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Understanding Personal Carers' Experiences of Caring for Older People in Pain

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**Understanding personal carers'
experiences of caring for older
people in pain**

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This thesis submitted in Partial Fulfilment of the requirements for the award of
Bachelor of Nursing (Honours)

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USE OF THESIS

The Use of Thesis statement is not included in this version of the thesis.

ABSTRACT

Pain is a complex phenomenon that can be challenging for staff working in residential aged care facilities (RACFs) (Fisher et al., 2002; Twycross, 2002). A high prevalence of pain reported by older individuals has been reported and suggests that further study in this area is warranted (Higgins, Madjar & Walton, 2004). Research suggests that a significant barrier to effective pain management in the elderly is the provision of primary care by care staff who have little or no education about pain, pain assessment or pain management (Allcock, McGarry & Elkan, 2002). Studies have identified personal carers as being in a unique position to improve pain management, because of their working relationship with residents (Ferrell, 1996; Horgas & Dunn, 2001). However, there is a lack of literature which specifically examines personal carers' perspectives of providing care to residents in pain on a daily basis.

This thesis presents a study of personal carers working in RACFs in regional Western Australia. A descriptive and explorative qualitative approach has been applied to examine the experience personal carers' have had with older residents in pain. A purposive, convenience sampling method allowed access to six personal carers currently employed in regional Western Australia. Data was generated by in-depth interviews focusing on the personal carers' experiences of caring for older people in pain. Interviews were audiotape recorded, transcribed and coded to ensure confidentiality and anonymity of participants. The findings of this study provide an understanding of the complex care needs of older residents in pain and illuminate the role of personal carers in the pain management process.

A constant comparison method of analysis was used to develop a central theme and a sub-theme with associated categories. The central theme, *Perfect Positioning*, emerged from the data to encompass all aspects of the position personal carers have in the pain management process. Five associated categories, *Frontline*, *Knowing the Residents*, *Emotional Attachment*, *Teamwork* and *Rewards for Getting It Right*, provide explanation of the pivotal role of personal carers in RACFs in pain

management. A sub-theme, *Extended Roles*, describes the additional responsibilities associated with pain management that are inherent in the personal carers' role. Two related categories, *Clinical Judgements* and *Nagging* were identified and highlight the responsibility of personal carers in the pain management process. This study contributes an understanding of the issues related to the experience of caring for older residents in pain. The research findings and recommendations established from this study have implications for clinical practice, education, administration and for future research in the aged care setting.

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- iii. Contain any defamatory material**

Signed
.....

Dated

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LIST OF ABBREVIATIONS

ABS	Australian Bureau of Statistics
AGS	American Geriatric Society
ASGM	Australian Society of Geriatric Medicine
AIHW	Australian Institute of Health and Welfare
ANF	Australian Nursing Federation
APS	Australian Pain Society
CDoHA	Community Department of Health and Ageing
DoHA	Department of Health and Ageing
ECU	Edith Cowan University
EN	Enrolled Nurse
IASP	International Association for the Study of Pain
NBWA	Nurses Board of Western Australia
PC	Personal Carer
PRN	as needed
RACF	Residential Aged Care Facility
RCNA	Royal College of Nursing, Australia
RCS	Resident Classification Scale
RN	Registered Nurse
%	Percentage

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CHAPTER ONE

Background and Significance

Introduction

Pain is a complex phenomenon and is a significant problem for residents living in residential aged care facilities (RACFs). As the Australian population is ageing, the number of people requiring residential care is projected to increase (Australian Institute of Health and Welfare [AIHW], 2006). The high prevalence of pain in older individuals has been recognised in recent times and has prompted research into this area (Higgins et al., 2004). The primary care givers in RACFs are increasingly becoming staff who have no formal qualification, namely personal carers (Richardson & Martin, 2004). Personal carers in Australia provide general care to residents under the supervision of a registered or enrolled nurse. Studies have identified personal carers as having a unique position to improve pain management because of their close proximity in working with residents (Horgas & Dunn, 2001; Weiner & Rudy, 2002). However, there has been a paucity of research examining the personal carer's experiences of caring for older residents in pain. The purpose of this study was to explore and describe the experiences of personal carers who care for older residents in pain. This section provides background information regarding residential aged care in Australia, personal carers in this setting and pain experienced by older people, to highlight the need for research into this area. The purpose and significance of the study are detailed and specific research objectives are identified.

Background to the Study

Australia's Ageing Population

The terms 'older' or 'elderly people' traditionally refers to people over the age of 65 years (AIHW, 2006). In 2006 approximately 2.7 million Australians, 13.3 percent of the total population were aged over 65 years (Australian Bureau of Statistics [ABS], 2006). The proportion of the population that is over this age has steadily increased since the beginning of the 20th century and is projected to continue to increase over the next 50 years, to become more than a quarter of the total

Australian population (ABS, 2005). Older people represent the fastest growing segment of the population and consume a significant proportion of health resources in many countries (AIHW, 2006).

Australia's mixed private and public health system spend approximately 79 billion dollars per year on health (Department of Health and Ageing [DoHA], 2006). Changes in the health care system have shifted the care of older people from extended hospital stays to care in the community and RACFs (Herr & Mobily, 1996). Under the Aged Care Act (1997) the Australian Government subsidises both RACFs and community care packages. Community care packages are funded to allow older persons at home to receive the same level of care available in RACFs (ABS, 2006). While the number of residential care places per 1000 has decreased since the 1980s, community care of various kinds has been developed and expanded (ABS, 2006). The rapidly ageing population has meant an increase in expenditure on aged care in recent years, with approximately seventy six percent of annual aged care expenditure being used for the provision of residential care services and twenty percent for community care and support for carers (DoHA, 2006). Approximately five percent of the population over 65 years will require admission to a RACF (ABS, 2006), and even more require assistance in the community. In 2004-2005, there were 194,002 people who received permanent residential care in Australia and 36,023 people who received respite care, which includes the 15,517 people who were later admitted to permanent residential care (AIHW, 2006).

A RACF is defined as an institution devoted to providing long-term care for older individuals (Richardson & Martin, 2004). Residential aged care in Australia has traditionally been provided by two main types of facilities; high level care facilities, commonly known as nursing homes and low care facilities commonly known as hostels (Commonwealth Department of Health & Ageing [CDoHA], 2002; Richardson & Martin, 2004). High level care facilities aim to provide care to people who require a significant amount of assistance and are unable to perform activities of daily living independently. Low level care facilities provide care for individuals who

require some assistance with activities of daily living but are capable of performing a number of tasks unaided (AIHW, 2006). The two tiered system; high and low care, has previously operated as two quite separate systems. However, the distinction is somewhat difficult to determine since the Federal Government Structural Reform in 1997 proposed 'Ageing in Place' (CDoHA, 2002). 'Ageing in Place' relates to the provision of residential care that is responsive and flexible to the care needs of older individuals, it also recognises that a RACF is the home of residents. This enables residents in low level care facilities who have increasing care needs and higher levels of dependency to remain in the low level care facility or receive community care services, rather than be transferred to a high level care facility (CDoHA, 2002; Gibson, Rowland, Braun & Angus, 2002). As a consequence hostels are providing high level care and therefore experiencing many of the same issues as high level care facilities.

The majority of people admitted to RACFs are over the age of 75 years, exhibit co-morbidities and have high dependency needs, therefore requiring complex care (Allcock et al., 2002; Ferrell, 1996). The average age of older people in RACFs is approximately 85 years (AIHW, 2006). There are a greater proportion of women (72%) in RACFs (AIHW, 2006). The longer life expectancy of women may explain their higher occupancy rates in RACFs. The majority of people admitted to residential care have either profound (85%) or severe (10%) activity limitation (ABS, 2006). That is, they require assistance with at least one personal activity such as showering or toileting. The majority of older people in RACFs require assistance with self care, mobility, oral communication and health care (see Table 1) (ABS, 2006). Furthermore, the prevalence of cognitive impairment (which includes delirium and dementia) is as high as 90 percent (Mann, Schneider & Mozley, 2000). Thirty to forty percent of residents in RACFs suffer clinical depression (Mann et al., 2000). More than 80 percent experience significant vision or hearing difficulties and more than 40 percent experience major sleep disorders (Australian Society of Geriatric Medicine [ASGM], 2001). Despite the increase in management of acute conditions and complex care issues associated with the types of residents in residential care,

facilities are often not equipped or staffed to manage such residents (Ferrell, 1995; Herr & Mobily, 1996).

Table 1. Percentage of Residents Requiring Assistance with Specific Personal Activities (ABS, 2006).

Specific Personal Activity	% of Residents Requiring Assistance
Self Care	91
Mobility	87
Oral Communication	63
Health Care	95

Staffing in Australian Residential Aged Care Facilities

Australian RACFs are generally staff with a multidisciplinary team, including personal carers, registered and enrolled nurses, physicians, administrative workers and allied health professionals (Richardson & Martin, 2004). The existing knowledge about the demographics of staff who are employed in the aged care sector workforce is largely limited. The workforce has an age distribution that is older than the total Australian workforce. Only 43 percent of employees are under 45 years of age and approximately one quarter of personal carers are aged over 50 years (Richardson & Martin, 2004).

The aged care sector has an increasingly poor record of retention and attraction of staff (Richardson & Martin, 2004). The increased need to reduce financial costs and inability to retain staff in RACFs has resulted in a reduction in the number of qualified staff, namely registered and enrolled nurses, and an increased reliance on non-professional staff for the provision of primary care (ABS, 2005; Chou, Boldy, & Lee, 2002; Richardson & Martin, 2004). These care providers are known as personal

carers, nursing assistants, care aides or care workers (ABS, 2005). In Australia, a personal carer is a person who is employed in an RACF to provide basic care and practice under the supervision of a registered or enrolled nurse (Australian Nursing Federation [ANF] & Royal College of Nursing, Australia [RCNA], 2004). The role of personal carers differs greatly throughout the world. However, in Australia personal carers are increasingly providing more complex care (ABS, 2005; Richardson & Martin, 2004).

In 2003, it was estimated that there were approximately 67, 000 personal carers employed throughout the Australian aged care workforce (Richardson & Martin, 2004). They comprise 50 to 60 percent of staff in Australian RACFs (Nay & Closs, 1999) and provide 80 to 90 percent of all direct care (Horgas & Dunn, 2001). Registered nurses are available in some but not all RACFs, with many working on an 'on call' basis. A study by Rohr, Schneider, Good and Sattler (2003) found that only 40 percent of examined Australian hostels had a registered nurse available to conduct assessments. It is also important to note that even in facilities with registered nurses, personal carers may be conducting assessments and relaying information to registered nurses in up to 60 percent of cases (Rohr et al., 2003). This reliance on personal carers may mean that they are working outside their scope of practice (Horgas & Dunn, 2001).

In Australia, scopes of practice documents for personal carers employed in RACFs are not available. There are no identifiable national consistencies in position statements nor is there a regulatory body which monitors the employment of personal carers in Australian RACFs. While personal carers in Australia are not required to possess a particular educational qualification, vocational education is available. The Certificates III and IV in Aged Care are available. Research suggests that 60 percent of personal carers employed in RACFs in Australia have a Certificate III, while only 6 percent hold a Certificate IV in Aged Care (Richardson & Martin, 2004). However, these educational programs provide minimal education regarding the assessment of pain in the elderly population. Despite the increase in complex care needs of older

people in RACFs, personal carers continue to practice without formal education or training.

Australian RACFs experience difficulties with staff recruitment and retention. Problems are compounded by low staff to resident ratios, high staff turnover and a large proportion of casual or agency staff who work short or split shifts to supplement the limited number of regular staff (Herr & Mobily, 1996). These factors are associated with an increased level of work related stress experienced by health care staff (Chou et al., 2002). There is often limited access to diagnostics, pharmacists and other consultation services. Furthermore, physicians generally have a private practice outside the RACF and visit residents infrequently (Chou et al., 2002; Ferrell, 1996; Gartell, 2005; Herr & Mobily, 1996). As a result of the staffing in RACFs it is evident that many facilities rely on non-professional staff for the provision of primary care (Horgas & Dunn, 2001; Richardson & Martin, 2004). Personal carers employed in RACFs have a great deal of responsibility that is compounded by the limited staff to resident ratio and heavy workload (Horgas & Dunn, 2001). Due to the staff structure in RACFs it may be the personal carers' undefined role to monitor a resident's health status because there is no other health professional available to do so.

Pain in Older People

Pain has been defined by the International Association of the Study of Pain [IASP] (1994) as “an unpleasant emotional experience which we primarily associate with tissue damage or describe in terms of damage or loss”. It is a subjective feeling and is defined by McCaffery (1979, p.11) as “whatever the person says it is and existing where ever the person say it does”. Most pain experienced by older people is referred to as chronic or persistent (Ferrell, 1996) and therefore these terms will be used throughout this study. The terms ‘chronic’ or ‘persistent pain’ are often used interchangeably. Chronic pain is persistent and defined as lasting longer than six months and persisting beyond the expected normal healing time (IASP, 1994). Pain, with it's complex interplay of sensory and emotional variables, results in signs and

symptoms that varies between individuals. Furthermore, age associated changes in physiological and psychological functioning cause unusual presentations of illness and pain in many older people (Ferrell, 1996; Gartell, 2005).

Pain is a widely acknowledged problem for residents in aged care facilities (Australian Pain Society [APS], 2005). Although pain is not part of the normal ageing process, estimates suggest that between 45 (Ferrell, 1995; Higgins et al., 2004) and 80 percent (Allcock et al., 2002; Ferrell, 1995) of residents in RACFs are experiencing regular pain. The main sources of pain in older people include musculoskeletal disorders such as osteoarthritis, osteoporosis, bone fractures and rheumatoid arthritis (Farrell, Gibson & Helme, 1996; Gartell, 2005). Neuropathic pain, malignant pain and other painful conditions such as peripheral vascular disease occur more frequently with age (American Geriatric Society [AGS], 2002; Ferrell, 1995). Furthermore, pain in older people is often multifactorial, because older people tend to have increased incidence of multiple chronic health problems that are compounded by factors associated with ageing (Ferrell, 1995; Higgins et al., 2004; Keefe, Beaupre, Weiner & Seigler, 1996).

Older people provide many challenges for health professionals trying to effectively manage pain (Herr & Mobily, 1996). Pain is a highly subjective experience and there is a heavy reliance on self reporting for the identification and assessment of pain (Keefe et al., 1996). The high incidence of sensory and cognitive impairment among older people complicates and hinders the accurate assessment of pain, because residents are limited in their ability to describe their pain (Clark, Jones & Pennington, 2004; Herr, 2002a; Herr & Mobily, 1996; Keefe et al., 1996). Estimates suggest that approximately 60 percent of residents in Australian RACFs have dementia (Jorm, 2001). These residents typically have deficits in memory, attention, visual spatial skills and language (Ferrell, 1996). In addition behavioural problems are often associated with dementia, which further complicates the identification of pain because behaviours can be misinterpreted (Keefe et al., 1996). Pain assessment tools such as visual analogue scales and non-verbal behavioural

indicators have only been partially validated in older people (Ferrell, 1995). The high incidence of these impairments may impede the adaptation and use of such tools and result in difficulty communicating discomfort that can be understood by health care providers (Ferrell, 1995; Herr & Mobily, 1996).

There is a tendency for older people to under-report pain (Allcock et al., 2002; Ferrell, 1996; Herr, 2002a). Broad societal beliefs and common misconceptions about ageing and pain can lead to stoicism, preventing older people from communicating pain to health professionals (Herr & Mobily, 1996). Many older people may discount symptoms or be fearful about indicating the extent of their pain because of misunderstandings about the effects of analgesia, concerns about the side effects of treatment, acceptance of pain as a normal part of ageing and fear of what pain may represent (Gartell, 2005). Older people in RACFs may also fail to report pain or request pain management, because they do not want to bother staff, or feel that their pain won't be acknowledged (Ferrell, 1995; Yates et al., 2004). There is also considerable fear and anxiety surrounding analgesic use in older people, for both health professionals and older people themselves. Nevertheless, these reasons do not justify failure to relieve pain (AGS, 2002).

The consequences of persistent pain for nursing home residents have been well documented (Ferrell, 2004). The complications are extensive and varied and affect many aspects of an individual's life, from their psychological and physical state, to their general daily functioning (Horgas & Dunn, 2001). Research suggests that older persons suffering pain are more likely to have severe impairment to the activities of daily living, sleep disturbances, impaired mobility, increased depressive signs and symptoms and less frequent involvement in social activities (Won et al., 1999). Furthermore, health problems such as malnutrition and cognitive dysfunction are among the many conditions that are associated with or exacerbated by the presence of pain (Ferrell, 1995). Therefore, pain has major implications for the quality of life of older individuals (Herr & Mobily, 1996; Horgas & Dunn, 2001; Won et al., 1999).

Barriers to Effective Pain Management in Residential Aged Care Facilities

There are a number of barriers to the identification and effective management of pain for individuals in RACFs (Higgins et al., 2004). Effective pain management is influenced by several personal, institutional and environmental factors (Ferrell, 1996; Herr & Mobily, 1996). There are many variables that prevent elderly residents from being active participants in pain control. As already discussed, these include sensory and cognitive impairment, in addition to resident misconceptions and fears about pain and its management (Allcock et al., 2002; Ferrell, 1995; Herr & Mobily, 1996).

RACFs may lack appropriate equipment such as hoists or mobility aides and access to professional staff required for provision of effective pain management (Herr & Mobily, 1996). Physicians who dictate residents' pharmacological interventions generally practice off-site and visit residents infrequently (Ferrell, 1995). Allied health staff such as occupational therapists and physiotherapists are generally employed or sub-contacted to visit RACFs on a part-time basis, creating delays in assessments and commencement of therapy. The particularly complex care needs of this population require skilled professionals (ASGM, 2001) who have current knowledge of pain management in the elderly (Herr & Mobily, 1996). Logistical barriers such as lack of access to diagnostic laboratories, radiographic and pharmaceutical services make the ability to complete prompt, accurate assessments and provide appropriate treatment more difficult (Ferrell, 1996).

A significant obstacle to effective pain management for residents in RACFs is the heavy reliance on non-professional staff for the provision of primary care (Herr, 2002a; Higgins et al., 2004; Horgas & Dunn, 2001). In Australia, personal carer's basic education, which is not mandatory, provides minimal education regarding pain identification and treatment (Richardson & Martin, 2004). Access to registered nurses is available in some, but not all facilities (Rohr et al., 2003). The increased reliance on personal carers in RACFs, means that they may be working outside their scope of practice.

Personal carers work closely with residents (Ferrell, 2004) placing them in a unique position to be able to identify residents in pain and to implement pain management interventions as they have more direct contact with residents than other health care providers. Although the role of personal carers in pain management is not clearly defined, it could be suggested that pain management is outside their scope of practice given their limited education. However, in RACFs staffed mainly by personal carers, the management of pain by necessity requires the involvement of personal carers. Nevertheless, research suggests many personal carers have limited education about pain, but has identified that personal carers do play a role in the management of pain (Horgas & Dunn, 2001; Weiner & Rudy, 2002). In particular, the experiences of formal caregivers, namely personal carers, who in RACFs provide care on a daily basis to older residents in pain, has not been examined.

Research Aim

The intent of this study is to highlight the importance of the personal carers' role in caring for older people in pain by producing in-depth, accurate descriptions of their experiences with caring for residents in pain.

