they were not able to adequately care for their patients:

I have responsibility to care for many patients whilst doing many routine tasks due to inadequate staffing. I must face and deal with this situation. Actually, I can't control these conditions. Sometimes I feel ineffective, tired, lack motivation and experience self-conflict because I can't provide optimal care for my patients. (P#2)

Some nurse participants expressed the belief that they lacked the control to effect change in their workplace and also said that they feared the consequences if they tried. They believed that their voice was not heard by hospital nursing managers. One participant commented:

I think it is difficult to have a voice to get some action. I do not know the way. I wish to complain about our working conditions here, but I am afraid it will affect my job. (P#23)

The nurses experienced a lack of control in the workplace when caring for hospitalised children in pain, due to the hierarchy of medical dominance and the minimal value given to nursing within this context. This situation created professional distress and role conflict for them as they felt undervalued, inadequate and dissatisfied with their working conditions. This situation impacted on their ability to provide effective pain care for paediatric patients. Having control over the context of nursing practice is essential and represents another type of power that nurses need in delivering nursing care (Kramer & Schmalenberg, 2003; Liaschenko

& Peter, 2004). It is important that nurses be more meaningfully involved in the running of hospitals to assist in achieving this (McClure & Hinshaw, 2002).

5.2.2.2 Lack of professional autonomy

Professional autonomy means having the authority to make decisions and the freedom to act in accordance with one's professional knowledge base (Skar, 2010; Weston, 2008). According to this definition, nurses are considered to be professionals and with this designation come the power and responsibility necessary to exercise autonomy within their designated scope of practice (Liaschenko & Peter, 2004). One aspect of autonomy that was missing for the nurse participants was their independent and interdependent (collaborative) involvement in pain management decisions. The nurses wanted professional autonomy to make decisions regarding how best to implement the most appropriate nursing care, based on their professional knowledge and experience. However, they felt that they lacked professional autonomy and control over their practice within this context.

Nurses considered that they lacked authority to control or influence institutional practice and that their professional opinions often were not valued within this context. Therefore, they frequently doubted their own ability and their status as nurses, and were unsure about their professional autonomy. They perceived that they did not have a voice in patient care decisions. When their autonomy was threatened or removed, nurses experienced powerlessness and dissatisfaction, all of which exacerbated the state of being unable to provide effective pain care. As one nurse explained:

Nurses still do not have the authority to make decisions about pain treatment. Only doctors do it; they do not involve nurses to give their opinions about therapy. Doctors always wish nurses to follow their orders. Actually, as professional nurses we should be involved in making decisions because we have the same responsibility to provide optimal care for our patients. Sometimes I wonder whether nursing is a profession or a job. This situation makes me felt powerless. (P#18)

Although the nurses considered themselves professionals, in reality, within this context, they were unable to act autonomously, and as such were unable to fulfil the requirements of their role. The reason that the nurses felt undervalued was that they

lacked autonomy in making decisions related to the culture of the organisations in which they worked. As a result many nurses found their work situation physically and emotionally draining. Moreover, they claimed it was fraught with professional dilemmas as they were not able to provide patients with optimal care, and as a consequence their commitment to the profession was undermined.

Nurses perceived that they were unable to act upon their own practice ideals, especially when these conflicted with the values of the doctors. A major consequence of this was that the nurses had difficulty reconciling treatment plans for patients when they thought the prescribed treatment was not effective. Within the organisation's culture, doctors had authority over pain treatment plans. As such, many participants followed the doctor's instructions and orders, although they believed that they should be part of the pain decision-making and management process. This in turn resulted in their belief that they were ineffective and powerless, which led to feelings of frustration and hopelessness because of their perceived failure to provide effective pain care:

“Regarding treatment, we are not involved in making decisions, because of the doctor's authority. Even when I know that the pain therapy are not effective in reducing the patient's pain and ask the doctors to change the treatment. But some doctors just say, 'please follow the orders'. I think I should have autonomy as a professional nurse to ask doctors about medications. I cannot do anything. I feel frustrated and hopeless because I can't alleviate the patient's pain. (P#15)

When the nurses were further questioned about their participation in the decision-making related to pain treatment plans, they explained that although they had an important role in caring for the patient during hospitalisation (including pain management), they considered that the nurse's role was invisible in the health care setting and not powerful like that of the doctor. They mentioned that a number of the doctors considered that they had the final authority over all patient care decisions and treatment recommendations. Therefore, it appeared that medical dominance still occurred in the clinical practice setting and some nurses were still treated as the doctor's helper, with little or no authority of their own. One nurse remarked:

I suppose that the nurses' role in managing children's pain is important. However, I believe the nurse's role is not visible and powerful like doctors

because we still lack knowledge and confidence. Even some nurses still assume that they are only the doctor's assistant and some doctors still have the perception that nurses are their helpers. Therefore, many nurses only follow the doctor's orders. (P#19)

Some nurses questioned their own professional role and identity and felt less confident about their profession when they considered that they were not listened to or heard by physicians:

Sometimes, it makes me question myself about the nursing profession. Is it because we are only nurses and they are doctors? (P# 4)

The findings of the study revealed that because the nurses lacked professional autonomy, they were not able to raise their status and professional identity, define their area of expertise, or have influence or hold control over their professional practice. This contributed to their feeling powerless within the health care team and the clinical setting. There were a number of circumstances that led to this outcome, including the physician-centred culture of the hospital:

I think nurses should have latitude to participate in making decisions related to pain management, to be able to do what I can do for my patient, and we must have the right to have our voice heard. But certain conditions in the hospital have restricted us. Physician-centredness is still dominant. (P#23)

Nurses in this study considered that they had no real autonomy because of the perceived oppressive and patriarchal conduct of the physicians. For a few nurses the lack of autonomy caused emotional conflict and distress. Nurses in some situations lost confidence and felt frustrated and uncertain, and were unable to provide optimal pain care. As one participant put it:

I feel frustrated and uncertain about my role in caring for patients, due to us not having the authority to decide something. We can't work independently... keep waiting for doctor's instructions. (P#15)

The organisational culture influenced the nurses' ability to use their professional autonomy in delivering quality patient care. They felt unable to deliver the quality of pain care they believed was required. In addition, they faced a values conflict with

doctors and these situations led them to feel powerless and lack confidence in delivering quality patient care.

5.2.2.3 Being unable to act as a patient advocate

The role of patient advocate is not new for nurses (Negarandeh, Oskouie Ahmadi, Nikravesh, & Hallberg, 2006). Advocacy is a philosophical principle in nursing and is embedded in nursing practice (Vaartio & Leino-Kilpi, 2004). Advocacy is a social responsibility of nurses (Primomo, 2007), and part of the professional nurse role (Negarandeh et al., 2006). Therefore, it is not surprising that participants in this study perceived that one of their roles was to act as a patient advocate. The advocacy role included informing and educating, valuing and respecting, supporting, and promoting continuity of care for patients. For example:

Pain is a nursing problem. It is our obligation as a patient advocate to alleviate the patient's pain, giving comfort, educating the patient and family and providing continuity of care. (P#28)

Acting as an advocate required the nurse participants to act as an intermediary between patients and doctors and accept responsibility for helping the patient to obtain appropriate health care outcomes. The nurses perceived that the role of patient advocate was very important. However, participants perceived that their advocacy role was not visible in comparison to that of the doctors because the structure and culture of the organisation was still physician-centred:

The nurse's role in pain management is important. We should provide optimal pain care, which includes acting as patient advocate. However, our role is still not visible compared to the doctors. (P#4).

Nurses acknowledged that patient advocacy was an important role for their practice, but in practice, acting as an advocate was often a difficult role for the nurse to perform. The nurses explained that they lacked confidence to speak up because they considered that on occasions the doctors did not value their opinion. Some nurses felt that they became entrapped in situational dilemmas when they had insight into the problem at hand but they lacked the professional authority or knowledge to make decisions:

We are working together when caring for patients in pain, but when I know that there has been inappropriate treatment, I lack the confidence to speak to the doctors because sometimes they do not listen, and wish us to follow their instructions. My knowledge about pain treatment also is limited compared to the doctor's. (P#2)

Furthermore, some of the nurse participants in the study did not feel comfortable, were passive and lacked the confidence to speak to doctors on behalf of the patient, or ask about alternative modes of treatment. This was especially significant when the doctor was a specialist, because the nurses considered that specialists were very powerful. The nurses claimed that they felt powerless with regard to going against the doctor's decisions, and this situation also led to inadequate pain relief:

I realise that it is very hard to talk on behalf of the patient, even when you have good knowledge of the matter. I think it is usual here to not discuss with doctors regarding the treatment especially if the doctors are doctor consultants or doctor specialists. Usually, nurses just follow the doctor's instructions or wait for the doctor's orders. (P.18)

The participants noted that they were on the front-line of care compared with other health professionals and as such their advocacy role was essential. They were responsible for the appropriateness and coordination of patient care, including the oversight of potentially conflicting treatment and medications. However, it was revealed in the data that nurses worked in an environment that supported the culture of medical dominance. Participants believed that medical dominance was an important factor that made it difficult for them to act as a patient advocate. The perceived oppression by doctors and lack of control over patient pain management decisions was influenced by nurses' knowledge deficit and lack of professional authority. Consequently, they considered themselves to be inadequate as patient advocates, as they were not able to influence pain management decisions. This situation made them feel ineffective in and dissatisfied with their working conditions:

I think the nurse has the largest part in patient advocacy, but the role is not considered yet here because of the physician-led system here. All decisions about patient care are in the doctor's hands. Nurses must follow the doctor's instructions, especially about treatment planning. We are not able to be involved in pain management decisions. I feel ineffective and dissatisfied with working conditions like this. (P#15)

The nurses felt that their medical colleagues and nursing managers did not support them in the role of patient advocate. As a result, they confronted a professional dilemma where they experienced role conflict and role ambiguity, which impacted on their ability to provide effective pain care for paediatric patients.

5.2.2.4 Lack of a team approach to pain management

Teamwork refers to the interaction or relationship of two or more health care professionals who work interdependently to provide patient care (Borrill, West, Shapiro, & Rees, 2000) and has been shown to be essential for the delivery of effective health care services (Forte & Fowler, 2009). However, the nurse participants in this study highlighted that the organisations in which they worked did not have a teamwork approach to pain management. They identified that the lack of a team approach to pain management was another factor that contributed to their being unable to provide effective pain care:

I suppose the hospital has not yet established a team approach for pain management. This is essential actually. (P#28)

Nurse participants perceived that despite all their efforts to collaborate with doctors, little had been gained for nursing in Indonesia, and there was still no real partnership or team approach to decision-making related to pain management. One participant explained:

We have tried to collaborate with doctors about patients' care. But sometimes it is difficult to perform because we are not working as a team, we are still nurses and they are still doctors, it is difficult to change... (P#9)

This lack of collaboration resulted in conflict for nurse participants as they felt professionally bound to follow physicians' directives; as a result they felt undervalued and experienced role conflict. The findings demonstrated that the existing hierarchy within the organisations in this study's context continued to position nurses as doctor assistants or 'handmaidens'. Furthermore, a lack of collaborative professional practice between nurses and doctors remains, within the Indonesian practice setting. These factors impacted on the nurses' professional role

in delivering patient care and as a result created role conflict for them. Nurses perceived this situation as a barrier to providing effective pain care.

The following section will now describe the second core category that emerged from the data, called ‘nurses’ perception of the role’. This category explains the nurses’ perspective of their role in pain management in the clinical setting when caring for hospitalised children in pain.

5.3 Core category—Carrying out the pain management role

In this study, carrying out the pain management role was another core category that emerged from the data. Findings showed that when the nurse participants talked about ‘providing effective pain care’, they referred mainly to their motivation to facilitate and engage in pain management practices that alleviated pain and gave maximum comfort for their patient, to the best of their ability:

‘As a nurse I have professional and personal responsibility to provide optimal pain care for my patients who are experiencing pain. I always try to do my best to reduce the paediatric patients’ pain when caring for paediatric patients who are experiencing pain. (P#30)

Nurses in this study realised that on most occasions they were unable to provide effective pain management, and acknowledged the difficulties they faced when caring for hospitalised children in pain. Furthermore, they were aware that many of the conditions present in their work environments were not easily resolved and how these in turn made them experience role tensions and decreased their job satisfaction. However, even with this knowledge and understanding they continued to hold positive attitudes and maintained their aspiration to provide pain care and give comfort and psychological support to their patients to the best of their ability. Although they were aware of their own limitations and those of the organisation they were able to reflect on the occasions that they were successful in managing pain, and provided strategies that could be implemented in the future to overcome the difficulties that they had identified.

The core category of carrying out the pain management role consisted of three sub-categories: nurses’ values and attitudes towards pain management; nursing care

related to pain management, and suggestions to improve nursing practice in the context of pain management. The core category of carrying out the pain management role, together with its sub-categories and their relevant properties, is illustrated in Table 5.6

Table 5.6 Core Category—Carrying out the pain management role

Core category	Sub-categories/Strategies	Properties
Carrying out the pain management role	Nurses' values and attitudes towards pain management	<ul style="list-style-type: none"> • Desire to alleviate patient's pain • Wanting the best for the paediatric patient
	Nursing care related to pain management	<ul style="list-style-type: none"> • Accepting caring responsibilities • Assessing pain • Preparing patients for a painful experience • Administering analgesic drugs • Providing non-pharmacological intervention • Involving parents in managing pain • Seeking support from nursing colleagues
	Suggestions for improving nursing pain management	<ul style="list-style-type: none"> • Empowering nurses to provide effective pain care • Gaining professional autonomy • Increasing knowledge and skills.

5.3.1 Nurses' values and attitudes towards pain management

Nurses in this study were motivated to engage in pain management practices and attempted strategies to relieve pain because of the values and attitudes they held toward their patients. Attitudes are the values nurses hold, and include their thoughts and feelings about how professional nurses should act (RCN, 2013). The core values

expressed by nurses in this study related to their professional responsibility to alleviate pain.

The findings of this study showed that during caring episodes the nurses demonstrated compassion and commitment to their patients because they felt they had a professional responsibility to provide effective pain care. They had good motivation and a genuine desire to engage in practices that they hoped would alleviate the patient's pain to the best of their ability. They asserted that paediatric patients had a right to access the best possible pain care available to them:

Reducing paediatric patients' pain is an essential part of our role as nurse professionals to provide the best possible pain care for such patients. All paediatric patients have the right to get the best pain care. (P#24)

They said that relieving pain was an important component of caring for hospitalised children. Thus, they always tried to reduce paediatric patients' pain:

I always try to alleviate paediatric patients' pain because it is part of our professional and personal responsibility. I know that relieving patient suffering and pain is an essential component of caring for paediatric patients. (P#25)

There were two properties related to nurses' values and attitudes to pain management, namely a desire to alleviate the patient's pain, and wanting the best for paediatric patients. The sub-category of nurses' values and attitudes to pain management is illustrated in Table 5.7

Table 5.7 Sub-category—Nurses' values and attitudes towards pain management

Nurses' values and attitudes towards pain management	
Properties	Elements
Desire to alleviate patient's pain	<ul style="list-style-type: none"> • Feeling a personal responsibility to provide effective pain care
Wanting the best for the paediatric patient	<ul style="list-style-type: none"> • Desiring that the patient feel better • Hoping the patient's pain improves.

5.3.1.1 Desire to alleviate the patient's pain

Managing children's pain is an important element of paediatric care (RCN, 2013). Nurses are bound by their professional code of ethics to alleviate children's pain by demonstrating correct behaviour and adequate knowledge (RCN 2013, 2008; Gimpler-Berglund et al., 2008; Olmstead, Scott, & Austin, 2010). Nurses in this study had a strong desire to alleviate any pain experienced by their paediatric patients. This motivated them to do their best within the context of their work environment and personal challenges. Providing pain care to the best of their ability was integral to the patient's wellness and was strongly aligned with their feeling a personal responsibility to alleviate paediatric patients' pain. This responsibility motivated their care and they persevered with trying to provide pain care to the best of their ability despite the difficulties that they encountered in their workplace. Personal responsibility was linked with the nurse participants' role as carers. In this study context, caring was often unquestioned and accepted as part of their responsibility as a professional nurse:

I have personal responsibility as a carer to provide pain care to paediatric patients. So I always try to facilitate the patient's wellbeing by providing pain care to the best of my ability although I face some difficulties in the workplace. It is part of a nurse's role as a professional and I accept that.
(P#28)

This sense of professional and personal responsibility was grounded in the nurses' knowledge base and experience, and fostered genuine care and concern for the

patient. All nurses in this study believed that pain management was a primary and important role of the nurse. They attempted to commit the time, effort and skill to their provision of care, even though they often faced constraints and challenges in fulfilling their desire to alleviate patients' pain:

I have a responsibility to alleviate paediatric patients' pain and I always try to do the right thing to provide effective pain care based on my knowledge and experience, although I face some constraints such as limited facilities for pain assessment. (P#18)

According to several nurses the motivation to reduce patients' pain influenced their thoughts, feelings and actions throughout the care process. This in turn resulted in their experiencing tension between what they wanted to achieve and the actuality of the care environment. Nurses felt empathy for their patients and as such wanted to help them relieve their pain or improve their level of comfort. Participants thought about the paediatric patient's pain even when off-duty and away from the child in question, indicating how strongly this desire to alleviate pain was felt. These thoughts influenced the decisions they made about what they had to do and how they tried to manage within their work environment to alleviate paediatric patients' pain:

... when I know my patients' pain is still present and they are still suffering and keep crying, even though I have given analgesics as per doctor's orders and used distraction techniques, I feel empathy toward them because I know they are suffering with pain. Sometimes, when I am away from the patients I cannot stop thinking about them, so that way I always try to give them comfort, alleviating the patient's pain by using non-pharmacological interventions and reporting the patient's condition to doctors and asking whether the doctor will give other analgesia for reducing the patient's pain. (P#30)

The nurse participants highlighted how they tried to alleviate the patient's pain and they often expressed the desire to do as much as their ability and time would allow:

I wish to reduce the patient's pain as soon as possible and provide comfort to paediatric patients. I always try to reduce the patient's suffering as best I can, even though I have limited time and face a high workload on the ward. (P#31)

It was evident from the participant quotes that they had a desire to alleviate the pain that their paediatric patients experienced. Findings indicated that the nurses in this study had strong motivation and a need to give the very best care to hospitalised children experiencing pain. The participants felt a professional and personal responsibility as well as a willingness to alleviate their paediatric patients' suffering and to give comfort to the best of their ability.

5.3.1.2 Wanting the best for the paediatric patient

The findings of this study indicated that when caring for their patients, the nurses tried to work towards achieving the best for each patient they cared for. Wanting the best for the paediatric patient involved hoping that the child's pain would be alleviated and that they would make a full recovery. The nurses wanted their patients to feel better, be comfortable and unstressed:

I cannot see the patient suffering with pain and I always wish to reduce his suffering as soon as possible. I want to see the patient free from their pain, so that they can enjoy life and play during their hospitalisation. (P#28)

Nurses hoped to see improvements and tried their best to engage in pain management strategies to alleviate paediatric patients' pain. These strategies included administering medication as per the doctors' orders as well as providing non-pharmacological interventions:

I always want to see improvements in the patients' pain condition because if their pain is still present they will cry all the time and they cannot sleep well. So I try my best to alleviate the patient's pain by giving them analgesia as per doctor's orders and using distraction techniques. (P#29)

Nurses in this study really paid attention to and wanted to alleviate their paediatric patients' pain. Providing the best possible care involved ensuring all was done to alleviate the pain and provide comfort. When this outcome was achieved participants experienced a feeling of satisfaction with the care they provided.

5.3.2 Nursing care related to pain management

Nurses in this study realised that they were rarely able to achieve their goal of providing effective pain care; as a consequence of this finding they experienced role conflict, job stress and dissatisfaction. The reasons for their inability to provide effective pain care have been described in the previous section. However, a few nurse participants mentioned that on occasion they had been successful in alleviating the patient's pain. This success was attributed to their engaging in pain management practices, to the best of their ability, and this outcome was a potent way to increase their job and personal satisfaction, and also the paediatric patients' level of comfort. Therefore, the second sub-category—nursing care related to pain management—emerged from analysis of the explanations from those few nurses who had, on occasions, successfully provided nursing care for paediatric patients experiencing pain. Providing effective pain management for hospitalised children is an important aspect of paediatric patient care, and relevant to all nurses (Hockenberry & Wilson, 2007; Ladak et al., 2013; McCleary et al., 2004).

The findings of this study identified that there were seven properties that emerged in the sub-category of nursing care related to pain management. These were: accepting caring responsibilities, assessing pain, preparing patients for a painful experience, administering analgesic drugs, applying non-pharmacological interventions, involving parents in caring for their child, and seeking support from nursing colleagues. The sub-category of nursing care related to pain management is illustrated in Table 5.8.

Table 5.8 Sub-category—Nursing care related to pain management

Nursing care related to pain management	
Properties	Elements
Accepting caring responsibilities	<ul style="list-style-type: none"> • Having compassion and facilitating the paediatric patient’s wellbeing
Assessing pain	<ul style="list-style-type: none"> • Identifying paediatric patient’s pain problem • Knowing the patient • Having a good rapport with the patient • Spending time with the patient
Preparing patients for a painful experience	<ul style="list-style-type: none"> • Reducing patient stress • Increasing the patient’s understanding and cooperation
Administering analgesic drugs	<ul style="list-style-type: none"> • Following the medication chart
Providing non-pharmacological techniques to manage children’s pain	<ul style="list-style-type: none"> • Independent decision making • Using distraction, relaxation, and guided imagery
Involving parents in managing pain	<ul style="list-style-type: none"> • To be present and helping nurses to take care of their child during hospitalisation
Seeking support from nursing colleagues	<ul style="list-style-type: none"> • Mitigating negative feelings, and protection from distress • Sharing experiences with nursing colleagues

5.3.2.1 Accepting caring responsibilities

The findings of this study identified that despite experiencing workplace constraints that impacted on their ability to deliver effective pain management, nurse participants accepted a great deal of professional responsibility to alleviate their paediatric patients’ pain and considered that pain management was a priority in their care practice. Participants wanted their paediatric patients’ pain to be managed, controlled and, at the very least, to be tolerable:

Pain management is a priority of nursing care. We have a responsibility as nurse professionals to facilitate the paediatric patient's wellbeing, manage and control the paediatric patient's pain. (P#30)

The findings of this study identified that nurses' attitudes to caring were an important factor that shaped their philosophical beliefs about nursing care. Caring was central to participants' efforts to achieve pain management goals and has been described as the 'core of nursing' by nursing theorists (Leininger, 1984; Newman, Sime, & Corcoran-Perry, 1991; Watson, 1990; Watson & Smith, 2002).

5.3.2.2 Assessing pain

Nurses in this study understood that assessing pain was an important component of pain management in paediatric patients during hospitalisation. However, they acknowledged that their inability to conduct pain assessment adequately was due to the unavailability of pain assessment tools, and lack of time. As such, they were often unable to provide routine and optimal pain assessment. Nevertheless, those few nurses who did have time and who had basic knowledge of pain assessment and the necessary pain assessment skills, did try to conduct pain assessment to the best of their ability:

I know assessing pain for paediatric patients is important to conduct routinely, but I realise that I am not able to conduct it routinely. However, when I have time I always try to do pain assessment as best I can, according to my knowledge and available facilities in the ward. (P#30)

Results of this study identified that pain assessment tools were not routinely being used to measure pain intensity because they were not available in the paediatric wards. When some nurses were asked further about how they conducted pain assessment, they mentioned several common criteria that they used to identify the patients' pain. The first criterion was observing the patient's behaviour, such as facial expression, crying, yelling, screaming, distress, mobility, and playing. The second criterion related to listening to what the patient said, which emphasised the subjective nature of pain and relied on the patient's description of the pain experience, and the parents' report. The third criterion required them to assess and measure physical and vital signs. Here is an example of how a participant was able to differentiate between the pain responses of children from different age categories:

I know if a patient is in pain or not, based on some indicators. For instance, infants usually have prolonged crying, are very fussy, they cannot sleep well and don't want to have breast milk. Toddlers and preschool age, they usually cry with screaming, are restless and fussy and they are able to tell you that they are in pain. Meanwhile for school-age children, some of them cry loudly, they usually say 'ow ...ow!' or 'hurts'. (P#25)

Some nurses said that it was necessary to listen to and observe paediatric patients. Based on these observations they could identify behavioural cues related to his/her experience of pain:

I usually observe children's expression, whether they are grimacing with pain or not and how they are crying, how they are moving, whether they can turn to their left or right side, how they are sitting and walking post-surgery. Patients with severe pain usually cannot sleep well. (P#9)

However, some nurses acknowledged that it was not easy for them to make clinical decisions based upon their observations:

If a patient cries, this could be a sign of pain or fear. It is not easy to differentiate between pain and fear, especially in young children. (P#2)

Further, some nurses explained that when a child was more than three years of age they were able to ask them to provide information about the location, quality and intensity of their pain. In this way nurses relied on the patients' self-report of their pain symptoms. Self-report is the primary source of assessment for a verbal, cognitively intact person and is the 'gold standard' in pain assessment (AAP & APS 2001). As one participant said:

...for older children such as preschool age children and school-age I usually ask the patients how much pain they are in. They usually can tell you about their pain, whether the pain is mild, moderate or severe. (P#18)

A few nurses were able to identify some elements that impacted on paediatric pain assessment: knowing the patient, having a good rapport with the patient and spending time. According to Blondal and Halldorsdottir (2009) knowing the patient facilitates application of pain management principles to meet individual patient needs. The

participants emphasised that knowing the patient was important to facilitate pain assessment:

I suppose when caring for paediatric patients we must know the patient's condition and his/ her personality well. If I know the patient well it makes it easy to identify the patient's pain problem and conduct pain assessment. (P#31)

For participants, knowing the patient meant understanding and recognising the patient's situation and responses to their health problem. This recognition allowed the nurse to select and individualise the intervention. The nurses used their knowledge of the patient to make care choices:

I think when I do not know about the patient's condition well, it can be very difficult to know their problem, such as how much pain they are experiencing, and then decide which pain interventions will be used. If I know the patient well it makes it easy to identify their problem and select a procedure. (P #17)

According to some participants, having mutual trust and a good rapport with their patients facilitated a better understanding and enabled them to conduct appropriate nursing interventions:

We must be able to build good communication with the patient and his parent. It is necessary when building a trusting relationship between patient and nurses. If they already have trust in us they can cooperate with nurses and make it easier for nurses to identify the patient's problem and conduct nursing interventions. (P.31)

A few participants identified that not having a good rapport with the patient could result in the patient not being compliant with pain care, which may result in ineffective care:

If we know the paediatric patients well and they have trust in us, it makes it easier for nurses to do nursing interventions. Meanwhile if we do not know them well it can be an obstacle to providing some interventions and can result in ineffective care. (P#15)

Some participants felt that by spending time with their patient they were able to ascertain the differences in the patient's crying and changes in the patient's mood such as withdrawal and distress.

We should spend more time with a patient in order to know about their condition and it will make it easier for me to identify pain cues such as change in their facial expression, vocal cues and change in mood. (P#28)

Another nurse indicated that she had to rely on what she knew about the patient in order to determine when something was wrong:

Many patients in here can't tell us how much pain they are experiencing so we must have a way of knowing if they are in pain... lots of times they still cannot tell us what their problems are. They might be crying, screaming or keeping silent and we must be able to decide what the patient's problem is based on their diagnosis and history. Maybe the patient has other health problems besides pain, such as anxiety. But we must have more time beside the patient. (P#30)

Thus, spending time with the paediatric patient is a prerequisite for getting to know the paediatric patient's pain condition. The literature reveals that time nurses spend in direct care activities as a determinant of better patient outcome and fewer errors (Duffield et al, 2011).

