

Registered Nurses' View of Performing Pain Assessment among Persons with Dementia as Consultant Advisors

Christina Karlsson^{*,1,2}, Birgitta Sidenvall¹, Ingrid Bergh² and Marie Ernsth-Bravell³

¹Department of Nursing Science, School of Health Sciences, Jönköping University, Box 1026, SE-551 11 Jönköping, Sweden

²Department of Health Care Sciences, School of Life Sciences, University of Skövde, Box 408, SE-541 28 Skövde, Sweden

³Institute of Gerontology, School of Health Sciences, Jönköping University, Box 1026, SE-551 11 Jönköping, Sweden

Abstract: *Background:* Pain assessment in persons with dementia is well known as a challenging issue to professional caregivers, because of these patients' difficulties in verbalising pain problems. Within municipal dementia care in Sweden, pain assessment has become problematic for registered nurses, as they have entered a new role in their nursing profession, from being clinical practitioners to becoming consultant advisers to other health care staff.

Aim: To present municipal registered nurses' view of pain assessment in persons with dementia in relation to their nursing profession as consultant advisers.

Methods: Purposive sampling was undertaken with 11 nurses invited to participate. Data were collected by focus groups. Qualitative content analysis was used to analyse the data.

Findings: Four categories were identified to describe registered nurses' view of pain assessment: estrangement from practical nursing care, time consuming and unsafe pain documentation, unfulfilled needs of reflection possibilities, and collaboration and coordination.

Conclusions: The performance of pain assessment through a consultant advising function is experienced as frustrating and as an uncomfortable nursing situation. The nurses feel resistance to providing nursing in this way. They view nursing as a clinical task demanding daily presence among patients to enable them to make accurate and safe assessments. However, due to the consultative model, setting aside enough time for the presence seems difficult to accomplish. It is necessary to promote the quality of systematic routines in pain assessment and reflection, as well as developing professional knowledge of how pain can be expressed by dementia patients, especially those with communication difficulties.

Keywords: Municipal dementia care, pain assessment, registered nurses.

INTRODUCTION

Municipal Registered nurses (RNs) have a key function in community care and in elderly nursing care due to their nursing knowledge [1]. In RNs' nursing care, patients' pain problem is frequent. Pain assessment in persons with cognitive impairment and dementia is a well known challenging issue for professional caregivers, due to these patients' difficulties when it comes to verbalising their pain problems [2, 3]. Furthermore, pain in persons with dementia remains reported undertreated and undermanaged [4]. In attempts to assess pain, RNs use their nursing knowledge in a variety of ways. However, within Swedish municipal dementia care, pain assessment has become a problematic issue for RNs, as they have entered a new role in their nursing profession - a transition from being clinical practitioners to becoming consultant advisers to other health care staff, such as certified nursing assistants (CNAs) [5]. This means that they practice their profession to a greater

extent within an administrative context, rather than practicing nursing among patients on a daily basis.

BACKGROUND

The prevalence of dementia is increasing throughout the Western world [6]. At the same time, nursing home residents have become frailer with an increasing need of care, where persons with dementia require most care [7]. Moreover, a majority of the oldest elderly people spend their last days and receive end-of-life care in the nursing homes [8]. Municipal RNs have an overall responsibility for providing nursing at all levels and larger patient groups than they did before. What is more, once working in a team, RNs have become more isolated workers [9] and lack access to specialist physicians. Prior research, in Sweden as well as internationally, shows that RNs often experience high levels of time pressure and frustration in their work within municipal health care [10], and within dementia care in particular [11].