Significance of the Study

The elderly are a rapidly growing segment of the total population and specific care issues such as pain management will continue to be a major concern for the health care sector (Herr, 2002b). Complications of unrelieved pain are widespread. Physical, functional and psychological health conditions are associated with or exacerbated by pain (Won et al., 1999), therefore having major implications for the quality of life and care of older individuals (Ferrell, 2004). Deconditioning, malnutrition, cognitive dysfunction and falls are conditions that are potentially compounded by pain (Ferrell, 1995; Won et al., 1999). Pain and its association with other conditions leads to further disability and dependency, thus severely impacting on the quality of life and care of older individuals (Herr & Mobily, 1996; Horgas & Dunn, 2001; Won et al., 1999). Furthermore, the health care system has an obligation

to provide comfort and pain management for older people (APS, 2005; Ebener, 1999).

Personal carers are working as primary care providers in many Australian RACFs and often work independently and largely unregulated. The increased care needs of residents in these facilities means that non-professional staff are fulfilling many roles that were once performed by registered or enrolled nurses (Richardson & Martin, 2004). This study seeks to gain an increased understanding of the roles and tasks related to pain management performed by personal carers in the residential care setting. The study has implications for the provision of clinical care in Australian RACFs. The study also has implications for work force planning, particularly for Australian nursing bodies, as it affects issues such as scope of practice and delegation.

Information is needed for health care planners, educators and funding providers for the future direction of aged care. This study will begin to provide empirical data about personal carers in Australian RACFs and to gain an understanding of the experience and involvement with older residents in pain. This study will also begin to provide information to understand how personal carers cope with caring for residents in pain. Previous research has identified a knowledge deficit by staff who work in the aged care setting (Allcock et al., 2002; Horgas & Dunn, 2001). This study aims to identify factors that personal carers feel are necessary to provide optimal care, including the effective management of pain for older residents. This study has implications for identifying ways to improve pain management in RACFs and therefore enhance the quality of life for older residents, because health care providers have an obligation to optimise the quality of life and wellbeing of older people (Ebener, 1999; Ferrell, 2004).

The economic and social costs associated with pain are considerable (AGS, 2002; Niv & Kreitler, 2001; Loeser, 1999). Reduction in pain and pain related problems may be instrumental in reducing health care costs for the individual and for

the health care system in general (Loeser, 1999). Therefore any attempt to improve the quality of life for older individuals, the working environment of their primary care providers and the associated costs, is a consequential research endeavour.

The Purpose of the Study

The purpose of this study is to explore and describe the experience of personal carers who have provided care for residents who are in pain. A qualitative method of inquiry was selected due to the paucity of literature pertaining specifically to the personal carers' experiences in their daily work life. Qualitative methods permit the topic to be examined in-depth and in-detail without constraint from preconception (Patton, 1990). The emphasis is on a holistic understanding rather than striving to isolate characteristics of interest, as in quantitative methods. A descriptive, exploratory approach has been applied to facilitate a thorough exploration of the personal carers' subjective experiences (Beanland, Schneider, LoBiondo-Wood & Haber, 1999). The experience will be defined by the feelings, attitudes and perceptions expressed by the personal carers. The primary research question for this study is: What is it like for personal carers to care for older people in pain?

The specific objectives of this study are as follows:

- To describe personal carers' experiences of caring for older residents who are in pain.
- To describe meanings that personal carers ascribe to their experience of caring for older people in pain.
- To explore what is perceived as helpful by personal carers to assist in providing care for elderly residents in pain.
- To explore what personal carers perceive as barriers to providing care for elderly residents in pain.

Conclusion

This chapter has discussed the need for undertaking research about pain in the aged care sector. As the population continues to age, issues relating to the care of older individuals will inevitably be an important matter for the health care sector (Herr, 2002b). To date, there has been minimal research conducted which examines the personal carers in RACFs perspectives of caring for older people in pain. Health care planners, educators and funding providers require information for the direction and improvement of aged care services and facilities in Australia. This descriptive, exploratory, qualitative study produces data that allows for a greater understanding of the knowledge and skills required by staff and the complex care issues associated with pain management in the aged care setting.

CHAPTER TWO

Literature Review

Introduction

The goal of a literature review is to develop comprehensive knowledge about the subject to guide the focus of the study (Polit, Beck & Hungler, 2001). However the knowledge uncovered during a critical review of the literature poses a problem for qualitative researchers, because it may contribute to researcher bias, preconception and premature closure of data collection (Beanland et al., 1999). To prevent problems associated with conducting a literature review early in the research process, this literature review was conducted to demonstrate that the research is necessary to address the gaps in the current literature, to justify the need for a qualitative methodology using a descriptive and exploratory approach and to guide sampling and the initial stages of the research process.

A literature review was undertaken using the databases of CINAHL, Medline, OVID, PubMed and Blackwell Synergy. A manual literature search was conducted using reference lists of related articles and dissertations. Relevant texts were also reviewed. The search revealed a limited number of studies which examined personal carers in the aged care setting. Therefore, the scope of this literature review was expanded to include topics relevant to pain management in RACFs. Three main themes were evident from the literature; pain from the residents' perspective, the caregivers' perspective of caring for people in pain and barriers to the effective management of pain in RACFs.

Pain in Residential Aged Care Facilities: The Residents' Perspective

Pain is a highly subjective experience (McCaffery, 1979). Evidence suggests that there are several biological and psychological factors that influence individuals' perceptions of pain (Ferrell, 1996). Models of health emphasise the importance of taking into account the circumstance in which pain is occurring to understand how a person responds to pain (Keefe et al., 1996). The best source of information about a

person's pain experience is gained from the individual experiencing the pain (Gartell, 2005). This section examines literature which portrays the experiences of older people living with pain.

Several researchers have explored the older persons' experience with pain (Carson & Mitchell, 1998; Higgins et al., 2004; Sofaer et al., 2005; Yates, Dewar & Fentiman, 1995). An Australian qualitative study by Yates and colleagues (1995) examined the beliefs, attitudes and perceptions of elderly people in pain. The sample of 42 older people, who resided in five large residential care settings in Queensland, attended focus groups to examine their experiences with pain. Three main themes emerged; resignation to pain, ambivalence about the benefits of action and reluctance to express pain. Findings suggested that older people often felt that pain is a normal consequence of growing old and that little can be done to relieve their pain. Additionally responses depicted the reluctance of residents to report pain because of the consequences of worrying staff or being labelled a 'complainer'. Furthermore, respondents from the study expressed that they perceived staff to be too busy or disinterested to attend to their pain management needs. These perceptions, regardless of their accuracy, have important implications for the residents' pain experience and self-reports of pain. The study illustrated the importance of staff identifying factors that may influence an individuals' response to pain (Yates et al., 1995).

Another Australian qualitative study by Higgins and colleagues (2004) explored the lived experience of chronic pain in elderly people in residential care. The study highlighted the residents' (n=13) experiences with pain and how pain impacted on their everyday lives. The main theme portrayed was being constantly in pain. Similar to Yates and colleagues' study, a theme 'Being Forgotten', emerged from this study. Respondents described how requests for pain relief came after deliberations about whether to bother staff, and their requests were often forgotten. Additionally a theme, 'Unvoicing Pain', reflected how participants concealed their pain in order to get on with their lives, or sometimes for fear of being marginalised by staff. Consequently residents from this study rarely spoke of their pain (Higgins et al., 2004).

A study by Sofaer and colleagues (2005) applied a Grounded Theory approach to ascertain from residents (n=63) between the ages of 60 and 85 years the practical, physical and psychological limitations they faced because of chronic pain and the strategies they used to deal with pain. Two main themes emerged: the desire for independence and control and adaptation to life with chronic pain. The researchers noted that there was a link between the two themes, hypothesising that when independence and control are maintained, older people may in-fact adapt better to chronic pain. The study concluded that health professionals require an increased understanding of the needs of older people in relation to pain and should aim to encourage self help and the independence of residents (Sofaer et al., 2005).

The characteristics of older people, such as the way they experience pain, their perceptions of the outcomes and adverse effects of pain management interventions have been investigated by Blomqvist and Edberg (2002). The study of older people (n=90) identified four ways of viewing oneself as a person in persistent pain; competent and proud, confident and serene, misunderstood and disappointed and resigned and sad. Respondents expressed that the consequences of pain were considered a greater problem than the pain itself. All referred to pain as a restriction in their lives. The way respondents viewed themselves and their pain differed, which emphasised that staff need to understand an individuals' experience and emphasise with their situation (Blomqvist & Edberg, 2002). The findings suggest that by listening and believing the complaints of older people, the care and management of pain could be improved (Blomqvist & Edberg, 2002).

Carson and Mitchell (1998) conducted a descriptive, exploratory study which examined the experience of people (n=17) living with persistent pain. The majority (n=12) resided in long-term care facilities, three participants were in hospital for short stays and two participants were out-patients. Similar to other qualitative studies examining the individuals' experience with pain, all participants in this study spoke of the difficulties of living with pain and how it altered their lives. Participants

described how they invented personal strategies to help them cope and endure life with pain. This study again emphasised the primary care providers' responsibility to listen and respect those who wish to discuss their pain. Importantly, the authors of this study highlighted that the ability to listen to stories of human pain is not an easy task and that "maturity and courage are required to embrace lived experiences of pain" (Carson & Mitchell, 1998, p.1247).

Pain is a private, intrinsic experience (McCaffery, 1979). The perspectives of older people who experience pain provide valuable information for the improvement of managing their pain (Higgins et al., 2004). The literature describes the individual's experience with pain, however older residents' descriptions of the pain experience frequently focused on their primary caregiver, on whom they are largely dependent.

Providing Care for Older Residents: The Caregivers' Perspective

Caring for individuals in pain can be challenging (Ferrell, 1996). As each individual experiences pain in a unique way, so too are the experiences of caregivers unique. This section examined the caregivers' experiences of caring for older people in pain. There was a minimal amount of literature identified that examined formal caregivers' experiences with residents in pain. Therefore, because many older people experiencing persistent pain reside in the community and are cared for by informal or family caregivers, this section was expanded to include such perspectives.

The physical, psychological, social and economic implications related to the informal care giving role are described extensively in the literature (Ferrell, 1996). Many people in the community with chronic pain frequently have significant others such as a spouse or child as their primary caregiver. The strain on families associated with the care giving role has been widely documented. Family functioning, relationships, financial stability and coping are all affected as a result of the responsibility of care giving (Ferrell, 1996; Wynaden et al., 2006).

Yates and colleagues (2004) investigated informal caregivers' experiences and involvement in pain management. The consequences of inadequate pain management are detrimental to all domains of the health and wellbeing of the individual (Yates et al., 2004). However the informal caregiver who closely interacts with the individual is exposed to the adversity of pain and can therefore endure a degree of suffering as well (Ferrell, 1996; Yates et al., 2004). The Australian study by Yates and colleagues (2004) involved 75 patient-caregiver dyads. Findings indicated that while family caregivers reported high levels of confidence and willingness to participate in pain management, they experienced a high level of distress and difficulty assisting with the management of pain (Yates et al., 2004).

A descriptive study performed by da Cruz and de Matton Primentia (2004) examined informal caregivers (n=30) of people with chronic pain. The study aimed to explore the caregivers' role. Results indicated that caring for family members can cause exceptional strain because of the emotional involvement. Furthermore the caregiver sacrifices their own activities, work and social interaction (da Cruz & de Matton Primentia, 2004). Of the caregivers (n=30) in this study, 93 percent demonstrated characteristics of caregiver role strain. The remaining 7 percent had risk factors for caregiver role strain. Although 80 percent of the participants were providing care to individuals with oncologic pain, the results demonstrate that caring for people with chronic pain has a meaningful impact on caregivers (da Cruz & de Matton Primentia, 2004). It is uncertain whether this level of emotional involvement would also occur in paid caregivers, because staff in RACFs provide care to residents consistently and often for several years. Therefore, RACF staff may develop a familiarity and closeness to residents that wouldn't necessarily be obtained in other health care settings.

Barriers to Effective Pain Management in Residential Aged Care Facilities

The barriers to effective pain management in aged care facilities are varied (Herr, 2002a). The experience of pain encompasses many aspects of an individual's life. For older people in RACFs poor pain management is often associated with a

complex interplay of factors. From the literature reviewed, barriers to effective pain management can be described relating to three main factors:

- Organisational factors
- Lack of staff knowledge and education
- Staff attitudes and misconceptions.

Factors relating directly to residents, such as their perceptions and understanding of pain are not discussed in this section.

Organisational Factors as Barriers to Effective Pain Management

The organisational structure of many RACFs provides barriers to effective pain management for the residents (Ferrell, 1996; Herr & Mobily, 1996; Horgas & Dunn, 2001). This section explores potential barriers to effective pain control that are created by the organisational composition of RACFs.

Ferrell (2004) proposed that the lack of readily available access to diagnostic laboratories, radiographic and pharmaceutical services delays the response to treatment. The fact that physicians typically practice away from RACFs and make infrequent visitations to residents may compound the problem of delivering prompt and appropriate pain management (Ferrell, 2004). Access to allied health professionals such as occupational therapists, physiotherapists, dietitians and other consultative services is limited and the shortage of convenient and appropriate transportation may make access to needed services impossible or fraught with difficulty (Ferrell, 1996).

Additional constraints created by the organisational structure of RACFs that are evident in the literature are; the staff to patient ratios, the heavy work load of staff, lack of time to adequately assess pain and the reliance on non-professional staff for the assessment and management of pain (Chou et al., 2002; Ferrell, 1996; Horgas & Dunn, 2001). A study by Weiner and Rudy (2002) found that residents (n=75), nurses (n=75) and nursing assistants (n=75) all reported that lack of time was the

most common reason for inadequate pain management. Another study by Rohr and colleagues (2003) suggested that the limited access to qualified personnel contributed to the ineffective management of pain, because administration of PRN (as needed) and opioid medications was delayed.

A study by Bowers, Lauring and Jacobson (2001) investigated the work roles and quality of care as perceived by staff members (n=18) working in long-term care facilities in America. Lack of time was a particular problem expressed by participants. Staff emphasised that limited time created difficulties completing the required tasks. Another organisational barrier associated with the inadequacy of care that was described in this study was personnel shortages. Staff described strategies they implemented to 'keep up' or 'catch up' with the workload. These strategies included minimising time spent doing required tasks, creating new time and modifying work responsibilities. Despite the implementation of strategies to cope with the work, there were negative consequences. Staff described conducting assessments that were 'necessary' and doing so in a rapid manner, rather than thoroughly. Although this study did not specifically address pain management in the residential aged care setting, the organisational constraints described would have had implications for the assessment and management of pain (Bowers et al., 2001).

Another organisational factor that may be a hindrance to the adequacy of pain management in RACFs is the organisation/facility policies relating to pain management. A study by Allcock and colleagues (2002) investigated nursing homes (n=52) in England. Sixty nine percent (n=47) did not have a written policies regarding the assessment and management of pain. Moreover, 75 percent (n=51) did not have a standardised pain assessment tool. The need for a more formal approach to pain management in RACFs is evident in the reviewed literature. The literature suggests that by having pain management policies and implementation of standardised pain assessment tools, the assessment and management of pain could be greatly improved (Allcock et al., 2002).

Lack of Staff Knowledge and Education Regarding Pain in Older People

A significant challenge to providing effective pain management in RACFs that is prominent in the literature is the lack of knowledge about pain in the residential care setting and the lack of pain related education available to staff (Ferrell, 1996; Herr & Mobily, 1996). According to the AGS (2002), health care professionals have traditionally not been adequately trained in pain assessment and management for older people. It is possible that lack of attention to this problem in the past has contributed to the under-recognition and under-treatment of pain in older people (AGS, 2002).

Herr (2002a) claims that lack of understanding about pain management issues in the elderly by health care providers, is a major factor impeding effective pain management, particularly in RACFs (Herr & Mobily, 1996). A recent exploratory study performed by Neville, McCarthy and Laurent (2006) investigated the pain management education needs of nurses (n=72) and personal carers (n=120) working with older people with dementia in regional Australia. The majority (66%, n=130) of all participants were not aware of formal education programs exploring pain, or stated that those available did not meet their needs. Of the respondents who had attended pain management programs, 92 percent believed it was helpful for their practice. Findings indicated that personal carers felt they didn't have the knowledge or competence to manage pain effectively. In addition, the study demonstrated that although personal carers were likely to acknowledge the presence of pain, they were less likely than a registered or enrolled nurse to take action to relieve it. Although pain management is not necessarily the role of a personal carer, in RACFs where they are often the only staff on duty, it may be necessary for personal carers to be involved in pain management.

Most apparent in the literature is the lack of staff knowledge and skills related to the pharmacological and non-pharmacological management of pain (Herr & Mobily, 1996). The age related changes in the pharmacokinetics and pharmacodynamics of analgesic drugs further complicates the ability of staff to have current and extensive

knowledge. The changes associated with ageing increase the complexity of providing care for older people and emphasise the need for well educated and knowledgeable care providers in RACFs (Herr, 2002a; Pepp & Portenoy, 1996). Herr and Mobily (1996) suggest that knowledge deficits of health care providers in RACFs specifically relating to effective prescribing, dosing and administering patterns in older people, result in pharmacological interventions being implemented less often than necessary (Herr & Mobily, 1996).

The educational needs of health professionals working in a range of care settings have been the focus of a number of studies (Allcock et al., 2002; Davies, Slack, Laker, Philip, 1999; Ferrell, 1996; Twycross, 2002). However, literature examining the educational preparation of staff in RACFs, particularly personal carers, is limited (Davies et al., 1999). The literature reviewed highlighted a need for pain management programs tailored to the needs of all aged care staff (Herr & Mobily, 1996; Horgas & Dunn, 2001; Neville et al., 2006), however personal carers continue to be largely excluded from the literature. Several English studies have included personal carers and found that they had little, if any, education regarding pain and its management (Allcock et al., 2002; Davies et al., 1999). A study by Allcock and colleagues (2002) into the management of pain in 52 nursing homes revealed that 85 percent of nursing assistants had no training regarding pain. Of the investigated nursing homes, only 34 percent provided education sessions for their care assistants, with only approximately one third providing training for either qualified or unqualified staff in the management of pain in residents with communication difficulties. The lack of pain related knowledge depicted in this study highlights the need for further education and support for the staff in the residential aged care setting (Allcock et al., 2002).

Davies and colleagues (1999) investigated the educational preparation of staff (n=660) in nursing homes in three regions of England. Within most facilities only a minority of staff were undertaking any form of professional education at the time of the study. The authors offered potential explanations for the poor numbers involved

in professional education. The majority of facilities sampled were owned by private organisations that were possibly unwilling to support the cost associated with educating staff. Additionally where education was provided, it is possible that it was directed at qualified nurses rather than personal carers, in hope that the information would filter down to other staff. Findings indicated that despite the identification of the need for education, opportunities to undertake education and training continue to be infrequent (Davies et al., 1999).

Assessing older people in pain is likely to be a problem for staff in RACFs (Herr & Mobily, 1996). In the residential aged care setting the health provider who is primarily responsible for the assessment of pain is most likely to be a personal carer. A study by Rohr and colleagues (2003) identified that even in facilities with registered nurses, personal carers were performing pain assessments and relaying clinical information to nurses in 60 percent of cases. The literature identified personal carers as being in a unique position to conduct pain assessments because they worked closely with residents, performing activities such as showering and toileting. Therefore, carers often notice changes in function or behaviour related to pain earlier than other RACF staff (Horgas & Dunn, 2001). Furthermore, the intimate nature of care provided by personal carers and the long term element of residential care, allows personal carers to develop knowledge of individual resident's normal level of functioning and can identify pain related changes in functioning that other health care providers may overlook.