5.3.2.3 Preparing patients for a painful experience

According to some nurse participants, paediatric patients were often distressed when faced with painful procedures such as insertion of an intravenous cannula, administration of an injection, and chemotherapy. Therefore, in order to be able to engage in the pain management process they suggested that it was essential to prepare the paediatric patient before conducting a procedure:

I usually prepare paediatric patients before I conduct a painful procedure such as inserting an infusion or chemotherapy, by explaining the procedure to reduce their distress, particularly for patients more than three years old. (P#14)

Another nurse mentioned that patients would be more cooperative if they had been adequately prepared for the painful experience:

If I prepare the patients before I conduct a painful procedure, by explaining what kind of procedures will be conducted and how they can control their pain by deep breathing or praying, the patient usually is able to cooperate with us. It is good for the patient to understand the procedure and why it must

be conducted. It is particularly useful for children more than three years old. (P#30)

Some nurses emphasised the need to prepare paediatric patients for painful medical procedures, to assist children to cope better with the experience, and to reduce the child's experience of stress. According to LeRoy et al. (2003) preparation helps children face a range of stressful and painful procedures.

5.3.2.4 Administering analgesic drugs

Nurses understood that they were ultimately responsible for the administration of medication to paediatric patients. The data indicated that the nurses engaged in the administration of analgesics by following doctors' orders regarding pain management. Nurses agreed that the administration of appropriate analgesia was the speediest and most effective strategy for alleviating pain. One of them commented:

I believe analgesic drugs are effective in alleviating the patient's pain soon. (P#25)

Senior nurses were aware that prescribing analgesia was the doctor's responsibility, and checked the patient's medication chart to see what the doctor had ordered for pain:

When I knew a patient was in severe pain, it meant that the patient needed an analgesic drug to alleviate the pain. I checked the doctor's instruction about medication therapy in the patient's notes. At that time the patient was prescribed [the drug] Antrain 100 mg IV. Then I administered the medication to reduce his pain as per the doctor's order. But when the patient was still in pain I tried to report that to the doctor. (P#25)

A few nurses in this study were able to negotiate with the doctor to adjust an analgesic prescription when necessary. The following comment by a participant indicated that nurses tried and desired to collaborate with their medical counterparts:

If a patient is still in pain before the pain medication is due to be re-administered, I usually discuss this with the doctor and ask if I can administer the analgesic before the time prescribed in the order. I always ask the doctor regarding treatment of patients. (P#30)

Nurses applied pharmacological treatments by following doctors' orders because they perceived that these were more effective to alleviate paediatric patients' pain than non-pharmacological approaches.

5.3.2.5 Providing non-pharmacological techniques to manage children's pain

Besides administration of analgesics, a number of nurses in this study also used non-pharmacological interventions to alleviate paediatric patients' pain. They made independent decisions to use these treatment strategies, based on their knowledge and experience. Since most non-pharmacological interventions could be performed immediately, and without a doctor's order, this approach was used by these nurses to help relieve or reduce pain. However, they realised that they were not able to provide non-pharmacological interventions regularly especially when they faced heavy workloads in the wards:

I use non-pharmacological interventions to reduce the patient's pain and distress. I can use these strategies any time if a patient is in pain. We can apply these strategies independently due to it being a nursing intervention. However, I realise that I am not able to provide these interventions regularly if I have many tasks to do. (P#31)

When they had enough time, some participants utilised different non-pharmacological interventions as part of their pain management strategies:

When I know a patient is in pain and I have time, I usually try anything that I can do to alleviate the patient's pain based on my knowledge and experience. For instance, giving comfort such as rubbing, and asking them to do deep breathing. In order to distract the patient I encourage them to play a game on the hand phone. These strategies are used for older children. Meanwhile for young children such as infants or toddlers I touch, hold and sponge their body. (P#24)

Some nurses acknowledged that for moderate to severe pain, non-pharmacological techniques could not be used alone without combining them with the administration of prescribed analgesics. In such cases, they considered that to provide maximum pain relief it was important that the child received both analgesics and alternative treatments:

I believe that non-pharmacological interventions cannot be used alone to reduce a patient's pain, particularly when they have moderate and severe pain such as patients with major burn trauma—the patient needs analgesics and non-pharmacological interventions such as distraction and relaxation techniques. So combined methods are effective for reducing the patient's pain, can be used to control the patient's pain. (P#30)

The literature reveals that using non-pharmacological interventions—including education, relaxation, distraction, imagery, massage, application of heat or cold packs—can reduce the need for drugs for mild pain, and enhance pharmacological treatment of moderate to severe pain following surgery (Goldman et al., 2006).

5.3.2.6 Involving parents in managing pain

Nurse participants in this study suggested that parents are an important source of information for them in caring for hospitalised children in pain. This is because parents are aware of their children's history of pain and their usual ways of coping with it, so they can provide valuable baseline data for the nurse involved in pain assessment. Some nurses in this study mentioned the importance of a parent or a family member being present and helping them to take care of the paediatric patient. Therefore, nurses in this study actively involved parents in managing patients' pain. The parents were acknowledged for taking care of the child's health problems as well as their overall wellbeing. Nurses particularly valued the presence of the mother. A common phrase used by the nurses was 'the child's bed is the mother's bed'. The nurses reported that a child always coped better with hospitalisation if their mother was present:

Paediatric patients always need their mothers beside them. The patients will cope better if their mother is there. It can be said that the child's bed is the mother's bed. (P#27)

Nurses in this study involved parents in managing paediatric patients' pain, especially in providing alternative care. The nurses paid attention to the parent or family caregivers and gave them opportunities to participate in the care of their child. Some nurses commented that the parent's presence could reduce the patient's distress and help make the child feel more comfortable:

I think the parent's presence is very important when caring for children during hospitalisation because they can make children feel comfortable and non-stressed, especially young children. (P#26)

Some nurses pointed out that the importance of the parent's presence was to assist them in providing basic care such as feeding, bathing and comforting their child. Similarly, the literature has identified that it is necessary to admit a parent with the paediatric patient as the parent is able to free the nurse up to provide pain management by attending to the child's feeding and hygiene needs (Shields & Nixon, 2004; Shields, 2001). The parent also provided the nurses with information about any changes in their child's condition. In addition, the parent was expected to administer their child's oral medication and provide some non-pharmacological interventions such as distraction, relaxation, and comforting. A further benefit of involving the parent in the care of their child was a reduction of the nurses' workload:

Parents can also help nurses in caring for and managing the patient's pain especially during afternoon and evening shifts. Parents can observe the patient's condition and do basic care and some non-pharmacological interventions. Therefore, parents help nurses to reduce their workload. (P#24)

According to several nurses, many hospitalised children were fearful of them (the nurses), especially early in their admission. This fear made it difficult for nurses to establish emotional contact whilst performing painful procedures. Thus, the nurses greatly valued the presence of the parent because they served as a bridge in communication between the nurses and the child:

Many paediatric patients are afraid of us, especially young children, because they feel a nurse will do something hurtful to them. This situation makes it difficult for us to perform a painful procedure or to create emotional contact. So parents can explain our role to their child. (P#30)

The nurse participants' point of view clearly showed that parental involvement in caring for hospitalised children in pain is important. The presence of the mother made the child more comfortable and provided emotional and psychological support.

5.3.2.7 Seeking support from nursing colleagues

Nurse participants in this study realised that they were not able to provide effective pain care for paediatric patients because of organisational factors and constraints and these situations created job stress and role conflict; as a result they felt inadequate and ineffective. They understood that they faced difficult situations in their workplace and could not resolve these situations alone. Therefore, they sought support from their colleagues. The nurses in this study used seeking support as a strategy to reduce negative feelings. Participants also considered that support from nursing colleagues had the most effect on their ability to fulfil their role in caring for paediatric patients who were experiencing pain. For example, when an attempt to ask a doctor to change an ineffective analgesia failed, the more junior participants usually elicited the help of other senior nurses to request a change to the prescription. This strategy was used in the belief that the more senior nurse could convince the doctor to change the pain medication:

I usually talk with senior nurses when I feel I have failed to ask a doctor to change the analgesic drug when it was not effective in reducing the patient's pain. I hope she (senior nurse) can convince the doctor to change the prescribed analgesic. (P#7)

Findings demonstrated that most nurses used their nursing colleagues, especially those they had developed a close friendship with, to talk, discuss and debrief about their experiences in caring for paediatric patients. By using this strategy nurses were specifically seeking to mitigate their negative feelings in order to protect themselves from distress:

I always talk or discuss with close friends in the wards when I have problems regarding patients and treatment. For example, when I know that my patient is still in pain although I have administered analgesics as ordered by the doctor. I feel inadequate and ineffective. I talk about this with my friend...I think it is good to share with nurse colleagues to reduce our stress. (P#31)

Sharing experiences with nursing colleagues was important to the wellbeing of the nurses in this study because they were able to express the feelings that they experienced when providing care for their paediatric patients. They used these opportunities to explore the caring episodes and to convince themselves and each other that they had tried their best to provide pain care for their patients. Thus,

supporting each other in this way assisted them to resolve the negative feelings that might otherwise have caused them distress.

5.3.3 Suggestions for improving nursing pain management

Relieving paediatric patients’ pain was an important responsibility for nurses in this study. However, in reality, on most occasions they were unable to provide effective pain care because of external and internal constraints, which led them to experience role conflict and job stress. Nurses in this study were aware that it was not easy to resolve all these tensions, especially those related to external constraints such as organisational and socio-cultural factors. However, all of the nurses provided suggestions that if implemented may improve nursing-practice pain management for paediatric patients in the future. The findings of this study identified four properties in the sub-category of suggestions to improve nursing pain management: empowering nurses to provide effective pain care gaining professional autonomy; building connections with doctors, and increasing knowledge and skills. The sub-category of suggestions to improve nursing pain management is illustrated in Table 5.9.

Table 5.9 Sub-category—Suggestions for improving nursing pain management

Suggestions for improving nursing pain management	
Properties	Elements
Empowering nurses to provide effective pain care	<ul style="list-style-type: none"> • Seeking support from nursing managers, medical colleagues and organisation managers
Gaining professional autonomy	<ul style="list-style-type: none"> • Adjusting to working conditions constraints • Having professional autonomy • Needing cultural change
Building connections with doctors	<ul style="list-style-type: none"> • Effective communication • Creating teamwork approach to pain management
Increasing knowledge and skills	<ul style="list-style-type: none"> • Attending education/training sessions related to pain management • Advancing educational qualifications

5.3.3.1 Empowering nurses to provide effective pain care

Power, defined as a combination of authority and influence derived from a variety of sources, is basic to professional practice (Manojlovich, 2007). Therefore, in order to influence doctors, patients, other health care professionals and each other, it is necessary for nurses to have power (Zelek & Phillips, 2003). Nurse participants acknowledged that one factor that decreased their ability to optimally manage a patient's pain and that also increased their work stress and role conflict, was their perceived lack of power. The previous sections highlighted the key issues that were typically present in situations involving powerlessness: power imbalance between nurses and doctors, working under medical direction, and issues within the health care system that complicated nurses' ability to provide effective pain care. Therefore, to minimise their sense of powerlessness and to cope with the conditions in their working environment, participants recognised that they needed to have power and empower themselves within the organisation:

I know many nurses here feel a lack of power due to some barriers faced in our working place which hinder their ability to provide effective pain care. I think nurses need to organise themselves and take some power to be able to reduce and cope with those barriers. (P#18)

According to Benner (2001) power also includes those caring practices nurses use to empower patients. Laschinger & Finegan (2005) suggested that nurse empowerment is needed to enhance the quality of nursing care, increase patient safety and job satisfaction.

Some nurses acknowledged that they worked in complex and unpleasant environments, dominated by medical views with minimal acknowledgement of the value of nursing. Therefore, nurse participants considered that in order to provide effective pain care it was important that the doctors recognised and supported the professional roles of nurses, which included acting as the patient's advocate:

I think doctors should understand our role as patients' advocates and that we should have professional autonomy in delivering patient care. I believe that if doctors know about nursing roles when caring for patients, including pain management, they will involve us in making decisions and we can work as a team. We really need to be supported by medical colleagues. (P#30)

Hagbaghery, Salsali and Ahmadi (2004) suggested that support from managers motivated nurses to feel stronger and thereby resulted in better quality care. In addition, some nurses also highlighted the need for hospital nursing managers to provide adequate resources to effectively provide pain care basics—such as pain assessment and pain management SOPs— and other appropriate pain assessment tools for assessing children’s pain.

In order to empower nurses to be able to provide effective pain care, I think we need to be supported by hospital managers providing guidelines or SOPs for pain assessment and management, and pain assessment tools for assessing paediatric patients’ pain. (P#37)

Moreover, nurse participants stressed that hospital management should increase the number of nurses available on the wards, thereby improving the nurse-to-patient ratio, and helping to decrease the workload stress that they experienced. They believed that this strategy would then enable nurses to provide effective pain care:

I suppose the hospital managers should increase the number of nurses to reduce the nurse and patient ratio imbalance in order to deliver quality of pain care. The managers should consider this. (P#15)

The influential, dominant medical culture that placed nursing as a subordinate profession was another factor that caused nurses to feel powerlessness, prevented nurses from working autonomously and decreased their ability to provide effective pain care. Participants considered that one way to empower themselves and increase their autonomy as related to patient care was to change attitudes throughout the organisation. Nurses emphasised the need for organisational change to support and empower them to increase their professional autonomy when providing pain care. A nurse supervisor commented:

I think the working situation here needs to be changed. The hospital organisation should support and empower nurses to develop professional autonomy and be more involved in making decisions about patient care. (P#28)

Participants recognised that the power imbalance had to be addressed by both professions. In this way nurses’ feelings of powerlessness would be reduced and the

medical profession would have an increased understanding of nurses' role as carers and patient advocates. This in turn would create a healthy working environment:

I think the power imbalance in the workplace should be addressed by both the medical and nursing professions in order to reduce nurses' powerlessness and increase physicians' understanding of the nurses' role. I believe it would create a healthy working environment. (P#36)

The findings from this study showed that nurses had considered several initiatives that the hospital and nurse executives could implement in the future to create an empowering environment for nurses, where they would have access to resources they need to support them in achieving their goal of providing effective pain care. They highlighted the importance of managerial support, which they believed would enable them to decrease their sense of powerlessness and enable them to provide effective pain care in the future. The literature notes that when nurses have appropriate support from the hospital organisation to provide autonomous nursing practice, they feel powerful and believe they have authority and control over their practice (Aiken, Clarke, & Sloane, 2000; Brown, 2002; Laschinger, Finegan, & Shamian, 2001). Moreover, other issues found in this study that should be addressed included the need to acknowledge the power imbalance from both the medical and nursing perspective and suggestions that this strategy, if implemented, might create a healthy working environment.

5.3.3.2 Gaining professional autonomy

Several nurses believed that in order to take control over their practice they needed professional autonomy. According to the nurse participants, professional autonomy meant having the authority to make clinical decisions and the freedom to act in accordance with their professional basic nursing knowledge:

Having professional autonomy is essential for nurses in taking control over practice. So nurses have power and authority in making clinical decisions and freedom to act in accordance with our basic knowledge. (P#35)

One of the characteristics of a profession is that professionals have power over the practice of their discipline, which is often referred to as professional autonomy (McDonald, 2002). The ability to make autonomous decisions based on

comprehensive knowledge, clinical expertise and research evidence is a hallmark of professionalism (Papathanassoglou et al., 2012). Some senior nurse participants believed that if they were given the opportunity to work more autonomously in delivering paediatric patient care, it would enhance their power to influence their working conditions and job satisfaction. A senior nurse added:

I believe if nurses can work more autonomously in delivering patient care, it will enhance nurses' power and nurses' job satisfaction in the workplace and improve patient outcomes because nurses will be able to make care plans for paediatric patients. (P#33)

Participants stressed their desire to have professional autonomy in order to enhance their ability to provide effective pain management practices. Those nurses who had completed the Bachelor of Nursing program wanted to be able to provide pain relief based on the knowledge they had gained in their basic education. However, they felt that they were unable to achieve this objective because their professional autonomy was still unrecognised, and as a result not trusted by other health care professionals and the organisation itself:

I think nurses' professional autonomy is still unknown by other health care professionals and the organisation, I believe nurses will have power when they show their ability to relieve patients' pain by using appropriate ways such as combining the pharmacological and non-pharmacological approaches which I have learnt when I took the Bachelor's degree program in nursing. (P#18)

Nurses in the study stressed that to enable them to optimally deliver nursing care, organisational managers were required to support nurses' professional and autonomous roles. A nurse supervisor said:

I think managers in the hospital must recognise nurses' professional autonomy and support nurses to work autonomously when delivering patient care so we are able to provide optimal pain care independently of and interdependently with doctors. (P#18)

Some nurses believed that if doctors valued and supported their professional nursing autonomy they would then be able to work inter-professionally through collaboration and cooperation:

I believe if our professional autonomy and nursing roles are valued and supported by medical colleagues, we can collaborate and work inter-professionally when caring for paediatric patients in pain. (P#23)

Some nurse participants discussed ways management could change the working culture in the hospital in the future, by means such as praising nurses or valuing new ideas that nurses had: As a nurse supervisor said

It is time to change. There are some ways to change the working culture such as praising any new ideas from nurses, increasing collaboration when working, and developing a team approach toward pain management, acknowledging the nursing role as a patient advocate and empowering nurses in making decisions about patient care. (P#34)

Senior nurses believed that building a new culture and working environment that supported nurses' autonomy would provide positive results for nurses and patients. Nurses would feel more rewarded if they had flexibility in fulfilling their duties, and have a higher degree of autonomy; as a result they would then have the confidence to make decisions regarding pain management in children, based on their knowledge and clinical judgement. Therefore, they would be able to take control over their practice. This would also prevent nurses from experiencing job stress. They believed that by making these changes they would be able to enhance the quality of paediatric pain care, and patients' and families' satisfaction with nursing care would be increased. Said a senior nurse:

I think building new working environments which support nurses' autonomy would enhance nurses' ability to provide quality pain care for paediatric patients. Nurses would have flexibility in fulfilling their duties and it would enhance their power to be involved in making decisions about pain management and to take control over their practice. This would prevent nurses experiencing job stress. Patients and their families would also feel satisfied about the nursing care given to them. (P# 28)

Nurses emphasised the need for a cultural change before these outcomes could be achieved. This change would require the development of collaboration based on a relationship of interdependence that is built on respect, trust and understanding of the unique and complementary perspectives of each profession. In the context of health care, collaboration refers to the way in which nurses and doctors interact with each

other in relation to clinical decision-making (Stein-Parbury & Liaschenko, 2007). Nurses suggested that collaboration between nurses and doctors is necessary, to be able to provide effective pain care. However, there was a strong sense that this change could not occur without the resolution of the power imbalance between nurses and physicians. As a head of a nursing department commented:

It would be great if interdisciplinary collaboration between nurses and doctors could be developed which is based on respect, trust and understanding of each health profession—it could reduce the power imbalance between nurses and doctors. (P#36)

From the findings it was suggested that in order to enable nurses to provide effective pain care for children, the organisation needed to facilitate nursing autonomy and create interdisciplinary collaborative professional practice. Having autonomy was seen to be essential for nurses, to enhance their own power, to be involved in pain management decision-making, and to take some control over their nursing practice.

5.3.3.3 Building connections with doctors

Nurses in this study realised that some factors that affected their ability to provide effective pain care related to themselves as individuals, their work environment, the culture of the organisation, and professional factors. These situations led them to feel powerless and experience role tensions, conflict and job stress, and consequently this affected their ability to provide appropriate pain care to children. However, because they had a commitment to provide optimal pain care, they identified solutions that may be implemented to improve the situation for the patient and themselves. One such solution was developing a team approach to pain management. The nurses acknowledged that if they had a good connection with doctors, then a teamwork approach to pain management could be developed:

Although it is difficult, it will be great if we can create a teamwork approach for pain management so the goal of relieving paediatric patients' pain can be achieved effectively. But we must have a good connection, cooperation with doctors. (P#30)

Nurses in this study wanted to build a good connection with doctors to be able to share an understanding of pain management and work as a team in managing paediatric patients. They considered that this strategy would increase their ability to

provide effective pain management, and improve their collaboration. The literature notes that improved teamwork and collaborative care have been found to improve the quality of patient care and patient safety (Borrill et al., 2000; Zwarenstein & Bryant, 2000).

5.3.3.4 Increasing knowledge and skills

Although some of the participants attended education and training sessions, many considered that they lacked the required knowledge to provide effective pain care. Therefore, another initiative that the participants identified as necessary to increase their confidence and ability to provide patient advocacy was the improvement of their current knowledge base. Adequate and correct knowledge is a prerequisite for providing effective pain management practice (Blondal & Halldorsdottirs, 2009; Egan & Cornally, 2013; Rejeh et al., 2008). Nurse participants highlighted the importance of gaining professional knowledge and skills as a way to increase their self-confidence, and to enable them to act as a patient advocate. They believed that these skills were needed to increase their professional power and in turn would support them in their ability to provide effective pain care:

I think knowledge is power, knowledge is essential for nurses to have power. If we have good knowledge of pain and its management, we will have the self-confidence and competency to provide effective pain care. (P#33)

In relation to patient care delivery, knowledge can give nurses greater self-confidence and power to take action in making clinical decisions. A lack of knowledge can leave them feeling powerless to provide safe or effective care (Bucknall, Manias, & Botti, 2007; Innocent, 2011; Manias & Williams, 2007) because knowledge is power and those having knowledge can influence others (Sneed, 2001). Having rich professional knowledge and making the right decisions in response to patients' needs have been shown to be the most important conditions that create personal power in nurses (Hagbaghery et al., 2004). Nurses have been shown to demonstrate their professional power via their expertise, knowing how to do the job and possessing a wide range of knowledge (Kuokkanen & Leino-Kilpi, 2001).

Participants highlighted that in order to increase their knowledge and skill regarding pain management in children it was important for them to attend pain management

training, in-service education, and workshops provided by the organisation. The nurses perceived that through attending such education sessions they would gain the knowledge and competence to provide effective pain care and as a result decrease the tension they experienced because of their lack of competence to achieve this goal:

I think nurses' knowledge and skills about pain management must be increased by attending in-service education or training related to pain assessment and management in children, and the hospital must provide such training. If we have good knowledge about pain and its management we will have confidence and power so that we can provide effective pain care. (P#17)

Several participants identified topics that in-service programs should focus on including physiology of pain; patho-physiology of acute and chronic pain ; pain assessment and measurement in infants and children; pharmacological approaches to pain management; non-pharmacological approaches to pain management; duration, action and equivalent doses of analgesic drugs, and true risks for addiction.

For instance a senior nurse explained:

Nurses should have this knowledge in order to relieve patients' pain effectively. (P#35)

Some participants perceived that nurses who had graduated from the diploma of nursing program often lacked confidence to speak up or discuss pain management with doctors because their education level was lower when compared to that of the doctors. Therefore, to bridge this gap and empower themselves, participants considered that at the minimum, all nurses should have a Bachelor's degree in nursing:

I realise my knowledge is still limited so I often lack confidence to discuss pain management with doctors because I graduated from a diploma level only. Having good knowledge is necessary for nurses to empower ourselves and to provide best care. This is why I decided to undertake a Bachelor's degree in nursing. (P#22)

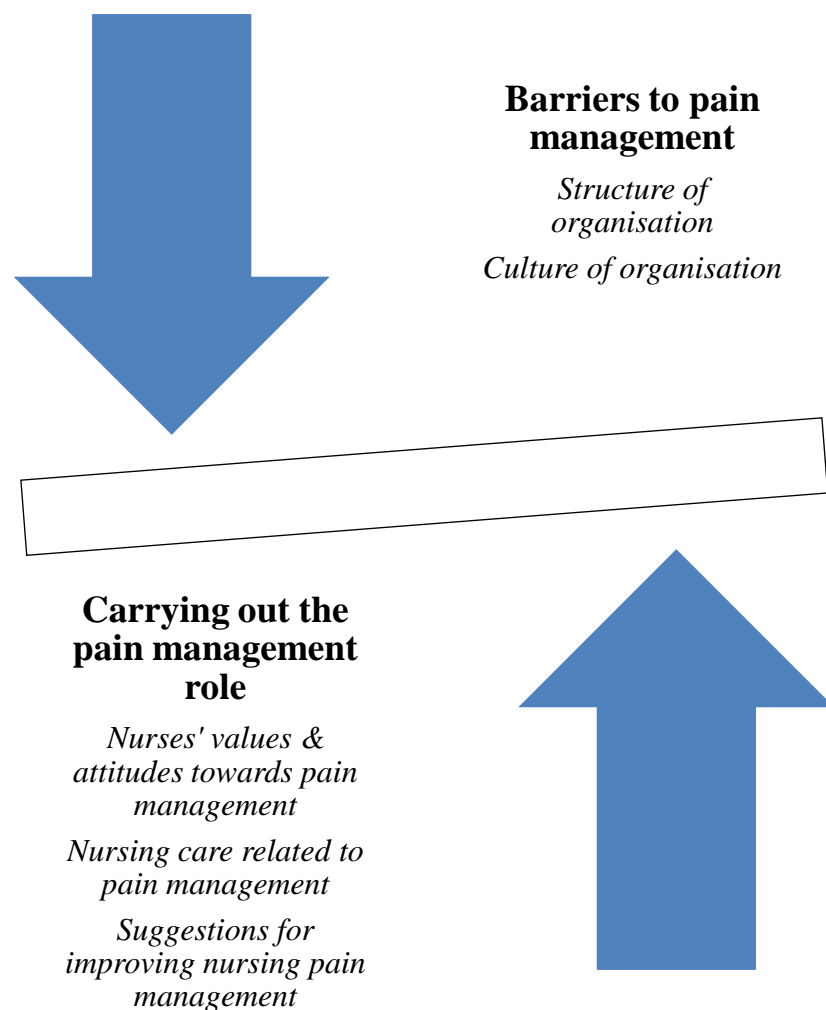
As demonstrated in the above comments, participants thought that it was necessary for nurses to attend training courses about pain management in children. They

believed that attending such courses would increase their confidence to effectively manage paediatric patients in pain. The literature also notes that training increased clinical performance, confidence, nursing power and changed patient care. Thus, power is maintained through knowledge development (Darmichi, Mehrane, Hafezian, Kani, & Gholizadeh, (2014).

5.4 Core concern/problem—Experiencing professional role tensions

Figure 5.1 below depicts the relationships between the properties and conditions that define the problem or core concern of professional role tensions experienced by the participants.

Figure 5.1 Core concern/problem —Experiencing professional role tensions



The previous sections described two core categories that emerged as important in nurses' experiences and perceptions with regard to how they provided care for hospitalised children in pain in paediatric clinical settings. The nurse participants were able to verbalise the necessary care required for paediatric patients experiencing pain and they understood that pain management was an important priority. As nurses they also accepted that they had a professional responsibility to provide quality pain care for their paediatric patients experiencing pain. However, they were aware that in reality they were often unable to relieve children's pain because of the workplace and personal barriers that affected their ability to provide effective pain care. These situations created role tensions for them. The nurse participants articulated that their role tensions related to role conflict, job stress and feeling frustrated, inadequate, unhappy and powerless because they were unable to provide what they believed to be effective pain care for their paediatric patients. Professional role tensions were identified in the data as the participants' main concern or core problem. The problem, identified through analysis of data, was experienced by the group, who shared the experience of the phenomenon being investigated (Hutchinson, 1986).

As described earlier, one of the conditions that sustained this tension was the work structure, which sometimes conflicted with nursing's theoretical base. The participants were unable to adequately provide effective pain care due to the time constraints in their workplace. The nurses emphasised that having enough time was very important to being able to provide pain care. The nurses found that their time was limited by the demands placed on them to complete routine tasks. These demands interrupted their nursing work and limited their ability to manage time. This factor, combined with inadequate staffing and heavy workloads, forced them to adopt a task-oriented approach to care. In the reality of the practice setting, staffing remained one aspect of the organisational structure that caused the participants role tensions and role conflict.

In addition, the conditions under which nurses worked disempowered them, as they found themselves in situations where they lacked knowledge, authority and control over their professional role domain. Therefore, the nurses felt unable to act as patient advocates. Moreover, they complained that other health professionals still did not recognise nursing as a profession and that in general, nurses still worked under

medical directions. Furthermore, nurse participants felt that although they had been professionally educated, they were unable to control their own working environment and practice. Being able to control situations for which they were responsible was important and necessary for these nurses because only then did they feel that they could effectively care for the paediatric patients. When they felt that control had been wrested from their grasp, they experienced feelings of powerlessness. When they felt powerless their self-assurance began to decrease, confidence levels began to fall and self-doubt increased; they began to question what they knew and what they could do. All these conditions resulted in their finding themselves in the situation of being unable to provide effective pain care, and created professional role tensions for them.