Pain is a common symptom among older community-dwelling adults [12] and nursing home residents [13]; it is estimated that as many of 40-80% of individuals living in European long-term care facilities experience pain [14]. In

*Address correspondence to this author at the Department of Nursing Science, School of Health Sciences, Jönköping University, Box 1026, SE-551 11 Jönköping, Sweden.; Tel: +46 500 44 84 06; E-mail: christina.karlsson@his.se

prior research, the field of pain assessment has mainly concentrated on pain assessment instruments [15, 16]. Comparatively, less is known about RNs' experiences of being consultant advisers and how this affects pain assessment. RNs' changed role in pain assessment is both a medical and a nursing problem; with the growth in aging population in Sweden, as well as in Europe [17], requiring professional dementia care [18], and the quality of pain management urgently needs to be discussed. Pain in persons with cognitive impairment and dementia raises serious ethical concerns for pain clinicians in terms of what methods should be used to find out about pain problems, especially as dementia puts the person in a vulnerable situation and dependent on professional health care staff for his or her health and well being. For this reason, RNs' professional knowledge is an essential matter for dementia patients.

Nursing homes and home nursing are parts of Swedish municipalities' health care service and are mainly financed by taxes. Only a small part, about 5%, is financed by individuals themselves. Each nursing home has a manager in chief who is responsible for economic and organisational issues. Patients in need of professional nursing care in nursing homes apply for an individual contract for their lodging and other living costs. Inquiries for the provision of home nursing assistance, in the individual's own residence, are accounted for by the individual him/herself. Swedish municipal care is regulated by two separate laws. The Social Services Act [19] governs the work of care managers and CNAs. The Health and Medical Act [20] regulates the work of RNs and physicians. According to current regulations, municipalities must be able to offer health service up to the level of those provided by RNs. Regularly, doctors from primary health care service make medical visits to nursing homes, and become available at telephones to RNs for medical issues concerning home nursing. However, RNs may delegate to CNAs to carry out nursing care and administration of pharmacy [21]. Nevertheless, RNs have the overall responsibility for providing health care and to act as medical and nursing supervisors for CNAs. In Sweden, 290 municipalities provide health care for older people living in nursing homes and in ordinary housing supported by home nursing. As in other countries in Europe, dementia care in Sweden is performed in special small-scale care units within nursing homes, where specialization in dementia care has developed from traditional institutions into smaller, more homelike facilities [22]. In nursing homes, residents are cared for by health care staff round the clock. In the year 2009, nearly 6% of the Swedish population 65 years and older were living in nursing homes [23]. Within home nursing, health care staff made daily visits to residents' ordinary housing for care contributions and food distribution. In 2008, just about 200,000 persons over 65 years of age received home nursing based on their needs of service and caring contributions [24]. Of the total number of RNs employed within Swedish health care, which accounts for about 70,000 persons, 20% are working in the municipal health care sector [25]. Most of these RNs have a greater consultant advising role than a clinical nursing function [26].

The transformation of RNs' professional nursing started when the national legislation *ÅDELreformen* was introduced, where a restructuring of elderly care in Sweden took place and the responsibility for care of older persons was

transferred from county councils to municipalities. As a result of this restructuring, a consultative advising function of the RNs profession was adopted [5]. However, due to the financial cuts brought about by restructuring, staff reduction and structural changes appeared in the Swedish health care sector. Despite these changes, in their promotion of safe and effective care, RNs are expected to carry out assessments, treatments and medication instructions independently. Moreover, they are expected to keep up to date with evidence-based nursing [26]. Evidence-based recommendations require the delivery of standardised and comprehensive pain care. However, assessment of pain in persons with dementia relies on nurses' ability to detect pain cues due to dementia patients' difficulties in verbalizing their pain problems. Pain assessment often starts with nurses' skilled and advanced understanding of these persons' behaviors.

AIM

The aim of this study was to present RNs' view of pain assessment in persons with dementia in relation to their municipal nursing profession as consultant advisers.

