Applied Nursing Research 48 (2019) 22–29

Contents lists available at ScienceDirect

Applied Nursing Research

journal homepage: www.elsevier.com/locate/apnr

# Nurses' culturally mediated practices influencing pain care provision for older people in acute care: Ethnographic study

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Registered nurses (RN) have a pivotal role (Gorawara-Bhat, Wong, Dale, & Hogan, 2017) when undertaking pain care provision for their hospitalised patients. Pain care provision is person-centred and involves a comprehensive history, assessment, management and provision of education about pain for a patient, as well as provision of relief they find acceptable and deem safe. Numerous instances within research have identified known discrepancies between nursing assessment of pain and the pain experiences of patients (Dihle, Bjalseth, & Helseth, 2006; Gunningberg & Idvall, 2007; Schafheutle, Cantrill, & Noyce, 2001; van Dijk, Schuurmans, Alblas, Kalkman, & van Wijck, 2017; Watt-Watson, Stevens, Garfinkel, Streiner, & Gallop, 2001). Understanding and insight is lacking into why discrepancies and differences between nurses' and older persons' (those aged 65 years and over) perceptions of pain care provision are occurring. Presented here is an ethnographic insight from a nursing doctoral ethnographic study designed to explore practices of RN pain care provision for the older hospitalised person. This study provides understanding on how nursing culture can act as a barrier for effective pain care provision. The findings offer insight into why pain care provision can be less than ideal for the older person, despite the availability of evidence-based practice (EBP) guidelines. Furthermore, these findings are relevant for insight into the organisational context and how targeted measures in relation to education and managerial support are required for pain care.

Söderhamn and Idvall (2003) identified nurses will speak of placing a high value on relieving pain and undertaking a creative approach to pain problem solving. However, Dihle et al. (2006) noted discrepancies and incongruence between nurses' perception and action on how they dealt with post-operative pain for adults. Gaining knowledge of the behaviours displayed by nurses during pain care provision within one group, can help anticipate the nursing care behaviours of others, not only in that group, but also within other geographically diverse groups (Leininger, 1988). The studies of Clabo (2008); Kim, Schwartz-Barcott, Tracy, Forthin, and Sjostrom (2005); Klopper, Andersson, Minkkinen, Ohlsson, and Sjostrom (2006); Manias (2012); Manias, Botti, and Bucknall (2002); Wikström, Eriksson, Årestedt, Fridlund, and Broström (2014), Karlsson, Edberg, and Hallberg (2017) and Willson (2000) all have identified nurses referring to patients as having a heterogeneous typology of pain and then placing their own values on the intensity of the pain experience.

## 1. Aim

The aim is to explore the culturally mediated practices of RNs in acute care units when assessing and managing pain for older people in order to provide insight into possible barriers and facilitators.

The research questions were:

1. What are the culturally mediated practices of nurses during the assessment and management of pain when caring for older people in acute care?
2. What are the culturally mediated facilitators and barriers to practice?

## 2. Method and design

This study used Focused ethnography (FE) as the methodological approach for this ethnographic study and stems from processual ethnographies which describe an aspect of a social process, such as how culture and social systems are interrelated within a limited period of time (Boyle, 1994, p. 159). A FE approach (Werner & Schoepfle, 1987) allowed exploration for development of insight and understanding into pain care provision by RNs in acute care settings for the older person. Instead of focusing on the entire culture of the hospital, the use of FE provided a topic orientated focus of looking, listening and thinking

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https://doi.org/10.1016/j.apnr.2019.05.010
Received 12 March 2018; Received in revised form 7 March 2019; Accepted 7 May 2019

(Morse, 1991) about the application of pain care provision within a small group (McFeat, 1974) while maintaining a holistic, contextual and reflective manner (Hammersley & Atkinson, 2007; Werner & Schoepfle, 1987). An adaptation of Leininger's (1988) culture care theory has underpinned this study as a novel application for capturing aspects of how nurses will use their knowledge to provide culturally congruent pain care for the older person. With Bourdieu's (1977) theory of practice was also used to guide the exploration of nursing practice in this specific clinical field as this approach specifically addresses practices in the everyday world. These theories, used in conjunction with FE allowed identification and understanding of how nursing cultural rules, norms and values were not only interrelated but also how they contributed to knowledge that directly related to clinical practice (Thorne, Stephens, & Truant, 2015). The first author was the researcher, and she conducted the interviews, observations and document review.