Furthermore, the nurses experienced tension between their need and desire to try to provide effective pain care to hospitalised children and the reality in practice. They had a genuine desire to provide effective pain care and relieve pain to the best of their ability. They were aware of the importance of alleviating hospitalised children's pain but they realised that because of the time constraints this was not always possible. They felt a great deal of professional responsibility to effectively alleviate paediatric patients' pain and provide comfort to them during their hospitalisation. The provision of care was based on their ability, which was grounded in their knowledge base and experience.

There were issues with the culture of medical dominance within the workplace that impacted on their nursing work and created further tensions and role conflict. In some cultures, including Indonesia's, it is not common or considered right for nurses to give advice about pain treatment to doctors (Hagbaghery et al., 2004; Negarandeh et al., 2006). As described earlier, some nurse participants were afraid to speak up to doctors. This culture of fear may inhibit an individual nurse's power and professional development. In addition, in this practice setting doctors did not understand that nurses had professional autonomy and were required to act as patient advocates. Participants believed that the internationally accepted nursing role in regard to managing paediatric patients' pain was perhaps not clearly understood by their medical colleagues.

The findings from this study clearly identified that participants experienced professional role tensions when caring for hospitalised children experiencing pain and that these were the main concern for these nurses. These tensions affected the care they provided to their patients, and their own emotional wellbeing. However, the nurse participants realised that they should try to deal with their role tensions in order to be able to continue working and fulfil their professional responsibility to provide effective pain care for their paediatric patients within these complex working conditions. They struggled to react and respond to the professional role tensions faced in the clinical practice setting by using the core process of managing professional role tensions. The core process of managing professional role tensions will be explained in the next chapter.

CHAPTER 6

A GROUNDED THEORY OF THE PROCESS OF MANAGING PROFESSIONAL ROLE TENSIONS

6.1 Introduction

The aim of this study was to explore Indonesian nurses' perceptions of and experience with pain management of hospitalised children, with a view to discovering the factors that impacted on their ability to provide effective pain management. Secondly, it aimed to develop a substantive theory that explained how Indonesian nurses attempted to resolve the main concern experienced by them when caring for children in pain in paediatric wards. Chapter Five described the core problem, the process of managing professional role tensions, that nurse participants in this study experienced when attempting to manage children's pain. This chapter presents the grounded theory (GT) of the process of managing professional role tensions, which was developed using a Glaserian GT approach (Glaser & Strauss, 1967; Glaser, 1978, 1992; 1998). The theory of the process of managing professional role tensions explains how Indonesian nurses in this study utilised strategies to manage their professional role tensions in order to maintain their emotional wellbeing, and provides a theoretical framework that explains the way in which they processed this concern.

6.1.1 Overview of the theory

The nurses sampled in this study considered that they had a moral, ethical, professional and personal responsibility to provide effective pain care. They understood what was expected of them with regard to pain management, and wanted to provide effective pain care for their patients to the best of their ability. However, they realised that they lacked the skills and/or personal and organisational resources necessary to meet these expectations. Within the reality of the practice setting they experienced many professional role tensions when managing pain in hospitalised children, which influenced their perceptions of their role as professional nurses. This core category was central in accounting for much of the variation in the data, recurred frequently, had a stable pattern, and related in a meaningful way to other variables (Glaser, 1978, 1992). Professional role tensions in the context of this study were interpreted as conflicts, ambiguities, issues, crises and inconsistencies (Hales,

Doherty & Gatenby, 2012). Nurses experienced conflict between their personal values and beliefs and professional, institutional and socio-cultural norms. As a result of this struggle nurses experienced professional role tensions when caring for hospitalised children in pain. The professional role tensions occurred as a result of the conflict between the nurses' perceptions of the barriers to pain management and their views on how the role of pain management should be carried out. These professional role tensions were created by situations and conditions within the clinical setting which led to their feeling that they lacked autonomy and were not supported within the ward environment and the overall organisation. Moreover, participants faced work-related 'stressors' such as excessive workloads, increasing work demands, time and resource difficulties. The conditions under which they worked disempowered them, as they found themselves in situations where they lacked knowledge of as well as authority and control over their professional role domain. Thus, they felt unable to act as patient advocates. Moreover, they perceived that they lacked professional recognition because they felt other health professionals still did not recognise nursing as a profession and, in general, that nurses still worked under medical direction. These professional role tensions tended to fluctuate over time and in intensity, and resulted in feelings of frustration, disappointment, anxiety, and dissatisfaction with their work.

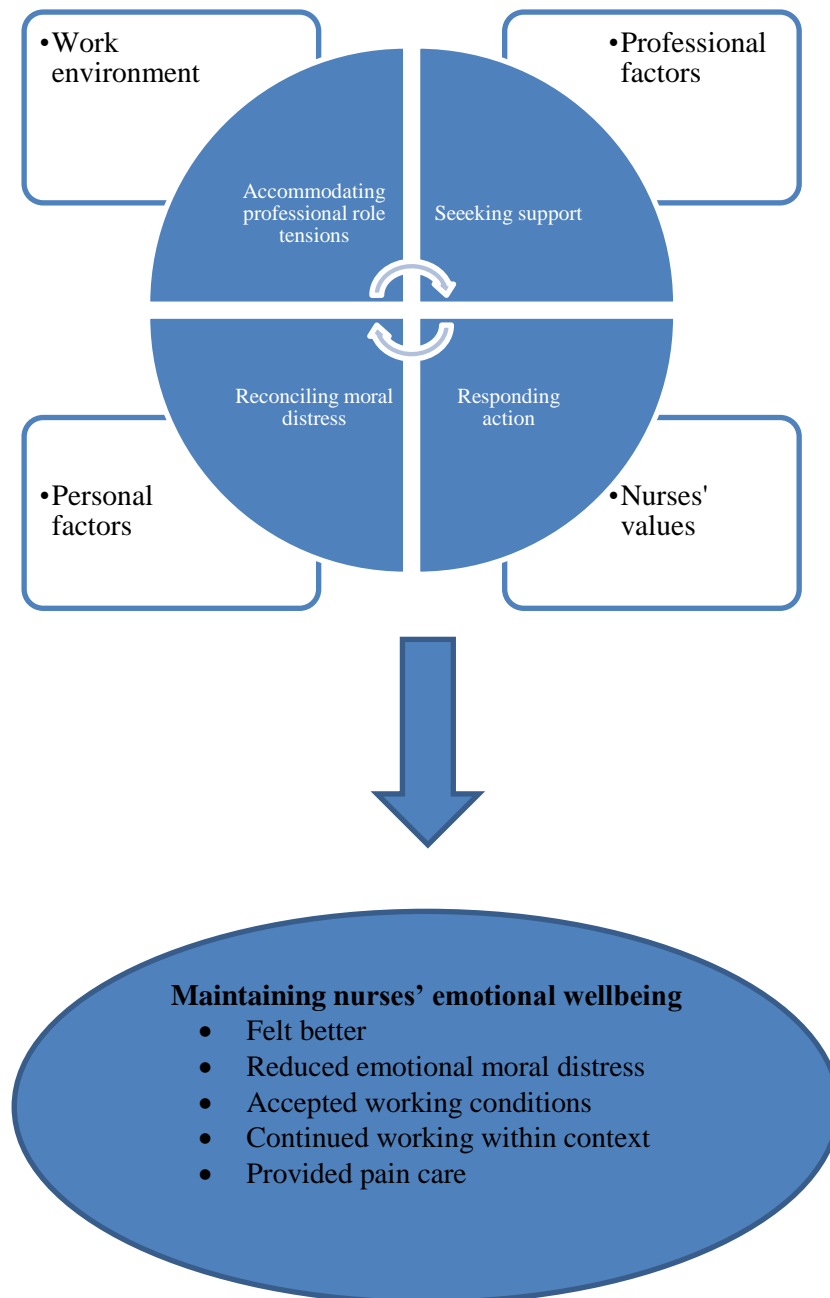
Nurses experienced role ambiguity because they felt they had been provided with unclear and vague role descriptions and guidelines. These related to several factors: firstly, the lack of clarity afforded to them from their superiors or their organisation regarding their role in delivering paediatric patient care. Secondly, nurses had little formal understanding of the tasks related to their job, or the authority boundaries guiding their practice; as a result they experienced inadequate role occupancy. They were unsure of how they should engage with their role, between ideal role expectations and the actual reality (Chang & Pai, 2006). Thirdly, because they were required to conduct many routine and administrative tasks, they experienced difficulties with prioritising these responsibilities. As a consequence of the number of duties and lack of guidelines, they often experienced role ambiguity and were unable to provide effective patient care. These factors resulted in the nurses experiencing professional role tensions, feeling conflicted, and being distressed. These professional role tensions led to their experiencing competing demands,

perspectives, or thoughts in their practice and, as such, they struggled to react effectively and respond to the professional role tensions that they encountered.

The nurses in this study understood that in order to provide effective paediatric care they were required to regulate their own emotions and manage or minimise their professional role tensions. This adjustment was essential in order for them to remain diligent in their practice and maintain their emotional wellbeing when caring for patients and their families. They attempted to manage these professional role tensions by using several strategies. These were accommodating professional role tensions, seeking support, responding action, and reconciling moral distress. These strategies provided the nurses with both immediate and long-term resolution, where the nurse made a conscious decision to actively manage and reduce his or her professional role tensions. In this way the nurses could protect themselves and maintain their emotional wellbeing when working and caring for hospitalised children in pain. These strategies assisted nurses to minimise their professional role tensions by enabling them either to provide pain management practices to the best of their ability, or to negate any personal responsibility for ineffective pain management outcomes. Thus, they were able to adapt to the situations in their workplace and were able to continue working in their current context.

The following diagram (Figure 6.1) is a visual representation of the substantive theory of the process of managing professional role tensions that emerged from the data in this study. The interplay between the constructs in the figure demonstrates the process nurses used to manage professional role tensions within the Indonesian context.

Figure 6.1 The process of managing professional role tensions



6.2 Resolving the core problem—the process of managing professional role tensions

The nature of their work required the nurses to actively navigate personal and professional boundaries in order to deliver what they perceived to be competent and compassionate care. The process of managing professional tensions was a social strategy that enabled nurses to match their behaviour with the construct of providing effective pain care.

Nurses considered that there were certain conditions in the workplace that created professional role tensions for them when they wanted to provide effective pain care. However, because of the reality of the practice setting in which they worked, they were often unable to provide effective pain care. Most nurses in this current study agreed that caring for paediatric patients experiencing pain was demanding and required great dedication that encompassed both positive and negative aspects of their role. Role tensions resulted from the continuing interplay of contradictions that created, shaped and maintained behaviour associated with their roles as nurses (Apker, Propp & Ford, 2005). Apker et al. (2005) identified that nurses do experience embedded professional role tensions in providing patient care. For instance, nurses experienced professional role tensions when they attempted to provide compassionate care to their patients. Their attempts were blocked, however, because of many other duties that have to be performed, such as completing paperwork; drug preparation; administering drugs; coordinating care across the health care continuum; supervision of junior staff, as well as basic nursing duties such as wound care and assessing patients' health status. As a result their involvement at the patient's bedside is often limited. Nurses in this study understood that their professional role tensions affected their emotional wellbeing and also the outcomes for their paediatric patients. The emotional impact arising from these professional role tensions impacted on the nurses' sense of job satisfaction. In order to remain consistent in their practice, and protect their emotional wellbeing it was essential that the participants managed these professional role tensions when dealing with paediatric patients and families. They believed that this resolution might afford them some control over their practice and enable them to provide effective pain care.

The theory of how these participants managed their professional role tensions shows how fundamentally these nurses desired to manage or minimise their role tensions and the moral distress that they encountered as a consequence of being unable to provide effective pain care in their workplace. Thereby, the process enabled them to cope with as well as adjust and control their working conditions, and to adapt to reality. As a basic psychosocial process, the process of managing professional role tensions was influenced by the context, consisting of the interrelated conditions of the nurse participants: (1) work environment including structure and organisational culture; (2) professional factors including the nurses' roles; (3) personal characteristics of nurses, such as knowledge and experience; and (4) the nurses' values. Within this context the process of managing professional role tensions comprised four strategies, as outlined in Figure 6.1: (1) accommodating professional role tensions; (2) seeking support; (3) responding action; and (4) reconciling moral distress. These four strategies were not exclusive of one another and did not necessarily occur in a linear fashion. However, these four strategies may occur simultaneously. Therefore, the model clearly explains the interplay among the strategies. The following section will explain the context further.

6.2.1 The context

As stated earlier, the four interrelated conditions influenced the process of managing professional role tensions. It was this psychosocial context that influenced the management process.

Work environment. The nurses' work environment consisted of the structure of the workplace and the organisational culture. Factors in the work environment that nurses most often mentioned as constraints to providing effective pain care were:

1. The structure of the organisation, which consisted of (a) imbalanced nurse-patient ratios; (b) a lack of sufficient education and/or training; and (c) a lack of organisational support;

2. Constraints related to the culture of the organisation, which consisted of (a) feeling powerless; (b) a lack of professional autonomy; (c) being unable to be a patient advocate; (d) a lack of organisational management support; and (e) the lack of a team approach to pain management.

The nurses perceived that there was a relationship between their working conditions and the professional role tensions that resulted from their being unable to provide effective pain care for their patients. For instance, they found that when fewer instances of role conflict arose, they experienced fewer threats to their moral integrity and less job stress. However, the degree of congruence between the nurse's desire or ideals (for example, their preferred role and relationship with the patient and the doctor) and the reality of their clinical practice, affected how they managed conflict situations. This in turn created professional role tensions and influenced the degree to which nurses believed that they had managed their professional role tensions in the process.

Professional factors. The nurses in this study experienced professional role tensions because they considered that they were unable to perform in their perceived role as carer and patient advocate, hence were unable to provide effective pain care. This conflict arose as a result of their beliefs about their nursing responsibilities and the reality of what they could accomplish in the practice setting. The actuality of the practice setting was in contrast to what international nursing bodies and theorists have stated regarding the role of the nurse (ICN, 2010). The nurses considered that their role was that of employee and health care professional, skilled in the provision of nursing care as learnt through their nursing education and based on their practical experiences. However, because of their own educational and training limitations, and the structure of the organisations in which they worked, they were often unable to fulfil all of the roles required of a professional nurse. For example, they were often unable to conduct pain assessment optimally and routinely, and unable to develop therapeutic care plans and provide pain management effectively, because they faced heavy workloads and time constraints in the workplace. These work conditions hindered nurses from delivering what they perceived to be holistic professional care. In addition, they felt unable to work in a collegial manner with doctors. They perceived that despite all of their efforts to collaborate with doctors, little had been gained for nurses in the study context, and there was still no real partnership in delivering paediatric patient care, including pain management. They felt professionally bound to follow physicians' directives and as a result they felt undervalued and powerless, and were unprepared to be actively involved in decision-

making about pain management. Further sources of tension for the nurses in the study included their perceptions of the attitudes of other professionals in positions of authority in the workplace hierarchy. They perceived that the existing hierarchy within the organisations in this study context continued to place nurses as doctors' assistants. These factors affected the nurses' professional roles in delivering patient care. They were unable to work as a team and meet the expectations of management that they perform across various roles in delivering paediatric patient care. These situations caused nurses to experience professional role tensions.

Personal Factors. Knowledge that the participant nurses obtained from personal experience, consulting with other nurse colleagues, and observing how others managed their role tensions, conflict and job stress, influenced the process of managing professional role tensions. However, it was their own values and beliefs and an awareness of how their actions affected others that sensitised nurses to the professional role tensions they experienced. This insight impacted on their ability to provide effective pain care; when their endeavours were unsuccessful, this in turn resulted in their experiencing job dissatisfaction and distress.

Nurses' values. This concept refers to the beliefs held by the nurses about what was of value or worth to them, the degree to which these views were morally and professionally binding for them, and the framework they used to justify their actions professionally. Values are defined as global beliefs or attitudes that a person holds, which guide actions and influence how people conduct their behaviour, and which assist them with making decisions (Butts & Rich, 2005). This belief framework or perspective, which was unique to each nurse, influenced their willingness and ability to manage or minimise their professional role tensions, as well as the strategies they used to do so. For instance, some nurses preferred to cope with the situations they encountered and work within their and the organisation's limitations, and so manage their professional role tensions. In this way they were able to protect themselves from distress and maintain their emotional wellbeing and remain diligent in practice so they could provide pain care to the best of their ability. However, others chose to blame the situation and conditions in their workplace, and reflected on and rationalised the reasons they perceived were preventing them from providing effective pain care. Although these nurses looked outside of themselves for the

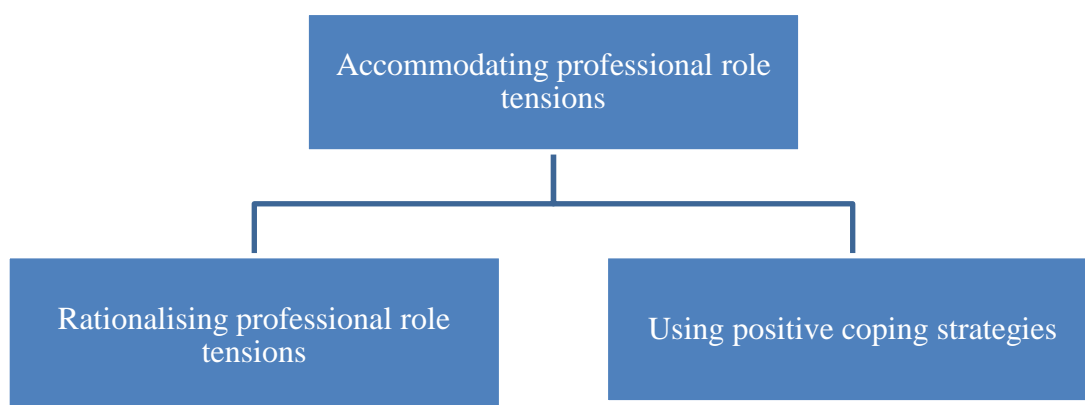
reasons they were unable to provide effective pain care, they also accepted the situations they found in their workplace, and provided routine care based on ritual and common practice. Although variations existed, nurses understood that they had to deal with or manage their professional role tensions. They employed four strategies to manage their professional role tensions. These will be explained in the following section.

6.2.2 Accommodating professional role tensions

Accommodating professional role tensions was the first strategy nurses used to deal with and manage their professional role tensions. 'Accommodating' was the way the participants adjusted or adapted to professional role tensions they experienced when caring for hospitalised children in pain. The process began when the participants encountered a situation in which their needs and desires to provide effective pain care were juxtaposed with a reality where, because of workplace constraints, they were often unable to relieve the child's pain adequately. Professional role tensions existed as the consequence of each the different nurse's expectations of his or her perceived role as compared to what they actually achieved while performing their role (Hales et al., 2012). Therefore, professional role tensions occurred when there was incongruence between perceived role expectations and actual achievement of the role (Chang & Hancock, 2003). Dialectical tensions (when opposing or incompatible forces exist simultaneously) clearly existed for nurse participants as they encountered barriers to providing effective pain care. This situation resulted in nurses feeling dissatisfied with their working conditions and was the main reason participants emphasised the need to accommodate role tensions. This strategy required them to shape or reshape their role to fit with their sense of professional identity in providing pain care for the paediatric patient. Nurses adapted and adjusted to the situations they encountered in their workplace that created professional role tensions for them. They were aware and understood that they needed to manage situations that resulted in professional role tensions as best they could. They believed that these professional role tensions affected both patient outcomes and their own emotional wellbeing. Relieving paediatric patients' pain was an important priority for them. Hence, they decided to accommodate their professional role tensions and take on a role that would enable them to maintain their emotional wellbeing while working in paediatric wards, so they could provide their patients with pain care, to the best of their ability.

As depicted in Figure 6.2, integral to the strategy of accommodating professional role tensions were the properties of (a) rationalising professional role tensions, and (b) using positive coping strategies.

Figure 6.2 Accommodating professional role tensions



6.2.2.1 Rationalising professional role tensions

Rationalising professional role tensions was another tactic used by nurses to manage their professional role tensions. Rationalisation is a defence mechanism and is used by nurses as a coping strategy (Cramer, 2006; Stanescu & Morosanu, 2005).

Rationalisation is characterised by trying to justify or formulate a logical reason for when and/or why something disappointing happens that it is difficult to accept (Cramer, 2006).

In this study, nurses used rationalisation when they perceived a conflict situation and needed to deal with emotional conflict, or internal/external stressors. Simply put, rationalising was the process of making excuses and justifications for being unable to provide effective pain care. By doing so some nurses avoided self-blaming or being blamed by others. Making excuses was also about blaming workplace constraints for their own inability to provide effective pain care. Nurse participants rationalised their tensions by blaming situations, others, the hospital organisation, the nursing administration, and themselves. Many factors in the hospitals' working environment contributed to the escalation of professional role tensions within nurses' practice settings. Work structure, ritual practices, patient acuity, time constraints and

workloads in the hospitals affected the delivery and practice of nursing within paediatric ward settings. Organisational demands combined with professional issues caused nurses to experience professional role tensions. This situation made them feel inadequate and ineffective and they rationalised their role to understand the practice reality that impacted on their ability to provide effective pain care. Therefore, nurse participants used rationalisation to convince themselves that there was a logical reason for not being able to provide effective pain care. This action helped nurses to cope with feelings of concern and inadequacy about being unable to meet their own expectations of being a good nurse and being able to alleviate paediatric patients' pain.

In psychology, rationalisation is the process of constructing logical reasoning for a decision that was originally arrived at through a different mental process (Funnell, Koutoukidis, & Lawrence, 2005). This process can range from fully conscious, for example to present an external defence against ridicule from others, to mostly subconscious, for instance to create a block against internal feelings of guilt (Stanescu & Morosanu, 2005). Through the process of rationalisation, nurse participants developed an awareness of conflict situations in the workplace and tried to understand their experiences and make sense of the professional role tensions that impacted on their ability to perform their roles. Rationalising their understanding of the situation helped nurses analyse the complexities of the context in which they worked and helped them manage or minimise professional role tensions to remain consistent when delivering nursing care to their paediatric patients. Thus, they were able to maintain their emotional wellbeing and accept the reasons for their inability to achieve the goal of providing effective pain care. This process aided nurses to create a psychological block against internal feelings of guilt, and assisted them to continue to provide pain care to the best of their ability, within the constraints of the study setting.

6.2.2.2 Using positive coping strategies

In general, coping is a strategy that assists people to minimise stress and solve problems (Chang, Tugade, & Asakawa, 2006). In this study, using positive coping strategies was another mechanism for accommodating professional role tensions. Nurses in this study perceived that caring for children in pain could be challenging

and stressful, especially when they were unable to effectively fulfil their role of providing pain relief, because of workplace constraints. Nurse participants emphasised the need to cope positively with the professional role tensions in their working environment, by expressing their emotions rather than suppressing them. For them this did not mean that they became angry or aggressive or necessarily yielded to the situation when they experienced professional role tensions. Instead, they felt that they had to develop the wisdom to know what choices to make about a given situation, and learn to deal with the professional role tensions in productive ways. For instance, when nurses experienced role tensions on a shift due to heavy workloads and time constraints, some of them tried to adjust to the situation by understanding and accepting the work constraints and the inherent nature of providing nursing care. The literature notes that when people cope with adverse events, adopting a positive affect helps with effective coping and reduces defensiveness (Eilerman, 2006; Lewis & Haviland-Jones, 2000). The ability of these nurses to effectively cope with or control the professional role tensions they experienced in their daily professional activities enhanced their ability to protect themselves from their professional role tensions and the ensuing distress. Thus they were able to maintain their emotional wellbeing while working in the paediatric wards or to more easily accept it when they were unable to achieve the goal of providing effective pain care.

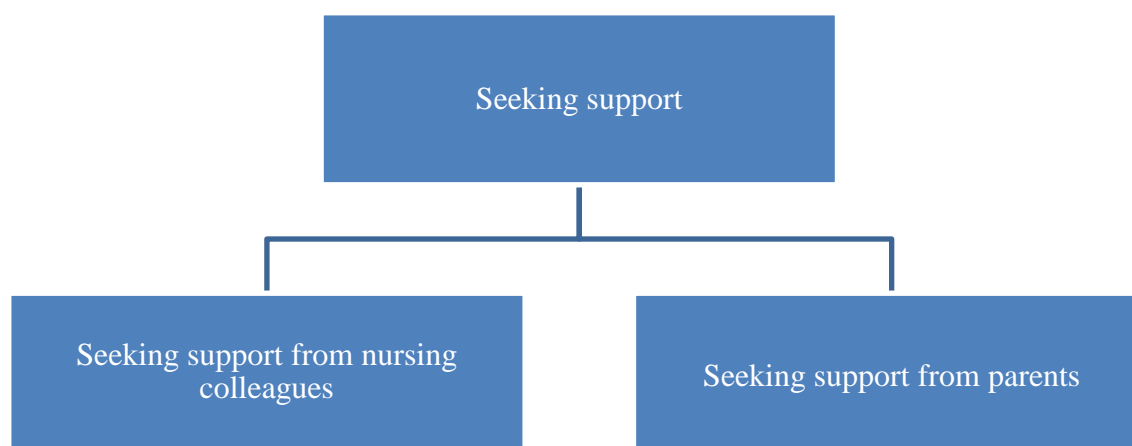
Another method used by the nurses to manage their feelings and professional role tensions was talking to nursing colleagues about their experiences. Developing an informal support system enabled participants to cope with their feelings of conflict and distress. In addition, participants coped with their professional role tensions by using different cognitive strategies, for example not thinking about work when off-duty, distracting themselves through participating in leisure activities, and obtaining support from their families. Most nurse participants acknowledged that support from family and their nursing colleagues or friends enabled them to talk about their experiences and feelings. The sharing of experiences with their spouse and family helped them to express negative feelings about providing ineffective pain relief, such as feeling guilty and inadequate. Friends within the profession understood what the participants were going through, thus the support from those nursing colleagues was valued and assisted the nurses participating in this study to cope with the daily

demands of work. Participants mentioned that nursing colleagues or friends had similar experiences and understood the constraints in the workplace that impacted on their provision of pain care for paediatric patients. They considered that by sharing their experiences and talking with nursing colleagues, they were able to alleviate the stress they felt and make peace with the situation, and accept the level of care that they provided.

6.2.3 Seeking support

The literature notes that greater support is associated with lower role stress, lower psychological distress and greater job satisfaction (Quimby & O'Brien, 2006). Nurses in this study used seeking support as a strategy to manage their emotional distress and role tensions when they provided pain care for hospitalised children. Most of the nurse participants were aware that caring for paediatric patients experiencing pain was challenging and complex, and they described needing support from colleagues to identify the underlying cause of their professional role tensions and assure themselves that they had tried to provide pain care to the best of their ability. Nurses in this current study also sought the support of parents of hospitalised children to help provide pain care for their children. As depicted in Figure 6.3 below, there were two features that made up the strategy of seeking support: seeking support from nursing colleagues, and seeking support from parents. These properties will be described in the following section.

Figure 6.3 Seeking support



6.2.3.1 Seeking support from nursing colleagues

Seeking support from nursing colleagues was an important approach used by the nurses to manage or reduce their professional role tensions so that they were able to maintain their own emotional wellbeing. This approach was characterised by attempts to seek emotional support or to seek practical help and advice while providing pain relief. Seeking support from peers reflected the nurses' need to be understood in relation to their professional role tensions and it provided validation of their role as a nursing professional caring for children in pain. Nurses realised that they could not deal with or reduce their professional role tensions alone.