MATERIALS AND METHODOLOGY

Setting and Participants

A purposive sample of 13 RNs with a consultant advising function, working in one municipality in western part of Sweden was invited to participate in this study. The RNs were selected in capacity of that they were included in a network consisting of RNs from various nursing homes and home nursing districts. Inclusion criteria were being an RN and employment within municipal nursing care. The nurses had varied experiences from dementia care and clinical nursing, as well as in terms of training. Two RNs were unable to participate because of illness. Eleven RNs were interested and gave their consent to take part in the study. The participants were all women aged 42-63 years, and their work experience as RNs ranged from 5-40 years. They were all born in Sweden. All nurses were working full time in daytime shifts. One of the nurses had a master's degree in nursing; six nurses had bachelor's degree; and four nurses had an older nursing education from before 1993 (in 1993, the nursing education changed from vocational training to academic education). Nine nurses were working at special dementia care units within nursing homes. Two nurses were working both within nursing homes and in home nursing.

Ethical Considerations

This study was approved by the Regional Ethics Committee in Gothenburg, Sweden (Dnr-004-09). The participants received oral and written information, and were informed that their participation was voluntary with the possibility to withdraw at any time, and that their responses would be treated confidentially. Written consent was obtained from all participants.

Data Collection

The focus group conversations were conducted in April 2009. The first author was moderator and familiar with the topic. The moderator's role was to guide the conversation and stimulate the participants to share their experiences. Two focus groups (seven participants in the first group and four participants in the second group) were organized. The

conversations took place at one of the nursing homes and each focus group lasted for 1.5-2 hours.

Initially, the moderator introduced the subject for the conversation, *i.e.* pain assessment in persons with dementia in relation to RNs' nursing profession as consultant advisers. The participants were informed about how to act in a focus group conversation and the moderator's role during the session. An interview guide was used to match the topics under investigation. Two main questions were designed for the conversation sessions; 'What experience do you have from working as a RN?' and 'What experience do you have from pain assessment in persons with dementia?' Follow-up questions were asked during the sessions to gather all aspects of each topic (Table 1). All questions were formulated in a dialogical way, allowing the participants to talk freely about their experiences. Notes were written for reflection of the participants' interaction, *i.e.* how the participants agreed, disagreed, negotiated and generated meaning in terms of the subject investigated. The conversations were audio-taped for later verbatim transcription.

Table 1. Overview of the Interview Questions

Main Questions	Example of Follow-Up Questions
What experiences do you have from working as a RN?	<ul style="list-style-type: none"> • Please describe your working tasks? • In what way have your working tasks changed? • What is it like to work as a consultant adviser? • How do you feel about this?
What experiences do you have from pain assessment in persons with dementia?	<ul style="list-style-type: none"> • How do you perform pain assessment as a consultant adviser? • How do you find out if the person is in pain? • To what extent do you think pain exists in your patients?

Data Analysis

To grasp the RNs' perspective as members of a group and of a profession, the analysis started with careful verbatim transcription, including stops, intonations and overlapping speech (Table 2) [27]. The transcribed conversations were then analyzed using manifest qualitative content analysis [28]. Central to the analysis procedure was the gathering of information about the participants' experiences by identifying concepts and comparing and contrasting data. At the same time, however, it was important to retain an open attitude to alternative interpretations of the participants' shifting opinions. Each focus group was regarded as one unit of analysis, where the main purpose was to search for manifest content, *i.e.* the visible and obvious components in order to explore the RNs' view of pain assessment.

First, transcripts were read individually several times to obtain an overall picture of the context and to identify concepts emerging from the conversations. Open coding was performed by making marks and writing notes in the text margins of the transcripts while reading them, to search for all aspects of the phenomenon investigated and to generate categories. After that, words or sentences for each meaning unit related to the main questions were identified and condensed. In the next step, condensed meaning units were compared and coded referring to phenomena related to the

dementia context, and organized into categories and subcategories. Meaning units, codes and categories dealt with the manifest content of the transcriptions. The organization of categories implicated some level of interpretation and abstraction, to identify mutually exclusive categories based on concepts belonging to the main questions. Notes from the conversations were read thoroughly and reflected on in a comparative analysis in relation to identified categories and subcategories. Four categories and nine subcategories were identified that described the RNs' view of pain assessment (Table 3). Finally, all authors discussed coding and categories in an open and critical dialogue to reach a consensus.