Previous studies have been conducted to examine the accuracy with which health care providers assess pain. These studies have investigated the congruence of self-reported pain ratings and caregiver ratings (Horgas & Dunn, 2001; Weiner, Peterson & Keefe, 1999). Reports of pain can be poorly correlated with an individuals' rating of their own pain. A small study by Horgas and Dunn (2001) investigated the congruence between residents (n=45) and caregivers (n=16) perceptions of pain. The study found that residents and caregivers disagreed in their pain assessments 62 percent of the time. Caregivers identified only 11 percent (n=15)

of residents who reported they were in pain as having pain, and reported 24 percent as having pain when they reported no pain at all. However, the findings of this study also suggested that caregiver characteristics such as age, education and work experience were not significantly associated with the accuracy of pain assessment. These findings highlight the complexities of assessing pain.

Similarly, a study by Weiner and colleagues (1999) compared perceptions of behaviours identified as being related to pain between residents (n=42) and their nursing home and family caregivers. For the majority of pain related behaviour items there was poor congruence between residents and their caregivers severity of pain ($\kappa < 0.30$). The findings of a study by Engle, Graney and Chan (2001) of nursing assistants and licensed practical nurses (sample size not disclosed) and residents (n=252) concluded that nurses and nursing assistants underestimated residents' pain frequency and pain intensity ($\kappa = 0.72$). However, they also reported that nursing assistants were less likely to underestimate pain frequency and intensity than enrolled nurses ($t=1.8, p=0.16$). None of these studies provided information about the educational preparation of the caregivers in each study.

The literature reviewed in this section clearly identifies that the lack of knowledge and education of staff in RACFs is a notable barrier to effective pain management in this setting. The findings of these studies highlighted the importance of examining the personal carers' perspective of caring for residents in pain with the view of providing future direction for improving the accuracy of pain assessment performed by personal carers.

Staff Attitudes and Misconceptions Relating to Pain in Older People

According to Courtney, Tong and Walsh (2000) attitude influences practice. The implication of caregiver attitudes and beliefs relating to pain management has been investigated by several researchers (Closs, 1996; Courtney et al., 2000; Herr, 2002a). Misconceptions held by staff about the ageing process, the nature of pain and analgesics, can influence effective management of pain (Allcock et al., 2002; Horgas

& Dunn, 2001). This section examines studies which have explored staff perceptions, attitudes and common misconceptions related to pain in older people.

The widespread misconceptions about ageing complicate the management of pain in elderly (Pasero & McCaffery, 1996). Although pain is not a normal part of the ageing process (Ferrell, 2004), Herr (2002a) suggests that pain as a direct consequence of ageing is a common misconception throughout the public and medical community. An intervention study by Jones and colleagues (2004) found that only 27 and 36 percent of participating nursing home staff (n=173) felt that residents had the right to expect total pain relief. Furthermore, 74 to 94 percent of participants implied that residents should experience pain before administering analgesia. A study by Closs (1996) of 208 nurses reported that almost one third of participants felt that pain and discomfort were an inevitable consequence of ageing. These beliefs could potentially lead to the neglect of pain which should be treated.

Further obstructing the effective management of pain are the fallacies about older people held to be true by health care staff. According to Pasero and McCaffery (1996) many health care providers mistakenly believe that the perception of pain decreases with age (Gartell, 2005). Studies which have investigated the effect of ageing on the perception of pain show conflicting evidence. Some suggest that there is an increase in pain threshold while others do not (McCance & Huether, 1998). Moreover, Herr and Mobily (1996) stated that there is a broad belief that if older people do not complain, they are not experiencing pain. These beliefs must take into account that many older people have an “inherent stoicism” restricting them from voicing their pain (Herr, 2002a, p.22). Conversely, the literature suggests that many residents do not communicate pain for the fear of being labelled as ‘demanding’ (Herr, 2002a; Herr & Mobily, 1996; Yates et al., 2004).

According to the literature, there continues to be a considerable level of concern from health professionals in relation to the use of analgesia in the elderly population (AGS, 2002; Herr, 2002a; Herr & Mobily, 1996; Pasero & McCaffery, 1996).

Literature suggests that health care providers are often reluctant to give analgesia for fear of addiction, tolerance and side effects (Ferrell, 2004; Herr & Mobily, 1996). Closs (1996) reported that many nurses had inaccurate understandings of the pharmacological treatment of pain and exaggerated the risks associated with intervention. Nevertheless, these misconceptions, fears and beliefs do not justify the failure to provide effective pain management to elderly people (AGS, 2002).

Conclusion

This literature review has examined the pain experience from the residents' perspective, the informal caregivers' and the nurses' perspective and has highlighted some issues relating to providing effective pain management in RACFs. In summary, evidence suggests that pain is likely to be a problem for a significant proportion of residents in RACFs and furthermore a complex care issue which impacts on those who provide primary care. Despite the literature which identifies personal carers as being in a unique position to conduct pain assessments, there is a paucity of literature specifically examining the personal carers' experiences with residents in pain, particularly in Australia.

In summary, the reviewed literature pertinent to pain experienced by residents in Australian RACFs suggests that:

- Pain is commonly experienced by residents in RACFs.
- Pain is a subjective experience for residents and staff in RACFs.
- Older people feel that their pain is often under-recognised.
- The level of emotional burden, stress and burnout for informal caregivers has been acknowledged, however formal caregivers such as personal carers have not been examined in the literature.
- There are several barriers influencing the effective management of pain for residents in RACFs relating to organisational factors, lack of staff knowledge and staff attitudes and misconceptions.

Of the reviewed literature there were few studies which applied a qualitative approach and thus much of the information available is statistical data that fails to examine the human perspective (Beanland et al., 1999). The lack of literature directly relating to personal carers and pain in the aged care setting underscores the necessity for research in this area, which will contribute to the body of health knowledge and provide direction for future research, practice and education.

CHAPTER THREE

Research Methodology

Introduction

This chapter details the methodology applied to guide this study examining the experiences of personal carers caring for older people in pain. The application of a qualitative methodology will be justified and explanations for the use of a descriptive, exploratory approach will be presented. Details of the methodology including sampling, participant characteristics, data collection and analysis are offered in this chapter. Measures employed to maintain the rigour of the research process are discussed and consideration of ethical issues related to the research and the research process are also provided.

Paradigm

Qualitative research is interpretive in its approach and focuses on a holistic view of the human experience (Denzin & Lincoln, 1998; Marshall & Rossman, 1999). According to Denzin and Lincoln (1998), qualitative research attempts to make sense of, or interpret the phenomena in terms of the meanings people bring to them. Researchers using a qualitative method strive to understand the phenomenon as a whole, taking into account the social and political context that make a complex system. Qualitative methods permit a broader understanding and deeper insight into the topic of interest than may be obtained through quantitative approaches (Beanland et al., 1999). By nature, quantitative methods require substantial knowledge about the phenomenon being studied (Polit et al., 2001). There is minimal empirical data about personal carers and their experience with residents in pain, because their perspective has not been fully researched in the past. The in-depth, probing nature of qualitative research is appropriate to the task of answering the question; what is it like to be a personal carer providing care to older people in pain?

Qualitative research designs have a naturalistic approach (Patton, 1990). According to Patton (1990) a naturalistic inquiry is selected when the researcher

wants to minimise researcher manipulation. The researcher does not attempt to manipulate the environment, but rather to gain an understanding in the naturally occurring setting (Patton, 1990). This study sought to understand and document the day to day reality of personal carers in the residential aged care setting, making no attempt to manipulate or control the environment, but to accept the complexity and reality of caring for older people in pain. The primary aim of the study is to gain insight and an understanding of personal carers' experience of caring in RACFs, therefore a naturalist inquiry was imperative (Beanland et al., 1999).

Qualitative methods are orientated towards exploration and discovery and attempt to understand rather than explain the phenomenon (Patton, 1990). Qualitative data can serve as the basis for insights, categories, themes and theories (Patton, 1990). The goal of this study was to interpret the phenomenon of caring for older people in pain, describe personal carers' experiences of caring for residents in pain and to understand the meanings associated with these experiences. The qualitative paradigm enabled data to reflect the complexity of social interaction as perceived by personal carers in the aged care setting (Denzin & Lincoln, 1998; Marshall & Rossman, 1999).

Methodology

A descriptive, exploratory methodology has been selected to use as an inductive and holistic research method (Beanland et al., 1999). A descriptive, exploratory inquiry is a useful qualitative approach that is broad ranging, purposive and designed to maximise discovery in the chosen area (Stebbins, 2001). It has been used to describe personal carers' experience with caring for older residents in pain.

Exploratory studies are undertaken when a new topic is being investigated. The approach is particularly useful when there is little empirical data or little is known about the phenomenon. The main goal in exploratory research is the production of inductively derived generalisations about the topic under study and to investigate the full nature of the phenomenon and other relating factors (Polit et al., 2001). The

exploratory researcher is looking for new knowledge, new understandings and new meanings (Brink, 1998).

Descriptive studies involve the complete description of concepts or phenomenon within a given population (Brink & Wood, 1998). A descriptive design allows the researcher to use in-depth methods to describe the dimension, variation and meaning of the phenomenon (Brink & Wood, 1998).

Combining the descriptive and exploratory research methods allows a comprehensive research design that provides an appropriate method for researching health care related phenomenon (Brink & Wood, 1998). The researcher using this methodology believes that understanding the human experience is as important as focusing on explanation, prediction and control (Patton, 1990). The decision to employ a descriptive, exploratory design was made because the researcher had no preconceived ideas or notions of experiences personal carers would describe about caring for people in pain. This design facilitated thorough exploration and provided meaningful data that was easily interpreted.

This descriptive, exploratory research design required the researcher to be purposefully flexible and commence the study with an open mind. The flexibility of this research design means that the focus of the study was originally broad, but became progressively sharpened as the inquiry proceeded. The purpose was a move towards a clearer understanding and to evolve concepts from the personal carers' perspective (Blumer, 1969). The researcher was required to be insightful, allowing the development of new ideas, concepts and theory (Brink, 1998). The researcher using this methodology does not set out to prove or disprove an existing theory, instead the aim is to explore concepts from the personal carers' perspective (Brink, 1998).

The purpose of this descriptive, exploratory study is to discover and capture the experiences of personal carers in RACFs and to provide a comprehensive and

accurate picture of their involvement with caring for residents in pain. Therefore, this study will assume the perspective of the persons being interviewed to facilitate an in-depth exploration of their experiences. This design will enrich our understanding of experiences of personal carers through humanistic and empirical dialect.

This design, although appropriate for this study, has several limitations. The design may be difficult to replicate because as people can change their minds, beliefs and positions as a result of new experiences (Brink, 1998). Thus the findings of this study are true to this particular sample, setting and time. A significant limitation of the methodology selected is that the recounted experiences told by personal carers are influenced by many factors such as motive, values and opinions (Beanland et al., 1999; Polit et al., 2001). The self report method of data collection is associated with weaknesses. According to Polit and colleagues (2001) participants may respond in a way that is not indicative of their real feelings, because they potentially provide information that they feel is desired by the interviewer. Also, as the researcher is an active participant in data generation, researchers are selective in what they perceive and report. Nevertheless this design is suitable and applied to study the personal carers' experience. Despite these limitations this study has the potential to contribute to health knowledge and has implications for future research, education and practice.

The personal carers' perspective has been inadequately researched in the past, therefore, this design will facilitate an in-depth exploration of the experiences of personal carers. Given the scope of the study associated with an Honours degree level research project, the time limit imposed on this project restricts the depth and breadth of analysis.

Theoretical Orientation for the Study

This descriptive and exploratory qualitative study seeks to examine in-depth the experience of caring for older people in pain. For the purpose of this study, defining a conceptual framework prior to commencement of the study may have caused the researcher to have preconceptions about the data to be collected. A framework was

constructed using the concepts that emerged from the data collected during the study and is examined in the following chapter.

Sandelowski (1993) recommended that when applying a qualitative research paradigm a theoretical basis is imperative. Symbolic interactionism is the theoretical orientation chosen for this study and provides a foundation for guiding the study (Polit et al., 2001). Symbolic interactionism is a down to earth approach to the study of human life and human conduct (Blumer, 1969). The term symbolic interaction refers to the character of interaction that takes place between people and suggests that people interpret each others' actions instead of merely reacting, and their response is based on the meanings which they attach to other actions. Symbolic interactionism theorises that people's actions are related to meanings derived from past social interactions and modified by the interpretative process (Blumer, 1969).

Symbolic interactionism is humanistic in its approach. It suggests that although the meanings are established by an interpretive process, people are active participants in their environment and are capable of changing their meanings (Blumer, 1969). In recognising that individuals' formation and realisation occurs by taking the roles of others, symbolic interactionism provides a theoretical orientation that is attuned to the social experience and appropriate to examine personal carers' experience with pain in older people. According to Wood (1982) symbolic interactionism is effective in evaluating human interaction and has been used to guide the researcher throughout the study. This has relevance for this study as past experiences of personal carers may impact on their current role of caring for residents in pain.

Sample and Setting

Qualitative inquiry focuses on discovering meaning, therefore generalisability is not a guiding criterion. A descriptive, explorative approach requires that the participants selected for the study are currently experiencing the topic of inquiry and are able to articulate and convey their experience (Beanland et al., 1999). According to Brink (1998) descriptive, exploratory designs need a small sample that is

deliberately chosen to represent the desired perspective. For the purpose of this study a purposive, convenience sample was selected. The sample population was drawn from personal carers currently employed in RACFs in the South West of Western Australia. Three RACFs were selected to recruit the sample population. Two of the facilities provide low level care and the other provides high level residential aged care. Initially the nurse manager from each of the facilities was sent a letter detailing the proposed study and requesting permission to recruit their staff (see Appendix A). Subsequent meetings were held with the Directors of Nursing and management from each facility to discuss the study. All were supportive and offered their assistance. Once permission was obtained from the facilities, recruitment occurred by advertising for expressions of interest at the selected RACFs (see Appendix B). Contact details of the researcher were included in this advertisement. Despite several advertisements being placed in each RACF, no response or expression of interest was obtained. The researcher held several short information sessions held during staff hand-over at each of the selected facilities to attract further interest in the study. Following the information sessions seven potential participants expressed interest in participating by contacting the researcher. Each individual was given an information package containing an information letter (see Appendix C) and declaration of informed consent (see Appendix D).

The researcher sought participants who varied with regard to their characteristics; age, gender, level of education and duration of employment as a personal carer. Participants were required to be personal carers with at least six months experience and be able to speak English. Participants were screened to see if they had experience with the phenomenon under investigation (pain in older residents), met the inclusion criteria and declared informed consent. As the descriptive, qualitative methodology is not concerned with statistical generalisability, this sampling method was utilised to recruit participants who would illustrate a variation of personal carers working in regional Western Australia (Beanland et al., 1999).

The sampling process was guided by data collection, therefore the exact sample size was unknown at the commencement of the study. The sample size was dictated by the need to continue interviewing until data saturation was achieved. There was evidence of redundancy of data after conducting five interviews and a final interview was used to verify themes and categories which had been proposed from the data collected. Verification of tentative findings occurred in follow-up meetings with participants.

Data Collection

The descriptive and exploratory qualitative approach requires a method of data collection that will be a reflection of the participants' experiences (Patton, 1990). Data was collected through semi-structured, open-ended narrative style interviews. In-depth interviewing was used to provide detailed data that facilitated an understanding of personal carers experience caring for older residents in RACFs.

According to Patton (1990) an informal conversation approach allows questions to be individualised and in-depth communication to be established. The interviews were conducted in such a manner to ensure that the participants' accounts were accurately obtained and to protect the subjective nature of the data from possible researcher bias. A basic interview guide was used to provide direction for the interviews (see Appendix F). The questions used were broad and open-ended, using a narrative style to encourage participants to tell their stories. According to Brink (1998) perhaps the most important element in descriptive, exploratory research is not the questions asked during data collection but the interview itself. Therefore analysis was based on the interview in its entirety. It is also important to acknowledge the researcher as an important component in the data generation process. As a practicing registered nurse in the aged care sector, the researcher entered this study with prior knowledge and experience with personal carers in the aged care environment. The researcher's experiences and understanding in the aged care setting facilitated in-depth discussion throughout the interview process (Wimpeny & Gass, 2000).

Data collection commenced with a broad perspective and became increasingly focused as data was generated. Hunches about emerging patterns were noted in memos and the researcher directed future interviews to pursue these emerging patterns (Beanland et al., 1999). However, the direction of each interview was influenced by the individual participant. The interview guide was adapted as the researcher deemed necessary through the data collection process, to expand on emerging concepts or extend on themes and therefore the interview guide was not meticulously adhered to. Demographic questions were included at the commencement of each interview to enable the characteristics of the sample to be described encompassing; age, gender, and duration of employment as a personal carer and level of education. Participants were interviewed in private meeting rooms in the participant's workplace and one interview was conducted at a participant's home. The locations were chosen for participant convenience to provide a quiet and comfortable environment, which facilitated participant and researcher rapport. When interviews were conducted in workplaces, the rooms were arranged in comfortable speaking positions and a do not disturb sign placed on the door. Each interview was audiotape recorded and was between 20 and 40 minutes in duration. Several participants were contacted following data analysis to present findings for verification, to strengthen data and enhance credibility (Polit et al., 2001).

Data Analysis

Data analysis in descriptive, exploratory research, like data collection, requires a fluid, flexible and intuitive interaction between the researcher and the data (Brink, 1998; Patton, 1990). Following data collection each audiotape recorded interview was transcribed verbatim by a secretarial service or by the researcher. The transcriber signed a confidentiality agreement prior to the commencement of transcribing (see Appendix G). Once each interview was transcribed, the analytic process commenced. The data analysis process required a holistic procedure to examine all information within its context (Patton, 1990). A constant comparison method was employed as data collection and analysis occurred simultaneously to allow themes that captured the essence of the data to emerge (Patton, 1990). The data containing the

respondents' descriptions of their experiences was analysed using a three stage process (see Figure 1, p. 37) (Beanland et al., 1999). The researcher was immersed in the data to attain an understanding of the frame of reference of the participants. Although this process was systematic, it was not sequential, because the constant comparison method employed required the data to be re-examined as necessary.

The initial phase of content analysis was open coding, which involved identifying key concepts from words or phrases in the data. The interview transcripts were analysed line by line to identify concepts in the data (Strauss & Corbin, 1990). Significant statements in the transcripts were highlighted, grouped together and labelled. Twenty eight concepts were identified during open coding.

The next stage of analysis is categorisation. This process involved examining the basic codes and formulating meanings. Codes in the data were clustered with similar concepts to create categories. These categories were then examined, developed and collapsed to form seven categories; *Frontline*, *Knowing the Resident*, *Emotional Attachment*, *Teamwork*, *Rewards of Getting It Right*, *Clinical Judgements* and *Nagging*.

Finally the categories were integrated to create two themes, which reflected the experiences portrayed by the personal carers. Continuous review of the emerging categories and themes in consultation with the principal supervisor developed a conceptual framework.