Nurses perceived that this approach provided an opportunity for sharing solutions with other nurses who were also experiencing professional role tensions. In addition, sharing solutions revealed the importance and benefit of fostering and maintaining this important source of support in this context. Nurses in this study used their nursing colleagues, especially those they had a close friendship with, to discuss and debrief about their experiences of caring for paediatric patients. Nurses especially wished to talk over their feelings of inadequacy, ineffectiveness, guilt, powerlessness and role conflict when they felt unable to relieve their paediatric patients' pain. At times nurses still felt inadequate and guilty even after they had administered the

prescribed analgesics and provided the non-pharmacological interventions that had caused them professional role tensions.

Some nurses talked to senior nurses about their work to validate their experiences of caring for paediatric patients experiencing pain. They perceived that senior nurses had a much better understanding of how to care for children in pain and could share strategies from similar experiences, and provide them with support. Nurses believed that support from nursing colleagues enabled them to care for paediatric patients experiencing pain and reduce their feelings of professional role tensions as well as their experience of moral distress. The findings of this study show that nursing colleagues benefited from being able to talk, share and reflect with other nurses about their negative feelings and the problems they encountered during their work, and the process of caring for patients in paediatric wards. Participants believed that support from nursing colleagues had the most effect on their ability to fulfil their role in caring for paediatric patients who were experiencing pain. For example, the findings identified that when some nurses unsuccessfully requested that a doctor change an ineffective analgesia, the more junior participants would ask for the help of other senior nurses to request a change to the prescription. This strategy was used in the belief that the more senior nurse could convince the doctor to change the pain medication. Moreover, the nurses also believed that supporting each other could provide them with collective power; as a result they could accept their complex working conditions and enhance their ability to deal with or reduce their professional role tensions. Sharing their ethical or moral concerns helped empower them to manage difficult situations and emotions (Pauly, Varcoe, Storch, & Newton, 2009).

For the nurse participants in this study, support in the form of debriefing was used as a way of reducing their professional role tensions and protecting them from job stress and feelings of ineffectiveness. This strategy was useful for them to reduce their moral distress and maintain emotional wellbeing. Nurses were aware that they had a professional responsibility to provide quality care for their patients. Therefore, when they were unable to relieve their patients' pain effectively, they saw this as a failure. Thus they debriefed with their colleagues in order to seek clarification and receive feedback to validate their actions regarding whatever pain management strategies they did use. Nurses wanted also to check their work with their colleagues, to

ascertain whether they were doing the right or wrong thing in the clinical setting. This approach was effective because nurses were able to explore the caring episode and reassure themselves that they had done the best they could to alleviate the paediatric patients' pain in that particular set of circumstances. They felt more comfortable after talking and sharing with their colleagues. Therefore, seeking support from colleagues was acknowledged as a helpful strategy that nurses used to maintain emotional wellbeing while working in paediatric wards, so they could cope with their professional role tensions and moral distress. Many authors have identified that when nurses have adequate support from nursing colleagues, they feel that they have positive, collegial relationships and this will help to develop a healthy work environment that produces positive outcomes for both nurses and patients (Baltimore, 2006; Gerardi, 2004; Kramer et al., 2007; Schmalenberg & Kramer, 2009). This approach enabled the nurses in this study to make peace with, and feel comfortable about, their work situation and the care they provided.

6.2.3.2 Seeking support from parents

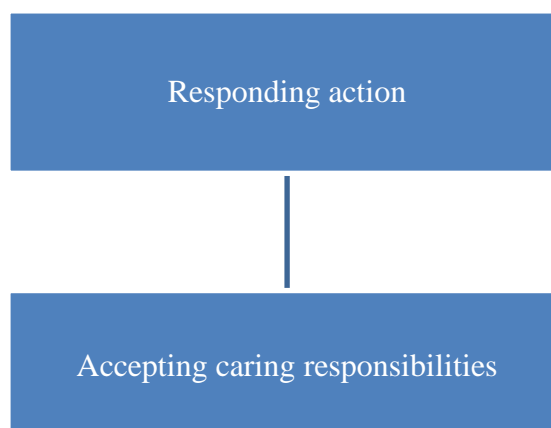
Seeking support from hospitalised children's parents was another method participants used to manage and minimise their professional role tensions. Nurses in this study involved parents in providing care, especially when this concerned the provision of non-pharmacological interventions and basic care such as feeding, bathing and comforting their child. Additionally, parents were a great source of comfort to the paediatric patients, and served as excellent 'distracters' from things that hurt, and were great anxiety reducers (Carter, McArthur & Cunliffe, 2002; Shields & Nixon, 2004; Simons, 2013). A further benefit of involving the parent in the care of hospitalised children was a reduction of the nurses' workload. Nurse participants acknowledged that parents were useful because they had intimate and extensive knowledge about their children and could act as an important source of information when nurses assessed and managed children's pain. Moreover, parents were aware of their children's history of pain and their usual ways of coping with it, so they could provide valuable baseline data for the nurse, for use when assessing the child's pain (Simons, 2013). Nurses found that involving parents in pain care episodes, such as conducting a painful procedure, meant that paediatric patients became more cooperative with them. For example, parental involvement assisted nurses to understand the child better, and provided strategies with regard to how the

nurses could best comfort the child. Nurses perceived that the parents' presence could alleviate the child's distress and help make the child feel more comfortable during hospitalisation. Thus the parents served as a bridge in communications between nurses and the child. A significant factor in achieving effective child care in clinical settings is the involvement of parents in care (Barnados' National Children Resource Centre, 2006).

6.2.4 Responding action

Responding action was another strategy nurses in this study used to take action to manage their professional role tensions in order to protect themselves from distress and maintain their emotional wellbeing. This conceptual category reflected the way in which nurse participants tried to adapt to situations in practice. Nurses articulated their desire and professional obligation to provide effective pain care to alleviate their paediatric patients' pain in accordance with their knowledge and experience. In responding action, the nurses accepted responsibility to respond to and manage the children's pain problem to the best of their ability, while at the same time acting responsibly to meet the needs of the paediatric wards as a whole. The participants realised that the resolution of professional role tensions was often fluctuating and temporary. Therefore, there was a sense that nurses were required to come to terms with these tensions in their unresolved or resolving state. As mentioned previously, not all tensions were resolved, and as a result they were often accompanied by feelings of guilt, powerlessness, frustration and inadequacy. As a consequence, responding action also meant accepting the difficulties and limitations of situations and trying to do what was possible in order to be able to provide effective pain care to the best of their ability. As depicted in Figure 6.4 below, the strategy of responding action comprised one property, namely accepting caring responsibilities. This property seemed to occur every time the nurses cared for paediatric patients experiencing pain.

Figure 6.4 Responding action



6.2.4.1 Accepting caring responsibilities

Accepting caring responsibilities was an approach used to manage nurses' professional role tensions in the workplace. Nurse participants were aware that they faced difficult situations that prevented them from providing effective pain care for paediatric patients. However, they were conscious of their obligations and professional responsibility to care for their patients and engage in pain management to the best of their ability. Nurses acknowledged that they experienced professional role tensions when caring for children experiencing pain and that these role tensions affected their work in the paediatric ward and impacted on their job satisfaction. They realised that the role tensions that they experienced may have affected their paediatric patients' outcomes. However, as mentioned previously, they understood that they needed to deal with these professional role tensions in order to protect themselves from distress and maintain their emotional wellbeing so they could provide pain care. They stated that an important part of providing effective care was focusing on the problems and needs of their patients and not on their own issues. Nurses emphasised the requirement to understand, manage and prioritise children's health problems. These feelings were compounded further when several nurses professed that the nature of nursing practice was based on altruism and caring for sick people, which was their motivation for entering the profession. According to their personal beliefs, helping to relieve or reduce paediatric patients' suffering allowed them to gain rewards from God, and also gave them job satisfaction. In the

context of this study, the religion of most nurses was Islam, as 88% of the total population of Indonesia is Muslim (Miller, 2009). Thus, for the participants in this study, religion influenced and encompassed the process of caring.

Caring was central to achieving pain management goals and has been described as the 'core of nursing' by nursing theorists (Leininger, 1984; Newman, Sime, & Corcoran-Perry, 1991; Watson, 1990; Watson & Smith, 2002). All participants agreed that pain management was an important component of care. When caring for paediatric patients experiencing pain, nurses perceived the alleviation of the patient's pain as their major function. Nurses had a strong desire to take care of children in pain. Nurses felt responsible and wanted to alleviate their paediatric patients' pain to the best of their ability. Providing quality pain care was aligned to their feeling a personal and professional responsibility to provide effective pain care. This professional responsibility motivated them to keep trying to provide effective pain care despite facing difficulties in their workplace. As a consequence, managing professional role tensions was important for the nurses in this study: they saw this process as part of their fulfilment of their professional and work responsibilities to manage or reduce their professional role tensions in order to protect themselves from distress and maintain emotional wellbeing, so that they could provide pain care to the best of their ability for paediatric patients experiencing pain.

Nurses realised that they were the key to effective pain management because they were more frequently at the child's bedside than any other health care professional. Some participants' views agreed with those found by von Baeyer, Marche, Rocha, & Salmon (2004), in that they saw the goal of pain management as being to alleviate pain and reduce paediatric patients' distress and anxiety, thereby preventing the patient from developing a fear of health care. Nurse participants knew that they required compassion to facilitate the paediatric patient's wellbeing by alleviating his or her pain through pharmacological and non-pharmacological pain management approaches. They acknowledged that paediatric patients were unable to relieve their pain by themselves, so it was their responsibility to alleviate pain to the best of their ability.

Pain relief has been described as a professional concern for nursing (Blondal & Halldorsdottir, 2009). For nurses in this study, caring was manifested in their desire to provide effective pain care. They revealed that nurses played an important role in pain management for paediatric patients. They were motivated to facilitate and engage in practices that alleviated pain and gave maximum comfort to their patients. These factors are reflected in some of the components of Benner and Wrubel's (1989) and Leininger's (1985) perspective on caring being a human trait. Caring is when nurses value human relationships and show commitment to their patients (Benner & Wrubel, 1989). Participants were committed to providing effective pain care based on their knowledge, experience, moral beliefs or religious principles. Nurses in this study placed emphasis on the aspect of spiritual care when caring for paediatric patients in pain. Caring was described as a religious obligation. Caring has been shown to incorporate religious beliefs, practices and actions intended to meet the psychological, social, spiritual, and cultural needs of the patient (Lovering, 2008; Wehbe-Alamah, 2011).

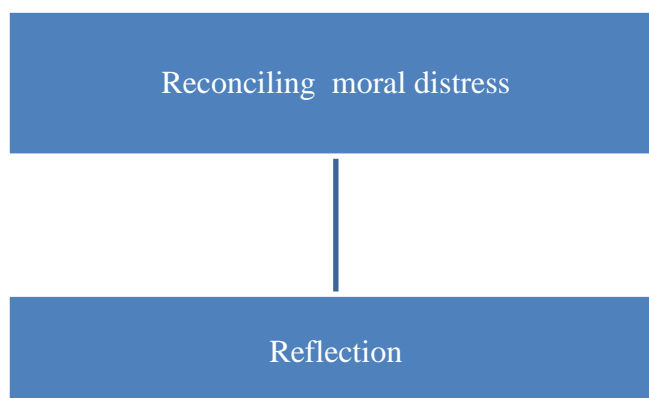
6.2.5 Reconciling moral distress

Reconciling moral distress was another strategy used in the process of managing professional role tensions. Nurses in this study faced great challenges when performing their duties and roles in providing care for paediatric patients experiencing pain in paediatric wards. However, they felt uneasy when trying to fulfil their role in caring for paediatric patients in pain and simultaneously managing their own high work demands. Nurses experienced moral distress because they knew what was needed to provide effective pain care, but in the context of their practice reality they felt unable to meet their important role in relieving paediatric patients' pain; this in turn resulted in feelings of conflict, unhappiness, sadness, frustration, disappointment, dissatisfaction, guilt, powerlessness, and inadequacy. Nathaniel (2006) defined moral distress as feeling pain or anguish when faced with a situation in which the person is aware of a moral problem, acknowledges moral responsibility, and makes a moral judgement about the right action, but due to perceived constraints, acts in a manner that is perceived to be morally wrong. Baldwin (2010) theorised that moral distress happens when the nurse knows the right thing to do, but organisational or institutional constraints make it difficult to pursue the right course of action. Thus, moral distress occurs when the personal values of nurses and perceived obligations

are incompatible with the needs and prevailing views of the external environment (Epstein & Delgado, 2010). The main reason for moral distress is conflict between personal demands, hopes and reality (Corley, 2002). As the study findings indicated, nurse participants experienced a sense of moral distress because they often perceived that they were unable to act upon their own values due to the conflicting values of the doctors and the constraints of their organisations. Therefore, individual and organisational factors influenced their experience of moral distress. The situation in the clinical setting created professional role tensions, dilemma and conflict for study participants. As a result nurses experienced a sense of moral distress because they could not match what they perceived to be integral to pain care with how they worked within institutional constraints. They felt they had no control over their work environment and practice.

Study participants acknowledged that their moral distress negatively impacted on fellow nurses and on the patients. Some nurses acknowledged that if their distress was not resolved or managed effectively, it would be prolonged. This would mean that they would not be able to overcome it by simple adaptation and that it could then lead to their experiencing burnout, which would affect their health and wellbeing. In addition, feeling moral distress also impacted on their ability and performance when caring for paediatric patients in pain. The nurse participants understood that they needed to manage or minimise these professional role tensions in order to protect themselves from distress and maintain their emotional wellbeing. The participants maintained their emotional wellbeing by adjusting and reducing moral distress through reconciliation. Nurses achieved this by developing an ability to understand and accept their complex working environment so that they were able to maintain their emotional wellbeing while working on paediatric wards. As depicted in Figure 6.5 below, the property of the strategy of reconciling moral distress was reflection.

Figure 6.5 Reconciling moral distress



6.2.5.1 Reflection

Reflection was a coping strategy used by the nurses in this study to manage or minimise their moral distress. Pau, Croucher, Sohanpal, Muirhead and Seymour (2004) defined reflection as a positive, emotion-focused strategy. Reflection is the practice of integrating emotion and reason and is essentially a process to enhance self-awareness (Lockyer, Gondocz, & Thivierge, 2004; Jack & Smith, 2007; Jack & Miller, 2008). As nurses told their stories during this study, they evaluated the conflict in the situations that caused them moral distress. They were able to examine their values and asked themselves questions about what caused role tensions and moral distress while they provided patient care. In addition, they reflected on who could be to blame, how they could handle this situation differently, and how they could avoid similar situations in the future. For these nurses, recognising situations in the workplace that caused professional role tensions and moral distress was an important step towards resolution of that distress. Some nurses in this study, when faced with moral distress, reflected and searched for meaning to help them understand a situation. Through using reflection they examined their values as nurses with a professional responsibility to provide the best possible care for paediatric patients, and asked themselves questions about why they were unable to provide effective pain care and how they could help their patients alleviate their pain. Reflection enabled the nurses to keep a check on what they were doing and how they themselves responded. It allowed them to explore alternative actions or interventions

in alleviating paediatric patients' pain. At all times they were consistent in their desire to be 'good' nurses. For instance, when they knew that a patient was still experiencing severe pain, despite having been administered an analgesic drug as per the doctor's order, they asked themselves why the patient was still in pain and what else they might do to alleviate the patient's pain. Through reflection they tried to find a solution to reduce the patient's pain. They then provided non-pharmacological interventions to alleviate the patient's pain and asked the parent to monitor the child's condition and give comfort to the child. They used reflection as a way of making sense of what was happening and being comfortable with their own role in the situation.

By using reflection, nurses increased their awareness and understanding of how their complex working environment and the overall system impacted on their perceived roles when caring for paediatric patients in pain. This awareness included the nurses' concerns about not being able to conduct their perceived role effectively, their dilemma between personal values and professional ideals, and their feelings of inadequacy. Nurses explained that using reflection on their own was useful to comfort themselves when they felt emotionally upset and, distressed, or when they were questioning incidents occurring within the paediatric ward. In addition, understanding the system within which health care was delivered was necessary to enable them to address the conflict between their own internal environment and the health care setting (Epstein & Delgado, 2010). From their accounts of their experience, it was identified that the nurses reflected on what should be done in order to reach the goal of alleviating paediatric patients' pain.

Reflection was acknowledged as an effective method of reducing nurses' feelings of moral distress and maintaining emotional wellbeing while working in paediatric wards. Nurses felt better because reflection helped them to reduce feelings of emotional distress and helped them to evaluate and validate the care they gave to paediatric patients experiencing pain. Learning through reflection helped nurses to gain insight into, and understanding of, the situations that they found themselves in. This tactic also helped them to question themselves and explore alternative perspectives with regard to their own and others' thoughts, feelings, behaviour and actions (Horton-Deutsch & Sherwood, 2008).

6.3 Chapter 6 summary

The process of managing professional role tensions is a grounded theory that explains the way in which nurse participants in this study employed strategies to manage or reduce their professional role tensions when caring for paediatric patients in pain. It provides a theoretical framework that explains the way in which the nurses processed this concern. The process consisted of four strategies: (1) accommodating professional role tensions; (2) seeking support; (3) responding action; and (4) reconciling moral distress. These four strategies occurred both individually and simultaneously. The first strategy, accommodating professional role tensions, had two main properties: rationalising professional role tensions and using positive coping strategy. These two properties interacted with and influenced each other in the participant nurses' accommodation of their professional role tensions in order to protect themselves from distress and maintain their emotional wellbeing, so that they could keep working and providing pain care for their paediatric patients.

When it came to the second strategy, seeking support, nurses needed to determine whether they were doing the correct thing in the clinical setting. Seeking support was a strategy used by nurses to identify the underlying cause of their professional role tensions and assure themselves that they had tried to provide pain care to the best of their ability. Nurses in this study also sought the support of hospitalised children's parents to assist them in providing pain care for the children. This strategy was effective in reducing their professional role tensions due to organisational and hierarchical constraints, and helped them to accept the conditions within the workplace.

In the third strategy, responding action, nurses accepted responsibility for responding to and managing the paediatric patient's pain problem to the best of their ability, while at the same time acting responsibly to meet the needs of the paediatric wards as a whole. However, as a consequence of responding action, nurses accepted the difficulties and limitations of situations and tried to do what was possible in order to be able to provide effective pain care.

In the fourth strategy, reconciling moral distress, nurse participants tried to reduce moral distress and restore their moral integrity. They acknowledged that their moral distress, if not managed or resolved properly, could affect both nurses and patients negatively, and that their stress could lead to their experiencing burnout, as well as affecting their health and wellbeing. However, the nurses in this study knew that they must be able to reconcile their moral distress and to do this they tried to deal with the incongruence between their ideal concept of themselves and the reality of what transpired in practice. This strategy was effective in alleviating the nurses' moral distress so that they were able to maintain their emotional wellbeing during the process of working and caring for their patients in paediatric wards.

In the following chapter, the findings of this study, including the theory of the process of managing professional role tensions, will be discussed in relation to existing, relevant literature, and the implications and recommendations of this study will also be discussed.

CHAPTER 7

DISCUSSIONS, RECOMMENDATIONS AND CONCLUSIONS

7.1 Introduction

Using a grounded theory method, this study explored nurses' experience with and perceptions of pain management practice within the context of Indonesian paediatric wards. This methodology allowed the researcher to identify the core problem for study participants, which was their experience of professional role tensions. In addition it allowed for an explanation of how these nurse participants tried to manage these professional role tensions in order to protect themselves from distress and maintain their emotional wellbeing. Furthermore, the methodology has provided a theoretical framework that explains the way in which the nurses processed this concern. This study provided the researcher access to the Indonesian nurses' world and captured the reality of nurses' pain management practices when working with hospitalised children in pain. The process of managing professional role tensions explains how the nurses attempted to manage or minimise the role tensions they experienced. This process enabled them to protect themselves from distress and to maintain their emotional wellbeing; as a result they felt better able to continue working within the context of paediatric wards. The processes enabled them to reconcile their inability to alleviate paediatric patients' pain. Hence they adapted to the limitations imposed by the workplace. The findings from this study can be used to support nursing practice, by highlighting the issues that have led to these participants experiencing professional role tensions. It brings into focus both positive and negative aspects of the situation and of the nurses' resulting views and actions.

The findings of this study were presented in Chapter 5 and Chapter 6 and described the grounded theory of the process of managing professional role tensions. This chapter will present the discussion of the findings, as well as the implications for clinical practice, and the recommendations and conclusions of this study. This chapter provides a discussion of how the findings relate to existing literature and contribute to the field of pain management in children, and offers a deeper explanation of the theory. The chapter also discusses the ways in which the outcomes of this current study could be used, making specific recommendations for nursing

practice, education and future research. It concludes with a discussion of the limitations of the study and provides a concluding statement.

7.2 Discussion

The findings from this current study advance our understanding of the contextual issues influencing nurses' pain management in hospitalised children in Indonesia. As a result the findings will enable a more comprehensive targeted approach to better pain care. All the nurse participants knew what was expected of them with regard to pain management and wished to provide effective pain care for their patients to the best of their ability. However, among the findings were a number of contextual factors in the hospital settings, which participants considered to be impeding nurses' ability to provide effective pain care for hospitalised children. This outcome contrasted with their wish to provide effective pain care. The participants experienced conflict in these situations because even though they had the desire to provide effective pain care, in reality they were unable to achieve this objective. As a consequence of this dilemma, the participants experienced professional role tensions. The professional role tensions occurred as a result of the conflict between the nurses' perceptions of the barriers to the provision of effective pain management and their views about how the role of pain management should be carried out. The following section will discuss the major findings emerging from the concepts identified in this study, beginning with the core category of the barriers to the provision of pain management to paediatric patients, followed by the core category of carrying out the pain management role, and lastly, the substantive theory of the process of managing professional role tensions that emerged from this study, which is then related to the existing literature.

7.2.1 Barriers to pain management

The literature has indicated that although there has been significant knowledge development during the last two decades, and a number of guidelines for effective pain relief have been published internationally, the management of children's pain remains ineffective not only in Indonesia, but also globally (Buscemi et al., 2008; Stinson et al., 2008). As a result paediatric patients continue to suffer pain needlessly. Previous research has indicated that there are several factors that inhibit adequate pain management in hospitalised children, such as organisational factors,

nurses' knowledge, nurses' experience and nurses' beliefs and attitudes (Gimble-Berglund et al., 2008; Simons & Roberson, 2002; Twycross, 2011; Vincent, 2005; Vincent & Denyes, 2004). The findings of this study provided evidence to support the existence of these barriers to pain management in paediatric patients. The context of the organisation was identified by nurses as a barrier to providing effective pain care for children. There were two major organisational constraints that affected nurses' ability to provide effective pain management: structure of the organisation and culture of the organisation. The following section will discuss the organisational constraints hindering the provision of effective pain care to paediatric patients.

7.2.1.1 Structure of organisation

One important element of the work environment is the organisational structure (Campbell, Fowles, & Weber, 2004). For the nurses in this study the structure of the organisation was an important factor affecting the care and pain management of paediatric patients in the clinical setting. The organisation within which pain management took place often imposed a number of constraints, which unintentionally impeded the effectiveness of pain management in children. The study findings revealed that organisational practice, policies and procedures limited the extent to which the nurses could fulfil their roles in providing effective pain management. These findings also support those of some earlier studies, which indicated that organisational factors acted as barriers to pain management in children (Czarnecki et al., 2011; Gimble-Berglund et al., 2008; Rejeh et al., 2009; Rejeh et al., 2008; Simons & Roberson, 2002; Twycross & Collins, 2013; Vincent, 2005). This emphasis reflects the important role that the workplace environment plays in enabling nurses to provide effective pain management. A number of issues regarding the organisational structure, such as imbalance in nurse-patient ratios and lack of sufficient education and/or training, were identified in the data and impacted on nurses' pain management ability when caring for children experiencing pain. These issues will be discussed further in the following section.

7.2.1.1 1 Imbalance in nurse-patient ratios

Not surprisingly, barriers to the provision of effective pain management, such as imbalanced nurse-patient ratios, have been previously reported in the literature, (Aiken et al., 2001; Bucknall et al., 2007; Ely, 2001; Rejeh et al., 2009; Schafheutle,

Cantrill, & Noyce, 2001). Similarly, the findings of this study revealed that imbalanced nurse-patient ratios affected nurses' ability to fulfil their role and deliver quality patient pain care. Nurses in this study felt that this factor exaggerated the problem of being unable to provide effective pain care and that this had implications for both the nurses and their patients. Similarly, a study in America by Hart (2003) found that under-staffing made nursing care more task-oriented, giving less time to provide individualised patient care. Aiken et al. (2001) also found that nurses were not able to provide quality patient care because the number of nurses was inadequate. A previous study by Beck (2000) identified that a shortage of nurses was a barrier to providing optimal pain management in cancer patients. Nursing shortages constitute a difficult problem in the provision of health care and are a worldwide phenomenon (Kalisch, Lee & Rochman, 2010). The findings of this current study are supported by those in previous studies (Aiken et al., 2002; Patterson, 2011) where inadequate staffing levels prevented nurses from providing effective pain care. Moreover, because of inadequate staffing, nurses in this study felt dissatisfied with their work and working environment. Similarly, previous studies have identified that inadequate staffing leads to reduced job performance among nurses and also to decreased nurse and patient satisfaction; this results in burnout and increased nurse turnover rates (Aiken et al., 2001; Aiken et al., 2002; Campbell et al., 2004; Duffield & O'Brien-Pallas, 2003; Fletcher, 2001).

The situation of imbalanced nurse-patient ratios, staff shortages, and an escalation in the number of non-nursing duties meant nurses in this study experienced heavy workloads. The study results indicated that workload was a major characteristic of the work environment of paediatric care nurses. It was also one of the most important job stressors among nurse participants. Nurses in this study perceived that nurses' workload was the most influential extrinsic factor affecting nurses' roles in managing hospitalised children's pain. Due to the heavy workloads on the ward and inadequate staffing, they felt that they were unable to conduct pain assessments and apply non-pharmacological interventions effectively to relieve patients' pain according to what they had been taught during their pre-service education. Similar findings were derived from previous research (Ellis et al., 2007; Kaasalainen et al., 2007; Kuuppelomäki, 2002; Rejeh et al., 2009; Simon & MacDonald, 2004; Twycross & Collins, 2013). For instance, Rejeh et al. (2009) found that nurses' workload affected

nurses in managing patient pain. Nurses perceived that their efforts in conducting pain assessment and implementing interventions for their patients were disturbed, due to their workload and shifts. They had to take extra responsibilities, especially on night shifts, because of a lack of nursing staff on the shifts. Twycross and Collins (2013) also identified nurses' workload as an influence on nurses' pain management practices. Furthermore, the findings of this current study identified that the heavy workloads and the overtime they were expected to work made nurse participants feel fatigued and experience job stress. This finding was congruent with previous research that had identified that work demands and inadequate staffing may exceed an individual's ability to cope effectively and may lead to burnout, job dissatisfaction, injury and illness (Maslach, 2003; Tzeng, 2002). Thus, the results of this current study indicated that nurses' workload adversely influenced the quality of paediatric patients' pain care, and had adverse outcomes for the participants.

As well as inadequate staffing and heavy workloads, time constraints were another condition that hindered nurses in this study in their attempts to provide effective pain care. The study results demonstrated that when nurses faced time constraints they were unable to dedicate themselves to any one task for a long period of time. This condition prevented nurses from delivering what they perceived to be effective pain care. Within this context nurses tried to finish their assigned tasks as quickly as possible in order to complete all of their required duties. As such, they experienced conflict, believing that their professional voice was compromised because the focus of their care was task-oriented, which meant focusing more on activities rather than providing patient-centred care. Similarly, Nasrabadi, Emami and Yekta (2003) conducted a study of Iranian registered nurses' experience of nursing, and socio-cultural factors influencing that experience. This study used interpretative phenomenology method to analyse written descriptions by 75 nurses. The findings of Nasrabadi et al.'s study (2003) revealed that the majority of nurses adopted a task-oriented nursing approach because of inadequate staffing and heavy workloads.