RESULT

Four categories and nine subcategories were identified to describe RNs' view of pain assessment in relation to their nursing profession as consultant advisers (Table 3). The result is presented and illustrated by quotations from the focus groups.

Table 2. Transcription Conventions Used in the Study

<u>Underlining</u>	Overlapping /concurrent speech
Comma,	Continuation
Dot.	Conclusive intonation
Hypen --	Interruption
Bold	Emphasized speech
CAPITALS	Loud voice volume
(())	Sound marker
(.) (..) (...)	Pause marker, for shorter and longer pause

Estrangement from Practical Nursing Care

This category was formed by the RNs' descriptions of their changed nursing profession in terms of *feeling of remoteness from the patient, feeling of inconvenience in the consultative role and feeling of being a controller.*

The subcategory *feeling of remoteness from the patient* was formed by the RNs' descriptions of how they often felt in their role as consultant advisers. One of the RNs considered that not regularly participating in patients' daily care situations involves a risk of losing clinical practical knowledge:

Table 3. Overview of Categories, Subcategories and Codes of RNs' Experiences as Consultant Advisers in Pain Assessment

Categories	Subcategories	Codes
Estrangement from practical nursing care	Feeling of remoteness from the patient Feeling of inconvenience in the consultative role Feeling of being a controller	Rely on others Not working next to the patient Caught situation Being out of control Check-up function
Time consuming and unsafe pain documentation	Pain documentation procedures Being a second-hand receiver of pain information	Pen/paper documentation Computer-based documentation Documentation in two systems Receiving pain reports from others Diverse professional language used
Unfulfilled needs of reflection possibilities	Reflection Collegial supervising	Need for self-reflection Need for group-reflection
Collaboration and coordination	Changed profession areas New organisation	Nurses' own responsibility to collaborate Diverse working- and responsibility areas for registered nurses and certified nursing assistants Changed organizational structures for nursing

'in the end then when you are not performing any blood pressure or vein samples, then you don't have the knowledge about it any longer'(p10).

As consultants, the RNs found that they had to rely on others, mostly CNAs, for pain information. While the RNs reflected upon difficulties in assessing pain in persons with dementia, they frequently returned to their nursing profession as consultants, where they manifested that not being present in daily caring meant to be separated from the patient and to rely on other staffs members' pain information. This was experienced as a frustrating situation:

'You have to rely a lot on (...) other care staff' (p1)

'It is really difficult with dementia care (...) especially when you don't work among them and know them (...) you have to rely on those who are-- working as nursing assistants' (p2)

'Then who knows the patient best?'(Mod)

'It is the person closest' (p2)

'And who is that?'(Mod)

'Uhm (...) the care staff (...) nursing assistants' (p3)

'How do you feel about that?'(Mod)

'It is frustrating (...) really' (p2).

The RNs described their consultative nursing profession in terms of *feeling of inconvenience in the consultative role*. They questioned their new nursing role, in which they felt being caught, divided and out of control of daily care situations, such as in pain assessment. They expressed that they did not want to perform nursing in a consultative role:

'I feel that we are starting to question our own role (...) because it feels like you don't really know where you are-- you have to be in so many places-- it is so divided and I feel squeezed into our role against (...) nursing assistants'(p1)

'Earlier when one was participating in daily care (...) assisted (...) well we assisted in taking the patients up in the morning and you had a totally different control. Now you don't have that and it feels very strange but that's our new role I suppose (...) this is how we are supposed to work (...) as consultants and it started just a few years ago (...) just before the new (...) nursing re-organization' (p9)

'Well, I don't think any of us want to be consultants (...) we want to be among patients' (p11).

The following quotation reveals RNs' dissatisfaction owing to the consultative role and not being among the patients to the extent that they used to be. Here, one of the nurses, who had been in the profession for a shorter time, reflected on her individual situation:

'I am rather new in this job and I sometimes feel (...) what is my future as a nurse? Are we just going to delegate everything (...) and sit elsewhere. It doesn't work. I must see and feel myself and experience, too. I have to be among the residents and see (...) for example a sore area. I can't just depend on-- well it looks alright somebody says (...) my God I must SEE it myself' (p10).