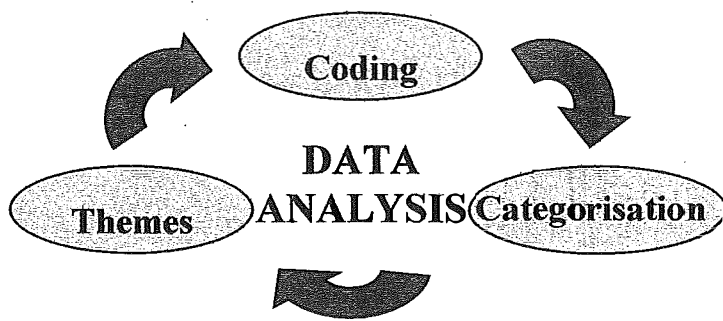


Figure 1. Data Analysis Process

Trustworthiness of the Research Process

Trustworthiness in qualitative research refers to the methodological accuracy and adequacy (Holloway & Wheeler, 2002). Quantitative studies rely on reliability and validity checks to govern the rigour in the research process, however these are not appropriate to qualitative research. To demonstrate trustworthiness in the research process the criteria proposed by Lincoln and Guba, credibility, dependability, neutrality and transferability are be applied to this study.

Credibility refers to the “confidence in the truth of the data” (Polit et al., 2001, p.312). A fundamental strength and weakness of qualitative research is the active involvement of the researcher (Patton, 1990). To reduce personal bias the researcher ‘bracketed’ personal beliefs and experiences about personal carers’ perception of pain prior to collecting data. Creditability was further enhanced by several techniques. The technique, triangulation was employed by using multiple participants and several settings to draw findings and allow for cross checking of information to enhance the depth of the investigation. This was achieved by conducting six interviews. A member checking technique was applied where respondents viewed tentative findings of categories and themes to ensure that they accurately captured the essence of their experiences. Furthermore, data was also coded by a research colleague. Credible data requires that sufficient time is spent collecting data (Polit et al., 2001). Data collection occurred over a period of six weeks with each interview between 20 and 40

minutes in duration. Additional time was needed for the verification of tentative findings by participants.

Dependability demonstrates a systematic and consistent research process (Holloway & Wheeler, 2002; Polit et al., 2001) that requires that all decisions and thoughts of the researcher to be documented (Beanland et al., 1999). Throughout this research, memos were made to document all theoretical decision making. These memos serve as a record of the research process and demonstrate how the researcher arrived at the constructs and themes. Furthermore peer involvement was an integral part of the research process (Beanland et al., 1999), as the study was discussed and validated by peers.

Neutrality refers to the objectivity of the qualitative research process (Polit et al., 2001). Neutrality requires that the research is without bias. The researcher must demonstrate that the findings of the study reflect those of the participants and are not based on prior assumptions and preconceptions held by the researcher (Beanland et al., 1999). To demonstrate neutrality a self-reflective journal was kept to document the researchers' own assumptions throughout the research process. This enabled any preconception about carers' perception of pain management in the elderly to be acknowledged and reduce researcher bias (Beanland et al., 1999) and was particularly important because of the researcher's nursing experience in aged care. Additionally, participants were recruited from facilities unknown to the researcher. To avoid bias during data collection, the researcher was aware not to disclose their own experiences or preconceptions by structuring the interviews with open-ended narrative style questions, which were established prior to the commencement of the interview process.

Ethical Considerations

Any research involving human subjects requires ethical consideration (Beanland et al., 1999). A proposal of this study was submitted to the Edith Cowan University's Human Research Ethics Committee for approval (see Appendix E). It was also subject to the specific ethical requirements of the organisations that provided assistance with sampling. A benefit that could be foreseen for participants, was the opportunity for personal carers to be involved in research directly related to their occupation. Providing personal carers with the opportunity to discuss issues in their work role, may have served as a debriefing session and was possibly advantageous to the participants. As the interviews were potentially providing a debriefing session, time was allowed following each interview to discuss issues that may have arisen during the interview. Although this study poses a low risk to the participants, issues relating to confidentiality and informed consent were addressed prior to commencement.

Confidentiality

Every effort was employed to guarantee the confidentiality of participants of this study. The RACFs that provided opportunities to recruit personal carers for their involvement in the study have not been identified. The personal carer population in Western Australia is large, nevertheless every effort was made to ensure that individuals involved in this study cannot be recognised. No names or specific demographic data has been included which could potentially identify participants. There was no identifying information included on the audiotape records. Audiotape records were destroyed following transcription and all transcriptions were assigned a numerical identifier. Transcripts were securely stored in the researcher's office and will remain securely stored separately from all other identifying information for five years, as per Edith Cowan Universities Human Ethics Committee requirement, after which time, they will be destroyed. Raw data was accessed only by the researcher and the principal supervisor. Participants were given the option to withdraw from the study at any stage and for all information provided to be removed from the study. Throughout the discussion of the findings of the study, words identifying particular

individuals or facilities have been changed to maintain the confidentiality and anonymity of the participants involved in this study.

Informed Consent

A proposal for this study was submitted and approved by the Edith Cowan University Human Research Ethics Committee. Personal carers were recruited in such a manner that ensured their participation was voluntary. No coercion was used to recruit participants. All participants who expressed interest in participating in the project were given a letter explaining the purpose and method of study and assuring confidentiality (see Appendix C). The opportunity was given for questions. Informants were then asked to sign a declaration stating informed consent prior to participation (see Appendix D).

Throughout the study the continued participation of the personal carers in the interview process and follow-up verification was considered continuing consent and the opportunity was available to withdraw if required. Declarations of informed consent have been stored separately from other data and will remain securely stored for the required period. Furthermore, because of the potential emotional issues discussed during the interview process, each participant was made aware of available counselling and support services should the need occur.

Conclusion

This chapter has described the research paradigm and defined the research design, which was selected to gain an increased understanding of personal carers' experiences of caring for older residents in pain. The methodological procedures have been presented. The setting and sample characteristics were illustrated. The process used to analyse data has been examined. Techniques applied to ensure rigour in the research process has been discussed. Finally, attention to ethical consideration was given.

CHAPTER FOUR

Research Findings

Introduction

This chapter presents the findings of this research project. The demographic characteristics of the sample and setting are presented, followed by an in-depth description of the findings of the qualitative analysis. The central theme, *Perfect Positioning* that emerged from the data is explained in this chapter as are the five associated categories, *Frontline*, *Knowing the Resident*, *Emotional Attachment*, *Teamwork* and *Rewards of Getting It Right*. The sub-theme, *Extended Roles* will be examined with explanation of the two related categories, *Clinical Judgements* and *Nagging*. Each component will be examined and supported by exemplars from the personal carers interviewed.

Demographic Characteristics

The aim of this study was to begin to provide a picture of the experience of personal carers caring for older people in pain who reside in RACFs. The inclusion criteria for this purposive sample were English speaking personal carers employed for greater than six months in one of three regional RACFs in Western Australia. The parameters for the sample were age, gender, education and duration of employment as a personal carer in the aged care sector.

As discussed in the previous chapter, the inclusion of between five and ten participants was estimated prior to commencement of the study. Data saturation was becoming evident by the fifth interview, however in order to verify themes and categories, a sixth interview was conducted.

Characteristics of the Setting

Participants of the study were identified through their employment in one of the selected RACFs (see Table 2, p. 42). Three RACFs agreed to participate. Two of the facilities provided low level care and the other provided high level care to residents.

The facilities were selected from a regional centre in Western Australia. Each facility provided care to more than 55 residents. The facilities differed in length of time operating as an RACF, varying from 12 to 34 years. Facilities also differed in the type of staffing employed. Although each facility employed registered nurses, only one facility had registered nurses regularly available for clinical practice, other facilities employed registered nurses predominately for management and administrative purposes. A greater number of enrolled nurses were employed in low level care facilities and access to a registered nurse, particularly overnight and on weekends was on an on-call basis. The staff structure of each facility was examined to determine if it impacted on the personal carers' experiences of caring for residents in pain.

Table 2. Characteristics of the Settings

Characteristics Sampled		Variations in characteristics	Number of defined characteristic
Service Type of RACF		High Level Care	1
		Low Level Care	2
Staffing and Residents	Facility 1	Residents	84
		Registered Nurses	3
		Enrolled Nurses	11
		Personal Carers	37
		Total Care Staff	51
	Facility 2	Residents	58
		Registered Nurses	2
		Enrolled Nurses	13
		Personal Carers	26
Total Care Staff	41		
Facility 3	Residents	59	
	Registered Nurses	14	
	Enrolled Nurses	6	
	Personal Carers	44	
Total Care Staff	64		
Length of time operating as a RACF		1-5 years	0
		6-10 years	0
		11-15 years	1
		>16 years	2
		NB: Facilities may have been up-graded during this time	

Characteristics of the Participants

A total of six personal carers participated in this study (see Table 3). The youngest of participants was in the age group 26-35 years and two participants were aged over 45 years. Of the six participants, five were females and one male. Each participant varied in their educational background. Only two of the six personal carers involved had commenced employment in the aged care environment with previous relevant education or training. Other participants had completed a Certificate III in Aged Care while employed as a personal carer, or had commenced studies for a Certificate III and had not completed their training at the time of their interview. The length of time employed as a personal carer varied. One participant had been employed as a personal carer for only six months, while one had been working in RACFs as a personal carer for 23 years. The variation in the sample served to provide a diverse view of the personal carers' experience with residents in pain.

Table 3. Characteristics of the Sample

Characteristics Sampled	Variation within Characteristics	Number of participants (n=6)
Age	<25years	0
	26-35 years	1
	36-45 years	3
	>46 years	2
Gender	Female	5
	Male	1
Education	Experience only	2
	Certificate III Aged Care	1
	Diploma of Aged Care	1
	Nursing Education (not practicing nurses)	2
Duration of Employment as a Personal Carer in the Aged Care Sector	0-5 years	1
	6-10 years	3
	11-15 years	1
	>16 years	1

Discussion of Findings

The central theme that emerged from the data generated throughout this study is that of *Perfect Positioning*. The theme describes the ideal position of personal carers employed in RACFs to be involved in the pain management process. Five associated categories emerged that directly relate to the central theme; *Frontline*, *Knowing the Resident*, *Emotional Attachment*, *Teamwork and Rewards of Getting It Right*. In addition to the central theme is a sub-theme, *Extended Roles*. *Extended Roles* describes the extra responsibilities of a personal carer's role in RACFs and includes two categories, *Clinical Judgements* and *Nagging*. The diagrammatic relationship between the themes is represented in Figure 2 (p. 45). The central theme, *Perfect Positioning* surrounds the resident, who is central to the carers' role. *Perfect Positioning* includes five categories *Frontline*, *Knowing the Resident*, *Emotional Attachment*, *Teamwork and Rewards of Getting It Right*. The sub-theme is portrayed as being peripheral to the central theme. *Extended Roles* is depicted using broken lines, which reflects the variation in the extra responsibilities performed by different personal carers and the lack of definition of the extended role that carers may have. Further research is required to explore more thoroughly the relationships between the themes and categories.

The central theme and sub-theme with their related categories will be discussed in this chapter. Each theme and category will be supported by exemplars from interview transcripts. Table 4 (p. 46) presents a brief overview of the themes and associated categories that are components of the conceptual framework developed from this research project. A simple definition has been included to define the categories and an exemplar from the interview transcripts is provided, to offer further meaning for each category. Words used by personal carers in the exemplars which may serve to identify particular individuals or facilities have been changed to maintain the confidentiality and anonymity of the participants involved in this study.

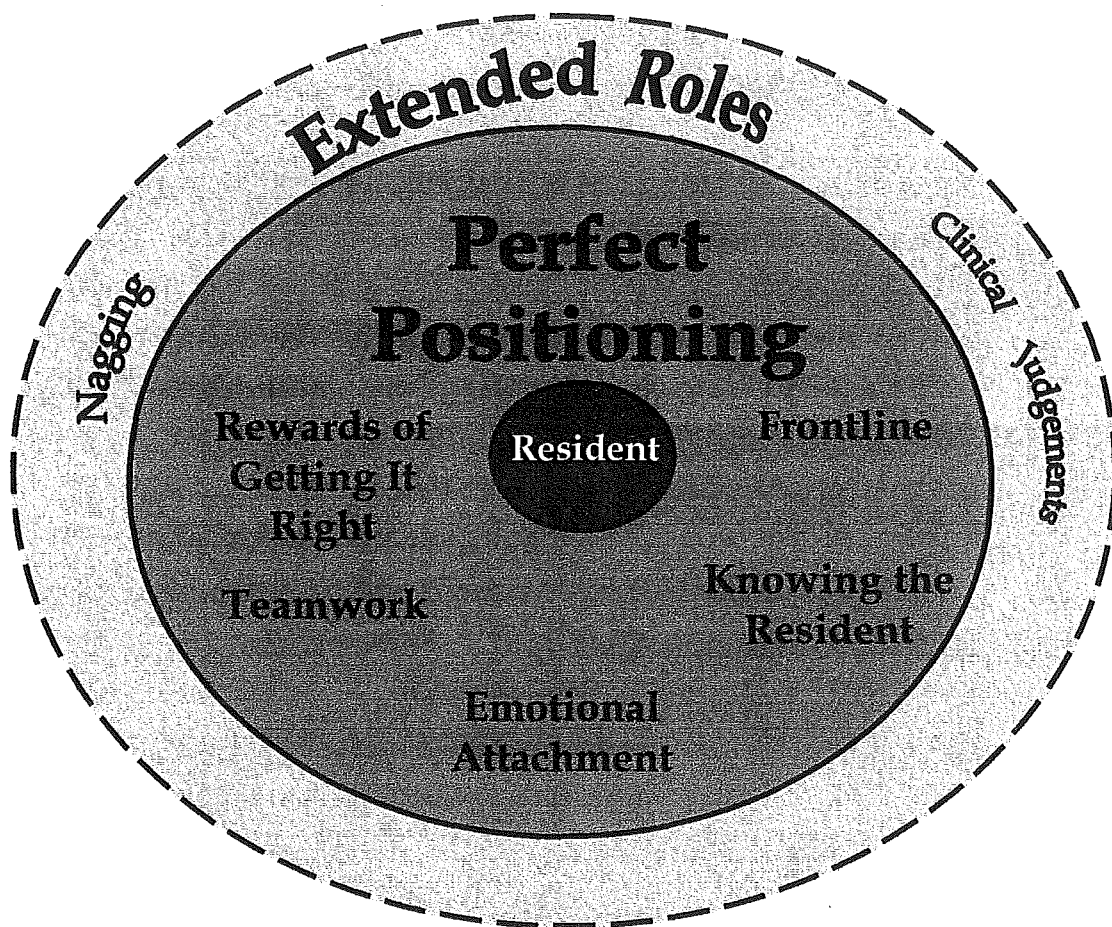


Figure 2. Diagrammatic Representation of the Conceptual Framework

Perfect Positioning

Perfect Positioning emerged as the central theme during the data analysis process. The theme *Perfect Positioning* depicts the ideal position of personal carers to be directly involved in the pain management process in RACFs. The facilities involved in this study are staffed primarily by personal carers. Consequently, personal carers provide the majority of care and work most directly with residents. The central theme describes the centrality of the personal carers' situation in the pain management process. The central theme overlies all components of the findings, in that it represents the ideal role of the personal carer. Within this central theme are five significant categories, which help to describe the unique position personal carers are in to be involved in the pain management process.

Table 4. Themes and Categories related to the Conceptual Framework Describing the Personal Carers Experience of Caring for Older People in Pain.

Theme	Category and Definition	Exemplar
Perfect Positioning	Frontline Personal carers work closely with residents and are in a unique position to provide early identification of pain and initiate pain management strategies.	<i>Well certainly we are the first line. Because the RNs and ENs don't do the hands on so...so they're not there, and we are there when they [residents] get out of bed, or when they transfer, so they [RNs and ENs] wouldn't know unless we told them (PC3).</i>
	Knowing the Resident Familiarity with residents enables personal carers to notice changes in behaviour that may be indicative of pain.	<i>Basically a lot of it is just knowing the resident because you have been working with them for so long, for such a long time, you get to know them... (PC2)</i>
	Emotional Attachment Developing an emotional, family-like bond with residents means that personal carers provide a 'homelike' environment. However emotional involvement may blur the carers' role boundaries.	<i>Yeah and you get so attached to them they are like your family, your mum or your dad or your grandparent (PC4).</i>
	Teamwork Is a crucial component of the personal carers' role. Teamwork is helpful for assisting them to make decisions regarding residents care and team support is also employed to cope with the demands of their role.	<i>...pretty much it's a team thing.... We all get on really well... Umm I think probably the carers sort of draw off each other actually... Yeah we do really. If we are worried about things we tend to talk to each other and bounce off each other... (PC2).</i>
	Rewards of Getting It Right Being sustained by the rewards of seeing residents respond to care provided.	<i>Oh rewarding....yeah when they give you a smile or they are looking chirpy that's terrific and when they are happy that's great... 'cause that's what we're here for (PC2).</i>
Extended Roles	Clinical Judgements Clinical decision making that is required of personal carers in some situations regarding implementing pain management strategies.	<i>... 'cause I could see she was in a bit of pain so I gave her analgesia and within a short amount of time I could see the difference (PC3).</i>
	Nagging Continually pursuing nurses to follow-up pain management issues.	<i>Yeah, its mainly nagging at nurses who then have to nag at doctors to come (laugh) its a never ending circle... Nag, nag, nag.....And eventually everyone gets [so] sick of youthat they eventually cave in and come and do something (PC2).</i>

Frontline

The category *Frontline* emerged from the data to describe the positioning of personal carers at the forefront of the pain management process in RACFs.

Regardless of the level of care provided by the facility, personal carers described working more closely with residents than other health care professionals. Personal carers acknowledged their primary role in resident's care. One personal carer said:

Well certainly we are the first line. Because the RNs[registered nurses] and ENs [enrolled nurses] don't do the hands on so...so they're not there, and we are there when they [the resident] get out of bed, or when they transfer, so they [RNs and ENs] wouldn't know unless we told them. So it really is up to us to notice any changes (PC3).

The facilities involved in this study are staffed predominately by personal carers. The descriptions by participants depicted the reliance on personal carers for direct care. A personal carer spoke of how in their area, personal carers were the only staff providing 'hands on' assistance to residents all of the time. Assisting residents to transfer, ambulate and provide support for other activities of daily living offered the opportunity for personal carers to notice changes in function that may be indicative of pain. Although area staff included enrolled nurses and access to a registered nurse, the nursing role was predominately administrative and personal carers described providing the majority of care:

Well up here at the moment we have an EN, who has only been up here for a couple of months but basically, she does the book work (PC2).

One senior personal carer spoke of the predominance of personal carers in low level care facilities:

There was a time when personal carers were the only staff, it was just personal carers and nurses would visit. Personal carers basically ran the place. We would have an EN

coordinator and when she went on holidays, we [personal carers] were it (PC6).

Currently registered and enrolled nurses are a requirement in RACFs and personal carers spoke of an increased level of support with having nursing staff available in facilities.

Directly assisting residents with activities of daily living like showering, dressing and toileting, allows personal carers to notice changes in a resident's level of functioning. Each participant in this study told stories of how they had identified a resident's discomfort while attending to their needs. One personal carer said:

....he was in a lot of pain we noticed, us carers when we were dressing him, he couldn't move his shoulder properly (PC1).

Another personal carer said:

....and when showering or helping them we notice it [pain] (PC4).