This current study's finding was congruent with the literature, where time constraints have been reported to impede nurses' ability to provide adequate pain assessment and management (Blondal & Halldorsdottir, 2009; Czarnecki et al., 2011; Dalton et al., 2001; Gimbler-Berglund et al., 2008; Kaasalainen et al., 2007; Manias et al.,

2005; Puls-McColl, Holden & Bushmann, 2001; Rejeh et al., 2009; Schafheutle et al., 2001; Vincent, 2005). For instance, nurses in Rejeh et al.'s study (2009) commented that time constraints forced them to revise work patterns so they could complete many tasks in a limited time, and that time constraints were a barrier to managing post-operative patients effectively. It is clear from the findings of this current study, and also supported by the literature, that a lack of time has been identified as a barrier to achieving effective pain management practice in clinical settings.

The study findings identified that inadequate staffing, workloads and time constraints resulted in nurses questioning the quality of the nursing care they gave, resulting in their feeling conflicted, frustrated, and stressed, and experiencing job dissatisfaction. Nurses in this study confronted serious ethical dilemmas when caring for hospitalised children in pain. When human resources were limited, and they faced heavy workloads and time constraints, the dilemma for nurses was how they could fulfil their professional roles to advocate for and provide effective pain care to paediatric patients. The working environment and the type of work carried out by nurses caused them to experience work stress, and produced role tensions. These study findings were congruent with previous studies, which had identified a link between workload, inadequate staffing and job stress (Aiken et al., 2002; Cho, Ketefian, Barkauskas, & Smith, 2003; Duffield & O'Brien-Pallas, 2003; Strachota, Normandin, O'Brien, Clary, & Krukow, 2003). For example, Strachota et al. (2003) found that 46% of nurses felt frustrated with the quality of care they delivered because of the lack of nursing staff and increased workloads. It is clearly identified from the study results that inadequate staffing levels, nursing workloads and time constraints negatively impact on Indonesian nurses' pain management of hospitalised children.

The condition of imbalanced nurse-patient ratios, time constraints due to heavy workloads, and inadequate staffing should be considered by nurses and nurse managers because it may affect not only the nurses but also patient outcomes (ANA, 2000; Buchan, 2006; Unruh, 2008). Nurse outcomes may impact on patient outcomes, and vice versa (Aiken et al., 2002; Australian Nursing Federation, 2009). For instance, when nurses felt unable to provide effective pain care, this made them feel dissatisfied with their work, which in turn decreased patient satisfaction with

care (Strachota et al., 2003). The literature has identified that the imbalance in nurse-patient ratios and also time constraints due to heavy workloads, and inadequate nursing staffing, enhance patient acuity and complexity (Buchan, 2009; Preston, 2009). Inadequate nursing staffing may put patients at risk of not receiving optimal care, and threatens patient safety outcomes (Aiken et al., 2002). There is evidence that shows that inadequate staffing results in adverse events such as post-operative infections, higher incidences of pneumonia, nosocomial infections, medication errors and mortality (Al-Kandari & Thomas, 2006; Doran, 2003; Unruh, 2008). Poor nurse and patient outcomes may translate into higher costs as a result of nurses' low productivity, high staff turnover, and longer hospitalisation.

One way hospitals and organisations may achieve quality of care, including pain care, is through the adoption of strategies such as the Productive Ward: Releasing Time to Care' program (NHS Institute for Innovation and Improvement & National Nursing Research Unit [NHSI & NNRU], 2010). The literature notes that the productive ward model of care has demonstrated an outcome of improved, quality patient care (Crump, 2008; NNRU, 2010). The productive ward program draws on principles of 'lean thinking' to help tackle everyday issues facing staff nurses. Lean thinking aims to diminish activities that do not add value (NHSI & NNRU, 2010, p. 8). The result is that more nursing staff time is released, better enabling nurses to provide direct patient care and to meet patient needs. The productive ward program offer a positive way to engage, support and acknowledge nursing staff and improve the nursing care services they provide (Crump, 2008; NHSI & NNRU, 2010; Taylor, 2006). The program has the potential to produce a subsequent improvement in patient and staff satisfaction, as well as a cultural change for the workforce (Wilson, 2009). However, 'lean thinking' must be applied with care, as it has its dangers, especially when used in health care delivery, as it can remove the caring and replace it with 'efficiency' (Shields, 2010 a; Winch & Henderson, 2009).

7.2.1.1.2 Lack of sufficient education and/or training

Another significant finding of this study was the gaps in nurses' knowledge. In particular, gaps were found in relation to pain assessment skills, and the basic knowledge and principles of pharmacological pain management, including pain medication, drug action and the side effects of analgesia and its management in

children. Nurses in this study did not always feel that they possessed the knowledge to make decisions and provide effective pain care. Similarly, previous studies have found that gaps remain in nurses' knowledge and this results in inadequate pain management (Alavi et al., 2008; Ellis, et al., 2007; Gimbler-Berglund et al., 2008; King, 2004; Malviya et al., 2005; Rieman & Gordon, 2007; Simons & Roberson, 2002; Simons & MacDonald, 2004; Twycross, 2004; Twycross, 2010; Twycross & Powls, 2006; Vincent, 2005, 2007; Vincent & Denyes, 2004). These studies have highlighted nurses' general deficiency of knowledge regarding pain and pain management strategies, in a variety of settings. Knowledge gaps were identified in previous studies, in areas such as physiology of pain (Twycross, 2004); pain assessment (Manworren, 2000; Rieman & Gordon, 2007; Salantera & Lauri, 2000); basic pharmacological principles (Manworren 2000); analgesic drugs (Manworren, 2000; Salantera & Lauri, 2000; Rieman & Gordon, 2007; Vincent, 2005); and non-drug methods (Manworren, 2000; Twycross, 2004; Vincent, 2005), as well as the psychological factors that may play a role in managing pain (Twycross, 2010). Such findings raise important questions about the kind, source, and adequacy of the clinical knowledge used by nurses to assess and manage paediatric patients' pain. Clearly, research has highlighted that because of nurses' lack of pain management knowledge there is little evidence of improvement in pain management practice over the last three decades. In particular, this current research supports previous studies, which have highlighted the influence of nurses' lack of knowledge about pain and its management on ineffective pain management in children. The literature has identified that nurses' lack of knowledge about how to manage pain in hospitalised children is an international problem (Enskar et al., 2007; Simons & Roberson, 2002; Van Niekerk & Martin, 2001).

This limited knowledge influenced nurses' actions in managing hospitalised children's pain and was one reason for nurses in this study stating that they lacked confidence. As a result nurses felt powerless and experienced role conflict; this situation led to their feeling that they were unable to collaborate with doctors and could only follow orders. Results of this study were congruent with previous research that has also identified that lack of confidence can negatively impact on competent nursing and hinder collaborative behaviour (Ulrich et al., 2010). When nurses lacked confidence in interpersonal collaboration, they tended to avoid interactions with

other health care professionals (Boswell, Lowry, & Wilhoit, 2004; Casey, Fink, Krugman, Propst, 2004; Fink, Krugman, Casey, & Goode, 2008; Pfaff, Baxter, Jack, Ploeg, 2014).

Insufficient education and/or training have been identified in this current study as contributing factors that hinder nurses attempting to provide effective pain care in children. The content of Indonesian curricula in nursing diploma programs was mentioned by nurses in this study as a barrier to providing effective pain care. Pain assessment and management were not specifically identified in the paediatric nursing syllabus. In addition, this statement by the nurses could suggest that because they had trained for a general role, pain management was covered, but not in the detail required to take on a specialised pain management role in paediatrics. As a result nurses did not know how to accurately assess paediatric patients' pain or effectively administer analgesic drugs. Insufficient educational preparation or basic training has been identified in previous research as one of the major reasons for nurses providing inadequate paediatric pain management (Namnabati et al., 2012; Malviya et al., 2005; Simons & Roberson, 2002).

From the study findings there has emerged a picture of nurses lacking knowledge of pain assessment and its management in children, and of an enduring theory-practice gap. However, it seems that nurses in this study may not have had the required theoretical knowledge to manage paediatric patients effectively. A theory-practice gap with regard to pain management has also been found in a number of previous studies (Ellis et al., 2007; Manworren, 2000; Salantera & Lauri, 2000; Simons & Roberson, 2002; Stanley & Pollard, 2013; Twycross & Powls, 2006; Twycross, 2007; Vincent & Denyes, 2004; Watt-Watson et al., 2001). It was clear from these studies' findings that inadequate knowledge of pain management among nurses occurs in many countries, including Indonesia (Abdalrahim, Majali, Stomberg, & Bergbom, 2011; Wang & Tsai, 2010). However, even though the previous research provided sufficient evidence of nurses' lack of pain knowledge, filling the gaps effectively remains elusive (Simons & Roberson, 2002).

Nurses in this study recognised that their knowledge of pain management was still limited. They highlighted the need to have good knowledge and skills as a way to

increase their self-confidence and to enable them to act as a patient advocate, this knowledge would be acquired through continuing education or training in pain assessment and pain management. Nurses believed that if they were better prepared regarding pain assessment and pain management, they would be able to provide effective pain care. Participants felt that knowledge and skills were needed to increase their professional power and in turn support them to provide effective pain care. Having more knowledge and improved skills could help to empower nurses, as shown in previous studies (Sawhney & Sawyer, 2008; Williamson-Swift, 2007). Thus, the findings of this study suggested that training and/or continuing education aimed at enhancing paediatric nurses' knowledge of paediatric pain management is needed. The training should include knowledge regarding (1) the physiology of pain; (2) the patho- physiology of pain (acute and chronic pain); (3) pain assessment and measurement in infants and children; (4) pharmacological approaches to pain management; (5) non-pharmacological approaches pain management; (6) duration, action and equivalent doses of analgesics drugs, and (7) the true risk of addiction. Previous studies have shown that nurses' knowledge and pain management was improved after a pain education program was provided (Abdallah et al., 2011; Lin, Chiang, Chiang, & Chen, 2008; Zhang et al., 2008).

7.2.1.1.3 Lack of organisational support

Another significant finding of this current study was the lack of support from the organisation. This lack of support was identified as another barrier to providing effective pain care in hospitalised children. Nurses felt that organisational management did not provide them with adequate resources to enable them to effectively manage children's pain. For instance, they needed pain assessment tools, pain management guidelines and SOPs for pain management. Moreover, nurses suggested that they were not able to provide effective pain care because of the absence of official directives or reinforcing guidelines from the hospital organisation to guide them in performing this aspect of their role. It would appear from the findings that these participants had a strong sense of an external locus of control where they felt that the care they provided, and any changes to care, needed to be directed from higher up within the organisation. People with an external locus of control are more likely to believe that their fate is determined by outside forces that are beyond their own personal control (Salazar, Pfaffenberg, & Salazar, 2006). They

believe that their failures or successes are dependent on others and not on their own efforts (Hsu, 2011; Karimi & Alipour, 2011). Nurse participants believed that, due to the lack of managerial support, they were unable to provide effective pain assessment and management, and that they were unable to control this situation. As a result of this situation they experienced role tensions and job stress. Managers or the organisation itself were seen as responsible for providing resources and facilities to promote the nurses' role in providing effective pain care for hospitalised children. Organisational support has a significant relationship with the employee's job satisfaction (Dawley, Andrew, & Bucklew, 2008).

The results of this study may correlate with the current absence of a regulatory body for nursing within the Indonesian context, and the absence of an official scope of practice. These results demonstrated that because of the lack of regulatory standards for nursing practice, and in the absence of nurses' job descriptions, nurses in this study were not able to provide effective pain care for paediatric patients. Nurses delivered nursing practice, including caring for paediatric patients in pain, without using frameworks or standard practice for pain assessment and its management. The absence of a job description could possibly affect how the nurses interpret the limits of their role and this might be reflected in their understanding of the tasks that must be performed. Working without a framework of practice created role conflict and ambiguity about their professional identity. Reinforcing these suggestions is the fact that in most parts of Indonesia, there is no registering authority for nurses (Shields & Hartati, 2003).

The problems associated with inadequate clinical standards of care within Indonesia could be addressed through the development of formalised regulatory frameworks for nursing practice. The framework or scope of practice complements the key professional elements of accountability for practice, advocacy, autonomy and collaboration (White et al., 2008). In particular, the scope of practice supports professional accountability when each individual nurse uses his or her professional discretion to make practice decisions (Girard, Linton, & Besner, 2003). Delivery of high-quality paediatric patient care depends on a nursing workforce that is empowered to provide care according to a known scope of nursing practice, or professional nursing standards. It is clearly identified from the study findings that the

hospital organisation was considered an important factor that prevented nurses from fulfilling their role in providing effective pain care. These findings are supported by literature that shows organisational practice, policies and procedures may limit the extent to which nurses can intervene to provide effective pain management (Ely, 2001; Twycross & Collins, 2013).

7.2.1.2 The culture of the organisation

The culture of the organisation was also identified as another significant factor that affected nurses' ability to provide effective pain management in hospitalised children. The culture of the organisation emerged in the narratives as a barrier to providing effective pain care in hospitalised children. Nurses in this study considered the organisational culture to be a complex environment with a bureaucratic institutional and hierarchical culture of medical dominance, and a defined chain of command, which tended inherently to promote stability and resist change. The results of this current study were supported by previous research, which has clearly identified that the culture of the organisation has an impact on pain management practice (Clabo, 2008; Hagbaghery, Salsali, & Ahmadi, 2004; Twycross & Collins, 2013). Many cultural organisational issues were mentioned by the nurse participants, including factors such as the lack of professional autonomy, powerlessness, inability to advocate for the patient and the lack of a team approach to pain management. In the following section these issues will be discussed further.

7.2.1.2.1 Feeling powerless

One important factor that was identified in the study that acted as a barrier to pain management was powerlessness. Participants felt powerless because they felt they lacked knowledge, authority and professional autonomy when making patient care decisions. All participants felt powerless in pain management because they were dependent on physicians' decisions and instructions. They suggested that physicians had all the authority and that medical dominance was still current in the Indonesian context. Medical dominance refers to the power of the medical profession in terms of authority and control over its own work, over the work of other health care professions and in relation to health policy and decisions (Germov, 2002). This study found that medical dominance was widespread and impacted on paediatric nursing care, including pain management, contributing to the workplace pressures that

caused nurse participants to experience role tensions. Significantly, the power of physicians made it difficult for individual nurses to provide effective pain care. Similarly, Dealy (2002) showed that medical dominance could be seen as one of the main difficulties affecting the implementation of successful pain management. This current study's finding on medical dominance was also congruent with previous studies conducted in Iran, describing the barriers to effective pain management (Nasrabadi et al., 2003; Rejeh et al., 2008).

It is important to consider that the similar findings between this and the previous study in Iran may be attributable to the fact that Indonesia and Iran share a similar historical, social and cultural context. Historically, the nursing profession in all countries, including these two countries, is largely female, although in Indonesia, 25% of nurses are men, and men largely dominate the higher echelons of power within the profession (Shields & Hartati, 2003). The difference may be that the subordination of women to men is still very strong in Indonesia. Women in Indonesia continue to lack equal rights with men. Indonesia has a patriarchal culture featuring gender inequality, in which women are taught to submit, and to devote their life to the wellbeing of the family (Utomo, 2006). Women are praised for being accepting of their fate, and are not expected to question authority. Meanwhile, men are acknowledged as heads of their households, and are superior in the family structure. Therefore, the power afforded to men in Indonesian society may be contributing to nurses' continuing lack of power within the work context. Conceptually, masculine power refers to the pattern of practice that allows men's dominance over women (Hearn, 2004). The literature notes that medicine has historically maintained a position of dominance and power within the health care system (Kenny, 2004). Although this has been changing as Indonesia modernises—as education for women increases and is more valued, and as the country's economy improves—a strong hierarchical order persists in family life as well as in public life (Hamlin & Brown, 2011), and there is a relatively large proportion of men in lead nursing roles. Thus, it is not surprising that the cultural or core values that influence the Indonesian context are reflected in the hospitals and in organisations (Hamlin & Brown, 2011).

Despite the larger number of men in nursing, the influence of medical culture clearly places nursing practice in a subordinate position in the delivery of patient care, in the

Indonesian context. The overarching structure of Javanese society makes it easy for doctors to assign subservient roles to nurses. Nurses have little scope for independence to make decisions regarding patient care. Nurses in Indonesia are not seen as being integral to the health care team in terms of decision-making about patient care (Hamlin & Brown, 2011). According to Gerrish and Griffith (2004) this attitude leads to nurses' reluctance to question the practice of medical doctors or to speak up on behalf of patients, and this contributes significantly to the continuing medical dominance in nursing practice. As found in this study, some nurses readily accepted doctors' orders without asking questions.

The study findings clearly showed that there were power imbalances between nurses and doctors. Power imbalance between nurses and doctors happens due to unequal exercise of power, professional socialisation patterns and lack of sharing in decision-making on patient care (Orchard, Curran & Kabene, 2005). Power imbalance leads to conflict within and among health care professionals, frustration amongst all parties who are not part of the decision-making process, and potentially leads to problems with patient safety (Orchard et al., 2005). Thus, gender-related power issues seem still to create problems in the working relationship between nurses and doctors.

The power of doctors arises from knowledge disparities and from social class (Zelek & Phillips, 2003). Many nurses traditionally came from lower social classes than most doctors (Sirota, 2007). In Indonesian society, doctors commonly enjoy significant prestige, respect, and financial success, and in the health care setting, they have greater autonomy than nurses. The difference in educational levels between doctors and nurses may be another factor affecting power imbalance between nurses and doctors (Sirota, 2007). Doctors' education emphasises scientific expertise, autonomy, and authority (Zelek & Phillips, 2003). The educational profile of nurses in Indonesia is still sub-optimal compared with that of doctors, with the majority of nurses educated to nursing diploma level only (Hennessy, Hicks, & Kawonal, 2006). Thus, it can be understood why nurses in this study felt powerless, and experienced professional role tensions. The issue of feeling powerless requires in-depth understanding in order to assist nurses such as those interviewed in this study to empower themselves and to overcome the perceived feelings of powerlessness, the

inadequacy and role tensions that have often hindered nurses from delivering effective pain care.

7.2.1.2.2 Lack of professional autonomy

Autonomy refers to the freedom to make decisions within the domain of an individual's profession, and to act according to one's knowledge and judgement, providing nursing care within the full scope of practice and exercising control over the content of nursing practice (Kramer & Schmalenberg, 2003; Varjus, Suominen, & Leino-Kilpi, 2003). One of the characteristics of a profession is that professionals have power over the practice of their discipline, a capacity that is often referred to as professional autonomy (MacDonald, 2002). The ability to make autonomous decisions based on comprehensive knowledge, clinical expertise and research evidence is a hallmark of professionalism (Papathanassoglou et al., 2012).

Unfortunately, the findings of this study revealed that nurse participants felt that nurses lacked professional autonomy. They did not have the freedom to make decisions about pain management in children. This situation was found to be a further barrier to the provision of effective pain management to hospitalised children. The nurses were unable to work autonomously due to the organisational constraints. In fact, it was the culture of the organisation and the physician-centred and task-oriented culture that required nurses to obey doctors' orders. Nurses perceived they had little authority in pain management decisions related to patient care, because they were working in an unsupportive institutional culture that did not formally support them to conduct their practice autonomously.

The findings of this study indicated that one aspect of autonomy that was missing for the nurse participants was their independent and interdependent (collaborative) involvement in pain management decisions. Nurses perceived that nurses and doctors did not share their perceptions of their own and others' roles in providing health care. Doctors were dominant when it came to making decisions related to delivering patient care, including patients' pain management. Some participants felt that they were still treated as the doctor's helper, with little or no authority of their own. This situation created role conflict and moral distress for nurses. Lack of professional autonomy and problematic interdisciplinary collaboration may inhibit nurses' ability

to use personal and professional moral reasoning, and this situation may lead to moral distress (Papathanassoglou et al., 2012). A previous study by Hamric and Blackhall (2007) on end-of-life decisions found that nurses who experienced moral distress were not satisfied with the level of care they provided and were more likely to report experiencing lower-level collaboration.

Lack of professional autonomy, combined with little authority or influence over the governance of hospitals, was a barrier preventing nurse participants from being able to take control over their practice and provide effective pain care. 'Control over nursing practice' refers to the nurses' ability to shape organisational policies and practice regarding nursing care (Weston, 2008). Findings of this study revealed that nurse participants were not able to take control over their practice, because they lacked professional autonomy and identity. Professional identity is a complex phenomenon that reflects the internalisation of the knowledge, skills and attitudes that are considered to reflect the particular profession (Takase, Kershaw, & Burt, 2002). Professional identity can be seen when nurses interact with others in the context of their role within the organisation, revealing itself in how they describe their roles, their self-image, and their perceptions of how they believe others view them (Cowin, 2001; Takase et al., 2002). Nurses in this study perceived that although they were professional within this context, in reality they were unable to act autonomously when fulfilling their professional nursing role. As noted earlier, nurses felt unable to speak up and voice their opinions regarding pain treatment to the doctors. The organisational culture did not recognise or reward autonomy in nursing practice. Participants considered that the nurse's role was invisible in the health care setting and was less powerful than the doctor's role. This situation confronted them with a professional dilemma as they were not able to appropriately care for their patients; as a result, their commitment to the profession was undermined. The study findings identified that participants perceived that, because they lacked professional autonomy, they were not able to raise their status and professional identity, define their area of expertise, or have influence on or control over their professional practice. This contributed to their feeling powerless and ineffective, and dissatisfied with the health care system in which they worked. The association between lack of autonomy, job dissatisfaction and collaboration between nurses and doctors was

identified in previous studies (Chaboyer, Najman, & Dunn, 2001; Finn, 2001; Keuter, Byrne, Voell, & Larson, 2000).

7.2.1.2.3 Unable to act as a patient advocate

The literature revealed patient advocacy as a moral obligation for nurses and as a philosophical foundation for practice (Cramer, 2002; McKeown & Gibson, 2007; Negarandeh et al., 2006). Advocacy in nursing has been described as part of the professional nurse role and as an important aspect of good care (Cramer, 2002; Hanks, 2007; Kubsch, Sternard, Hovarter, & Matzke, 2004; McKeown & Gibson, 2007; Negarandeh et al., 2006; Vaartio, Leino-Kilpi, Suominen, & Puukka, 2008). As a patient advocate, the nurse promotes, advocates for, and attempts to protect the health, safety and rights of the patient (ANA, 2001). Nurses play a key role advocating for children in decisions about their health because children are vulnerable patients (McClearly et al., 2004; Twycross, 2008; Vaartio et al., 2008). As a result of this vulnerability, they need advocacy on their behalf (McClearly et al., 2004; Negarandeh et al., 2006; Twycross, 2008).

All participants in this study understood that patient advocacy was one of the primary roles of nurses in delivering paediatric patient care. Unfortunately, in the practice reality, acting as an advocate was often a difficult role for the nurse to perform. Participants identified this situation as another barrier to the provision of effective pain management. The factors identified that prevented nurses from acting as a patient advocate were medical dominance, lack of managerial support, and powerlessness. Participants believed that the culture of the hospital system, such as physicians leading care, was an important factor that made it difficult for them to act as a patient advocate. The perceived oppression by doctors and lack of control over patient pain management decisions exacerbated nurses' perceived knowledge deficit and lack of professional authority. Consequently, they considered themselves unable to perform their role as patient advocate, or influence pain management decisions. This situation led them to experience professional role tensions including feelings of role conflict, and role ambiguity, which then impacted on their ability to provide effective pain care for paediatric patients. These findings were congruent with the literature. Negarandeh et al. (2006) suggested that one of the biggest obstacles to advocacy was the health care organisation itself, because patient advocacy often is

basically in conflict with the culture of the hospital system. All nurse participants argued that without collegial, physician and manager support for advocacy, they were unable to deliver this aspect of the nursing role. Davis, Konishi and Tashiro, (2004) concur stating nursing managers have a responsibility to assist nursing staff to advocate for patients and families.

Hellwig, Yam, and DiGiulio (2003) conducted a phenomenological study to examine how case managers seek creative ways to advocate for the best interests of patients, and found that there were some facilitating factors that could affect the use of advocacy. They noted that the main facilitating factors for advocacy were physician support, organisational support, and utilising a team approach (Hellwig et al., 2003) which was not evident in this study. In addition nurses in this current study emphasised the need for more knowledge about pain in children and its management, to enable them to perform their role as a patient advocate. This finding is supported by O'Connor and Kelly (2005) who suggested that the ability to advocate was based on good knowledge and expertise.

7.2.1.2.4 Lack of a team approach to pain management

According to nurse participants, having a team approach to pain management was essential to the provision of effective pain management. Unfortunately, the result of this study indicated that the organisations in which nurses worked did not have a teamwork approach to pain management. Nurses explained that although they had tried to collaborate with doctors, little had been gained for nursing in Indonesia, and there was still no real partnership or team approach to decision-making related to pain management. They believed that the existing hierarchy, within the organisations in this study's context, continued to place nurses as doctors' assistants or 'handmaidens'. This situation created role tensions for nurse participants as they felt professionally bound to follow physicians' directives. This finding was congruent with a previous study by Sandgren, Thulesius, Petersson and Fridlund (2007) which identified that when physicians and nurses do not share the same caring perspective, this causes conflict and difficulties with giving high-quality care (Sandgren et al., 2007).

Historically, the nurse-doctor relationship has been full of conflict (Orchard et al., 2005). However, the nurses in this study emphasised that collaboration with colleagues including doctors was essential to the provision of effective pain care. They realised that they were unable to provide effective pain care, particularly when using medications, without input from their medical colleagues, because doctors were the final decision-makers in relation to patients' treatment plans. Effective collaboration among nurses and between other health care professionals within organisations is essential in order to achieve quality patient outcomes (Bennet, 2003; Ellingson, 2002).

7.2.2 Carrying out the pain management role

Children are vulnerable and in need of others to recognise their needs, which exposes them to the risk of suffering from unresolved pain (Olmstead et al., 2010). Nurses are ethically bound by professional codes of conduct to promote health, to prevent illness, to restore health and to alleviate patient suffering, including suffering of pain (ICN, 2010). Thus, nurses should have the right level of knowledge to support nursing clinical practice (ICN, 2012). Nurses in this current study saw pain management as a primary and important role of the nurse. However, they realised that on many occasions they were unable to fulfil their professional role to effectively alleviate paediatric patients' pain. This outcome was due to the barriers existing in the context of paediatric settings, which in turn caused them to experience role tensions and decreased their job satisfaction. However, the findings of this study noted that they understood that they had a role to provide effective pain care for hospitalised children. The following section will discuss elements of carrying out the pain management role.

7.2.2.1 Nurses' values and attitudes towards pain management

The findings of this study indicated that nurses' values and attitudes towards pain management played a significant role in nurses' intention to provide effective pain care to the best of their ability. A genuine desire to alleviate paediatric patients' pain to the best of their ability was the motivation for caring and the concern for nurses in this study. They had the motivation to engage in pain management practices and attempted strategies to relieve paediatric patients' pain because of the values and attitudes they held toward their patients. This motivated them to do their best to

provide effective pain care, within the context of their work environment and various personal challenges. During caring episodes the nurses demonstrated compassion and commitment to their patients because they felt they had a professional responsibility to provide effective pain care. They wanted to alleviate their paediatric patients' suffering as best as they could. These values were in line with a nurse's ethical responsibility to provide quality, compassionate, competent, safe and ethical care that is not only technologically sophisticated, but also humane for their patients (ICN, 2010), and highlighted their perspective on caring as a moral ideal (Roach, 1997; Watson, 2001, 1988).

The study results showed that nurses held positive beliefs and attitudes that informed their behaviour and drove them to alleviate paediatric patients' pain to the best of their ability. The literature points out that the deepest motive for caring is the avoidance of pain and alleviation of suffering (Benner, 2003). The nurse participants attempted to commit time, effort and skill to their provision of care, even though they often faced constraints and challenges in fulfilling their desire to alleviate patients' pain and provide comfort. These findings support the work previously reported in other studies (Blondal & Halldorsdottir, 2009; Rejeh et al., 2008), which indicated that nurses' believe that pain management is one of the primary and important roles of nurses.

7.2.2.2 Nursing care related to pain management

Another important finding of this current study was that, on a few occasions, participants had successfully alleviated the patient's pain. This success enhanced nurses' motivation to engage in pain management practices; this outcome was also an effective way to increase their job and personal satisfaction, and the paediatric patients' level of comfort.