From a group perspective, the RNs reached a consensus in terms of what it meant to be a professional nurse and what nurses should do when they compared the way things were to the way they are now. They reflected that their new role was strange and that they felt a lack of control of patients' pain problems. To be a nurse was described as *'to see, get to know and be present' (p3)* among patients. Paradoxically, the RNs experienced that they often lacked time in those moments when they actually were visiting their patients. The main task at these times was most often to do check-ups of pharmaceutical products and CNAs' pain documentation.

The subcategory *feeling of being a controller* was formed by the RNs' descriptions of their performances of check-up

duties. One of the nurses reflected on her view of time pressure in her work duties by saying:

'I come into reflection in my own behavior sometimes when I run into the unit (...) when one runs into the kitchen where three or four persons are sitting "good morning" you say bright and lively and think you are very obliging "sure" ((laughter)) ((puffing)) I am not going to you I am going out in the office for checking medicines and see what it looks like (...) and as soon as one have gone round the corner one reflect in-- what did I just do? Not even have the time to talk to the persons who are sitting there' (p7).

Time Consuming and Unsafe Pain Documentation

This category was formed by two subcategories: *pain documentation procedures* and *being a second-hand receiver of pain information*, and focuses on RNs' experiences of how documentation of pain symptoms was performed and in what way they provided pain information. Documentation was considered as an important task in the consultative function, but also as a problematic issue.

Pain documentation procedures was reflected as problematic to manage because documentation was conducted using two different systems, first through day notes with pen/paper documentation performed by CNAs, and thereafter through computer-based documentation by RNs. This double documentation procedure was experienced as problematic because of its insecurity:

'I think other care staffs are rather bad in writing down (.) situations (.) well they often ask or it arrives things that should have been written down in their report. Then I get angry' (p3). In contrast, another nurse did not have the same problem: *'other care staff makes their day notes (...) they write problems when they for example have observed something, if someone is worried or anything about medication or that they have contacted a registered nurse' (p1).*

The subcategory *being a second-hand receiver of pain information* describes how the RNs obtained pain information. In the consultative role, RNs received information from other care staff, principally from CNAs, and often without having experienced reported phenomena themselves. Consequently, RNs experienced that they were dependent in CNAs' documentation and information when it came to gaining knowledge about the patients' pain problems:

'earlier, when we were performed caring procedures (...)for example in morning care activities (.) then you were seeing the residents every day, you were able to see changes and you saw for yourself. But nowadays, this is not our tasks any longer. We are supposed to do much more of documentation work. I spend most of my time in front of my computer' (p11).

The RNs' daily routines varied according to their workplaces. Most of them made daily visits in their units, while other nurses made visits only two or three times per week due to the conditions of their patients' health. At these visits, the nurses collected verbal information from CNAs about the patients, and simultaneously carried out documentation check-ups. According to the RNs, most of their day consisted of administrating pharmaceutical products, carrying out computer-based documentation, and making phone calls to other health care staff in the care chain of the community concerning organization of care places for patients. The RNs stressed that a lot of time was put into telephone conversations with patients' next of kin, who were worried about their loved ones. During the focus group conversations, the RNs reached a consensus to the effect that receiving pain information second hand was problematic to manage. They described that persons with dementia could show a variety of indistinct signs, often difficult for care staff to interpret and understand, and therefore it was important for nurses to be present so that they could make correct assessments. The RNs explained that their documentation routines were unsafe and ineffective.

Unfulfilled Needs of Possibilities for Reflection

To have time to talk together, nurse to nurse, was expressed as important in terms of *reflection* and *collegial supervising*. Nevertheless, this was something that the RNs experienced as lacking.