As well as personal carers' primary role in the identification of a resident's pain, personal carers described having a first-line role in both the pharmacological and non-pharmacological management of pain. A personal carer spoke of their role in the pharmacological management of pain:

And generally if there is pain, we [carers] can go into their [the residents] purse pack and there is PRN [as needed] medication. If it's ongoing pain management, then it generally goes into their regular pack [pharmacy packed medication] (PC3).

In contrast, some personal carers did not portray such confidence in their primary role in the pharmacological management of pain. Instead, other personal carers discussed how they would try numerous other strategies, for example heat packs and repositioning, before administering PRN medication such as paracetamol.

In summary, personal carers perceived their 'frontline' role in pain management to be an important determinant of whether a resident's pain is managed. It was evident through participant descriptions that personal carers often identified pain and initiated intervention, because there wasn't any other staff member in a position to do so.

Knowing the Resident

The category *Knowing the Resident* describes how personal carers felt that knowing the resident is a key part of their job and an important factor in the ability to assess for pain and monitor effectiveness of interventions. Personal carers involved in this study emphasised the significance of familiarising themselves with residents' normal behaviours and habits. Each participant told stories of getting to know residents personally. They reported that through knowing the resident, they improved their ability to notice changes and recognise behaviour that may signify pain. One personal carer said:

I think knowing the residents is the single most important thing, in this business that we are in. Having staff that are confident and know the resident. I mean if you don't know them [residents] how do you pick up on these things if you don't have that personal relationship. I mean it becomes like a family member, you know their responses, you know things that upset them. You know their cues and ways around them...you know how to transfer them. Who can walk; who can't walk, umm with dementia residents, they walk off without their wheelie walker. I mean, toileting, you know their behaviour associated with toileting. Emotions, you get to know who needs that extra personal input, the emotional support...That is the single most important thing, that you have staff that know the residents (PC3).

Another personal carer said:

Basically a lot of it is just knowing the resident, because you have been working with them for so long, for such a long time, you get to know them. Things like grimaces, behaviours in the

ones that aren't able to tell you. I mean they might be pale and you know that something is not quite right (PC2).

Personal carers described knowing individual residents' normal levels of functioning as crucial to the early identification of pain. Although personal carers recognised the importance of care plans, which describe residents' capabilities, they emphasised the limitations of care plans for assisting staff to recognise pain in those individuals unable to express their discomfort.

Sensory and cognitive impairments complicate a resident's ability to communicate pain in a way that can be understood by health care staff. Personal carers attributed the difficulties associated with accessing a resident's pain as being related to the communication deficits of residents. The ability of staff to recognise pain relies heavily on a resident's behaviour and their external presentation. Each personal carer told of their reliance on observing changes in behaviours that can be identified as relating to a resident's pain. One personal carer said:

...because a lot of them can't actually tell you, so you're really looking for these outward signs to do something (PC2).

Another personal carer said:

Well I mean you tell by do they look like they are in pain? And she certainly did. There was a lot of holding...a lot of grimacing (PC3).

Personal carers in this study further mentioned the importance of knowing the resident to assist with identifying pain, particularly if residents could not clearly express their discomfort verbally. One personal carer said:

Different people react differently. One person gets very verbally aggressive, very grumpy and that usually is an indication that something is going on there. Another person will just retreat and be very, very quiet. There is all sorts of different things that people do and it's just about knowing them (PC2).

Personal carers told stories of how they have become familiar with residents and then they are able to distinguish behaviours that relate to specific individual needs. One personal carer said:

...you know things about them [residents], all their good habits, their bad habits and simple things, like they [the resident] won't go to the toilet because they don't know they need to go to the toilet. [Instead] they present with little changes, so you sort of think hang on a minute...she was quite happy to sit there now she is sort of bit fidgety, grabbing at stuff so you think, oh yeah (PC4).

Personal carers discussed the importance of getting to know resident's normal behaviour and therefore being able to identify specific behaviours as unusual for that particular resident. Participants described how identifying specific behaviours of residents with communication deficits could be used to indicate particular needs of the individual such as toileting or pain. Relying on changes in resident behaviours for pain detection was seen as challenging and often unreliable. One personal carer described the difficulties associated with residents presenting with what are considered negative behaviours:

Sometimes it's really hard 'cause they can't tell you they've got pain. Um, I look for signs like restlessness, um aggression, and that comes a lot with pain ... the aggression, because they can't tell you where the pain is. It can be something as simple as you know, their thumb, but their whole body seems to be in pain (PC4).

Although personal carers recognised the difficulties associated with using changes in behaviour as an indicator of the needs of residents with communication problems, they acknowledged the helpfulness of knowing the resident to assist them to identify unusual behaviour.

Continuity of staff in RACFs emerged as a critical factor for knowing residents. Personal carers discussed how working in one area enabled them to develop rapport

with residents and to learn their personalities and capabilities. Having permanent staff working regularly in one area enabled staff to get to know residents, and also allowed residents to get to know staff. Being in a familiar environment, where resident's intimate needs are met by familiar staff was perceived as particularly important for residents care. One personal carer said:

Yeah, it's about knowing the person, knowing their physical capabilities, what they can and can't do, knowing their history as well (PC3).

Another personal carer expressed the importance of having permanent staff working in each area in the facility:

...because we have continuity on the wards now and you stay on the one ward. It was really hard to pick up [resident problems] if you get moved around and that is what happens quite a bit. You know, so you don't really get to know the residents on that much of a personal basis (PC6).

The problem of not having permanent staff may also mean that particular care needs are missed. One personal carer proposed:

...it's when there hasn't been regular staff on and when the regular staff come back they have picked up that Jo Bloggs is in pain and it [pain] hasn't been picked up because there hasn't been permanent staff (PC4).

This concern about casual staff working in facilities creates a dilemma for permanent staff taking days off. One personal carer spoke of being concerned about taking time off, knowing that casual staff would be at work and may not perform all the required care needs:

I always hate it when I have to go away on a couple of days off... and as soon as you come back you know it [required care] hasn't been carried out. So then you sort of start all over again (PC4).

The advantage of having continuity of staff in facilities was clearly expressed by personal carers. Regular staff become familiar with residents and residents' families. Families play an important role in RACFs and their active involvement in a resident's care can be crucial. Personal carers discussed the value of family involvement in the residents' care. One personal carer spoke of how continuity of staff helps family members to feel comfortable with carers:

There are about eight permanent carers I guess I'm not sure, but about that, who are here a lot so we all get to know the families pretty well. So it's good 'cause we can say what's happening with the residents and the families get to know us and they feel comfortable asking us (PC2).

Furthermore, personal carers spoke of how continuity allows them to become familiar with the multidisciplinary team and to be active team members in the resident's care-planning. One personal carer spoke of getting to know the residents' General Practitioners and feeling comfortable liaising with them:

...also doctors will ask us as well and generally there is one group of doctors....one practice that visits here so we get to know them fairly well (PC3).

Personal carers also discussed having a role working with physiotherapists, occupational therapists and other members of the team when required.

Knowing the Resident describes how personal carers placed an importance on the ability to know the individual who they provided care for on a daily basis. Continuity of staff in facilities and particular areas was perceived by personal carers as necessary to allow the opportunity to become familiar with residents, their families and other members of the health care team. By knowing the individuals residing in RACFs, personal carers considered that they were more confident to provide more personalised care and could identify changes in functioning that were possibly indicative of pain.

Emotional Attachment

RACFs provide care to residents on a long term basis. Working closely with residents over extended periods allowed personal carers to develop an attachment, that may not have occurred in an acute or short-term care facility. The category *Emotional Attachment* emerged from the data collected in this study and describes the emotional bond formed between carers and residents.

RACFs are designed to provide care to older individuals in a home-like environment. Personal carers acknowledged the importance of privacy, respect and providing a home-like environment for residents. Personal carers discussed how by working with residents on a daily basis they developed a relationship that could be equated to a family style bond. Several personal carers spoke of their parent or grandparent-like association with residents. One personal carer said:

Yeah and you get so attached to them. They are like your family, your mum or your dad or your grandparent (PC4).

Another personal carer explained how through their close emotional attachment with residents, they felt a greater personal responsibility for a resident's care:

We are their voice... we are an extension of their family (PC1).

The attachment was seen by personal carers to be a two-way relationship. Not only do personal carers become attached to residents, but they perceived that residents also became attached to them. Explaining the importance of such rapport between staff and residents, one personal carer said:

I can be away for three or four days and when you return and one or two of them [residents] will say "Hello Mary" and so they immediately recognise you as someone who is important to them and a part of their life. So that is so, so important (PC3).

Developing an emotional attachment with residents was seen as instrumental in personal carers establishing 'ownership' of residents. Several of the personal carers

in this study described residents as “my residents”. One personal carer spoke of how the attachment with residents meant they didn’t want to take days off:

Yeah and I keep refusing to have days off ‘cause when I have days off, I leave my residents... I know they’re not going to get the care and you know it’s very important (PC4).

When faced with this dilemma, personal carers only expressed confidence in the care provided by themselves and felt that other people would not provide care as thoroughly.

Personal carers who participated in this study were all unable to clearly define their professional boundaries. Instead, they focused on their personal relationships with residents. The close emotional attachment formed with residents and their families often meant that issues related to a resident’s care were perceived as personal issues for personal carers. When discussing how they felt about caring for residents in pain, personal carers spoke of subjective associations with the resident, rather than viewing care issues objectively. One personal carer told of caring for a lady in pain, who had refused pain management from nurses and doctors:

... I felt frustrated, I felt terribly sad (respondent teary) (PC2).

Another personal carer discussed the emotional stress of caring for a resident in pain, who had fallen and experienced severe pain:

...and that was quite devastating for me (PC4).

Personal carers in this study expressed concern about the stress of providing care for older people in pain. Personal carers acknowledged that at times they felt emotionally exhausted by their role, but had learned to cope. It appeared from descriptions of their experiences with residents in pain, that personal carers were emotive about the care provided to “their residents” and consequently lacked objectivity when speaking

about the care provided by other health professionals. Personal carers spoke of the attitudes that they perceived some nurses and doctors had about older residents. One personal carer told of the disregard they felt some health professionals had for older residents:

I think, it can be very upsetting, because it can be so difficult to keep up with what's going on, and I think to a degree that, in fact I'm bloody sure of it, that they [nurses and doctors] are kind of "well they [residents] are old and they have dementia" (PC2).

Another personal carer spoke of their perception of health professionals who were treating residents:

Then you find that some [nurses and doctors] try, but then just don't wanna deal with it. So that's where it is hard. Sometimes they'll say lets try Seranace to stop the behaviours, but in fact that makes them dopey and it makes the behaviour worse and they're [doctors and nurses] not willing to try anything else... Yeah that's where it's hard. They think the residents are old (PC1).

Furthermore, a personal carer voiced the opinion that doctors may not be adequately assessing or managing resident's pain:

...her doctor at the time was not forthcoming with any medication and he actually...umm he didn't visit very often and when he did there was very little communication with the staff and he wouldn't prescribe her anything better for her pain. He would only give Panadol and his response was that she isn't going to be here much longer, so yeah (PC6).

Personal carers' descriptions of other health professionals were often emotive. It seemed that personal carers believed that the problem with poor pain control for residents in RACFs was the responsibility of all health care team members.

In summary, the emotional attachment gained between personal carers and residents was portrayed to have both positive and negative consequences. The family-like relationship allowed personal carers to provide individualised care and for residents to feel at home. However, by not distinguishing between personal and professional boundaries, personal carers described an emotional involvement that may blur the objectivity of their professional role.

Teamwork

Working together is essential in the aged care environment. The category *Teamwork* describes an important aspect of the personal carers' role. The high dependency levels of residents means that even simple activities of daily living require the assistance of more than one personal carer. Personal carers are therefore required to work closely with one another to create a team that can provide care for frail individuals. All personal carers involved in this study emphasised the importance of the team environment. In particular, they reported that the team environment allowed personal carers to solve problems together. In the RACFs personal carers were often the only staff members working with residents and access to nursing staff was limited. Issues regarding residents care were discussed among the team of personal carers and decisions were made regarding whether to initiate interventions or to refer to an enrolled or registered nurse. One personal carer spoke of how problems were discussed with other personal carers in the area and decisions were made regarding resident's care:

...pretty much it's a team thing....We all get on really well...Umm I think probably the carers sort of draw off each other actually...Yeah we do really. If we are worried about things, we tend to talk to each other and bounce off each other (PC2).

Personal carers were also members of the larger multi-disciplinary team. Despite being important members of the team, personal carers reported that a hierarchy existed in the RACF workforce. The hierarchy that was explained by

personal carers depicted doctors at the top of the ladder, with responsibility to delegate tasks to registered nurses, who delegated to enrolled nurses and then to personal carers. Some found this structure reassuring, while other personal carers reported resentment towards this hierarchy. In general, personal carers were positive in their comments about the important role that enrolled and registered nurses play in the assessment and management of pain. One personal carer spoke of how the status of different professionals improves the management of pain in RACFs:

I think because we have that hierarchy, with the ENs and RNs it [pain] should be dealt with straight away (PC3).

Another personal carer said:

...we have our ENs and our RNs in place and if we feel there is a problem then we can go to them and it is quickly passed on and addressed (PC5).

One personal carer further praised the enrolled nurses and registered nurses for the skills they brought to the team and recognised the knowledge that can be learnt from them:

Yeah, just watching other people and how they deal with it and how they suss it out and sometimes it's so simple. And that's where having the EN come in and have a look makes a difference...[you] can also learn a lot from the ENs and RNs (PC4).

This personal carer went on to speak of the teamwork between carers and nurses. They portrayed a sense of equality between team members, who strive for the same goal of effective pain relief:

If we pick up that there is pain there, we can go to our EN coordinator, discuss it with her and if we can't nut it out with the EN we call the RN (PC4).

Within the RACFs there were distinct structured systems defined by the types of professionals employed. Permanent facility staff who provide direct care consist of registered nurses, enrolled nurses, personal carers and allied health workers (such as therapy assistant staff). Other health professionals such as General Practitioners, occupational therapists and physiotherapists were employed on a casual or contract basis. Each profession had individual job descriptions depending on specific facility requirements. It was perceived by personal carers that professional roles were relatively clearly defined. Personal carers were expected to perform general care such as assisting residents with activities of daily living and other daily needs and nurses were seen by personal carers to have an administrative role, but nurses were available if the personal carer felt the need arose. This mix of staff, although designed to provide effective care, was described by personal carers as a distinct hierarchy. A participant told of how in their time working as a personal carer, the hierarchy of staff had become more evident. They spoke of their support for the effectiveness of the hierarchical system:

...in my time here it has [the hierarchy] been progressive. I mean when I first started working here, there was 3 or 4 ENs, we had no RN, and then it became a more professional establishment and we now we have RNs and ENs, that are not just here to give out medications, but we have a resident EN here as day staff. So we now have all the avenues in place to cover it all, rather than catching up with an EN 2 hours down the track, because they're busy doing the medications and you're like... "Ohh such and such was in pain". So I have seen it progress to be a much more professional approach now (PC3).

Despite acknowledgement that personal carers are members of the wider team, personal carers reported that their role is under-valued and that they are at the lower end of the hierarchical system. One personal carer said:

We just follow instructions (PC2).

There was a feeling among some personal carers that they are subservient to other staff and are not actively involved in the decisions made regarding residents' care. Some personal carers perceived that they are largely excluded from the decision making process. One personal carer said:

Ohh, I think as carers we're at the bottom of the ladder, but we do the most important job. I'd like to see carers become more involved in the pain management side of it...I mean we're the ones in the wards and spend the bulk of the time with the residents. That um, we might pick things up [but] after that we don't have anything more to do with what is organised. They [nurses] might just come in and say their [resident] medication has been changed and you might say, "Well ok this is what we're doing now" (PC4).

Personal carers conveyed their exclusion from decisions as being a reflection of the value of their role held by other health professionals. However, personal carers maintained that because of their unique role working closely with residents they should be involved in clinical decisions relating to residents care.

The emotional difficulties associated with caring for people in pain were acknowledged by all participants in this study. Sharing or debriefing among the team of personal carers was a strategy employed to cope with the stressors of caring for individuals in pain. Furthermore, there was an awareness of the need for time away from some residents with challenging behaviours. One personal carer said:

Umm, I mean it takes its toll. Some behaviours... I have a short fuse with some behaviours. I mean everyone has their ones [residents] that they get along with. We have this resident who is hard to monitor, because she is very agitated, very repetitive, I usually say to another carer, you deal with her 'cause it really takes its toll... the same, the same, same (PC1).

Personal carers also reported the importance of looking after other team members. Participants described active team work within the personal care staff and acknowledged the significance of recognising each person's needs. Additionally,

personal carers spoke of adjusting the workload between residents to suit particular staff.

Residents' family members were recognised as an important part of the team. Personal carers acknowledged the family members' role in providing pain management and told stories of actively getting families involved in improving care for residents. A personal carer said:

Or you get relatives, who are quite strong, and they contact the doctor [to discuss pain management] (PC2).

Furthermore, families are seen as a source of support by many personal carers. The relationship between the personal carer and family members can provide comfort to all parties. One personal carer told of how families assist personal carers to cope with their role:

...and sometimes when you are comforting the families it comforts you back somehow (PC2).

Personal carers believed that teamwork is crucial in an aged care environment. Personal carers indicated that the multidisciplinary team generally enabled the provision of efficient care. However, personal carers described a hierarchical system within the team, which often caused personal carers to feel that their role was undervalued. Nevertheless, the team of personal carers was seen to provide both emotional and professional support.

Rewards of Getting It Right

The category *Rewards of Getting It Right* examines the way personal carers are sustained and fulfilled by the rewarding aspect of caring for older individuals in pain. Each personal carer involved in this study acknowledged the difficulties associated with caring for older people and particularly those unable to communicate their discomfort. However, all participants spoke of their passion, enjoyment and love for

their work. Despite the emotional distress associated with observing people in pain, personal carers identified gaining satisfaction from seeing residents relieved of pain:

Oh rewarding, yeah when they give you a smile or they are looking chirpy that's terrific and when they are happy that's great, 'cause that's what we're here for (PC2).

The satisfaction achieved from helping vulnerable people was portrayed as the main reason for personal carers staying in the role. Personal carers spoke of the poor financial gain they received and expressed the view that it was emotional fulfilment that made the job worthwhile.

Recognition of their involvement in the pain management process is gratifying for personal carers. One personal carer told of how the team had identified a resident who was in pain. Instead of delaying pain management intervention they had pursued the problem immediately and were later rewarded by seeing the resident comfortable. One personal carer explained that after treating a resident's pain it was pleasing to see a positive result:

...especially like this morning, because residents like Margaret hide away in their room and won't come out and this morning I went to get Margaret for breakfast and she had already come out....I was really, really quite excited as usually she won't come out. I felt really good about that. Instead of saying to her I've another shower to do, I will get to you later, and I dealt with it [her pain] straight away. Yep, that was good (PC3).

The caring component of the personal carers' role was described by all who participated in this study as the most important and rewarding part of their job:

I think it's the most fulfilling job. For me for the simple fact you're um caring on their last ride, their [residents] last stop over and if you can ease that pain and make it a bit more comfortable for them- not only are they going to be happier but it makes your job a lot smoother as well (PC2).