Nurses understood that pain management practices began with pain assessment, and so they moved toward preparing patients for a painful experience, administering analgesic drugs, and applying non-pharmacological interventions. They knew that pain assessment was an important component of pain management in children during hospitalisation and that it should be conducted regularly. However, they realised that they were often unable to provide routine pain assessment, or use appropriate pain

assessment tools, due to certain conditions in the ward setting such as the unavailability of pain assessment tools, and the existence of heavy workloads and time constraints. They knew that frequently they were unable to effectively assess paediatric patients' pain. This study result was congruent with those of previous studies that found pain assessment in paediatric patients was not regularly conducted and recorded, nor was formal reassessment routinely undertaken (Johnston et al., 2007; Simon & Moseley, 2008; Taylor et al., 2008; Shrestha-Ranjit, & Manias, 2010; Twycross, 2007; Twycross et al., 2013). This lack of regular pain assessment can lead to unreliable pain management practice (Shrestha-Ranjit, & Manias, 2010; Simons & MacDonald, 2004). Other studies also found that nurses did not use pain assessment tools when assessing children's pain (Simons & Roberson, 2002; Simons & MacDonald, 2004). Such findings raise important questions about the kind, source, and adequacy of the clinical pain assessment knowledge used by nurses to assess pain.

The literature notes that it is important that pain assessment should become a routine and integral part of paediatric patient care (Simons & MacDonald, 2004). Systematic, routine pain assessment using standardised, validated measures is known to be the basis of effective pain management for all patients, regardless of age, conditions and setting (Franck & Bruce, 2009; JCAHO, 2009). Evaluating behavioural and physiological factors using appropriate pain assessment tools, in conjunction with children's self-reporting of pain, is important for achieving accurate pain measurement (Nilsson, Finnstrom, & Kokinsky, 2008). Regular assessment leads to improved pain management, and results in overall patient, parent, and health care providers' satisfaction with pain assessment and management (Treadwell et al., 2002).

An important finding of this study was that some nurses were able to identify some elements that impacted on paediatric pain assessment. These elements included knowing the patient, having good rapport with the patient and spending time with them. Knowing the patient was supported by the literature as an important aspect of pain assessment and its management (Ball & McElligott, 2003). Having time is a necessary condition for providing quality patient care (Luker, Austin, Caress, Hallett, 2000). Nurses in this study emphasised the need to prepare the paediatric patient

before conducting a procedure, in order to assist children to cope better, and to reduce the child's experience of stress. It has been shown previously that preparation helps children face a range of stressful and painful events (Kain & Caldwell-Andrews, 2005).

Effective pain management in children requires both administering analgesics and providing non-pharmacological interventions (Twycross et al., 2013). In this study, nurses applied pharmacological treatments according to doctors' orders and provided non-pharmacological interventions based on their own knowledge and experience. However, they tended to use non-pharmacological interventions inconsistently because no guidelines were available for clinical implementation and also because they were too busy on account of the heavy workloads in the wards. The lack of non-standardised pharmacological approaches was also found in previous studies (Pölkki et al., 2001; Twycross et al., 2013) and could be related to these approaches not being considered as part of the nursing role (Twycross et al., 2013). A number of nurses in this current study preferred to administer prescribed analgesics because they perceived that the administration of appropriate medication was the speediest and most effective strategy for alleviating pain, as compared to non-pharmacological approaches. It was congruent with the International Association for the Study of Pain (IASP, 2005) which advocates the effective use of analgesic medication to prevent and treat pain in paediatric patients. However, the results of this current study have raised concern about the inadequate administration of analgesics, such as in terms of their dosages, and their timing. Giving analgesics round-the-clock and treating anticipated pain is best practice (Pasero, 2010). In addition, the results of this current study indicated that in the context of this study, pain management practice may not correspond to current best practice guidelines (IASP, 2005; Twycross et al., 2013).

The interaction between nurses and the child's parents was found to be influential on pain management practice. Findings identified that nurses in this study actively involved parents in managing paediatric patients' pain. They perceived that parental involvement in caring for hospitalised children in pain was important for them because parents assisted them to provide basic care such as feeding, bathing and comforting their child. Parents are an important source of information for nurses in assessing and managing pain in hospitalised children (Carter et. al, 2002). Parents

also acted as a great source of comfort for their child during hospitalisation (Shields & Nixon, 2004). Nurses mainly valued the presence of the mother. Literature noted that parental involvement was a good thing and may have an impact on the paediatric patient, promoting emotional welfare, reducing anxiety, pain, and negative post-operative outcomes (Shields & Nixon, 2004; Shields, 2001). It is widely considered that paediatric patients benefit from the continuous presence of their parents and the parents' presence has been shown to have a positive impact on the child's wellbeing during hospitalisation (Bryczynska & Simons, 2011; Shields & Nixon, 2004).

Seeking support from colleagues when providing pain care for paediatric patients was another important finding identified from this study. This strategy was essential, considering the difficulties nurses encountered when attempting to perform their role to provide effective pain care within the complex hospital organisation. Because they were unable to effectively alleviate patients' pain, the nurses sought support from their nursing colleagues by asking for help or advice. In this way they were able to reduce negative feelings, role conflict and job stress. This result was congruent with the work of Quimby and O'Brien (2006), which demonstrated that support was an effective means of reducing role stress, psychological distress, and enhancing job satisfaction.

7.2.2.3 Suggestions for improving nursing pain management

Another significant finding of this study was the nurses' suggestions for improving pain management practice in the context of paediatric settings in Indonesia. All the nurses were aware that they were not able to fulfil their professional role in effectively alleviating paediatric patients' pain, due to external and internal constraints, which led them to experience role conflict and job stress. They found it difficult to deal with all of the tensions they faced, particularly those external constraints such as organisational and socio-cultural factors. Nurses in this study recognised the reasons they experienced role conflict and stress, and they were able to offer several suggestions or strategies to improve nursing pain management practice for paediatric patients in the future.

One important suggestion was the need to empower nurses to provide pain care. Nurses in this study understood that one factor that caused their inability to

effectively alleviate paediatric patients' pain and that made them experience work stress, job dissatisfaction and role conflict, was their perceived powerlessness. The influential culture of physician-led care placed nursing as a subordinate profession, which added to their feelings of powerlessness. This situation made them perceive that they lacked both the authority and the self-confidence to make decisions regarding paediatric patient care. They recognised that in order to be able to provide effective pain care and exercise control over their nursing practice, they needed to empower themselves within the hospital's organisational system. Tomey (2000) argued that no profession can provide quality services unless its members have power and control over their own role and functions. This study's finding in this area was congruent with the literature, which revealed that nurses needed to have power in order to maintain control over their practice (Broussard, 2012; Vance, 2009). Nurses in this current study suggested that the hospital organisation and nursing managers should create work conditions that empowered and supported them to have authority in making decisions and providing pain care, based on their professional knowledge, skills and practical experiences. The literature noted that employee empowerment was an important factor in determining employee health and wellbeing in health care settings (Laschinger & Finegan, 2005). In nursing, empowering workplace conditions have been associated with positive organisational behaviours and attitudes that are consistently linked to the retention of nurses, such as job satisfaction, organisational commitment and autonomy (Laschinger, Finegan, Shamian, & Almost, 2001b). Other studies found that empowerment has also been significantly correlated with lower levels of emotional exhaustion (burnout) among nurses (Laschinger, Almost, Purdy, & Kim, 2004).

Nurses in this study wished to have more meaningful involvement in making decisions about pain management. They perceived that they had a professional responsibility to provide effective pain care, and wanted to have the authority to make independent and inter-professional pain management decisions based on their professional knowledge, judgment and experience. However, as discussed earlier, nurses in this study felt that they lacked autonomy in making clinical decisions within the context of paediatric care settings. Thus, they emphasised the need for nurses to have professional autonomy in making decisions within the domain of the nursing profession, and to act accordingly in providing pain care for hospitalised

children. The nurse participants valued working autonomously because they believed that it enhanced work satisfaction and their own wellbeing. The literature has highlighted the value and contribution of nursing autonomy and control over nursing practice in creating a healthy work environment (Aiken, Clarke, Sloane, Lake, & Cheney; Kramer & Schmalenberg, 2008). Moreover, the participants opined that the hospital and nursing managers and medical colleagues should support them to work more autonomously in delivering patient care, and should work towards finding a solution for developing nursing autonomy in health care services. As previous studies have indicated, having autonomy and control over nursing practice is associated with increased job satisfaction and improved patient outcomes (Aiken et al., 2008), and with decreased job stress, burnout, and staff turnover (Vahey, Aiken, Sloane, Clarke, & Vargas, 2004). Thus, it must be considered that achieving this outcome may improve the quality of paediatric patient care.

Nurses in this current study also emphasised the need to develop a team approach to pain management that would include both nurses and the medical profession. They believed that having good connections and collaboration with doctors was a strategy that was important to the provision of effective pain management. Previous studies found that nurse-doctor collaboration has been identified as a way of repairing the nurse-doctor power relationship and of enhancing nurses' autonomy (Keuter et al., 2000; Zangaro & Soeken, 2007). Effective nurse-physician collaboration has been associated with significantly better patient outcomes (Papathanassoglou et al., 2012; Manojlovich, Antonakos, Ronis, 2007). Nurses' professional autonomy, control over nursing practice, and effective inter-professional collaboration are viewed as core elements of nursing practice, and correlate with improved patient outcomes (Manojlovich et al., 2007). Thus, the importance of nursing autonomy and nurse-physician collaboration in paediatric nursing care cannot be overemphasised.

Another important aspect that emerged from the study findings was the need to increase nurses' knowledge and skill regarding pain management in children. They believed that knowledge was integral to enhancing their professional power to gain control over their practice, enhance nurses' autonomy, and that knowledge would in turn support them in their ability to provide effective pain care. Therefore, they suggested that the hospital organisation should provide nurses with training courses

or in-service education about pain management in children, and provide an opportunity for nurses who had graduated from the diploma of nursing program to undertake a Bachelor's degree in nursing. Additionally, they believed that having rich professional knowledge was essential to the process of empowering themselves. This finding was congruent with previous studies, which have found that possessing good professional knowledge has been shown to be the most important condition that can create personal power in nurses (Bucknall et al., 2007; Innocent, 2011; Hagbaghery et al., 2004; Manias & Williams, 2007)—because knowledge is power and those having knowledge can influence others (Sneed, 2001).

7.2.3 The substantive theory of the process of managing professional role tensions

The substantive theory of the process of managing professional role tensions developed through this study showed how fundamentally the nurse participants desired to deal with or minimise their professional role tensions, and exposed the moral distress that they experienced as a consequence of being unable to provide effective pain care for their paediatric patients. This substantive theory explained the basic psychological process of managing professional role tensions, used by the nurse participants to cope with, adjust and control their working conditions, and to adapt to reality. They understood that if they could not manage or minimise their tensions effectively, this would affect both patients' outcomes and their own emotional wellbeing. Therefore, they believed it was necessary to manage and minimise their professional role tensions in order for them to maintain their emotional wellbeing when caring for patients. As the theory's name suggests, a quest for managing professional role tensions was at the core of this process, as nurses sought to enhance wellness for themselves, and for their paediatric patients.

A search of the literature failed to identify any studies that investigated how paediatric nurses managed their professional role tensions when caring for hospitalised children in paediatric wards. Therefore, this study adds new knowledge and gives us a greater understanding of what nurses encounter and are influenced by when managing paediatric pain in the context of Indonesian hospitals. Participants primarily learned how to deal with and manage professional role tensions within their workplace. This study provides a deeper understanding of the process used by

nurse participants to manage or minimise their professional role tensions when caring for hospitalised children in paediatric care settings. As described in the previous chapter, the theory proposed four strategies in the basic psychosocial process: (a) accommodating professional role tensions; (b) seeking support; (c) responding action, and (d) reconciling moral distress. The developed theory postulated that nurses utilised the four strategies of the process when their feelings of experiencing role tensions escalated.

7.2.3.1 Accommodating professional role tensions

The first strategy, accommodating professional role tensions, enabled nurses to maintain their emotional wellbeing while working in paediatric wards, so that they could provide pain care to the best of their ability. The premise was that nurse participants tried to understand their role tensions, and adapted and adjusted to the situations which created the role tensions that they encountered in their workplace. According to the literature, accommodating is a way of dealing with conflict (Eilerman, 2006). The participants employed two types of defence mechanism as tactics to accommodate their role tensions: rationalising role tensions and using positive coping strategy. In terms of rationalising, nurse participants tried to make excuses and create justification that there was a logical reason for not being able to provide effective pain care. The findings of this study indicated that this tactic was useful in assisting nurses to analyse the complexities of the context in which they worked, and to manage or minimise professional role tensions so that they remained consistent when delivering nursing care to their paediatric patients. In this way they were able to maintain their emotional wellbeing and accept the reasons they could not achieve their goal of providing effective pain care. This study's findings about this tactic adopted by the nurses was supported by the literature, which shows that rationalisation is characterised by trying to justify or formulate a logical reason when and/or why something disappointing that is difficult to accept, happens (Cramer, 2006).

In times of facing stress or conflict, an individual normally engages in certain coping strategies to cope with stressful situations and their associated emotions (Folkman, Lazarus, Gruen, & DeLongis, 1986). Similarly, nurses in this current study were also able to use positive coping strategies to accommodate professional role tensions in

order to minimise their negative feelings of role tensions and conflict while working in paediatric wards. In this approach, the participants managed or minimised their professional role tensions by talking over their experiences and negative feelings with their nursing colleagues. They found that this approach was effective in alleviating their negative feelings and that it made them feel comfortable with the situation. This finding was congruent with previous studies which have found that nurses usually talk to other nursing colleagues about the problems they experience (Sherman, 2004; Wong, Leung, So, & Lam, 2001). In this current study some participants sought comfort by also talking about their negative feelings with their spouse or family. They believed that talking over their experiences with their spouse and family assisted them to express negative feelings about providing ineffective pain relief, such as feeling guilty and inadequate. They perceived that these coping strategies assisted them to maintain their emotional wellbeing while working in the paediatric wards, or to more easily accept reality when they were unable to achieve their goal of providing effective pain care. Sherman (2004) identified that speaking with colleagues can be of great value in helping nurses cope with stress. Wong et al., (2001) suggested that the more an individual adopts coping strategies, the less his/her stress, and the better his/her mental health.

7.2.3.2 Seeking support

Another important strategy used by nurse participants in the process of managing professional tensions was seeking support. In this strategy, they utilised two methods: seeking support from nursing colleagues and seeking support from parents. They believed this strategy was useful to minimise their role tensions and feelings of emotional distress when caring for hospitalised children in pain. They sought support from nursing colleagues because they recognised that they were not able to manage their professional responsibilities alone. The findings of this study indicated that nurse participants benefited from being able to ask for advice, guidance and suggestions from other nurses regarding the problems they encountered, such as feeling powerless and ineffective while caring for patients in paediatric wards. The literature noted that social support assists individuals to reduce psychological distress and enhance psychological wellbeing in the workplace (Folkman & Lazarus, 1991; Taylor, 2011). In this approach they also debriefed with their nursing colleagues in order to seek clarification and receive feedback, to validate their actions regarding

whatever pain management strategies they did use. Nurses wanted also to check their work with their colleagues to ascertain whether they were doing the right or wrong thing in the clinical setting. The literature notes the use of debriefing and reflection as means of seeking social support to adapt and normalise stressors (Badger, 2005; Cosway, Endler, Sadler, & Deary, 2000; Folkman & Lazarus, 1988). Additionally, the participants found that seeking support from nursing colleagues was effective in providing them with collective power and as a result they were better able to accept their complex working conditions; this enhanced their ability to reduce their professional role tensions. Previous research has identified that having support from nursing colleagues enhances positive, collegial relationships and assists in developing a healthy work environment that produces positive outcomes for both nurses and patients (Baltimore, 2006; Gerardi, 2004; Kramer et al., 2007; Schmalenberg & Kramer, 2009). This approach was found useful for empowering nurses who faced difficult situations and emotions (Pauly, Varcoe, Storch, & Newton, 2009). The participants felt that this approach made them feel at peace with, and comfortable about, their work situation and the care they provided.

Another important approach used by nurses to minimise their professional role tensions was seeking support from the parents of hospitalised children. They believed that seeking support from parents was helpful because parents' involvement in caring for their child assisted the nurses to reduce their job stress, particularly reducing their workload. Nurses in this study sought support from parents to provide care, especially when this involved providing knowledge of the needs of their child, non-pharmacological interventions, and basic care such as feeding, bathing and comforting their child. As mentioned in previous sections, other authors have also identified that parents are a great source of comfort to paediatric patients, and serve as excellent distracters from pain, helping to reduce the child's anxiety (Carter et al., 2002; Shields & Nixon, 2004; Simons, 2013). The study findings showed that nurse participants welcomed parents as partners in providing care for children during hospitalization, however, caution needs to be employed when involving parents, as they cannot be seen as replacements for nurses (Shields, 2010 b). In such situations, a danger exists that management will see parents as part of the nursing workforce, and reduce nursing numbers accordingly, when in reality, more nurses are needed to care for the child and parents who make up the unit of care in a truly family-centred

model (Shields, 2011). Thus, the current study suggested that partnerships with nursing, medical colleagues and parents need to occur in all aspects of paediatric care settings.

7.2.3.3 Responding action

All nurses in this current study recognised that the clinical context of paediatric care is complex and uncertain. Responding action was conceptualised as the strategy that nurses used to adapt to situations in the workplace. By using this strategy the nurses accepted their responsibility to respond to and manage the paediatric patient's pain problem, while at the same time acting responsibly to meet the needs of the paediatric wards as a whole. They realised that resolution of their tensions were not easy, because not all tensions could be resolved, such as inadequate staffing and facing heavy workloads. However, they were committed to engaging in care provision in order to promote patient health and the healing of pain, to the best of their ability.

In responding actions, the nurse participants accepted their caring responsibility to provide effective pain management. Nurses have obligations and responsibilities to the children in their charge. Accepting caring responsibility is a major component of responding action. Caring and managing pain was important for nurses in this current study and has been described as the 'core of nursing' by nursing theorists (Leininger, 1984; Newman et al., 1991; Watson, 1990; Watson & Smith, 2002). The nurses acknowledged that the nature of nursing practice was based on altruism and caring for sick people, which was their motivation for entering the profession. For nurses in this current study, caring was manifested in their desire to provide effective pain care to the best of their ability. Helping to alleviate the pain suffered by paediatric patients allowed nurses to have, according to their beliefs, rewards from God, assisted them to feel good about themselves, and increased their job satisfaction. The study results revealed that nurses also included the aspect of spiritual care in providing care for paediatric patients. This study result was congruent with findings in the literature that caring has been shown to incorporate religious beliefs, practices and actions aimed at meeting the psychological, social, spiritual, and cultural needs of the patient (Lovering, 2008; Wehbe-Alamah, 2011). The study findings clearly showed that the strategy of responding action provided a framework for caring behaviour. Nurses

tried to manage their role tensions between their philosophy of caring and the reality of their current working environment in the context of the constraints faced within the hospital's complex institutional culture, a process and strategy that has not previously been explained in the existing literature.

7.2.3.4 Reconciling moral distress

In this study, reconciling moral distress was conceptualised as a strategy in the process of managing professional role tensions. As identified in the findings of this current study, nurse participants experienced a sense of moral distress when caring for hospitalised children in pain, because they knew what was needed to provide effective pain care, but in the context of their practice reality they felt unable to perform their important role of relieving paediatric patients' pain. This in turn resulted in feelings of conflict, unhappiness, sadness and frustration, as well as disappointment, dissatisfaction, guilt, powerlessness and inadequacy. The literature defined moral distress as a painful feeling that occurs when nurses are not able to provide the care that is perceived to be right or best or appropriate for the patient (Corley, 2002). It was clear from the findings of this study that there were disconnects between what was perceived to be right and what was actually done. These disconnections created moral distress for the nurse participants. The study found that there were a number of factors that influenced this incongruence. These included such things as the lack of analgesics prescriptions for what the nurses perceived to be the most effective medication for a patient; time constraints on implementing the desired level of care; lack of autonomy; powerlessness, and a lack of human or material resources to provide effective pain care. Nurse participants understood that their moral distress might impact on both their patients and themselves. Therefore, they tried to manage or minimise their role tensions and moral distress in order to protect themselves from distress and maintain their emotional wellbeing, through reconciliation or conflict resolution. Reconciliation is conceptualised as the methods and processes involved facilitating the peaceful ending of conflict (Montoro-Rodriguez & Small, 2006).

Nurses in this current study used reflection to reconcile their role tensions and moral distress effectively. The literature noted that reflection was a coping strategy that enhanced self-awareness (Lockyer et al., 2004; Jack & Smith, 2007; Jack & Miller,

2008). The findings of this study identified that by using reflection, nurses were able to identify and understand the complexities of their working environment, and this influenced their perceived roles when providing pain care for paediatric patients. By using this coping strategy, they were able to comfort themselves when they were feeling emotionally upset or distressed, or when questioning incidents within the paediatric ward. They believed that reflection was a good way to minimise their feelings of moral distress and maintain emotional wellbeing, and that it assisted them to continue working with and caring for paediatric patients in the hospital.

To sum up, the substantive theory of the process of managing professional role tensions to overcome the nurse participants' main concern is unique in that it provides a comprehensive, detailed description and interpretation of the problems encountered by nurse participants in the Indonesian context when caring for paediatric patients experiencing pain; it explains how they moved through the process of managing professional role tensions in order to manage their main concern. The substantive theory portrayed the multidimensional views of each nurse participant through their voice and experiences, elements that have not been previously documented in-depth in the literature. The substantive theory of the process of managing professional role tensions, therefore, not only highlighted the problems experienced by nurse participants but also showed how they resolved their role tensions through the process of managing professional role tensions. Additionally, the substantive theory of the process of managing professional role tensions highlighted both the negative and positive aspects of their work experienced by nurse participants when caring for paediatric patients in pain in clinical settings. This study is the first to articulate the link between nurses' experiences of role tensions and their coping strategies in the area of paediatric pain management in the Indonesian context.

This study has suggested that in Indonesia:

1. Paediatric patients must receive effective pain care and nurses are uniquely positioned to facilitate this. The importance of providing effective pain care cannot be overemphasised. Effective pain care is reliant on nurses accurately assessing children's pain, administering prescribed analgesics, implementing

non-pharmacological interventions, and then evaluating the effective pain management strategies.

2. If caring for hospitalised children in pain is regarded as a moral activity and nurses want to feel that they are doing something morally good and right, then there is need to look at and understand how the structure and culture of the organisation hampers nurses attempting to provide effective pain care.
3. The experiences and emotional wellbeing of nurses, along with the impact of role tensions, have not been adequately recognised and addressed by organisations, heads of nursing departments and nurse managers, therefore it is important to know and understand the impact of role tensions on nurses' wellbeing and on paediatric patients' outcomes.
4. Nurses are on the front-line of care compared with other health professionals and as such their role as patient advocates is essential because nurses are responsible for the appropriateness and coordination of patient care, including the oversight of potentially conflicting treatment and medications.
5. Organisational resources were found to influence nurses' pain management practice. Nurses need a supportive and collaborative working environment, available and supportive medical colleagues and nursing colleagues, appropriate tools, and standard operational procedures or SOPs regarding pain assessment and its management. Without these organisational resources, effective pain care is difficult to achieve.
6. The development and implementation of frameworks or standards of practice for pain assessment and its management in paediatric patients is essential in order to define nurses' professional roles, responsibilities, and nurses' job descriptions. In this way, nurses will be able to deliver nursing practice based on their knowledge and competencies.
7. Nurses' knowledge gaps appear to persist, in particular in relation to pain assessment skills for assessing children's pain, basic knowledge and principles of pharmacological pain management for children, pain medication including the dosage, action and side effects of analgesic drugs and their management. Hospital managers should provide nurses with training or continuing education on pain assessment and its management.

8. The theory that has emerged from the analysis of the findings in this study can make an important contribution to pain management practice for paediatric patients, nursing education and nursing research in Indonesia.

The following section will present implications for clinical practice based on the study results. A summary of recommendations from this study and a concluding statement will follow.

7.3 Implications of the study findings for clinical practice

The most significant contribution of this study is the development of the substantive theory of the process of managing professional role tensions using grounded theory (GT) methodology. A salient finding of this current study was the tensions, role conflict and moral distress experienced by nurse participants when they cared for hospitalised children in pain in paediatric wards. This study identified the major causes and effects of role tensions, as well as the role conflict and moral distress encountered among the nurse participants. The study findings clearly indicated that environmental factors at the workplace, such as imbalanced nurse-patient ratios, inadequate staffing, heavy workloads, lack of time, lack of professional autonomy, lack of organisational and management support and a culture of medical dominance, were barriers to the provision of effective pain care, and also the factors that caused role tensions for nurse participants. This situation left the nurses experiencing emotional distress, powerlessness, frustration, guilt and dissatisfaction with their workplace because they were not able to effectively alleviate paediatric patients' pain. The substantive theory of the process of managing professional role tensions generated by this study explains the process that nurse participants engaged in to manage the shared problem of being unable to provide effective pain care, a process that involved physical, cognitive, emotional and moral dimensions. The substantive theory that has been developed in this study is limited to the context of nurses who care for hospitalised children experiencing pain in Indonesia.

The substantive theory of the process of managing professional role tensions has provided new insights and a unique perspective of Indonesian nurses' experiences by adding new knowledge and understanding of the issues for paediatric nurses who are caring for hospitalised children in pain. However, a review of the literature has

identified that the findings of this study are congruent with those of other previous studies conducted in other countries, even in developed countries such as the USA, UK, and Australia.

The results of this study broaden the scope of knowledge in revealing how nurses in this study generated actions and reactions to deal with and manage their role tensions. They used four strategies—accommodating role tensions, seeking support, responding action, and reconciling moral distress—when caring for paediatric patients experiencing pain in everyday clinical practice. This helped them to protect themselves from distress and to maintain their emotional wellbeing. As a result these nurses were able to accept the complex situations in their workplaces. Understanding the contextual issues that influenced nurses' pain management practice with children may enable a more comprehensive and targeted approach to better pain care.

The process of managing professional role tensions may be useful and could be applied in other paediatric clinical settings (Glaser, 2001). Even though this is the first study that has created a substantive theory of the phenomenon of Indonesian nurses' pain management practice, it is important to further confirm these findings by testing them within the broader paediatric health care arena, within Indonesia.

The study findings further extend beyond the current body of knowledge and provide a greater understanding of the psychosocial processes, interactions, and experiences faced by nurse participants when caring for hospitalised children in pain in the Indonesian context. This in-depth study has demonstrated that there are implications in these findings for both nurse participants' emotional wellbeing and for paediatric patients' outcomes. The results of this current study therefore emphasise a need to support nurses' efforts to provide effective pain care.

The major implication of this current study is the essential requirement for the provision of interventions to facilitate nurses' management of their professional role tensions. These interventions are essential to protect nurses from distress and maintain their wellbeing while they work in paediatric care settings. Effective techniques for cultivating coping responses and stress management should assist in reducing the potentially negative effects of accumulated, unresolved tensions and

distress, such as job dissatisfaction, moral distress and the increased risk of burnout of nurses in the health care system. Organisations need to provide all nurses with access to support systems within the clinical environment. Thus, nurses can talk about their role tensions, obtain assistance and become better able to cope with and deal with their tensions in a productive way. In this context, skills such as conflict resolution and effective communication need to be developed to help empower nurses. Among the nurses themselves, being self-aware, understanding and accepting the complex environment, understanding their personal desires and goals and their professional role and responsibility to provide effective pain care, as well as understanding their complex working environment, is important to this process. Applying the technique of self-reflection to foster awareness of their personal actions and reactions in different situations and circumstances is among the skills needed by nurses, in order to enhance their personal understanding of their own situation.