The RNs expressed that during their work shifts, they lacked of time for *reflection* in relation to nursing care problems, such as pain. They manifested that it was important to have time to sit down and reflect on the care information they received from other health care staff and things that had happened during their work shift. They also stated that the usual time for report meetings, between CNAs and themselves at the end of their working shift, had been reduced because of reorganization. The RNs experienced that there was no longer enough time to discuss nursing problems:

'well it is like-- we never get the time to sit down and talk to each other (...) because the report time is just getting shorter and shorter all the time. Everything just being overlapped so that (...) we don't see each other any longer as we used to do (...) just to ventilate things' (p11).

Some of the nurses presented another view of the possibility for reflection, where they maintained that they did have enough time to sit down and reflect together. This meant a lot to them:

'but there we have a huge advantage in our unit to have that time to sit down in the morning and reflect in different things. It is so valuable. Therefore, we feel that we are in control. Yes it feels really good' (p2)

Another view of group reflection discussed by the RNs was *collegial supervising* to support each other in complicated situations:

'I feel that you need time for reflection both of your own and together with nursing assistants

(.) colleagues (.) nurse colleagues o yes collegial supervising. You have to take time for that. Because (.) **everything** are supposed to be documented in caring journals. You need to get the chance to sit down and reflect a little bit (..) get stabilized' (p9).

Some nurses felt lonely in their position and where overwhelmed by their huge caring responsibility. The nurses expressed that collegial supervising could be a way to develop knowledge and to solve nursing problems:

'you need time for reflection both by yourself and together with nursing assistants and colleagues-- RN colleagues. Just to sit and do some thinking (..) collegial supervising (.)that you take the time for that' (p5). One of the nurses expressed her view of self reflection as: 'You have to take things into consideration and reflect on them and think about-- how do I do or can I do this in another way?' (p5).

Collaboration and Coordination

This category was formed from the two subcategories *changed profession areas* and *new organization*.

Based on perceptions of the consultative role in pain assessment, the RNs described both their own as well as CNAs' situation as *changed profession areas*:

'Working tasks for nursing assistants have been changed quite much over the last years, they have been ordered to do more things and more of documentation (.) they had not been given enough time to manage all information given them' (p6).

Some of the nurses reflected on collaboration as dissociation between the two occupational groups. At the same time, they stated the importance of shared responsibility for cooperation:

'I think it has become like this that many nurses think that **nursing assistants** in their area (...) and registered nurses (.) they are not supposed to (...) sit **together**(.) instead each of them would mind their own business and do their own job. I sometimes experience that it is like that' (p4)

'But there has to be an engagement and responsibility by us nurses, too. You can't just leave **over** everything to nursing assistants' (p3)

'There has to be **cooperation**' (p7).

The RNs illuminated the conditions for collaboration between themselves and CNAs, and that it was necessary to find a way to cooperate regardless of their different profession and different working areas. However, one of the nurses pointed out that they should not let CNAs take care of everything, but that RNs should rather look to their own responsibility concerning patients' care, *i.e.* their own commitment as RNs to provide nursing care for their patients' health. This was again reflected upon:

'It is important that you are **present** (.) that you are **there**, that you meet them and have discussions with them. If this fails the cooperation lacks and you are not even able to get to **know** what is happening in your unit' (p2)

'Then there will be somewhat of discordance (...) in the end then there will not be any good working environment' (p1).

The RNs reflected on cooperation within the *new organization*, and experienced that other occupational groups within health care, such as managers and care coordinators, did not have accurate knowledge of RNs' work and what RNs were supposed to perform in their new role, due to the organizational restructuring. This was discussed in terms of the fact that they, as RNs, often received incomplete information about patients' status before the patients arrived at nursing homes or applied for home nursing. This was reflected as a situation in which they lacked control:

'Bad cooperation with managers and care coordinators I feel' (p6)

'Yes, there has to be someone who **takes care** of this so that we have correct information' (p3)

'Earlier one had more **control** of this and one knew precisely' (p6).