Personal carers expressed satisfaction in being involved so intimately with residents in the last stage of their lives. One personal carer discussed their personal philosophy that described their role with residents:

My motto, I'm here and if I can make their last stay a comfortable time then when they do pass away I feel like I've done a good job. I have looked after them and made their last road trip a happy one (PC4).

Overwhelmingly personal carers derived satisfaction from their role in RACFs. In recognising the vulnerability of the resident population, the participants described having no expectation of being praised, instead identifying the fulfilment of seeing residents respond to the care that they received. Personal carers acknowledged that their job although not always easy, is undeniably rewarding.

Extended Roles

The sub-theme *Extended Roles* is related to the central theme, *Perfect Positioning*. *Extended Roles* describes the additional responsibilities that are shouldered by personal carers in RACFs. Two categories emerged that are directly associated with the sub-theme, *Clinical Judgements* and *Nagging*.

Extended Roles emerged as an important theme as personal carers in this study discussed their work practice and responsibilities. Personal carers described performing skilled tasks that were once performed by qualified staff. Participants in this study described personal carers making clinical decisions, initiating pain management and pursuing other health professionals to perform interventions.

Clinical Judgements

Clinical Judgements emerged as a category in the sub-theme, *Extended Roles*. This category describes the clinical decision making that was required of the personal carers in this study. Often personal carers were the only staff working in close

proximity to residents, therefore, they regularly described being in positions where they were required to make judgements about a resident's pain management.

Personal carers found themselves in a position which required them to identify residents who are in pain. Without formal training in pain assessment, personal carers discussed a reliance on their previous knowledge of residents to enable them to assess a resident's current pain status. Personal carers told stories of using external presentations such as facial grimacing and guarding to distinguish pain and using numeric rating scales to describe residents' pain intensity:

And you can usually tell if it is quite painful. You can actually tell by the expressions on his face or how he is presenting. You just sort of work it out from one to ten what you think it is and then tell the EN coordinator and tell them it's causing him grief (PC4).

Personal carers reported making personal judgements about pain described by residents. For example, some personal carers in this study suggested that residents often reported greater levels of pain than really experienced. Regardless of a resident's verbal expression of pain, some personal carers reported changing the level of pain intensity described by the resident to a 'more appropriate' level. They based their estimation of the resident's pain on previous experience with the resident. One personal carer described this process as follows:

...one gentleman up there suffers from bad back pain, so he is on a Panadol and he has three a day and you can say to him, "How does it feel between 1 and 10?" Ten being the highest, and he might say "It's a 7". Umm sometimes you think that might be a little over the top because you can actually watch him walk now and if that was a 7 you think nope pretty painful for me maybe about 4 or 5 (PC4).

Other statements were made that appeared to be describing common misconceptions about pain and the ageing process. Several participants reported the false belief that

older people experience less pain than others (Ferrell, 1996). Personal carers also suggested that pain is inherent in the ageing process.

Once pain is identified by the personal carer, it is their responsibility to decide on the course of action to be taken. Personal carers expressed three options that are selected by them in their daily practice. These are to provide personal carer driven interventions, communicate the problem to nurses, or to ignore the problem. These choices are illustrated in Figure 3.

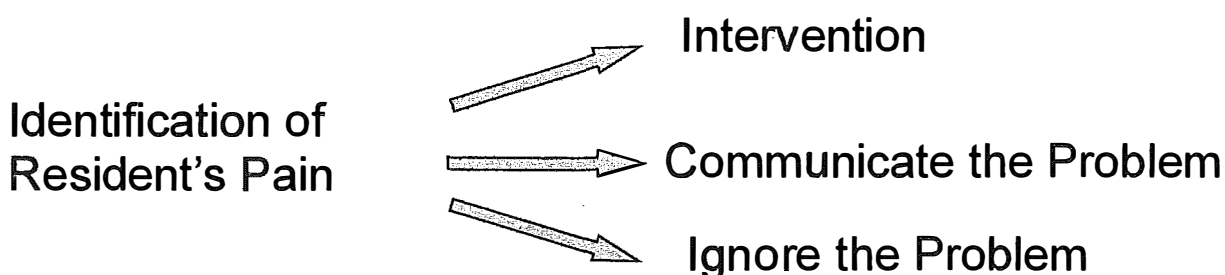


Figure 3. Clinical Decision Making of Personal Carers after Identifying Pain.

The ability to provide intervention varies considerably between the type of facility and levels of staffing. Staff from lower level care facilities appeared to have a greater level of responsibility than those in high level care facilities, which tended to employ a higher proportion of qualified nursing staff. However, all personal carers were required to provide general care for residents in pain, such as repositioning, tending to hygiene needs and reassurance. One personal carer described her role as follows:

As a carer the main care is making sure they are comfortable. Turning them every so often um... mouth washes um 'cause they are sort of not eating much keeping their mouth moist, um little lip balm on their lips just to keep them moist, yeah just making sure that they're comfortable (PC4).

The low level care facilities that were involved in this study required that their personal carers were trained and deemed competent in administering medication. Personal carers were expected to take responsibility for administering medication to residents from pharmacy packed medication (commonly known as Webster Packs). When asked about the training required to be deemed 'medication competent', one personal carer responded:

Well here apparently, it's quite an interesting technique, because we are not supposed to know anything about the medication we give out. We are supposed to have very minimal knowledge from a legal thing, you know...Funny hey...Nurses can know but carers can't (PC2).

Although personal carers were administering from pharmacy packed medication, PRN medication was also a personal carers' responsibility in the low level care facilities in this study. The decision to administer PRN medication required the personal carers to make a clinical judgement about the residents' pain status and then to initiate pain management. One personal carer said:

I could see she was in a bit of pain, so I gave her analgesia and within a short amount of time I could see the difference (PC3).

This personal carer portrayed a sense of confidence that pain management was within the personal carers' scope of practice. Several personal carers did not feel so self-assured about making decisions related to the management of pain and discussed referring problems to either other care staff or nurses immediately.

After identifying that a resident is in pain and deciding whether or not to provide appropriate intervention, it is the personal carers' responsibility to be proactive in initiating formal or informal communication of the problem to nursing or medical staff. Personal carers spoke of their responsibility to document in the resident's health record:

Personal carers do all the paperwork...we do care-planning. We get RCS [resident classification scale] training and documentation training (PC6).

The informal communication of issues related to identified pain was apparent in the interviews. All personal carers discussed their role in sharing information with nurses:

...we pass our information on. We tell the EN, then the doctor will come around and she'll tell them all the different problems (PC1).

A personal carer's professionalism plays a role in how pain is managed in RACFs. After identifying a resident in pain, it is the personal carer's decision whether to pursue the problem. One personal carer spoke of how ignoring the problem, although not morally or ethically appropriate, was a very real possibility for personal carers who work with low staff to resident ratios, limited time and heavy work loads. The personal carer said;

So yeah, it really comes down to your own approach, own professionalism. I mean in a dementia unit you really could just do nothing and no one is the wiser, but of course you have to be professional about it and I am sure we all do that (PC3).

Personal carer education related to pain and its management was discussed by participants in this study. Personal carers valued their general education but acknowledged the limitations of their education specifically related to pain. Personal carers emphasised the importance of their clinical experience and discussed the knowledge and skills learnt through their experience and obtained from working with other health professionals. Clinical experience was described by personal carers as the greatest way to learn. Nevertheless, participants expressed support for increased education related to pain and felt that it could be beneficial to their practice. One personal carer said:

I think any education would be a bonus, even if it is stuff you've learnt before, it never hurts to retrace it. Because after a while you don't forget it, but you stop thinking about it...[Education] about pain assessment would be good. In fact anything about pain would be good (PC2).

Regardless of the level of care provided by RACFs, personal carers described decisions they made regarding the management of pain for residents in their care. They articulated their own opinions about pain in older people and some participants described what appeared to be misconceptions about pain and its management in older people. Personal carers acknowledged the limitations of their education related to pain and were supportive of increased education specifically related to pain. The personal carers described making clinical judgements related to managing residents' pain, including whether or not to administer as-needed analgesia. Furthermore personal carers described performing advanced tasks that extend the general role in RACFs.

Nagging

The category *Nagging* formed as part of the sub-theme, *Extended Roles*. The *Nagging* category emerged in the analysis of the interview transcripts and describes the continual pursuance of pain management issues with other staff. *Nagging* also encompasses a concept of ownership of pain management issues by personal carers. Several personal carers perceived that pain management was often not a high priority for nurses and personal carers therefore felt that they had to 'nag' nurses to get appropriate interventions for residents.

Yeah, its mainly nagging at nurses who then have to nag at doctors to come (laugh) it's a never ending circle. Nag, nag, nag, and eventually everyone gets sick of you and they eventually cave in and come and do something (PC2).

Personal carers described advocating for residents as an important part of their role in pain management in RACFs. It appeared that personal carers took ownership

of the pain management problem and felt it was their responsibility to follow it up with nursing staff.

Personal carers also recognised the limitations of the nurses' role and described the 'nagging' process that nurses used to influence doctors in order to receive necessary action. One personal carer said:

Well we kept saying to the nurses and the nurses they kept telling the doctor but unfortunately every time someone came she [the resident] would say "I'm fine, I'm fine". So it was quite difficult to realize that she wasn't really "OK, OK, OK" and then eventually they conceded that she did really need something (PC2).

In summary personal carers perceived 'nagging' as inherent in the pain management process in RACFs. To receive prompt management of identified pain, personal carers saw themselves as resident advocates and described the need to pursue pain management matters with nursing staff.

Conclusion

This chapter has presented the findings of this descriptive, exploratory research project. Analysis of the interview transcripts revealed the experiences of personal carers who are providing care for someone in pain. The central theme, sub-theme and related categories have been explained. Each component of the conceptual framework has been discussed and exemplars used to clarify meanings expressed by personal carers. Importantly, the findings of this study have highlighted the involvement of personal carers in the pain management process in the residential care setting and the critical role that they play in determining the level of pain management received.

CHAPTER SIX

Discussion

Introduction

This study has begun to develop a picture of personal carers' experiences of caring for older people in RACFs who are in pain. This chapter presents a discussion of the findings of this research project. The discussion will examine the findings in relation to pertinent literature. This chapter also identifies limitations of the study and provides recommendations for clinical practice, education, administration and for future research. Finally, conclusions about the study's findings will be drawn.

Discussion

This project has allowed the development of a conceptual framework that depicts the personal carer and their involvement in pain assessment and pain management in RACFs. Throughout the aged care sector, personal carers are known as nursing assistants, care aides or care workers and therefore this chapter will include discussion which uses varying titles. A central theme to emerge from this study, *Perfect Positioning*, was developed from the data to describe the situation of personal carers and their pivotal role in the management of pain for residents in RACFs. Five categories directly related to the central theme; *Frontline*, *Knowing the Resident*, *Emotional Attachment*, *Teamwork* and *Rewards of Getting It Right*. Peripheral to the central theme, a sub-theme, *Extended Roles* emerged. *Extended Roles* explains the additional responsibilities expected of personal carers in their role in RACFs. Two categories were directly associated, *Clinical Judgements* and *Nagging*.

The Personal Carers' Pivotal Role

The main theme to emerge from the data is that of personal carers in RACFs being in an ideal role to be directly involved in the assessment and management of pain. The pivotal role of personal carers working with residents has been described previously (Ferrell, 1996; Herr, 2002a; Horgas & Dunn, 2001). These authors have emphasised that the direct contact and considerable amount of time personal carers

spend with residents allows personal carers a greater opportunity to identify residents in pain than other health care providers. Although the role personal carers play in pain management has been previously mentioned (Allcock et al., 2002; Ferrell, 1996; Horgas & Dunn, 2001), no research has examined the personal carers' experiences with residents in pain. This study has identified that personal carers do have a pivotal role in pain management in RACFs. Through their descriptions of their day to day practice, the personal carers who participated in this study reiterated previous researchers' suggestions that personal carers are conducting pain assessments and are instituting pain management strategies in some RACFs (Ferrell, 1996; Horgas & Dunn, 2001). It must be noted that although it is not necessarily the expectation of facilities that personal carers manage pain or that nurses are delegating care related to pain management to personal carers, the reality is that personal carers may often be the only staff available to perform such a role.

In Western Australia it has been reported that a personal carers' role is to provide general, basic care under the direct supervision and delegation of registered and enrolled nurses (Nurses Board of Western Australia [NBWA], 2006). However, personal carers represent a majority in the RACF workforce and it is apparent that in some facilities nurses are not on the facility premises at all times. Therefore, it is essential to more clearly define the role of personal carers working in RACFs, to ensure that professional boundaries are defined for the provision of safe and legally appropriate care for frail elders.

Educational Preparation

There are a number of studies that examine the educational preparation or education deficit of staff in RACFs (Allcock et al., 2002; Davies et al., 1999; Ferrell, 1996; Twycross, 2002). Recently it has been recognised that personal carers in Australia, America and the United Kingdom have minimal education and training to support them in an expanding role in RACFs (Allcock et al., 2002; Davies et al., 1999; Neville et al., 2006). Although this study did not aim to focus directly on the educational preparation of personal carers, it has touched on the personal carers'

perspectives of their preparation for their work role and the impact of educational preparation on their ability to assess and manage pain.

Two thirds of participants in this study had commenced employment as a personal carer without any relevant formal qualification, education or training. Although all participants had since completed, or were currently completing, relevant education in Aged Care, participants reported that they initially felt inadequately prepared for their role. In a study by Richardson and Martin (2004) personal carers reported deriving satisfaction from having the necessary skills and competency to perform the tasks expected of them. More adequate preparation may improve the provision of care and decrease the stress associated with commencing employment as a personal carer (Richardson & Martin, 2004). Personal carers in this study valued their education, but felt it was limited regarding pain management. Participants suggested that increased education would better prepare them for their role. Participants also highlighted the importance of their clinical experience in developing greater skills and understanding in the area of pain management. Clinical experience was gained by working closely with more experienced staff. Clinical experience was described by personal carers as the most valuable way to learn. Nevertheless, this study supports the literature that suggests that lack of education and understanding by personal carers may impact on the effectiveness of pain management in RACFs (Allcock et al., 2002; Ferrell, 1996; Twycross, 2002), because personal carers may not have the necessary knowledge or skills to accurately assess pain and implement appropriate interventions.

Common misconceptions, attitudes and beliefs about older people, pain and pain management were reported by the participants interviewed in this study. For example participants described the fallacy that pain is inherent in the ageing process. Previous research, although mainly focusing on nursing personnel, has suggested that many staff working in the aged care sector hold similar misconceptions about ageing and pain management (Allcock et al., 2001, Closs, 1996; Courtney et al., 2000; Herr, 2002a; Horgas & Dunn, 2001). This study supports the need for further education and

training for personal carers to minimise these misconceptions and equip staff with the necessary knowledge and skills to adapt to their extended roles (Ferrell, 2004; Gartell, 2001; Horgas & Dunn, 2001).

Previous studies, although having a nursing focus, have concluded that education about pain increases staff knowledge levels and can have a positive influence on staff behaviours (Allcock et al., 2002; Twycross, 2002). A study by Ward and Wood (2000) suggests that evaluation of education is the key to ensuring that education is effective in improving staff knowledge and skills, thereby influencing practice. However, a study by Eisenberg and Granot (1998) found that educating nurses about pain altered their perceptions of pain management, but the participating nurses did not maintain the knowledge or change their behaviours in the long term. Therefore, providing personal carers with increased knowledge may not be sufficient to improve the management of pain in RACFs (Briggs & Dean, 1998). Nevertheless, the degree to which education may influence the practice of personal carers is largely unknown. Hence, the findings of this study support suggestions by Horgas and Dunn (2001) that increased access to training and the implementation of mandatory education related to pain assessment and management for personal carers employed in Australian RACFs may be valuable.

Continuity of Staff and Care

The category *Knowing the Resident* emerged as a crucial aspect of identifying a resident's pain. The intimate nature of tasks performed by personal carers in long-term care facilities enables personal carers to develop familiarity and complex knowledge of residents. In several earlier studies personal carers described knowing the residents and their usual behaviours as important factors in determining a resident's pain (Mentes, Teer & Codogan, 2004; Wright, Varholak & Costello, 2003). The importance of staff having a good knowledge of the residents' normal behaviour has been highlighted in *The Australian Pain Society's Pain in Residential Aged Care Facilities: Management Strategies* (APS, 2005). Pain assessment tools such as the Abbey Pain Scale consider that a health providers' knowledge of a resident is a

crucial factor in the timely identification of pain (Abbey et al., 2004). Abbey and colleagues (2004) suggest that for effective use of this pain assessment tool previous experience and knowledge of a person is necessary. The health care provider is required to distinguish between normal and abnormal behaviour and changes in level of functioning, particularly when identifying pain experienced by individuals who are unable to articulate pain accurately (Abbey et al., 2004; APS, 2005; Brown, 2004). The personal carers in this study emphasised the importance of knowing residents for identifying and evaluating pain management, particularly where cognitive and communication impairments were apparent. Allcock and colleagues (2002) notes the significance of strategies such as becoming familiar with residents habits and normal behaviour, but highlighted problems associated with the reliability of the depending on knowing the residents for accurate assessment of pain.

Continuity of staff was seen by personal carers in this study to be a determining factor in the development of familiarity and knowledge of residents. The importance of continuity of staff for consistent, high quality care in RACFs has been identified in previous studies and is also inherent in the Australian Government Aged Care Act of 1997 (Allcock et al., 2002; Commonwealth of Australia, 2005). Although it would be ideal to maintain continuity of staff in RACFs, it can be difficult to maintain staff in the aged care sector because of poor pay and conditions offered to workers (Chou et al., 2002; Richardson & Martin, 2004). RACFs may need to rely on a high proportion of agency or casual staff due to unpredictable fluctuations in labour needs (Richardson & Martin, 2004). The reliance on non-permanent staff members diminishes the ability of workers to know residents and may impact on quality of care provided to residents. Personal carers in this study reported that resident care-plans and other documentation relating to a resident's function and abilities, although specific to individual residents, had limited usefulness in the identification and management of pain because of the inability to describe explicit detail. Instead, personal carers maintained that knowing the resident was the most important factor in pain assessment. Nevertheless, this study provides recommendations for investigation into improving care-planning and documentation relating to pain management. Also,

findings of this study support the implementation of incentives to recruit and retain staff in the aged care sector in an effort to improve pain management and thus improve the quality of life for residents.

Caring Practice

The caring experience has many dimensions (Wynaden et al., 2006). The concept of caring for people in pain is complex and the emotional burden has been reflected in the literature (Ferrell, 1996; Higgins et al., 2004). Many studies have focused on the family caregivers' experiences and the burden associated with this informal caregiving role (Carson & Mitchell, 1998; Higgins et al., 2004; Sofaer et al., 2005; Yates et al., 2004). Yates and colleagues (2004) suggests that family caregivers may experience a high level of suffering as they observe their loved ones experiencing unrelieved pain.

According to Ferrell (1996) formal caregivers in care facilities spend a limited number of hours at work with patients and then are able to finish work and go home. Thus the impact of pain and suffering they may experience may differ from informal caregivers, who provide care 24 hours a day. However, the staff in RACFs provide care to the same residents consistently and often for a number of years. Therefore, staff in RACFs may develop a familiarity and closeness with residents that may not be attained in an acute care facility. As depicted in this study, personal carers develop an emotional attachment that can be likened to familial relationships. This emotional attachment possibly mirrors that of informal or family caregivers and therefore personal carers may experience issues such as stress in a way similar to informal family caregivers. This study highlights a need for further investigation into the stressors associated with the personal caring role in RACFs.