## 3. Setting/participants

The research was located on the east coast of Australia in two (2) separate hospital sites and eight (8) acute care units, these units comprised of medical, surgical, oncology and sub-acute units. The first author set aside two (2) months to gain access and was immersed for six (6) months in the field. The participants in this study were purposively sampled and they consisted of an initial Eleven (11) RNs and 44 older person inpatients. Two (2) RNs dropped out at the beginning of the study due to change of employment, and two (2) of the older persons declined to take part stating they were 'too tired'. Leaving a total of nine (9) RNs and 42 older persons in the study. Excluded were those nurses who were not a RN and those patients aged under 65.

The age of the older persons ranged from 65 to 92 years old. Some were cognitively intact, and others had documented diagnoses of dementia, delirium, or cognitive impairment. Some older participants had disabilities, and some were in their active terminal end stage of palliation.

The average age of the nine (9) RNs in this study was 45 years, and they all held a nursing qualification of a baccalaureate degree. Eight (8) RN participants had more than five (5) years of full-time acute care nursing experience and seven (7) indicating they had undertaken further postgraduate studies. Eight (8) RNs self-identified as a 'senior nurse'.

## 4. Data collection

Participant observation was undertaken on the RNs and the consenting older persons, this period totalled 1041 h with 73 h spent as focused participant observation. Semi-structured interviews (n = 12) of cognitively intact older persons totalled 11 h. Twenty-three (23) semi-structured interviews on the nine (9) RN participants were undertaken during the fieldwork period and totalled 12 h and 38 min. The location of the interviews was determined by the participants' preference, with options provided for a private room, nursing station and/or bedside. All interviews were conducted in English, audio recorded, and transcribed by the first author. The document and policy review were also undertaken within the participating units of the hospitals.

## 5. Ethical considerations

Ethical approval was gained from both the Hospital Human Research Ethics Committee and the University Research Ethics Committee in accordance with the Australian National Health and Medical Research Council (2015) statement on ethical conduct in human research. All participants in this study provided informed consent. Informed proxy consent was also gained for those older persons with any form of cognitive impairment by third-party process consent. Pseudonyms are used for all participants, acute care units, and hospitals to ensure anonymity and confidentially.

## 6. Validity and reliability/rigor

Reflexivity began by the researcher before they entered the field by a statement of their assumptions and/or bias. The researcher kept a field journal for observation notes and pictorial maps of the acute care unit layouts. A separate reflective journal was also used to provide an account of daily study experiences. A further journal was kept for the document and policy review. The researcher is an RN but did not provide patient care and was not employed at any of the hospital sites.

## 7. Data analysis

The data analysis required the researcher to engage in an iterative, cyclic, and self- reflective process. A qualitative descriptive data analysis, guided by the work of Spradley (1980), was employed as the first analysis stage, followed by a second stage consisting of coding for emergence of themes for a thematic analysis (Morse, 1994). The software program 'Nvivo' was used to manage the data. Data saturation was deemed to occur when no new knowledge was gained either from RN participants or older person participants. Feedback from the data was gained by consultation with the RN participants and member checking was also undertaken with the older person participants.

Exploration of the research questions on the culturally mediated practices of nurses during the assessment and management of pain when caring for older people and the facilitators and barriers to practice, resulted in three (3) main themes emerging. Namely '*the nurses' experiences of providing pain care for the older person*', '*the experiences of the older person receiving pain care*' and '*pain care, tension and disjunction*'. This paper reports on the ethnographic insight from the first of these themes '*the nurses' experiences of providing pain care for the older person*'.

## 8. Findings

The nurses in this study spoke candidly regarding their perception of themselves as a clinical leader and they often used their experiences of problem-solving pain issues and concerns as a working example for the older person. They talked about their experiences of being a role model and of providing pain education for the other nursing staff. The study nurses shared their success stories of how they felt when they had a positive outcome in resolving a pain crisis for the older person.

### 8.1. Pain documentation

The document and policy review undertaken for this study found that both hospitals had different paper-based forms available for recording a comprehensive pain assessment. However, continuity was lacking when the patients were transferred from unit to unit, or from one hospital to another. None of the study locations used an electronic method of patient record keeping. When the study nurses were invited to speak about the paper-based forms, comments received ranged from *we don't use them* because *nobody reads them*, to *No, we haven't got one*. When RN Ann was asked about comprehensive pain assessment documentation her comments were:

> *Oh, those pain charts, they are so—nobody reads them—we don't use them and we don't fill them in and really, they are not ours.*
>
> [RN Ann interview 1]