Moreover, strategies to strengthen nurses' connections and collaboration with medical colleagues who can enhance their access to effective prescribed analgesics, and thus overcome their feelings of powerlessness, would seem important. A team-based approach to health care or to pain management is essential to promote teamwork synergy, enhance internal team relationships and assist the team in managing their work environment and the coordination of paediatric patient care. Teamwork approaches have long been used in health care services to achieve patient care effectiveness and efficiency (Poole & Real, 2003). Team-based health care or a team nursing model is associated with better communication and coordination of care (McGillis & Doran, 2004; Mitchell et al, 2012). Previous studies have demonstrated that professional collaboration among team members enhances team members' awareness of each other's knowledge and skills, leading to improved decision-making, and increases job satisfaction, fostering organisational commitment and heightening productivity (Adams & Bond, 2000; O'Daniel & Rosenstein, 2008). Collaboration, sharing responsibility for problem-solving and making consultative decisions about patients' pain care plans, are all essential elements in accomplishing effective pain care. The literature notes that there are some specific inputs needed to create effective nurse-doctor collaboration: (a) a clear understanding of their own roles and expertise; (b) confidence in their own abilities; (c) recognition of the boundaries of their own discipline; (d) commitment to the values and ethics of their

own profession; (e) knowledge of their own discipline; (e) mutual trust, and (f) effective communication among team members (Orchard et al., 2005; Mitchell et al., 2012) .

Furthermore, there is a need for strategies to enhance nurses' ability to find alternative ways to provide effective pain care, including supporting and facilitating nurses to work more autonomously, and empowering them to optimally perform their professional roles as a patient advocate. Because nurses are on the front-line of care, their role as patient advocate is essential because nurses are responsible for the coordination of patient care. Organisational structures that promote and support nursing autonomy may lead to higher job satisfaction and therefore the retention of nurses (VanOyen Force, 2005).

Another important research finding that should become a concern of the hospital organisation and well as nursing managers and the head of nursing, was the lack of regulatory standards for nursing pain management practice. This affected nurses' professional accountability for provision of effective pain care to paediatric patients. The findings of this study indicated that hospital organisations have inadequately defined the scope of nursing practice. Nurses delivered nursing practice, including pain management practice, without using frameworks or standard practice for pain assessment and its management in children. This contributed to the nurses' uncertainty about what expectations the organisation had of nursing practice. Nurses suggested that working without a framework of practice created role conflict and ambiguity about their professional identity. This also added to their perception of how doctors viewed them. Therefore, organisations should develop a scope of nursing practice, paediatric patient pain care standards, and clinical practice guidelines for nursing management of pain in paediatric wards. Clinical practice guidelines for nurses' paediatric pain management should be structured to reflect and reinforce the nurses' competencies, with particular emphasis given to key elements of effective pain assessment and pain management, and also to the documentation of pain management in children. These will provide clearer directions for a range of activities, such as assessing pain and both the pharmacological and non-pharmacological approaches that are appropriate for different levels of pain experience. Research has demonstrated that clinical pain protocols have been shown

to prompt nurses to conduct pain interventions without delay, reducing the length of hospitalisation and the amount of sedatives or opioids administered, without compromising the patients' level of comfort, and reducing the side effects of analgesic drugs (Alexander, Carnevale, & Razack, 2002). However, in order to facilitate the development of a scope of nursing practice, regulation of the nursing profession is needed in Indonesia. Thus, the nursing sector's leaders have a responsibility to focus on the development of a scope of practice for the profession. A profession's scope of practice is the full range of roles, functions, responsibilities, activities and decision-making capacities that individual nurses are educated, competent and authorised to perform (ICN, 2010).

The study findings further emphasised the need for modifications to current working conditions in order to enable nurses to effectively provide pain care for their paediatric patients. As perceived by nurses in this study, working conditions such as inadequate staffing, heavy workloads and time constraints, forced them to deliver task-oriented nursing in order to finish their tasks quickly, rather than using a patient-centred model of care. This resulted in their being unable to provide effective pain care for their patients. Therefore, initiatives that promote effective pain management practice for paediatric patients, such as developing a patient-centred care model, could be implemented. Research has found that such a model can bring a number of benefits to patient care, such as the improved quality of patient care experiences, a decrease in costs, shorter length of hospital stay, enhanced patient and health care provider satisfaction (Charmel & Frampton, 2008), and decreased mortality (Meterko, Wright, Lin, Lowy, & Cleary, 2010).

Regarding issues of inadequate staffing and nurses' workloads, the study findings further emphasised that hospital management needed to ensure that they provided an appropriate working environment and adequate resources for nurses to be able to provide quality nursing care, including pain care. The hospital management needs to take responsibility for providing adequate staffing, including nursing and non-nursing staffing such as administration staff. It is important that managers are alert to the clinical implications of inadequate resources, not only for the nursing care provided but also for nursing staff. The hospital management needs to focus on nurses' wellbeing as this has the potential to impact on the hospital's financial

outcomes. Another needed strategy is that the hospital management should develop computerisation of patient notes to reduce the time spent by nurses on recording patient notes. Thus, nurses would be able to focus on providing care for paediatric patients rather than doing routine duties such as clerical work. Improving nurse staffing levels may also minimise alarming turnover rates in hospitals by reducing burnout and job dissatisfaction (Aiken et al., 2002). The research evidence showed that adequate staffing and balanced workloads are vital to achieving quality patient outcomes, nurses' job satisfaction, and healthy financial outcomes (Unruh, 2008).

Lastly, the study findings suggested that nurses required a good understanding of pain management knowledge, including pain assessment, and pharmacological and non-pharmacological approaches, in order to effectively provide pain care. However, of the 37 nurses who participated in this study, in general no nurses had received any pain management education since qualifying as a nurse. Thus, nurses in this study spoke of the need for ongoing staff professional development programs centred on paediatric pain management.

7.4 Recommendations of this study

In conjunction with the literature reviewed, the findings of this study have implications for nursing practice, nursing education, and for nursing research. The study findings and recommendations are essential and are particularly directed to clinical nursing practice, nursing education, and nursing research. The following section will present a summary of recommendations arising from this study, and a concluding statement.

7.4.1 Recommendations for clinical practice

Nurses in this study employed some adaptive coping strategies to deal with their professional role tensions, as described in the previous chapter. Hospital managers should provide strategies to facilitate and support nurses in managing their professional tensions effectively. This will assist them to adapt to the complex situations within the workplace, protecting them from distress, maintaining their emotional wellbeing and allowing them to continue working within the context of paediatric wards. This can be done through:

- ❖ Developing appropriate resources and facilities:
 - Providing more nursing staff to adequately cover nursing workloads
 - Increasing administrative or clerical staff to reduce non-nursing duties
 - Developing computerisation of patient notes.
- ❖ Developing the scope of nursing practice and clinical practice guidelines for nursing management of pain management in children.
- ❖ Providing support for nurses and improving working conditions:
 - Providing stress management training.
 - Developing a patient-centred care model.
 - Clarifying nurses' roles, responsibilities and performance expectations so that nurses are able to deliver nursing practice based on their knowledge and competencies.
 - Supporting and facilitating nurses to work more autonomously and empowering them to perform their professional nursing role as a patient advocate. Nursing managers and medical colleagues have a responsibility to assist nursing staff to advocate for patients and families.
 - Developing a teamwork approach to pain management. This strategy is essential to strengthen nurses' connections with medical colleagues who can enhance their collaboration in the health care team, overcoming problematic feelings of powerlessness.
 - Developing the 'Productive Ward' program to facilitate nurses in releasing more time to provide direct patient care which will help to meet patient needs.

7.4.2 Recommendations for nursing education

- ❖ Developing continuing education and training for nurses:
 - Providing training on pain assessment and its management in children. The training should include knowledge regarding (1) the physiology of pain; (2) the patho-physiology of pain (acute and chronic pain); (3) pain assessment and measurement in infants and children; (4) pharmacological approaches to pain management; (5) non-pharmacological approaches to pain management; (6) the

duration, action and equivalent dosage of analgesic drugs, and (7) the true risk of addiction.

- Providing opportunities for relevant ongoing education to all staff nurses working within the clinical context.

7.4.3 Recommendations for future research

- ❖ Exploration and application of the substantive theory of the process of managing professional role tensions in other paediatric care settings and contexts.
- ❖ Testing and expanding the substantive theory within the broader health care environment within Indonesia to further validate this study's findings.
- ❖ Investigation of the suggested link between nurses' role tensions and pain management outcomes in paediatric patients.
- ❖ Exploration of nurses' care for paediatric patients experiencing pain in the paediatric care setting, from the perspective of paediatric patients, parents and the medical profession.
- ❖ Further inquiry into nursing teamwork and a team approach to health care delivery to improve teamwork and enhance the quality of paediatric patient care.
- ❖ Further research using observational methods to ascertain how nurses actually manage pain in hospitalised children and to explore whether pain management practices follow current best practice guidelines.
- ❖ Further exploration of the relationship between nurses' satisfaction with the delivery of nursing care in paediatric care settings and nurses' emotional wellbeing.

7.5 Strengths and limitations of this study

Grounded Theory offers conceptual power to the researcher, facilitating the extrapolation of qualitative data into conceptual theory (Glaser, 2003). A main strength of this current study was that it was the first to present a theoretical conceptualisation of how nurse participants manage their main concern of experiencing role tensions when caring for hospitalised children in pain. The phenomenon of pain management practice in children within the Indonesian context from the nurses' perspective was described, explained and analysed by using the GT

method. To date, this is the first study to describe how nurses manage professional role tensions when caring for hospitalised children in pain, in the context of Indonesia.

Secondly, the GT methodology allowed for rich descriptions of nurses' experiences. This enabled nurses to tell their story of how they cared for hospitalised children experiencing pain in paediatric care settings. Quantitative measures, such as a survey or questionnaire, are not able to produce such vivid findings or account for subtle differences across experiences, as these study designs focus on a few identified concepts which may or may not fit with nurses' experiences.

It is acknowledged that this current study has limitations which need to be taken into account when considering the study findings. The limitation of this current study was that, although the data provided a rich description of the barriers to the provision of effective pain care to hospitalised children, the study presents only one point of view, namely that of nurse participants. Additionally, the theory developed in this study was based on the experiences of nurse participants who engage in and care for hospitalised children in pain within paediatric care settings at two hospitals. As such, the applicability of the theory to other nurses in other settings (e.g. other services or regions) and in other provinces warrants further investigation.

The sample size of 37 participants could be viewed by some as a limitation of the study. However, it was adequate to satisfy data and category saturation, which in GT studies is the more important determinant of appropriateness of sample size, rather than the number of participants per se (Creswell, 2013; Glaser & Strauss, 1967; Speziale & Carpenter, 2007). There is no expectation that results from studies using qualitative approaches should be generalisable, since the experiences described by participants are unique to that sample (Creswell, 2013; Speziale & Carpenter, 2007). Generalisation of the findings to the broader community of paediatric nurses was not an aim of this current study. Rather, it was intended to develop a substantive theory from the data; the theoretical saturation was sufficient for that to occur. However, further theoretical sampling or additional research exploring individual theoretical positions would add to, refine and modify this substantive theory. As it is presented in this current study, however, it is considered sufficiently theoretically complete,

demonstrating ‘fit, work and relevance’ within the social world from which it derives. The theory itself can always be expanded or refined by adding or changing concepts through further theoretical sampling (Glaser, 1978). This is not a limitation of the study, but is indeed one of the major strengths of the GT methodology, whereby findings of the study were not presented as final but as dynamic concepts to be explored and developed (Glaser, 2002, 2001, 1978).

A major gap in the study is the lack of attention given to family-centred care (Shields & Nixon, 2003, Shields, 2010, Shields, 2011). However, the starting point for improving pain management in this particular setting indicates that would be best to address the systemic problems first, develop and implement a patient-centred model, and then move to a family-centred approach.

Another possible limitation of this study was that the data sources were restricted to interviews only and might have been strengthened by the addition of other sources such as observations, or interviews with medical colleagues. It is recommended that future studies should explore physicians’ perceptions and experiences regarding pain management practice in children. Thus, the phenomenon of pain management practice in children within the Indonesian context, seen from the points of view of both nurses and physicians, may provide an even more rich description of current paediatric pain management practice.

7.6 Concluding statement

The study aimed to explore Indonesian nurses’ perceptions of and experience with pain management of hospitalised children, with a view to discovering the factors that impact on nurses’ ability to provide pain management. Secondly, to develop a substantive theory that would explain how Indonesian nurses attempt to manage the main concern experienced by them when caring for children experiencing pain in paediatric wards within the context of Indonesia.

The findings of this current study were an outcome of the willingness of the nurse participants to share their experiences of caring for hospitalised children in pain in paediatric clinical settings. This study provided a portrait of the clinical reality for paediatric nurses from two Indonesian hospitals. In doing so, the study findings

indicated that nursing in the current working environment in Indonesian hospitals is a highly stressful endeavour fraught with difficulty and complications. This affects nurses' ability to optimally perform their role of providing paediatric pain management practice. Nurses in this study experienced role tensions and moral distress because they were not able to provide effective pain care for their paediatric patients due to the barriers they faced in their workplaces. However, nurses were aware of what was expected of them with regard to the provision of quality paediatric patient care, including pain management. They tried to cope with and handle their role tension experiences by using four strategies: accommodating role tensions; seeking support; responding action, and reconciling moral distress in order to protect themselves from distress and maintain emotional wellbeing. Thus they were able to reconcile the situation they found themselves in and remain working as nurses within the paediatric wards in a complex working environment.

It was through nurses' voices that a deeper understanding of their experiences was obtained, which enhanced an awareness of the significant contributions nurses make in delivering paediatric patient care, including pain management. Moreover, knowledge gained from this current study can contribute to better paediatric pain management practices and to an improved working environment, so that nurses may no longer experience role tensions and moral distress when caring for hospitalised children in pain. The study's findings can help to inform relevant initiatives and strategies to improve clinical nurses' performance and competency in providing pain care to paediatric patients, so the quality of such care can be continually improved into the future.

Additionally, effective pain management in hospitalised children depends on nursing teamwork efforts and collaboration between nurses and doctors. Educating nurses on their professional role in the workplace and empowering nurses to work more autonomously will enhance nurses' ability to manage their role tensions when encountering barriers while caring for hospitalised children in pain, and will improve the quality of paediatric patient care. This study's research findings have the potential to influence change in the nursing profession in the area of clinical initiatives, education and research.

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Note

Every reasonable effort has been made to acknowledge the owners of copyright material. I would be pleased to hear from any copyright owner who has been omitted or incorrectly acknowledged.

LIST OF APPENDICES

Appendix 1: Information for Directors of Dr Hasan Sadikin General Teaching Hospital

**CURTIN UNIVERSITY
SCHOOL OF NURSING & MIDWIFERY FACULTY OF HEALTH**

INFORMATION FOR DIRECTORS OF Dr HASAN SADIKIN GENERAL TEACHING HOSPITAL

Indonesian nurses management of pain in children: A Grounded Theory Study

My name is Henny Suzana Mediani and I am currently enrolled in PhD studies with the School of Nursing & Midwifery Faculty of Health at the Curtin University, under the supervision of Professor Linda Shields, PhD FRCNA, Dr Rose Chapman PhD and Dr Alison Hutton, PhD.

In this study I am investigating Indonesian nurses' pain management in children. I am seeking your help to facilitate the process of recruiting suitable participants for the study.

The eligibility criteria for inclusion in this study includes that participants be:
Nurses with a minimum three years nursing experience in pediatric wards (pediatric surgical ward, pediatric medical ward, pediatric emergency care unit and pediatric intensive care unit)

I am seeking your assistance to distribute letters of introduction (see attached) describing the study to nurses in your hospital. I hope to recruit at least 25 nurses who meet the above criteria from your hospital.

The attached letter indicates that anyone who is interested in participating in the study can contact me directly for an information package. All that I am asking you to do is to distribute the introduction letter to nurses likely to meet the criteria for inclusion in the study.

I would be happy to meet with any group of potential participants, at their invitation and convenience, if they would like to meet me in person, or have me explain any aspects of the study to them. If convenient to you, such a meeting could be scheduled and should not take more than 15-20 minutes. If you have any questions regarding this procedure or the study itself, I can be contacted by telephone on +62) 812217864/ (+61)402640556, E-mail: hennysuzana1965@yahoo.co.id. Also, if you would like to speak with my thesis supervisors, she is Prof Linda Shields, PhD FRCNA and you can contact her on +61 (0)892662192 or Fax +61 (0) 892662959

Thank you for your consideration of this request.

Yours sincerely

Henny Suzana Mediani
Researcher

Professor Linda Shields, PhD FRCNA
Research Supervisor

Appendix 1a: Information for Director of Gunung Jati Hospital Cirebon

CURTIN UNIVERSITY SCHOOL OF NURSING & MIDWIFERY FACULTY OF HEALTH

INFORMATION FOR DIRECTORS OF GUNUNG JATI HOSPITAL CIREBON

Indonesian nurses management of pain in children: A Grounded Theory Study

My name is Henny Suzana Mediani and I am currently enrolled in PhD studies with the School of Nursing & Midwifery Faculty of Health at the Curtin University, under the supervision of Professor Linda Shields PhD, FRCNA, Dr Rose Chapman, PhD and Dr Alison Hutton, PhD.

In this study I am investigating Indonesian nurses' pain management in children. I am seeking your help to facilitate the process of recruiting suitable participants for the study.

The eligibility criteria for inclusion in this study includes that participants be:
Nurses with a minimum five years nursing experience in pediatric surgical wards, Pediatric medical ward, pediatric emergency care unit and/or pediatric intensive care unit

I am seeking your assistance to distribute letters of introduction (see attached) describing the study to nurses in your hospital. I hope to recruit at least 15 nurses who meet the above criteria from your hospital.

The attached letter indicates that anyone who is interested in participating in the study can contact me directly for an information package. All that I am asking you to do is to distribute the introduction letter to nurses likely to meet the criteria for inclusion in the study.

I would be happy to meet with any group of potential participants, at their invitation and convenience, if they would like to meet me in person, or have me explain any aspects of the study to them. If convenient to you, such a meeting could be scheduled and should not take more than 15-20 minutes. If you have any questions regarding this procedure or the study itself, I can be contacted by telephone on (+62) 8122175864/ (+61)402640556, E-mail: hennysuzana1965@yahoo.co.id. Also, if you would like to speak with my thesis supervisors, she is Prof Linda Shields PhD, FRCNA and you can contact her on +61 (0)892662192 or Fax +61 (0) 892662959

Thank you for your consideration of this request.

Yours sincerely

Henny Suzana Mediani
Researcher

Professor Linda Shields PhD, FRCNA
Research Supervisor

Appendix 2: Information sheet for potential participants

CURTIN UNIVERSITY SCHOOL OF NURSING & MIDWIFERY FACULTY OF HEALTH

INFORMATION SHEET FOR POTENTIAL PARTICIPANTS IN THE STUDY ON

Indonesian nurses management of pain in children: A Grounded Theory Study

My name is Henny Suzana Mediani, and I am currently enrolled in PhD studies with the School of Nursing & Midwifery at the Curtin University, under the supervision of Professor Linda Shields PhD, FRCNA, Dr Rose Chapman, PhD and Dr Alison Hutton, PhD.

Thank you for considering involvement in this research project. The aim of this research is to investigate what influences Indonesian nurses' pain management practice in regards to relieving hospitalised children's pain. In order to achieve the above, the researcher will need to be in attendance in the pediatric clinical wards during some hours of some of your shifts.

Thank you for your interest in the research project in which I am investigating "factors influencing nurses' pain management in children" I plan to include around 30 nurses in the study from Dr Hasan Sadikin general teaching hospital. If you agree to be part of the study, I will ask you to take part in one face-to-face of semi-structured In-depth interviews, lasting approximately 45 - 90 minutes at a place convenient to you

With your agreement, the interview will be audio-taped for transcription at a later date. If during the interview you make any comments that you do not wish to be recorded, the tape recorder will be stopped, or if already recorded, the comments will be erased before continuing the interview. You will also be given the opportunity to review the written transcript of your interview and will be free to delete, add, or change anything that you said during the interview. The interview will focus on asking you: (1) provide an overview of your personal experiences and perceptions about pain assessment and its management in children; (2) to describe and explain your own experiences and perceptions of factors that affect nurses pain management practice and (3) discuss how you have managed children experiencing of pain. At the end of the interview, I will ask you to provide me with some basic demographic information, including your age, previous work experience, time since completion, and the types of clinical settings in which you have worked since graduation.

A degree of anonymity will be provided in this part of the study since you will not be required to include your name with your response, and no attempt will be made to link specific responses with individual nurses. If you agree to participate we will negotiate a mutually convenient time and place for the interview. Opportunity will be given for you to ask any questions you have about the study, and you will then be asked to sign a consent form indicating your willingness to be a participant.

I will also ask for 6-8 volunteers from among the nurses who take part in the interviews to meet with me individually again at a later date (possibly 4-6 months later). This meeting will be used to discuss the findings of the study and to obtain feedback on my preliminary interpretations. It will not involve another interview, and will not ask for new data from the nurses who agree to take part.

All data gathered from you will be treated with confidentiality and used only for the purposes of this study. Participants will not be identified in any way in the research report, or

in any subsequent publications that may develop from the findings of the study. Pseudonyms will be used in any published work.

If you agree to take part in this study, you are reminded that you have the right to:

1. Ask questions about the study at any time, and to seek information about the results on completion;
2. View any written notes made during the interview;
3. Decline to answer any questions during the interview, or to ask for the tape recorder to be turned off, or a portion of the tape to be erased;
4. Terminate the interview, or re-schedule it if necessary; and
5. Withdraw from the study at any time, without having to provide a reason.

This study has no connection with your current employment status.

You may find taking part in the study personally helpful, particularly as it gives you an opportunity to reflect your perceptions and experiences regarding pain management in children that you have had to face in the clinical area. You are reminded that you have complete control over the information you decide to share during the interview.

The audio-tapes and any notes from the interviews, the transcripts of the audio tapes, and the written responses will be kept in a secure place, and be accessed only by myself, although you will be offered the opportunity to read your own transcript for accuracy and modification if you wish. The only other individuals who will have access to the transcripts and written responses (for supervisory reasons alone) are my three research supervisors, but they will not know your identity. When the study is completed, the tapes will be erased. The transcripts and other written material collected during the study (with all identifying information removed) will be stored in a secure place at School of Nursing & Midwifery Curtin University for the mandated period of five years, following which they will be destroyed.

If you are willing to take part in this study, please complete the enclosed form and post it in the stamped, addressed envelope provided.

If you have any questions regarding this study please feel free to contact me telephone on (+62)8122175864/ (+62)2285440805/ (+61)402640556 or email: hennysuzana1965@yahoo.co.id

Postal address: Henny Suzana Mediani

Jl Kastuba C2 – 10 Pasadena Residence Caringin Bandung 40223

Thank you for your interest in this project.

Henny Suzana Mediani
Researcher

Professor Linda Shields PhD, FRCNA
Research Supervisor

Complaints

This project has been approved by the Curtin University Human Research Ethics Committee, Approval No.

and the Research Ethic committee Dr Hasan Sadikin General Teaching Hospital, Approval No x xxx.....

Should you have any concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred, to the Human Research Ethics committee, c/- office of Research and Development, Curtin University, GPO Box U1987, Perth or telephoning 9266 2784 or emailing hrec@curtin.edu.au.

Appendix 3: Indication of intention to participate in the study

**CURTIN UNIVERSITY
SCHOOL OF NURSING & MIDWIFERY FACULTY OF HEALTH**

INDICATION OF INTENTION TO PARTICIPATE IN THE STUDY

Indonesian nurses management of pain in children: A Grounded Theory Study

I, **(please print name)** _____ am interested in participating in the above named study. I give my permission for you to contact me to organise an appointment for an interview at a time and place that is suitable to me.

I can be contacted by:

(Please write in the information that applies to you, and indicate your preference)

Phone: _____

Email: _____

Post to: Henny Suzana Mediani
Jl Kastuba C2-10 Pasadena Residence Caringin
Bandung Indonesia 40223 or
Email: hennysuzana1965@yahoo.co.id

Appendix 4: Consent form for participants

CURTIN UNIVERSITY
SCHOOL OF NURSING & MIDWIFERY FACULTY OF HEALTH

CONSENT FORM FOR PARTICIPANTS

Indonesian nurses management of pain in children: A Grounded Theory Study

I, (please print name) _____ agree to participate in the above named study to be conducted by Ms Henny Suzana Mediani, and I give my consent freely.

I understand the study will be carried out as described in the information statement, a copy of which I have read and retained. I understand that whether or not I decide to participate my decision will not affect my current employment in any way. I also understand that I can withdraw from the study at any time and do not have to give any reasons for withdrawing. I understand that all information I provide will be treated in confidence. I have had all questions answered to my satisfaction.

I am aware that, should I reveal any details of specific incidents that are of a reportable nature, the researcher has a responsibility to report such to the appropriate authorities. I am aware that I have complete control over the information I decide to share during the interview. I am also aware that it may not be in my interest to disclose information that may have legal implications.

It has been explained to me that the research project will be carried out according to the principles in the National Health and Medical Research Council Statement on Ethical Conduct in Research Involving Humans (2002) and has been approved by the YY (name not included in thesis to maintain anonymity) Ethics and Research Committee.

Participant's Signature

Date

Signature of Witness

Date

Appendix 6: Interview guides

CURTIN UNIVERSITY SCHOOL OF NURSING & MIDWIFERY FACULTY OF HEALTH

INTERVIEW GUIDES

As the researcher used semi-structured interviews, these questions represented a sample of what the researcher asked the participants during interview.

- Please could you tell me of your experiences of working as a nurse in this hospital?
- Please describe to me what is pain and how do you know your patients in pain?
- Could you please tell me how do you manage a paediatric patient in pain (what helps, what hinders)
- Can you tell me about your experience in the situation when you were caring for a paediatric patient who was in pain (Prompt: pain assessment, interventions, health care team)
- What did you do? And how would you describe the experience from a personal and professional perspective?
- Can you tell me what were the roles you played within the team
- Was there anything that helped you to manage this paediatric patient?
- Do you have difficulties to manage this paediatric patient's pain
- Was there anything that made it more difficult to manage this patient's pain
- How did you feel?
- Could you please tell me how are you feeling now about your experience caring for this paediatric patient's pain?
- Can you tell me what factors that hinder your role?
- Is there anything you would like to add?

Appendix 7: Information for Directors of Dr Hasan Sadikin General Teaching Hospital in Bahasa Indonesia

CURTIN UNIVERSITY SCHOOL OF NURSING & MIDWIFERY FACULTY OF HEALTH

SURAT PENGANTAR UNTUK DIREKTUR RS PENDIDIKAN Dr HASAN SADIKIN

Saya Henny Suzana Mediani, saya sekarang tercatat sebagai mahasiswa PhD School of Nursing & Midwifery Faculty of Health Curtin University, dibawah bimbingan supervisor Professor Linda Shields PhD FRCNA, FRSM Dr Rose Chapman PhD dan Dr Alison Hutton, PhD.

Pada studi ini saya akan meneliti “Penanganan nyeri pada pasien anak oleh perawat Indonesia: sebuah study grounded theory”. Saya mohon bantuan bapak Direktur Utama untuk dapat memfasilitasi proses pemilihan partisipan yang sesuai dengan studi ini.

Kriteria yang diharapkan untuk menjadi partisipan pada studi ini adalah perawat yang mempunyai pengalaman bekerja minimum selama tiga tahun bekerja di ruang perawatan anak (ruang perawatan bedah anak, ruang perawatan penyakit dalam anak, ruang perawatan Intensif anak dan ruang emergency anak). Saya mohon bantuan dari bapak untuk mendistribusikan surat pengantar (appendix 2) yang akan menjelaskan maksud dan tujuan dari penelitian kepada perawat-perawat yang bekerja di rumah sakit yang bapak pimpin. Akan dilampirkan pula surat persetujuan untuk menjadi partisipan dalam penelitian ini dan jika bersedia mereka bisa menghubungi saya secara langsung untuk mengetahui secara keseluruhan maksud dari penelitian ini.