The RNs reflected on problematic caring situations concerning short-time patients, *i.e.* patients who were in need of nursing care for just a shorter time. The problem mainly concerned responsibility for each patient and who was responsible for what in the care chain. The RNs found it problematic when patients appeared in nursing homes and no one had the overall responsibility for them; as a result of lacking information, no one had the correct knowledge about the patient and the patients' needs. The nurses stated that this problem was due to the new organizational structure and emphasized this issue as another basic problem in pain assessment procedures:

'you can notice this when a patient arrives to short-time care (.) if nobody knows, nobody has documented and done things that had to be done-- then you notice. It generates in several links (..) there will be lacks. It is not a personal accuse (.) it is due to the structure of the organization' (p2).

DISCUSSION

Reflections on the Findings

The key findings from this study suggest that RNs' lack of presence among their patients leads to feelings of being out of control in daily care routines such as pain assessment, as well as in managing complicated procedures related to pain documentation. These findings are similar to findings from other studies [29]. They might even suggest serious consequences of RNs' function as consultants and strategies for supporting safe pain assessment. The RNs in our study emphasized the importance of *being there*, with the patients in their daily care, as a prerequisite to being able to observe and compare known behaviors with new and unknown ones.

This is in line with prior research, which has suggested that pain assessment in persons with dementia should involve observation of pain behaviors during mobility, where specific and new movement patterns may be considered as pain indicators [30]. However, organizational restructuring in the nursing context seems to prevent RNs from performing this task to the extent they wish to do so.

RNs' professional *know-how* [31] is a crucial issue to illuminate in society, as changes in Swedish municipal care have implied complex cooperation between different actors, as well as in organizations where RNs are responsible for providing patients' health care at basic levels as well as in advanced nursing within nursing homes and home nursing. Further, RNs' medical nursing knowledge is necessary when it comes to maintaining dementia patients' health and providing high quality of dementia care. The findings from our study expose how the participants negotiated upon their experiences of the difficulties in being not only a carer, but also an administrator. The nurses clearly expressed that pain communication with dementia patients was difficult to manage. At the same time, they stressed the complexity in understanding and interpreting patients' behavior, as they were not present as RNs to observe patients' expressions or make initial pain assessments. It might be argued that this is problematic when, for CNAs, standardized assessment criteria validated for this staff category to use in their daily work in dementia care to identify signs and symptoms of pain are still lacking [32]. However, in this study, it was found that collaboration between RNs and CNAs seems to be limited due to changed structures of the nursing profession; this has consequences for the assessment and management of pain.

In this study, the RNs reached a consensus in terms of what nurses are supposed to do as consultant advisers, and they expressed that felt emotional uncomfortable with performing nursing in such way. These findings support earlier research within the dementia context, where experiences of emotional and conflicting demands were more common among RN in dementia care compared to RNs in general care [11, 33]. Furthermore, the findings from our study demonstrates that RNs' time to reflect on patients' health, as well as the time available to work with quality improvements in evidence-based care, seems lacking. These findings are surprising given that RNs, with their central role within health care, have the responsibility to provide nursing care based on scientific knowledge and well-learned experience.

Prior research points to reflection as an important aspect in pain assessment [34]. Similar to other Swedish studies [9], the RNs in our study expressed a high degree of time pressure and lack of time for reflection. From a nursing perspective, this strongly affects opportunities to detect indicators of pain. Prior nursing research has found that RNs need competences in medicine, caring, and pedagogic as well as in personal maturity to manage their role within municipal elderly care [9]. We argue that quality of pain assessment necessitates of all these competences to ensure dementia patients' health and wellbeing. The RNs in our study experienced being in a split situation. Supporting this, other studies have found a clear feeling of loneliness in decision making among RNs [35]. We consider these

findings to be important, as they allow us to reflect on aspects that may affect well-grounded and effective decision making for pain assessment.

The adopted consultative model has meant that RNs within municipal dementia care must act in a new capacity, as indicated in this study. For the promotion of pain assessment procedures, we believe that it is important to attend to this. RNs' changed role is without doubt a barrier to adequate pain assessment. Other barriers found in this study are the construction of pain documentation systems and the lack of evident systematic routines for pain assessment.