Both study site hospitals used a state-wide version of a national paper chart, known as the Standard Adult General Observation chart (SAGO), which was implemented by the Australian Clinical Excellence Commission (2013) and its purpose is for detecting a deteriorating patient (Elliott et al., 2011; Horswill et al., 2010; Preece et al., 2013). The SAGO charts in each unit undergo routine auditing for determination of the frequency and the completeness of vital sign documentation undertaken as recommended by Preece, Hill, Horswill, Karamatic, and Watson (2012) for quality improvement processes. The

chart is for vital sign documentation and requires nurses to place a single numerical value to represent a pain score for a patient out of ten. When speaking about pain score documentation, RN Barbara picked up a SAGO chart and opened it to show the location of the pain score section and, while jabbing with her finger, she stated:

*The only thing* [form] *that you have got for pain, if you ask any nurse, she'd actually go "That one"* [opens up a SAGO chart]. *Where is it?* [Hand hovers briefly before pointing to the numerical pain score scale on the SAGO chart] *there* [jabs finger].

[RN Barbara interview 3]

The reason provided for recording pain scores on the SAGO chart was, as RN Fran's statement exemplified, for *not getting a black mark against the ward* during quality improvement audits:

*You are taught about the SAGO* [chart]. *The reality, if you don't fill it in—when they do an audit* [4 second pause] *the whole thing is wiped, and it is naughty, Right? So…if you haven't got everything filled in* (…) *if any is not filled in, then that is a black mark—a black mark against the ward.*

[RN Fran interview 1]

The onus on not receiving a *black mark* for the unit and being compliant was viewed by the study nurses as being important. RN Georgina talked on checking on her colleagues for compliance:

*I don't think that it* [the SAGO] *gets filled out as good as what it could be and I do check it, it's my pet thing having everything filled out* (…) *A lot of people were missing the pain score— like it wasn't being filled out* [and] *you know what? Then people just wrote zero out of ten, zero out of ten, zero out of ten, zero out of ten* (sighs and groans) (…) *Now I think "Duh!" someone has just put in that pain score so as to fill it in, just filling out the numbers, they haven't really asked the patient if they have pain, they have just done it— scribbled it in and done it to say that the paperwork has been done.*

[RN Georgina interview 1]

One study nurse, RN Barbara, questioned the notion of *a good audit*:

*Ok. We may get 100% in our audits* [of the SGAO chart] *but is that really a good audit? You know, are you* [Jabs table with forefinger] *addressing it on your feet? That* [pain score numerical value] *means nothing to me, apart from "Have you got pain?" I mean what kind of pain is it, where is it— what does it do? Where did it go—what did you do about it?*

[RN Barbara interview 3]

When talking about the benefits of using the SAGO chart, RN Fran spoke of her personal *empowerment* to use the chart as proof of compliance:

*I like the SAGO charts because it really gives you a little bit more empowerment. A good part of it is* [Taps table with forefinger to emphasis point] *"Well why didn't you check their pain?" It is written in there as proof, but also when a patient says, "Oh I have been lying in bed all day no-one checked on my pain, and no-one asked me!" They can say "Well yes that nurse did— look* [taps table] *see, it's signed here".*

[RN Fran interview 1]

The comments by RN Fran suggest that some patients may not be aware that their pain has been assessed.

### 8.2. Pain assessment for the older person

When asked about pain in the older person, a common response from all the study nurses was that many older people *denied* or *ignored* their pain and *they will not tell* the nurses they have pain, as exemplified by RN Elise's comment below:

*You know, some of these older people ignore pain, they deny it or whatever. They won't tell you.*

[RN Elise interview 1]

Many versions of assessing pain processes were observed to be undertaken, with some study nurses explicitly asking about pain and others appeared to be looking for signs of pain. The study nurses stated the importance of pain assessment as part of a patient's vital signs, with RN Elise noting:

*Well yeah here it's your sixth vital sign or is* [it the] *fifth?* [She begins counting off her fingers] *Resps—sats—heart rate—temp, and blood pressure. Nope it's your sixth.*

[RN Elise interview 2]

The study nurses were observed to explicitly ask their stationary and at rest older person patients to provide input for a pain assessment during vital sign rounds. This was when they asked them to rate their pain by use of a numerical pain score.

*Have you got any pain? Can you give me a score out of ten, if ten is the worst and zero is nothing? Can you give me a score?*

[RN Danielle Field journal entry period 1]

RN Georgina talked about her approach during her rounds when checking patient's vital signs, which she called *OBS*:

*I ask people every couple of hours when I do their OBS "and how is your pain at the moment and is it a zero?" That sort of thing being out of ten.*

[RN Georgina interview 1]

The nurses' recollection of how they asked the older person about their pain during vital sign rounds differed from the observation periods. It was noted they used a very formulaic approach of questioning when the older person was at rest when they were having their blood pressure taken.