Saya akan merasa senang bila bisa bertemu dengan teman-teman perawat yang akan menjadi partisipan dalam penelitian ini, saya bisa menemui mereka kapan saja bila diperlukan. Saya bisa menjelaskan secara detail setiap aspek dari penelitian yang akan dilakukan. Bila diperlukan bisa dibuat jadwal untuk dilakukan pertemuan yang akan membahas tentang penelitian yang akan di lakukan, dan pertemuan ini tidak akan memerlukan waktu yang lama, sekitar 15-20 menit . Bila ada hal-hal yang akan ditanyakan berkaitan dengan penelitian ini bisa menghubungi saya ke nomor telephon ini (+62) 8122175864/ (+61)402640556, E-mail: hennysuzana1965@yahoo.co.id. Atau bisa menghubungi supervisor saya untuk menanyakan tentang penelitian yang akan saya lakukan, beliau adalah Prof Linda Shields PhD, FRCNA, FRSM dan beliau bisa dihubungi melalui no telephon +61 (0)892662192 or Fax +61 (0) 892662959

Sekian, terima kasih atas perhatian dan bantuan yang bapak Direktur berikan.

Hormat kami,

Henny Suzana Mediani
Researcher

Professor Linda Shields, PhD FRCNA, FRSM
Research Supervisor

Appendix 8: Information for Director Gunung Jati Hospital Cirebon in Bahasa Indonesia

CURTIN UNIVERSITY SCHOOL OF NURSING & MIDWIFERY FACULTY OF HEALTH

SURAT PENGANTAR UNTUK DIREKTUR RSUD GUNUNG JATI CIREBON

Saya Henny Suzana Mediani, saya sekarang tercatat sebagai mahasiswa PhD School of Nursing & Midwifery Faculty of Health Curtin University, dibawah bimbingan supervisor Professor Linda Shields PhD FRCNA, FRSM Dr Rose Chapman PhD dan Dr Alison Hutton, PhD.

Pada studi ini saya akan meneliti tentang “Penanganan nyeri pada pasien anak oleh perawat Indonesia: sebuah study grounded theory” Saya mohon bantuan bapak Direktur Utama untuk dapat memfasilitasi proses pemilihan partisipan yang sesuai dengan studi ini.

Kriteria yang diharapkan untuk menjadi partisipan pada studi ini adalah perawat yang mempunyai pengalaman bekerja minimum selama tiga (3) tahun bekerja di ruang perawatan anak (ruang perawatan anak, ruang perawatan Intensif anak dan ruang emergency anak). Saya mohon bantuan dari bapak untuk mendistribusikan surat pengantar (appendix 2) yang akan menjelaskan maksud dan tujuan dari penelitian kepada perawat-perawat yang bekerja di rumah sakit yang bapak pimpin. Saya berharap bisa memilih sejumlah perawat minimal 15 orang yang telah memenuhi kriteria yang telah dijelaskan sebelumnya. Akan dilampirkan pula surat persetujuan untuk menjadi partisipan dalam penelitian ini dan jika bersedia mereka bisa menghubungi saya secara langsung untuk mengetahui secara keseluruhan maksud dari penelitian ini.

Saya akan merasa senang bila bisa bertemu dengan teman-teman perawat yang akan menjadi partisipan dalam penelitian ini, saya bisa menemui mereka kapan saja bila diperlukan. Saya bisa menjelaskan secara detail setiap aspek dari penelitian yang akan dilakukan. Bila diperlukan bisa dibuat jadwal untuk dilakukan pertemuan yang akan membahas tentang penelitian yang akan di lakukan, dan pertemuan ini tidak akan memerlukan waktu yang lama, sekitar 15-20 menit . Bila ada hal-hal yang akan ditanyakan berkaitan dengan penelitian ini bisa menghubungi saya ke nomor telephon ini (+62) 8122175864/ (+61)402640556, E-mail: hennysuzana1965@yahoo.co.id. Atau bisa menghubungi supervisor saya untuk menanyakan tentang penelitian yang akan saya lakukan, beliau adalah Prof Linda Shields PhD, FRCNA, FRSM dan beliau bisa dihubungi melalui no telephon +61 (0)892662192 or Fax +61 (0) 892662959

Sekian, terima kasih atas perhatian dan bantuan yang bapak Direktur berikan.

Hormat kami,

Henny Suzana Mediani
Peneliti

Professor Linda Shields, PhD FRCNA, FRSM
Supervisor Peneliti

Appendix 9: Information sheet for potential participants in Bahasa Indonesia.

CURTIN UNIVERSITY SCHOOL OF NURSING & MIDWIFERY FACULTY OF HEALTH

SURAT PENGANTAR UNTUK PARTISIPAN PADA STUDI INI

Saya Henny Suzana Mediani, saya sekarang tercatat sebagai mahasiswa PhD School of Nursing & Midwifery Faculty of Health Curtin University, dibawah bimbingan supervisor Professor Linda Shields PhD FRCNA, Dr Rose Chapman PhD dan Dr Alison Hutton, PhD.

Saya sangat berterima kasih apabila saudara berkenan terlibat dalam penelitian ini. Pada studi ini saya akan meneliti tentang “Penanganan nyeri pada pasien anak oleh perawat Indonesia: sebuah grounded theory study” Tujuan dari penelitian ini adalah meneliti bagaimana persepsi dan pengalaman perawat Indonesia dalam penanganan nyeri pada pasien anak serta menggali faktor-faktor yang mempengaruhi perawat dalam penanganan nyeri pada anak dengan menggunakan grounded theory study. Dalam rangka mencapai tujuan penelitian tersebut, peneliti harus berada di ruang perawatan anak kurang lebih selama beberapa jam pada saat anda bertugas. Saya mempunyai rencana untuk memilih 25- 30 orang perawat di RS Dr Hasan Sadikin untuk terlibat dalam penelitian yang akan saya lakukan. Apabila anda bersedia ikut berpartisipasi pada penelitian ini, saya akan meminta saudara untuk bersedia diwawancarai secara langsung secara semi struktur dan mendalam selama kurun waktu antara 40-60 menit.

Sesuai dengan kesepakatan, wawancara akan direkam kemudian akan dibuat transkrip wawancara. Saat proses wawancara berlangsung, apabila menurut saudara bahwa apa yang telah saudara utarakan itu tidak perlu direkam, saya akan menghentikan rekamannya, atau bila sudah terekam, saya akan menghapusnya sebelum wawancara dilanjutkan. Saudara nanti akan diminta untuk mengecek hasil transkrip wawancara dan saudara bisa menghapus atau menambahkan kata-kata saat wawancara bila saudara anggap itu perlu.

Pada penelitian ini nama saudara tidak akan muncul dan akan dijaga kerahasiaannya. Jika saudara setuju untuk berpartisipasi dalam penelitian ini, waktu dan tempat untuk proses wawancara akan diatur dan disesuaikan dengan saudara. Saya akan memberi kesempatan kepada saudara untuk bertanya bila ada hal-hal yang perlu ditanyakan berkaitan dengan studi ini dan saya akan meminta saudara untuk menandatangani surat pernyataan kesediaan menjadi partisipan dalam penelitian ini sebagai bukti bahwa saudara bersedia jadi partisipan. Saya akan meminta 6-8 orang perawat yang terlibat dalam penelitian ini untuk bertemu dengan saya beberapa bulan kemudian (4-6 bulan) setelah pengumpulan data selesai. Tujuan dari pertemuan ini adalah untuk mendiskusikan hasil penelitian dan meminta feedback saudara terhadap interpretasi hasil penelitian. Saya tidak akan melakukan wawancara lagi atau meminta data-data yang baru dari saudara yang bersedia memberikan feedback.

Sebagai jaminan semua data atau informasi yang diperoleh dari saudara akan dijaga kerahasiaannya (confidentiality) dan akan dipergunakan hanya untuk keperluan studi ini. Semua identitas partisipan tidak akan teridentifikasi dalam hasil penelitian, laporan penelitian atau publikasi. Pseudonym (nama samaran) akan dipakai untuk keperluan publikasi.

Apabila saudara setuju dan bersedia ikut terlibat dalam studi ini, saudara mempunyai hak untuk:

1. Bertanya tentang studi ini dan hasil akhir dari studi ini
2. Memberi pandangan atau masukan terhadap cacatan peneliti selama proses wawancara berlangsung;
3. Menolak untuk menjawab pertanyaan selama proses wawancara atau meminta peneliti untuk menghentikan rekaman wawancara atau meminta untuk menghapus beberapa bagian dari hasil rekaman wawancara.
4. Menghentikan proses wawancara atau membuat jadwal baru untuk wawancara bila diperlukan
5. Mundur menjadi partisipan dalam studi ini kapanpun walaupun tanpa memberikan alasan yang jelas.

Perlu diketahui studi ini tidak ada hubungan apapun dengan status kepegawaian anda sebagai perawat di tempat kerja saudara yang sekarang ini. Apabila saudara terlibat dalam studi ini, secara personal saudara diberi kesempatan untuk merefleksikan persepsi dan pengalaman saudara dalam pelaksanaan penanganan nyeri pada anak yang memang akan selalau saudara hadapai di setting klinik. Perlu diketahui bahwa saudara yang memutuskan sejauhmana informasi yang harus disampaikan selama proses wawancara.

Rekaman wawancara, transkrip wawancara dan setiap catatan selama proses pengumpulan data akan disimpan ditempat yang aman dan hanya peneliti yang bisa mengaksesnya. Untuk kepentingan supervisi atau pengawasan tiga orang supervisor peneliti bisa melihat hasil transkrip wawancara dan catatan proses pengumpulan data, akan tetapi mereka tidak akan mengenali identitas saudara partisipan. Apabila penelitian ini telah selesai rekaman wawancara akan segera dihapus. Transkrip wawancara dan catatan tertulis lainnya selama proses pengumpulan data (data identitas akan dibuang/dihapus) akan disimpan ditempat yang aman di School of Nursing & Midwifery Curtin University selama tujuh tahun dan setelah itu akan dimusnahkan.

Apabila saudara bersedia ambil bagian dalam studi ini, dipersilahkan untuk mengisi surat pernyataan kesediaan menjadi partisipan, kemudian masukan kedalam amplop tertutup dan mengirimkannya ke alamat berikut dibawah ini. Jika ada pertanyaan berkaitan dengan studi ini, saya persilahkan untuk menghubungi saya pada no telephon (+62)8122175864/ (+62)2285440805/ (+61)402640556 atau via email: hennysuzana1965@yahoo.co.id
Alamat rumah Henny Suzana Mediani: Jl Kastuba C2 – 10 Pasadena Residence Caringin Bandung 40223

Demikian, terima kasih atas keikutsertaannya dalam penelitian ini.

Henny Suzana Mediani
Peneliti

Professor Linda Shields, PhD FRCNA, FRSM
Supervisor Peneliti

**Appendix 10: Indication of intention to participate in the study in Bahasa
Indonesia**

**CURTIN UNIVERSITY
SCHOOL OF NURSING & MIDWIFERY FACULTY OF HEALTH**

**SURAT PENYATAAN KESEDIAAN UNTUK BERPARTISIPASI DALAM STUDI
INI**

Saya, (silahkan tulis) tertarik untuk berpartisipasi dalam penelitian yang berjudul Penanganan nyeri pada pasien anak oleh perawat Indonesia: sebuah study grounded theory. Saya mengizinkan peneliti untuk menghubungi saya untuk membuat jadwal pertemuan untuk dilakukan proses wawancara dengan waktu dan tempat yang sesuai dengan saya

Saya bisa dihubungi melalui:

No Telephon:

Alamat Email:

Poskan kepada: Henny Suzana Mediani
JI Kastuba C2-10 Pasadena Residence Caringin
Bandung Indonesia 40223 atau
Email: hennysuzana1965@yahoo.co.id

Appendix 11: Consent form for participants in Bahasa Indonesia

CURTIN UNIVERSITY SCHOOL OF NURSING & MIDWIFERY FACULTY OF HEALTH

SURAT PERSETUJUAN MENJADI PARTISIPAN

Saya, (silahkan tulis nama) Setuju untuk berpartisipasi dalam penelitian yang berjudul Penanganan nyeri pada pasien anak oleh perawat Indonesia: sebuah study grounded theory yang akan dilakukan oleh Henny Suzana Mediani, dan saya akan memberikan persetujuan dengan bebas.

Saya memahami maksud dan tujuan dari penelitian seperti yang sudah dijelaskan dalam surat pengantar penelitian, saya sudah membaca dan sudah saya kembalikan kepada peneliti. Saya mengerti bahwa keputusan saya untuk ikut berpartisipasi dalam penelitian ini tidak akan berpengaruh pada status pekerjaan saya sekarang. Saya juga mengetahui bahwa saya bisa mundur dari keikutsertaan saya dalam penelitian kapanpun tanpa memberi alasan apapun. Saya juga mengerti bahwa seluruh informasi yang sudah saya berikan akan dijaga kerahasiaannya oleh peneliti. Saya telah menjawab semua pertanyaan dan telah menjawabnya dengan sebisa saya dan saya merasa puas. Saya menyadari bahwa jika terjadi hal-hal yang tidak diinginkan, saya harus melaporkan, dan peneliti bertanggung jawab untuk melaporkannya kepada pihak yang berwenang. Saya sadar bahwa saya harus menyampaikan informasi secara lengkap dan sebenar-benarnya selama proses wawancara berlangsung. Saya juga tahu bahwa saya tidak akan mengungkapkan informasi yang mempunyai implikasi secara hukum.

Seperti yang sudah dijelaskan kepada saya bahwa proyek penelitian ini mengacu dan berdasarkan kepada prinsip-prinsip yang telah dikeluarkan oleh the National Health and Medical Research Council Statement on Ethical Conduct in Research Involving Humans (2002) dan telah mendapatkan persetujuan yang dikeluarkan oleh YY Riset Etik komite (nama tidak muncul untuk menjaga supaya anonymity).

Tanda tangan partisipan

tanggal

Tanda tangan Saksi

tanggal

Appendix 12: Interview guides in Bahasa Indonesia

CURTIN UNIVERSITY SCHOOL OF NURSING & MIDWIFERY FACULTY OF HEALTH

PEDOMAN WAWANCARA

Berhubung dalam penelitian ini peneliti menggunakan wawancara semi terstruktur, pertanyaan-pertanyaan di bawah ini mewakili sebagian pertanyaan yang ditanyakan kepada partisipan dalam proses wawancara

- Bisa saudara jelaskan kepada saya pengalaman saudara bekerja di rumah sakit ini?
- Bisa saudara jelaskan tentang nyeri dan bagaimana saudara bisa mengetahui bila seorang pasien anak sedang dalam kondisi nyeri ?
- Coba tolong jelaskan bagaimana saudara mengatasi nyeri pada pasien anak (hal-hal yang membantu dan yang menghambat)
- Bisa saudara ceritakan pada saya tentang sebuah situasi atau kasus saat anda melakukan perawatan pada pasien anak yang mengalami nyeri (pengkajian nyeri, intervensi, dan team kesehatan dalam penanganan nyeri)
- Apa yang saudara lakukan? Bisakah saudara menceritakan pengalaman saudara ini baik secara personal maupun dari sudut professionalism?
- Bisa saudara jelaskan tentang peran saudara dalam team kesehatan?
- Bisa saudara jelaskan kepada saya hal-hal apa saja yang membantu saudara dalam melaksanakan peran sebagai perawat?
- Bisa saudara jelaskan kesulitan-kesulitan yang di alami sampai saat ini?
- Bagaimana perasaan saudara saat merawat seorang pasien anak yang mengalami nyeri?
- Adakah hal lain yang akan diutarakan?

Appendix 13: Demographic questionnaire for participants in Bahasa Indonesia

CURTIN UNIVERSITY SCHOOL OF NURSING & MIDWIFERY FACULTY OF HEALTH

PERTANYAAN BERKAITAN DENGAN DATA DEMOGRAPHY

1. Umur?tahun
2. Jenis kelamin? Laki-laki/Perempuan
3. Latar belakang pendidikan terakhir?
 - a. Magister keperawatan (S2)
 - b. Sarjana Keperawatan
 - c. Diploma III Keperawatan (AKPER)
 - d. SPK/SPR
4. Nama Institusi sekolah terakhir.....
5. Sudah berapa lama saudara bekerja setelah menyelesaikan pendidikan keperawatan?
..... tahun
5. Tulis ruang perawatan mana saja yang pernah menjadi tempat saudara bertugas setelah Saudara menyelesaikan pendidikan keperawatan terakhir

6. Apakah saudara pernah bekerja di tempat lain sebelum menjadi perawat? Ya / tidak
Jika anda menjawab ya, coba tulis dibawah ini
.....

Appendix 14: Ethic Approval from Curtin University



memorandum



To	Henny Suzana Mediani
From	Professor Dianne Wynaden
Subject	Approval: SON&M 27-2010
Date	25 th June 2010
Copy	Dr Rose Chapman; Professor Linda Shields

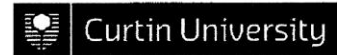
Thank you for your "Form C application for your Research with Minimal Risk (Ethical Requirements)" project titled "**INDONESIAN NURSES' MANAGEMENT OF PAIN IN CHILDREN: A GROUNDED THEORY STUDY**". On behalf of the Human Research Ethics Committee I am authorised to inform you that the ethics for the project is approved.

Approval of this project is for a period of twelve months from **25th June 2010** to **25th June 2011**. If at any time during the twelve months you have any amendments or if a serious or unexpected adverse event occurs, please advise me immediately. The approval number for your project is **SON&M 27-2010**. *Please quote this number in any future correspondence.*

Professor Dianne Wynaden
Low Risk Coordinator
School of Nursing and Midwifery

Please Note: The following standard statement must be included in the information sheet to participants: *This study has been approved by the Curtin University Human Research Ethics Committee. If needed, verification of approval can be obtained either by writing to the Curtin University Human Research Ethics Committee, c/- Office of Research and Development, Curtin University of Technology, GPO Box U1987, Perth, 6845 or by telephoning 9266 2784.*

Appendix 15: Renewal Ethic Approval from Curtin University



Memorandum

To	Ms Henny Mediani, Dr Rose Chapman, Professor Linda Shields
From	Professor Dianne Wynaden
Subject	Protocol Approval SON&M SON&M27-2010
Date	25 th June 2011
Copy	Dean Newman, Professor Gavin Leslie

Thank you for your "Form C renewal Application for Approval of Research with Low Risk (Ethical Requirements)" for the project titled "Indonesian nurses' management of pain in children: A grounded theory study". On behalf of the Human Research Ethics Committee, I am authorised to inform you that the project is renewed.

Approval of this project is for a period of twelve months from 25th June 2011 to 25th June 2012.

The approval number for your project is **SON&M 27-2010**. *Please quote this number in any future correspondence.* If at any time during the twelve months changes/amendments occur, or if a serious or unexpected adverse event occurs, please advise me immediately.

A handwritten signature in black ink, appearing to read "Dianne Wynaden".

Professor Dianne Wynaden
Low Risk Coordinator/Ethics Advisor
School of Nursing and Midwifery

Please Note: The following standard statement must be included in the information sheet to participants:
*This study has been approved by the Curtin University Human Research Ethics Committee (Approval Number SON&M 27-2010).
If needed, verification of approval can be obtained either by writing to the Curtin University Human Research Ethics Committee,
c/- Office of Research and Development, Curtin University of Technology, GPO Box U1987, Perth, 6845 or by telephoning 9266
2784 or hrec@curtin.edu.au*

CRICOS Provider Code 00301J

Appendix 16: Ethic Approval from Dr Hasan Sadikin General Teaching Hospital



FAKULTAS KEDOKTERAN UNPAD - RSUP Dr. HASAN SADIKIN BANDUNG
FACULTY OF MEDICINE UNPAD - Dr. HASAN SADIKIN GENERAL HOSPITAL BANDUNG
KOMITE ETIK PENELITIAN KESEHATAN
HEALTH RESEARCH ETHICS COMMITTEE



KETERANGAN PERSETUJUAN ETIK ETHICAL CLEARANCE

No.: 126/FKUP-RSHS/KEPK/Kep./EC/2010

Komite Etik Penelitian Kesehatan Fakultas Kedokteran Universitas Padjadjaran – RSUP Dr. Hasan Sadikin Bandung, dalam upaya melindungi hak asasi dan kesejahteraan subjek penelitian kesehatan dan menjamin bahwa penelitian berjalan sesuai dengan pedoman ICH-GCP dan aturan lainnya yang berlaku, telah mengkaji dengan teliti dan menyetujui proposal penelitian berjudul:

The Health Research Ethics Committee of Medical Faculty of Padjadjaran University - Dr. Hasan Sadikin General Hospital Bandung, in an effort to protect the basic rights and welfare of the subject of the health research and to assure that a research operates in accordance with ICH-GCP guidelines and other applicable laws and regulations, has thoroughly reviewed and approved a research proposal entitled:

"PENANGANAN NYERI PADA ANAK OLEH PERAWAT INDONESIA: SEBUAH STUDI GROUNDED THEORY)"
"INDONESIAN NURSES MANAGEMENT OF PAIN IN CHILDREN: A GROUNDED THEORY)"

Nama Peneliti Utama : Henny Suzana Mediani, SKp.,MNg.
Name of the principal investigator

Nama Institusi : Fakultas Keperawatan
Name of institution Universitas Padjadjaran
Bandung

Ditetapkan di : Bandung
Specified in
Tanggal : 7 Mei 2010
Date

Ketua,
Chairman,

Sekretaris,
Secretary,


Prof. Dr. Firman F. Wirakusumah, dr., SpOG-K
NIP. 19480115 197302 1 001




Prof. Dr. Dany Hilmanto, dr., SpA-K
NIP. 19630220 198711 1 001

**Appendix 17: Letter permission for conducting research in Dr Hasan Sadikin
Hospital**



**DEPARTEMEN KESEHATAN
DIREKTORAT JENDERAL BINA PELAYANAN MEDIK
RSUP Dr. HASAN SADIKIN BANDUNG**



Jalan Pasteur No. 38 , Bandung 40161
Telepon : (022) 2034953 (hunting) Faksimile : (022) 2032216, 2032533
Surat Email : perjan_rshs@yahoo.com, humas@rshs.or.id
SMS hotline : 081220050547

No : DM.02.01/CO2.2 *AKA* /IV/2010

5th April 2010

Prof. Linda Shields, Ph.D, MMedsci, BAppSci, FRCNA, FRSM
School of Nursing & Midwifery
Faculty of Health
Curtin University of Technology
Perth – Australia

In replying your letter regarding research project by Henry Suzana Mediani with title "Faktor-Faktor Yang Mempengaruhi Perawat Indonesia Dalam Penanganan Nyeri Pada Anak : Sebuah Studi Grounded Theory"

We hereby notify that principally we do not have any objection that she conducts the research in Hasan Sadikin General Hospital

We are looking forward to further response



Director of Education & Human Resources *rs*

[Signature]
Dr. Agus Hadian Rahim, dr, SpOT(K), M.Epid, M.HKes *Y*

Appendix 18: Letter permission for conducting research in Gunung Jati hospital Cirebon



PEMERINTAH KOTA CIREBON KANTOR KESATUAN BANGSA POLITIK DAN PERLINDUNGAN MASYARAKAT

Jl. Sasana Budaya No. 184 Telp. (0231) 222796 Fax. 222796 Kode Pos 45131
CIREBON

SURAT IJIN SURVEY

Nomor : 072 / O14 / KKBPPM

Memperhatikan :

1. Surat Keputusan Gubernur Propinsi Jawa Barat Nomor 300/SK.1215-HUK/90 tanggal 14 Agustus 1990 tentang Tata Cara memperoleh Ijin atau Rekomendasi yang berkaitan dengan Pembinaan dan Ketertiban Umum di Propinsi Jawa Barat.
2. Peraturan Daerah Kota Cirebon Nomor 13 Tahun 2004 Tentang Pembentukan Lembaga Teknis Daerah Pada Pemerintah Kota Cirebon.
3. Surat Keputusan Walikota Cirebon Nomor 52 Tahun 2008 Tentang Organisasi dan Tata Kerja Kantor Kesatuan Bangsa Politik dan Perlindungan Masyarakat Kota Cirebon.
4. Surat Komite Etika Penelitian Kesehatan Fakultas Kedokteran UNPAD Bandung Nomor: 126 / FKUP – RSHS / KEPK / Kep. /EC / 2011 Tanggal 07 Mei 2010 Perihal: Keterangan Persetujuan Etik / Penelitian.
5. Surat Unuversity of Technology Australia
6. Pertimbangan Kepala Kantor Kesatuan Bangsa Politik dan Perlindungan Masyarakat Kota Cirebon tentang Situasi dan Kor.disi wilayah Kota Cirebon.

Sehubungan dengan hal tersebut di atas, diajukan Rekomendasi untuk dapat diberikan Ijin / Rekomendasi untuk melaksanakan Penelitian / Survey / Riset di Wilayah Pemda Kota Cirebon.

Adapun Identitas Mahasiswa/i / Siswa/i, atas nama :

N a m a	: Henny Suzana Mediana,SKp., MNg
N I M	: 14211922
Jabatan	: Mahasiswa
Maksud dan Tujuan Kegiatan	: Melakukan Survey / Penelitan
Judul Penelitian	: “Penanganan Nyeri pada Anak-anak Indonesia, Sebuah Studi Grounded Theory ”
Pengikut / Peserta Kegiatan	: -
Penanggung Jawab Kegiatan	: Profesor Linda Shields,PhD,MMedSci,BappSci, (Nursing) FRCNA,FRSM
Lamanya Kegiatan	: 12 Januari 2011 s/d 12 Februari 2011
Lokasi Kegiatan	: Rumah Sakit Gunung Jati

Dengan ketentuan-ketentuan sebagai berikut :

1. Melaporkan kedatangan serta maksud dan tujuan kegiatan dengan menunjukan Surat Ijin kegiatan ini kepada Pejabat setempat yang dihubungi setelah tiba ditempat tujuan.
2. Sepanjang Kegiatan tersebut tidak mengganggu keamanan dan ketertiban Sosial Politik.
3. Memelihara hubungan baik dengan Pejabat setempat selama melaksanakan kegiatan tersebut.
4. Hasil kegiatan tidak boleh dipergunakan untuk kepentingan lain, selain dari tujuan kegiatan survey.
5. Segala pembiayaan yang berhubungan dengan kegiatan survey, ditanggung oleh yang bersangkutan.
6. Setelah selesai, melaporkan hasil Penelitian kepada Pemerintah Kota Cirebon melalui Kantor Kesbang dan Politik Kota Cirebon.
7. Surat Ijin ini akan dicabut dan dinyatakan tidak berlaku lagi apabila ternyata pemegangnya tidak memenuhi ketentuan-ketentuan sebagaimana tersebut di atas.

Demikian untuk menjadi maklum dan atas perhatiannya kami ucapkan terima kasih.

Dikeluarkan di : CIREBON
Pada Tanggal : 11 Januari 2011

KEPALA KANTOR KESATUAN BANGSA POLITIK
DAN PERLINDUNGAN MASYARAKAT
KOTA CIREBON


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ABBREVIATION USED IN THIS STUDY

Abbreviation	Full version
AAP	American Academy of Paediatrics
ANA	American Nurses Association
APS	American Pain Society
BAPPENAS	Badan Perencanaan Pembangunan Nasional
BPS	Badan Pusat Statistik
BSP	Basic Social Process
BSSP	Basic Social Structural Process
CGT	Classic Grounded Theory
GT	Grounded Theory
IASP	International Association for the Study of Pain
ICN	International Council of Nurses
IMR	Infant Mortality Rate
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
MDG	Millennium Development Goal
NHSI	NHS Institute for Innovation and Improvement
NHMRC	National Health & Medical Research Council
NICU	Neonatal Intensive Care Unit
NNRU	National Nursing Research Unit
PICC	Peripherally Inserted Central Catheter
PNKAS	Paediatric Nurses' Knowledge and Attitude Survey
PRN	Pro Re Nata
PTSD	Post-Traumatic Stress Disorder
RCN	Royal College of Nursing
SEARO	South-East Asia Regional Office
SGT	Straussian Grounded Theory
Six Cs'	Causes, Contexts, Contingencies, Consequences, Covariances and Conditions
SOPs	Standard Operational Procedures
U5MR	Under-Five Mortality Rate
WHO	World Health Organization