Numerous studies examine staff experiences with caring, however there is limited literature specifically examining staff in RACFs (Bassett, 2002; Sabo, 2006; Yam & Rossiter, 2000). Literature suggests that working with people with major health problems can be emotionally demanding and may be a significant predictor of stress and burnout (Stordeur, D'Hoore & Vandenberghe, 2001). A study by Kennedy (2005) examined the stress and burnout levels of staff (n=72) caring in a long term care facility, and reported that nursing assistants (n=47, 65.3%) experienced a moderate level of stress, that was higher than licensed practice nurses.

A paper by Sabo (2006) discussed how caring for people experiencing pain can affect caregivers' health, resulting in a phenomenon known as compassion fatigue. Health workers with compassion fatigue present with negative symptomatology such as experiencing distressing emotions (such as depression and anxiety) after caring for patients with prolonged pain or suffering (Sabo, 2006). Professional burnout has been reported as a syndrome which can occur after caring for people in pain. Professional burnout has been defined as experiencing emotional exhaustion and depersonalisation, which causes poor quality of care and negative effects on individuals' personal performances (Kennedy, 2005; Maslach & Jackson, 1986). Stress and burnout may also have other significant consequences. Unrelieved work stress has been reported to cause illness and other problems. On an institutional or organisational level, burnout may cause an increased staff turnover, missed work days and decreased productivity (Hayhurst, Saylor & Stuenkel, 2005). There is a need for investigation into the impact of the caring role for personal carers in RACFs.

A study by Richardson and Martin (2004) concluded that staff in RACFs derived satisfaction from helping people. Personal carers in this study considered the intrinsic pleasure of improving the quality of life of older people in their care important. The personal carers who participated in this study also perceived their role in RACFs as rewarding. Previous studies largely excluded personal carers when examining the rewards associated with the caring role and instead focused on nursing staff (Bassett, 2002; Spichiger, Wallhager & Benner, 2005). Nursing has been

described as a highly satisfying and rewarding job. In this study personal carers indicated that the caring aspect of their role was generally rewarding and an important component of their work. Literature suggests that caring is considered by many as a fundamental task of the nursing role (Bassett, 2002; Spichiger et al., 2005) and as personal carers share some duties with nurses, the similarity of the caring role of nurses and personal carers and care related issues such as carer fatigue, stress and burnout must be considered.

The Team in Residential Aged Care Facilities

Australian RACFs function as a multidisciplinary team (Richardson & Martin, 2004). Like many Australian RACFs, the facilities involved in this study were predominantly staffed by personal carers (ABS, 2005; Richardson & Martin, 2004). Personal carers are required to work closely with residents to provide efficient and effective care for older people. Richardson and Martin (2004) concluded that the quality of interpersonal relations with other staff is an attractive component of a personal carer's job. Personal carers in this study described the advantages of working in a team environment. The support provided by a team extends beyond the physical aspect of 'man power'. The carer team can provide support in decision making about resident's care. Furthermore, the care team was portrayed as a mechanism used to cope with the stressors associated with caring for residents, including those in pain. Moreover, a study of 27 nurses and nursing assistants suggested that job satisfaction was associated with working in a team environment (Moyle, Skinner, Rowe & Gork, 2003). The authors suggested that organisations need to focus on areas that increase job satisfaction to promote the recruitment and retention of staff in RACFs.

Personal carers provided strong evidence of a hierarchical system within RACFs. A study by Wicke, Coppin and Payne (2004) also reported a hierarchical system within aged care facilities. The nurses in the study (n=12) perceived that there was a 'vertical' hierarchy among health care providers, rather than a collaborative structure. This 'vertical' structure was described as being a distinct arrangement

between health care staff, which divided professions rather than having different specialities working together. Nurses were aware of difficulties associated with working in a hierarchical culture and aspired to promote teamwork where possible. The personal carers in this study reported feeling undervalued by other members of the health care team. The participants often felt that their contribution to assessing pain was overlooked by other team members. Several existing studies have noted the lack of communication between the different levels of staff as contributing to failure to identify and manage pain (Allcock et al., 2001; Engle, Graney & Chan, 2001; Wagner, 1997). Wagner (1997) revealed that communication breakdown between direct care staff, nurses, managers and physicians was one cause of the sometimes insufficient pain assessment and pain management practices in aged care facilities.

The Future of Personal Carers in Residential Aged Care Facilities

The change in delivery of services in the Australian health care system in recent years has meant an increased reliance on unlicensed health care workers in the aged care sector (NBWA, 2006). The greater demand for aged care services has resulted in an increase in personal carers' roles and responsibilities in the residential aged care setting (Ferrell, 1996; Richardson & Martin, 2004). This study reports the increase in duties delegated to personal carers in RACFs in relation to pain management. Personal carers in this study, from both high and low level care facilities, described performing roles that were directly related to the pain management process, including the assessment and implementation of pain management strategies. Personal carers in low level care facilities had a greater level of responsibility than previously allowed under the Nurses Act, 1992 (Government of Western Australia, 2006a; NBWA, 2006). The increased levels of responsibility were related to staffing levels that allowed for minimal clinical nursing time. The role of nurses in low level care facilities were reported as being primarily administrative and for treatment of acute situations (Engle et al., 2001). Personal carers in this study described identifying pain, assessing pain, implementing appropriate pain management interventions, including medication administration, and evaluating care outcomes. These tasks require critical clinical judgements to be made by the personal carer. A study by Rohr and colleagues

(2003) identified that in low level care facilities (n=32) registered nurses were not readily available to assess pain or to administer analgesia when required. Of the facilities involved only 40 percent had registered nurses available to conduct pain assessment and less than 70 percent had regular access to a registered nurse to administer as-needed opioid medication. It is important to note that in Australia dispensing opioid medication by non-registered nursing staff is prohibited (Government of Western Australia, 2006b). Therefore, it is imperative that the roles of personal carers in Australian RACFs are closely examined to determine the practical and legal implications of their current practice.

Despite the expansion in the level of clinical practice of personal carers in RACFs, there has been minimal advancement in the level of education required to prepare personal carers for their work role. Perhaps more problematic is the lack of a defined scope of practice and regulatory body for personal carers in Australia. The need for a defined scope of practice for personal carers is evident as personal carers perform tasks and make clinical judgements about residents' care that would traditionally have been considered a nursing duty. Scope of practice documents relating to personal carers would provide boundaries for practice, would govern appropriate delegation from health professionals to personal carers and guide the provision of safe care that is within the legislation (NBWA, 2006). Nonetheless, personal carers currently practice largely unregulated and are not monitored by any professional or government body. The Nurses Board of Western Australia has recently released a position statement on unlicensed health care workers in Western Australia (NBWA, 2006). The position statement is designed to assist personal carers and other health professionals working with unlicensed care staff to make decisions regarding clinical practice. The position statement focuses particularly on the appropriate delegation of care to unlicensed health care workers. This document is a step towards recognising the role of personal carers and assisting to define a scope of practice for personal carers in the aged care setting. However, questions related to professional delegation and who should be providing care to a vulnerable portion of

Australia's population need to be addressed. Therefore, there is an urgent need for further investigation into the role of personal carers in Australian RACFs.

Limitations of the Study

Given the scope of this Honours level research, this study has several identified limitations. The time and financial constraints of the study limited the sample and size of the study, which consequently influenced the data collected. However a purposive approach to sampling obtained rich and in-depth data from personal carers and data saturation was achieved.

The study was also restricted to the South West of Western Australia. Although providing data about regional RACFs, the facilities involved employed a high proportion of permanent staff. Unlike many metropolitan facilities, the RACFs sampled employed no agency staff and few people of ethnic origin (Richardson & Martin, 2004). These factors may have influenced the data generated, however this study has provided a regional perspective that has been neglected in previous studies.

Minimising researcher bias throughout this study was particularly important because the researcher is a registered nurse and has experience working with personal carers in the aged care setting. Researcher bias could have affected data collection and analysis and therefore the researcher was careful to ensure that the data generated reflected the views of the personal carers and not of the researcher. Furthermore, during the analysis process, coding of data was verified by another researcher. Having prior experience in this setting was, in fact, advantageous to the research process. Patton (1990) discussed the need for a researcher entering a field to learn the language of the culture. Having had experience in the aged care setting resulted in an increased understanding of the terminology and experiences portrayed during the data collecting process and assisted in building rapport with participants. Despite these limitations this study has contributed to health knowledge and has implications for future research, education and practice.

Recommendations

This section presents recommendations for clinical practice, education, administration and for future research related to personal carers in the Australian aged care setting.

Clinical Practice

The findings of this study have highlighted several recommendations for clinical practice in RACFs. Firstly, there is an apparent need for encouraging the employment of permanent staff in the residential care setting. Continuity of staff enables workers to increase their knowledge and familiarity with residents, which has been emphasised as important factors in the early identification and management of pain experienced by RACF residents. Although not always realistic in a sector with limited funding, it is necessary for facilities to explore more effective recruitment and retention strategies. The development of a program designed to attract and retain personal carers may be beneficial. This study found that some personal carers feel undervalued in their role and their dissatisfaction with their level of pay was also discussed. It may also be timely for aged care organisations to examine the financial aspect of the personal carers' position in an attempt to enhance recruitment and retention of these key workers.

This research suggests that the personal carers' role related to caring for people in pain can be stressful and highlights the importance of accessing support to maintain the well-being of personal carers in RACFs. According to McVicar (2003) clinical supervision, mentorship and preceptorship are recommended to support nurses, therefore a mentoring program for personal carers and other staff may be valuable in RACFs. A program particularly designed for experienced staff to support new staff may be effective in enhancing the support network for personal carers and minimising the effects on residents' care when being cared for by new staff members with limited qualifications and experience.

A strong recommendation to emerge from the findings of this study was the need for a defined scope of practice for personal carers in the residential aged care setting. There was a large discrepancy between the level of expected involvement in the pain management process for personal carers in different RACFs. The roles performed by participating personal carers differed depending on the level of care provided by the facility and the confidence individual personal carers felt in initiating care. Some personal carers portrayed confidence in managing pain, while others felt it was outside their scope of practice. A well defined scope of practice would provide guidelines and standardise personal carer practice in RACFs. Furthermore, it is clear that within organisations there is a need to define nursing and personal carer responsibilities relating to the provision of clinical care. For example, the administration of medications, including PRN medication, by care staff needs to be clarified.

Education

This research underscores the need for improving education for personal carers employed in RACFs. Personal carers involved in this study all described the limitations of their education and several had commenced employment as a personal carer without completing any relevant education or training. The education needs of personal carers extend beyond improving their knowledge related to pain and its management. Education and training related to coping strategies and developing professional boundaries would better assist personal carers in their role. The emotionally demanding role of many personal carers suggests that education about self-care techniques may be beneficial (Sherman, 2004).

According to Ward and Wood (2000) accessibility is vital if education is to reach the intended staff. Recommendations for education and training to be held within facilities and possibly during work hours would optimise staff involvement. Nevertheless, it is acknowledged that recommendations for education alone are not a guarantee of change in practice. Improving pain management requires health care providers to reflect on their actions, values and beliefs surrounding pain and how it

influences care (Brown, 2004). Consequently, this study recommends the need for focused, continued education for personal carers in RACFs. Moreover, all staff particularly nurses, need to model good pain management practices to personal carers.

Administration

The findings of this study demonstrate a need for administrators in RACFs, government authorities and health boards to carefully consider the position and role of personal carers in Australian RACFs. There is a need to develop scope of practice documents for personal carers. There is also a need to consider the implementation of nation-wide standards and consistency of education and training for personal carers to develop standardised health care in RACFs. There is a responsibility for staff, managers and administrators to ensure that staff have the necessary skills and knowledge base to enable them to perform their work roles effectively and to comply with their duty of care and other relevant requirements of RACFs (NBWA, 2006). This study also suggests that there is an argument for a review by the Australian Nursing and Midwifery Council and Australian nursing boards for the practice of delegation by nursing staff to personal carers employed in RACFs. It may also be timely for consideration of a study into the regulation of unlicensed health care workers in the Australian aged care setting.

Research

This study has underscored the need for increased research in the Australian aged care setting. Despite recent interest in the field, empirical data specifically related to personal carers and their involvement in pain management remains limited. This study has highlighted the involvement of personal carers in pain management in RACFs. However, reproducing this study with a larger sample size across a wider region, including metropolitan facilities, would yield valuable information that could be used to understand the working environment of personal carers and ultimately be applied to improve pain management in the residential care setting. Further

investigation of the themes and categories derived from this study would provide some important information about personal carers in RACFs.

Additional suggestions for future research include the following:

- A study of personal carers' knowledge related to pain and pain management in older people.
- A study of personal carers' attitudes and beliefs about pain in older people.
- A quantitative study investigating the effectiveness of educating personal carers about pain.
- An evaluative study of the subsequent changes in clinical practice related to pain management education.
- A qualitative study of personal carers' emotional stress associated with caring for residents in pain.
- A qualitative study to investigate coping strategies employed by personal carers to cope with their role in RACFs.

The difficulty implementing research findings into practice is well documented (Brink, 1998; Polit et al., 2001). Therefore a recommendation for considering action research in the aged care setting is made.

Conclusion

This thesis has presented the findings of a qualitative descriptive, exploratory study of personal carers' experiences when caring for older people in pain residing in RACFs in regional Western Australia. The findings illustrate the complex and pivotal role personal carers have in the assessment and management of pain for people in RACFs. The central theme *Perfect Positioning*, describes this pivotal role of personal carers in the pain management process. The central theme encompasses five related categories that describe this position; *Frontline*, *Knowing the Resident*, *Emotional Attachment*, *Teamwork* and *Rewards of Getting It Right*. The sub-theme, *Extended Roles*, depicts the additional responsibilities that are inherent in the personal carers'

position. This sub-theme is described by two categories, *Clinical Judgements* and *Nagging*.

These findings have been discussed in relation to the relevant literature. The study's limitations have been discussed and recommendations for clinical practice, education, administration and future research are provided. This project has yielded valuable insights into the important role of personal carers in RACFs and their involvement in the pain management process. This study has provided an opportunity to explore the experience of personal carers and the findings have implications for future research, education and practice.

REFERENCES

- Abbey, J., Piller, N., DeBellis, A., Esterman, A., Parker, D., Giles, L., et al. (2004). The abbey pain scale: A 1-minute numerical indicator for people with end stage dementia. *International Journal of Palliative Nursing*, 10(1), 6-13.
- Allcock, N., McGarry, J., & Elkan, R. (2002). Management of pain in older people within the nursing home: A preliminary study. *Health and Social Care in the Community*, 10(6), 464-471.
- Australian Bureau of Statistics [ABS]. (2006). *Australian social trends, 2006*. Canberra: Author.
- Australian Bureau of Statistics [ABS]. (2005). *Australian social trends, 2005*. Canberra: Author.
- American Geriatric Society [AGS]. (2002). The management of persistent pain in older persons: AGS panel on persistent pain in older persons. *Journal of American Geriatrics Society*, 50, S205-S224.
- Australian Nursing Federation [ANF] & Royal College of Nursing, Australia [RCNA]. (2004). *Joint position statement: Assistants in nursing and other unlicensed workers*. Retrieved 10th June, 2006, from <http://www.rcna.org.au>
- Australian Institute of Health & Welfare [AIHW]. (2006). *Residential aged care in Australia 2004-2005: A statistical overview*. Cat no. Age 45. Canberra: Author.
- Australian Institute of Health & Welfare [AIHW]. (2002). *Older Australia at a glance* . (3rd ed.). Canberra: Author.
- Australian Pain Society. (2005). *Pain in residential aged care facilities: Management strategies*. Sydney: Author.
- Australian Society of Geriatric Medicine [ASGM]. (2001). *Australian society for geriatric medicine: Position statement number 9: Medical care for people in residential aged care services*. Retrieved 2nd September, 2006, from <http://www.asgm>.
- Bassett, C. (2002). Nurses' perceptions of care and caring. *International Journal of Nursing Practice*, 8, 8-15.
- Beanland, C., Schneider, Z., LoBiondo-Wood, G., & Haber, J. (1999). *Nursing research: Methods, critical appraisal and utilisation*. Sydney: Mosby.

- Blomqvist, K., & Edberg, A. (2002). Living with persistent pain: Experiences of older people receiving home care. *Journal of Advanced Nursing*, 40(3), 297-306.
- Blumer, H. (1969). *Symbolic interactionism: Perspective and method*. Englewood Cliffs: Prentice Hall.
- Bowers, B., Lauring, C., & Jacobson, N. (2001). How nurses manage time and work in long-term care. *Journal of Advanced Nursing*, 33(4), 484-491.
- Briggs, M., & Dean, K.L. (1998). A qualitative analysis of the nursing documentation of postoperative pain management. *Journal of Clinical Nursing*, 7, 155-163.
- Brink, P. (1998). Exploratory designs, In P. Brink, & M. Wood (Eds.), *Advanced design in nursing research* (2nd ed.). Thousand Oaks: SAGE Publications.
- Brink, P., & Wood, M. (1998). Descriptive designs. In P. Brink, & M. Wood (Eds.), *Advanced design in nursing research* (2nd ed.). Thousand Oaks: Sage Publications.
- Brown, D. (2004). A literature review exploring how healthcare professionals contribute to assessment and control of postoperative pain in older people. *Journal of Clinical Nursing*, 13(6), 74-90.
- Carson, M. & Mitchell, G. (1998). The experience of living with persistent pain. *Journal of Advanced Nursing*, 28(6), 1242-1248.
- Chou, S., Boldy, D., & Lee, A. (2002). Staff satisfaction and its components in residential aged care. *International Journal for Quality in Health Care*, 14, 207-217.
- Clark, L., Jones, K., & Pennington, K. (2004). Pain assessment practices with nursing home residents. *Western Journal of Nursing Research*, 26(1), 733-750.
- Closs, S. (1996). Pain and elderly patients: A survey of nurses' knowledge and experiences. *Journal of Advanced Nursing*, 23(2), 237-242.
- Commonwealth Department of Health and Ageing [CDoHA]. (2002). *Ageing in place: A guide for providers of residential aged care*. Canberra: Author.
- Commonwealth of Australia. (2005). *Australian Aged Care Act. 1997, No.112 of 1997*. Retrieved 6th December, 2006, from <http://www.health.gov.au/internet/wcms/publishong.nsf.content/ageing-legislat-acal997>

- Courtney, M., Tong, S., & Walsh, A. (2000). Older patients in the acute care setting: Rural and metropolitan nurses' knowledge, attitude and practices. *Australian Journal of Rural Health*, 8, 94-102.
- da Cruz, D., & de Mattos Pimenta, C. (2004). Caregivers of patients with chronic pain: Responses to care. *International Journal of Nursing Terminologies and Classification*, 15(1), 5-14.
- Davies, S., Slack, R., Laker, S., & Philip, I. (1999). The educational preparation of staff in nursing homes: Relationship with resident autonomy. *Journal of Advanced Nursing*, 29(1), 208-217.
- Denzin, N.K., & Lincoln, Y.S. (1998). Entering the field of qualitative research. In N.K. Denzin & Y.S. Lincoln (Eds.) *Collecting and interpreting qualitative materials*. Thousand Oaks: Sage Publications.
- Department of Health & Ageing [DoHA]. (2006). *Health and ageing fact book 2006*. Canberra: Author.
- Ebener, M. K. (1999). Older adults living with chronic pain: An opportunity for improvement. *Journal of Nursing Care Quality*, 13(4), 1-7.
- Eisenberg, E., & Granot, M. (1998). Educating care providers about pain: How to do it the right thing the right way. *Pain Clinic*, 10, 245-252.
- Engle, V.F., Graney, M.J., & Chan, A. (2001). Accuracy and bias of licensed practical nurse and nursing assistant ratings of nursing home residents' pain. *The Journal of Gerontology*, 56A(7), M405-M411.
- Farrell, M. J, Gibson, S.J., & Helme, R.D. (1996). Chronic nonmalignant pain in older people. In B. Ferrell & B. Ferrell (Eds.), *Pain in the elderly: Task force on pain in the elderly*. Seattle: International Association for the Study of Pain [IASP] Press.
- Ferrell, B. A. (1996). Overview of aging and pain. In B. Ferrell & B. Ferrell (Eds.), *Pain in the elderly: Task force on pain in the elderly*. Seattle: International Association for the Study of Pain [IASP] Press.
- Ferrell, B. A. (1995). Pain evaluation and management in the nursing home: Diagnosis and treatment. *Annals of Internal Medicine*, 123(9), 681-687.
- Ferrell, B. A. (2004). The management of pain in long-term care. *The Clinical Journal of Pain*, 20(4), 240-243.