We submit that there is a lack of research within municipal nursing care as a topic that is essential to discuss and urgent to investigate, and must be further evaluated in relation to pain assessment and the structural change of RNs' nursing profession. Within next decades, due to the expansion of the aging population, there will be huge challenges for municipalities in terms of providing effective and safe dementia care based on clinical nursing knowledge. In this article, we argue that the shift in RNs' role has negatively affected pain assessment, and the foremost issue with this is that it causes unnecessary suffering among persons with dementia. Still, the findings of this study illustrate that RNs have an ethical intention beyond their concerns of their patients, where the process of pain assessment is not just about who is doing what. Instead, our findings seem to reflect a problem in professional structures in the dementia context, and point to the need to promote wellbeing in the performance of professional nursing for persons with dementia.

Methodological Considerations

Using focus groups was the strength of this study, as we were able to illuminate RNs' view of pain assessment in persons with dementia with reference to their nursing profession as consultant advisers. One limitation, however, could be the small number of focus groups. On the other hand, the sessions allowed for enriched conversations in which the participants' experiences could be explored in depth.

Central for the focus group conversations in this study was to explore RNs' experiences of pain assessment, but the conversations also touched on several other topics that the RNs linked to their situation as consultant advisers. The literature demonstrates that focus groups can take advantage of group dynamics to access shared knowledge of a subject [36, 37]. In this study, the conversations were characterized by flow among the participants, where they were concerned with narrating both their experience of being nurses and how they performed pain assessment within this profession. The RNs showed huge willingness to participate and narrate their individual and collective experiences. A reason for the enthusiasm could be due to that the first author, who was also the moderator in the group sessions, was familiar with the dementia context, and thus inspired trust in the participants. However, this could also be seen as a disadvantage, as familiarity may influence the way in which people speak. Nevertheless, the first author found that the group conversations elicited enthusiasm and true honesty.

Data analysis has already begun during the transcript preparation [28]. The transcription quality, then, became of

particularly importance in capturing the emotional content of the focus group conversations, as well as the words spoken when participants were responding not only to the questions being posed, but also to the experience of belonging to a group. In the present study, we wanted to pay attention to both *what* the participants narrated and to some extent *how* they narrated it in order to present their viewpoint of the conversation topic. To accomplish this, the conversations were transcribed using a transcription methodology that included manifestation principles, *i.e.* characters and layout that illustrated the participants' interaction. To avoid biases, all authors were involved in the analysis. In this study, we developed categories and subcategories using qualitative content analysis in order to organize the findings. This method served as an analytic strategy to keep both the individual and the group in the text, keeping their stories contextualized and maintaining meaning in a comprehensive way.

CONCLUSIONS

The findings from this study indicates that, in order to provide high-quality nursing care in pain assessment, RNs and their colleagues need more time together to reflect and reach consensus in pain assessment and how pain can be expressed among dementia patients. The findings highlight RNs' frustration with and resistance to providing nursing as consultant advisers. They feel uncomfortable in this function, and do not succeed in fitting into it. From the RNs' viewpoint, they consider their work as a clinical task demanding their presence among patients to be able to make accurate and safe pain assessments. However, this seems to be difficult to accomplish due to the consultative model adopted. To promote the quality of dementia nursing care, systematic methods for pain assessment and pain documentation are necessary, as well as professional knowledge of how pain can be expressed by persons with dementia, especially those with communication difficulties.

FUTURE RESEARCH

In order to promote skillful assessments, the implementation of standardized language among care teams must be prioritized, along with organizational support for nursing care in the dementia context. Further research is desirable to investigate CNAs' experiences of pain assessment in persons with dementia, as colleagues to RNs, in order to generate a comprehensive picture of the promotion of pain management within the municipal dementia context.

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AUTHOR CONTRIBUTORS

Study design: CK. Data collection: CK. Analysis: CK, BS, M E.B, IB. Manuscript preparation: CK prepared while BS, M E.B, IB provided critical revision and supervision.

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ABBREVIATIONS

RN = Registered nurse

CNA = Certified nursing assistant

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