- Fisher, S. E., Burgio, L. D., Thorn, B. E., Allen-Burge, R., Gerstle, J., Roth, D. L., et al. (2002). Pain assessment and management in cognitively impaired nursing home residents: Association of certified nursing assistant pain report, minimum data set pain report, and analgesic medication use. *Journal of the American Geriatric Society*, 50, 152-156.
- Gartell, M. (2005). Expression of description of chronic pain by older people. *Australasian Journal on Ageing*, 24(1), 33-37.
- Gibson, D., Rowland, F., Braun, P., & Angus, P. (2002). *Aging in Place: Before and after 1997 aged care reforms*. Canberra: Australian Institute of Health and Welfare.
- Government of Western Australia (2006a). *Nurses Act. 1992*. Retrieved 10th December 2006, from <http://www.slp.wa.gov.au/nursesact.htm>
- Government of Western Australia (2006b). *Poisons Act. 1965*. Retrieved 10th December 2006, from <http://www.slp.wa.gov.au/poisonsact.htm>
- Hayhurst, A., Saylor, C., & Stuenkel, D. (2005). Work environmental factors and retention of nurses. *Journal of Nursing Care Quality*, 20(3), 283-288.
- Herr, K. (2002a). Chronic pain: Challenges and assessment strategies. *Journal of Gerontological Nursing*, 28(1), 20-30.
- Herr, K. (2002b). Chronic pain in the older patient: Management strategies. *Journal of Gerontological Nursing*, 28(2), 28-37.
- Herr, K., & Mobily, P. (1996). Pain management for the elderly in the alternate care setting. In B. Ferrell & B. Ferrell (Eds.), *Pain in the elderly: Task force on pain in the elderly*. Seattle: International Association for the Study of Pain [IASP] Press.
- Higgins, I., Madjar, I., & Walton, J. (2004). Chronic pain in elderly nursing home residents: The need for nursing leadership. *Journal of Nursing Management*, 12(3), 167-173.
- Holloway, I., & Wheeler, S. (2002). *Qualitative research in nursing* (2nd ed.). Oxford: Blackwell Publishing.
- Horgas, A., & Dunn, K. (2001). Pain in nursing home residents: Comparison of residents' self report and nursing assistants' perceptions. *Journal of Gerontological Nursing*, 27(3), 44-56.

- Jones, K., Fink, R., Pepper, G., Hutt, E., Voojir, C.P., Scott, J., et al. (2004). Improving nursing home staff knowledge and attitudes about pain. *The Gerontologist*, 44(4), 469-478.
- Jorm, A. (2001). *Dementia: A major health problem for Australia*. Perth: Alzheimer's Association of Australia.
- Keefe, F., Beupre', P., Weiner, D. & Seigler, I. (1996). Pain in older adults: A cognitive behavioural perspective. In B. Ferrell & B. Ferrell (Eds.), *Pain in the elderly: Task force on pain in the elderly*. Seattle: International Association for the Study of Pain [IASP] Press.
- Kennedy, B.R. (2005). Stress and burnout of nursing staff working with geriatric clients in long term care. *Journal of Nursing Scholarship*, 37(4), 381-382.
- International Association for the Study of Pain [IASP]. (1994). *IASP pain terminology*. Retrieved 3rd July, 2006, from <http://www.iasp-pain.org/terms-p.html>
- Loeser, J.D. (1999). Economic implications of pain management. *Acta Anaesthesiol Scandinavica*, 43, 957-959
- Mann, A. H., Schneider, J., & Mozley, C.G. (2000). Depression and the response of residential homes to physical health needs. *International Journal of Geriatric Psychiatry*, 15, 1105-1112.
- Marshall, C., & Rossman, G. (1999). *Designing qualitative research* (3rd ed.). Thousand Oaks: SAGE Publications.
- Maslach, C., & Jackson, S.E. (1986). *Maslach Burnout Inventory* (2nd ed.). California: Consulting Psychologists Press.
- McCance, K. L., & Huether, S. E. (1998). *Pathophysiology: The biologic basis for disease in adults and children* (3rd ed.). St, Louis: Mosby.
- McCaffery, M. (1979). *Nursing Management of the patient with pain*. Philadelphia: Lippincott.
- McVicar, A. (2003). Workplace stress in nursing: A literature review. *Journal of Advanced Nursing*, 44(6), 633-642.
- Mentes, J.C., Teer, J., & Codogan, M.P. (2004). The pain experience of cognitively impaired nursing home residents: Perceptions of family members and certified nursing assistants. *Pain Management Nursing*, 5(3), 118-125.

- Moyle, W., Skinner, J., Rowe, G., & Gork, C. (2003). Views of job satisfaction and dissatisfaction in Australian long-term care. *Journal of Clinical Nursing*, 12(2), 168-176.
- Nay, R., & Closs, B. (1999). Staffing and quality in non-acute facilities. In R. Nay & S. Garrett (Eds.), *Nursing older people: Issues and Innovations* (pp. 172-190). Sydney: McClenen & Petty.
- Neville, C., McCarthy, A., & Laurent, K. (2006). Pain management skills of regional nurses caring for older people with dementia: A needs analysis. *Collegian*, 13(2), 31-36.
- Niv, D., & Kreitler, S. (2001). Pain and quality of life. *Pain Practice*, 1(2), 150-161.
- Nurses Board of Western Australia [NBWA]. (2006). *Position statement on unlicensed health care worker in Western Australia*. Retrieved 5th December, 2006, from <http://nbwa.org.au>
- Pasero, C., & McCaffery, M. (1996). Postoperative pain management in the elderly. In B. Ferrell & B. Ferrell (Eds.), *Pain in the elderly: Task force on pain in the elderly*. Seattle: International Association for the Study of Pain [IASP] Press.
- Patton, M. Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). Newbury Park: Sage Publications.
- Polit, D., Beck, C., & Hungler, B. (2001). *Essentials of nursing research: Methods, appraisal and utilization* (5th ed.). Philadelphia: Lippincott.
- Pepp, B., & Portenoy, R. (1996). Management of chronic pain in the elderly: Pharmacology of opioids and other analgesic drugs. In B. Ferrell & B. Ferrell (Eds.), *Pain in the elderly: Task force on pain in the elderly*. Seattle: International Association for the Study of Pain [IASP] Press.
- Richardson, S., & Martin, B. (2004). *The care of older Australians: A picture of the residential aged care workforce*. Adelaide: National Institute of Labour Studies, Flinders University.
- Rohr, Y., Schneider, J., Good, P., & Sattler, L. (2003). Availability of analgesia for breakthrough pain for palliative care residents in hostels. *Geriaction*, 21(4), 11-16.
- Sabo, B. M. (2006). Compassion fatigue and nursing work: Can we accurately capture the consequences of caring work? *International Journal of Nursing Practice*, 12, 136-142.

- Sandelowski, M. (1995). Sample size in qualitative research. *Research in Nursing and Health*, 18, 179-183.
- Sherman, D. (2004). Nurses' stress and burnout: How to care for yourself when caring for patients and their families experiencing life-threatening illness. *American Journal of Nursing*, 104(5), 48-56.
- Sofaer, B. Moore, A. P., Holloway, I., Lamberty, J., Thorpe, T.A., & O'Dwyer, J. (2005). Chronic pain as perceived by older people: A qualitative study. *Age and Aging*, 34, 462-466.
- Spichiger, E., Wallhagen, M., & Benner, P. (2005). Nursing as a caring practice from a phenomenological perspective. *Scandinavian Journal of Caring Sciences*, 19, 303-309.
- Stebbins, R.A. (2001). *Exploratory research in the social sciences*. Thousand Oaks, C.A.; A Sage University Paper.
- Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park: Sage Publications.
- Stordeur, S., D'Hoore, W., & Vandenberghe, C. (2001). Leadership, organizational stress, and emotional exhaustion among hospital nursing staff. *Journal of Advanced Nursing*, 35(4), 533-542.
- Twycross, A. (2002). Educating nurses about pain management: The way forward. *Journal of Clinical Nursing*, 11, 705-714.
- Wagner, A., Goodwin, M., Campbell, B., Eskro, S., French, S.A., Shepherd, P., et al. (1997). Pain prevalence and pain treatments for residents in Oregon nursing homes: Communication breakdown was associated with the failure to assess. *Geriatric Nursing*, 18(6), 268-272.
- Ward, J., & Wood, C. (2000). Education and training of healthcare staff: The barriers to it's success. *European Journal of Cancer Care*, 9, 80-85.
- Weiner, D., Peterson, R., & Keefe, F. (1999). Geriatrics: Chronic pain associated behaviours in the nursing home: Resident versus caregiver perceptions. *Pain*, 80(3), 577-588.
- Weiner, D., & Rudy, T. (2002). Attitudinal barriers to effective treatment of persistent pain in nursing home residents. *Journal of the American Geriatrics Society*, 50(12), 2035-2040.
- Wicke, D., Coppin, R., & Payne, S. (2004). Teamworking in nursing homes. *Journal of Advanced Nursing*, 45(2), 197-204.

- Wimpenny, P., & Gass, J. (2000). Interviewing in phenomenology and grounded theory: Is there a difference? *Journal of Advanced Nursing*, 31(6), 1485-1492.
- Wood, J.T. (1982). *Human communication: A symbolic interactionist perspective*. New York: Holt, Rinehart & Winston.
- Won, A., Lapane, K., Gambassi, G., Bernabei, R., Mor, V., & Lipsitz, L. (1999). Correlates and management of nonmalignant pain in the nursing home. *American Geriatrics Society*, 47(8), 936-942.
- Wright, J., Varholak, D., & Costello, J. (2003). Voices from the margin: The nurse aide's role in pain management of institutionalized elders. *American Journal of Alzheimer's disease and other Dementia*, 18(3), 154-158.
- Wynaden, D., Ladzinski, U., Lapsley, J., Landsborough, I., Butt, J., & Hewitt, V. (2006). The caregiving experience: How much do health professionals understand? *Collegian*, 13(3), 6-10.
- Yam, B.M., & Rossiter, J.C. (2000). Caring in nursing: Perceptions of Hong Kong Nurses. *Journal of Clinical Nursing*, 9, 293-302.
- Yates, P., Aranda, S., Edwards, H., Nash, R., Skerman, H., & McCarthy, A. (2004). Family caregivers' experience and involvement with cancer pain management. *Journal of Palliative Care*, 20 (4), 287.
- Yates, P., Dewar, A., & Fentiman, B. (1995). Pain: The views of elderly people living in long-term residential care settings. *Journal of Advanced Nursing*, 21(4), 667-674.

APPENDIX A

Letter of Invitation to Facility Management

Edith Cowan University
Faculty of Nursing, Midwifery and Postgraduate Medicine
Letter of Invitation

Kristi Holloway

[REDACTED]

Ph: [REDACTED]

Mob: [REDACTED]

Dear _____,

Re: Honours Project

Title: Understanding personal carers' experience of caring for older people in pain.

I am a registered nurse currently working in the aged care sector. I am undertaking an honours degree in Nursing at Edith Cowan University. As part of my degree I am conducting a project that will examine personal carers' experiences of caring for older residents in pain.

Purpose

The project aims to explore personal carers' perception of caring for residents in pain. Personal carers are valuable members of the aged care team and it is important that their experiences are understood. It is hoped that the findings of the project will highlight personal carers' role in pain management in the elderly and will encourage future research, funding and educators into this area.

Your Contribution

I am writing to invite your facility to be involved in this research. In order to contribute, I request that an advertisement be placed in a location that is visible to potential participants of this study. The advertisement will include the researcher's contact details for the personal carers' to express their interest to participate. Participants will be asked to be involved in an informal interview approximately 30-45 minutes long. The interviews will be audiotape recorded and transcribed for use in the project. All attempts will be made to guarantee the participants confidentiality and anonymity.

I will contact you to determine your interest in the study and to arrange a mutually convenient appointment to discuss your facility's involvement. Thankyou for your time.

Kind Regards

Kristi Holloway

APPENDIX B

Recruitment Advertisement

Residents in Pain in Your Care



- Are you a personal carer?
- Have you cared for older people in pain?
- Would you like to share your experience by volunteering to participate in a research study?

Contact: Kristi Holloway on
[REDACTED] for an information
package

APPENDIX C
Letter of Introduction

Edith Cowan University
Faulty of Nursing, Midwifery and Postgraduate Medicine
Letter of Introduction

Kristi Holloway

[REDACTED]
[REDACTED]
Ph: [REDACTED]
Mob: [REDACTED]

Dear _____

Re: Honours Project

Title: Understanding personal carers' experience with caring for older people in pain.

Purpose

I am a registered nurse currently working in the aged care sector and I am undertaking an honours degree in Nursing at Edith Cowan University. I would like to invite you to participate in a research project, which examines personal carers' experience with pain management in aged care.

You have been asked to participate in this research because you are currently working as a personal carer in an aged care facility in Western Australia. The project aims to explore personal carers' perceptive of pain management in residential aged care facilities. Personal carers' are valuable members of the aged care team and it is important that your experiences of pain management are understood. It is hoped that the findings of the project will highlight personal carers' role in pain management in the elderly and will encourage future research, funding and educators into this area.

Your Contribution

In order to contribute to this research, you will be asked to participate in an informal interview approximately 30-45 minutes long. The interview will be tape recorded and transcribed for the use in the project. All possible attempts will be made to guarantee your confidentiality and anonymity.

Further details regarding the research project may be found in the accompanying form. If you have any questions please do not hesitate to contact me on the above details. I will contact you in the next two weeks to determine if you are interested in participating and arrange a mutually convenient appointment. Thankyou for your time.

Kind Regards

Kristi Holloway

APPENDIX D
Edith Cowan University Ethics Approval Document

14th August 2006

JOONDALUP CAMPUS

100 Joondalup Drive,
Joondalup
Western Australia 6027
Telephone 134 328
Facsimile (08) 9300 1257

ABN 54 361 485 361

Ms Kristi Holloway
[REDACTED]
[REDACTED]

Dear Ms Holloway

Course: ***Bachelor of Nursing (Honours)***

Thesis Title: *Understanding personal carers experience of caring for older people in pain*

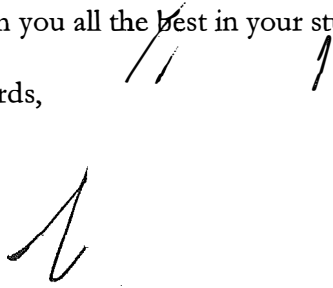
Date Approved: **14th August 2006**

Please be advised that your application to undertake research involving human subjects has been approved by the Faculty of Computing, Health and Science Human Ethics Sub-Committee for the Conduct of Ethical Research.

This approval is granted subject to the procedures outlined in your application and the conditions, if any, as outlined by the Committee in the attached memorandum.

Please note that the collection of data for your research must adhere to these conditions.

I wish you all the best in your studies.

Regards,


Prof. Robert U. Newton
Assoc. Dean Research & Higher Degrees
Faculty of Computing, Health & Science
Phone 08 [REDACTED]
Fax 08 [REDACTED]
Email [REDACTED]

cc. *Student File*
Ethics File
University Ethics Committee
Supervisor – Ruth McConigley

APPENDIX E
Consent Form

Edith Cowan University
Faulty of Nursing, Midwifery and Postgraduate Medicine
Consent Form

Project Title: Understanding personal carers' experiences of caring for older people in pain.

Researcher: Kristi Holloway RN BSc (Nursing)

The purpose of this project is to examine personal carers' experience of caring for older residents who are in pain in aged care facilities. It is anticipated that this study will highlight personal carers' role in pain management in the elderly and will encourage future research, funding and educators into this area. You have been selected as you are a personal carer currently employed in an aged care facility in Western Australia.

In order to contribute to this study, there will be an informal audiotape recorded interview approximately 30-45 minutes long. The time for the interview will be arranged at a time most convenient to you.

This study provides you with the opportunity to contribute to health research. The study poses low risk to participants. All possible attempts will be made to guarantee your confidentiality. When transcribing your recorded interview into a written form, a coded number will be used to ensure your anonymity and confidentiality. Raw data will be seen only by myself and my principal supervisor. During the interview process you do not have answer questions and you have the option of ceasing the interview at any point. Participation in this study is strictly voluntary. You may withdraw from this study at any time and all information you have provided will be destroyed.

My signature below indicates that I hereby voluntarily agree to participate in the study of personal carers detailed above. I agree that I have read and understand the outlined study. I have been given the opportunity to ask questions and all such questions have been answered to my satisfaction. I understand that the study may be published and that my name will not be associated with the research.

Participants Name

Researchers Name

Participants Signature

Researchers Signature

Date

Date

APPENDIX F
Interview Guide

Questions for Semi-structured Interviews with Personal Carers

Interview time: Approximately 30- 45 minutes

*Age

*Gender

*Highest qualification

*How long have you been a personal carer?

1. Can you tell me about a time when you have cared for a resident in pain?
 - **Prompts-** What happened? What did you do? How did you respond?
What was the end result?
2. Can you describe a particularly good experience for me?
 - **Prompts-** What happened? What did you do? How did you feel?
3. Can you describe an unpleasant experience where a resident was in pain?
 - **Prompts-** What happened? What did you do? How did you feel?
4. Can you describe for me how you recognize that a resident in your care is in pain?
 - **Prompts-** What do you look for? Is it something they have to say?
5. Are there any things that you feel could be done to improve your abilities to care for residents in pain?
6. Are there any other areas you would like to comment on?

APPENDIX G
Confidentiality Agreement of Transcriptionist

Edith Cowan University

Faulty of Nursing, Midwifery and Postgraduate Medicine

Confidentiality Agreement of Transcriptionist

Project Title: Understanding personal carers' experiences of caring for older people in pain.

Researcher: Kristi Holloway RN BSc (Nursing)

My signature below indicates that I hereby agree that I understand that the information that I will transcribe for the study mentioned above is to remain confidential. I understand that the participants of this study have been guaranteed that the data they provided will remain anonymous. I have been given the opportunity to ask questions and all such questions have been answered to my satisfaction.

Transcriptionists Name

Researchers Name

Transcriptionists Signature

Researchers Signature

Date

Date