### 8.3. Pain management

The study nurses were observed to rely on provision of oral medications for pain management and repositioning of the older person for comfort. Consistently, the study nurses spoke of monitoring other nurses whom they identified as junior nurses- those who had newly graduated from their baccalaureate degree. RN Clare spoke of being unsure about *junio*r nurses:

*So if a junior nurse comes to me and says, "Can I give them some morphine?" I will say to them "What's wrong with the patient, what have they had done* [type of surgical intervention] *blah blah blah* (…) *what's their OBS?* [Vital signs]*" to see if everything is ok and if I am still a little bit unsure, I will go there myself to the patient and go what are the numbers?* [Vital signs] *I will make sure that they* [the patient] *are all right.*

[RN Clare interview 1]

The following observational exemplar provides insight into how the study nurses responded to a newly graduated RN, when they requested them to co-sign out a restricted drug for pain relief for an older person.

*It is 0800 during a hectic busy morning shift 'Donna' says* [newly graduated] *RN Grant, urgently to RN Elise 'She's in a bad way, she is like, in really bad pain, like a ten out of ten pain she needs some Endone* [oral morphine tablet]*'. RN Elise then questioned him, 'But are you sure? She's already had some Panadol at 0600'. RN Elise then finished her task while RN Grant waited. Then they both go down the corridor and RN Elise stopped to speak to another RN "You got the* [drug *keys? It's for Donna, she's not on regular pain relief, but she is sitting there in pain- she was ok this morning". They all then walk back into Donna's room and RN Elise looks at her bedside charts and asks Donna about her pain. RN Grant and the other RN are both silent, nod and smile for encouragement, before leaving with RN Elise to then check out the restricted drug.*

[Field journal entry period 37]

The study nurses spoke of being unsure and were concerned about the risks of inadvertent narcotisation of an older patient. As RN Georgina stated:

*Pain wise, people forget. That people are older, and when they are 80-90* [years] *old, have dementia and a fracture or something and you give them opioids* [pain relief] *for their pain that you would give a younger person, it just—knocks them off…*

When asked to provide more detail on what she meant by *knocks them off*, RN Georgina replied,

*They will be awake, awake, awake and then go "bang" —flat* [slaps hand down on table], *for a day or several days, because it has just accumulated in their liver, and* [has been] *released in one go.*

[RN Georgina interview 2]

RN Danielle when asked, shared her thoughts on how older patients become narcotised from being given opioids:

*I think when you give the opioid IV it goes in the body quicker, therefore if you gave it too quickly you can't reverse the actions of it, but not like if you give it* [the opioid] *sub cut* [sub-cutaneous].

[RN Danielle interview 1]

And one study nurse spoke of narcotisation as being a situation to avoid:

*At the end of the day, that is a kind of emergency situation you want to avoid, because I always say to the other nurses, once you have given the opioid— you can't take it back, so you really have to assess the situation properly before you give it.*

[RN Clare interview 1]

Evident within the comments is the overt use of slang and neologisms by the study nurses, which may contribute to an inference of a lack of depth or understanding and knowledge on pharmacological management of pain for the older person. Alternatively, this also exemplifies how clinical practice can become based on a social construction of knowledge.

### 8.4. Being a mentor

Seven (7) nurses in the study commented as *team leader* they were a *resource person* and *mentor* who were always *teaching* other nurses. RN Barbara described this as:

*It is being a ward champion and a mentor at the same time* [and] *you know, you find your brain being pulled around some days.*

[RN Barbara interview 1]

Four (4) study nurses spoke of being in *time constrained* or pressured situations, where they were *keeping eyes and ears open*. Being a mentor was spoken of as being *very important* and a *serious undertaking*. When asked what the duties of a mentor comprised of, RN Danielle spoke of being available for *answering any questions no matter how stupid* and to inform the mentee nurse *this is what you do here*.

*I can tell them "This is what you do here— it's this, and this, and this, not that"* (…). *If they go "What is that?" You know— you just think "Oh thank goodness you asked, because I wasn't going to tell you"* (…) *part of being a mentor* [is] *you have got to make sure that you don't assume what they know or don't know, or whatever hmmm* [nods head]

[RN Danielle interview 2]

RN Georgina had undertaken a clinical supervision course and spoke of her unsuccessful attempts to implement it within her unit. She spoke of finding out this was *just not the done thing* in that unit; and she inferred the nursing unit manager (NUM) within the division of acute care *haven't heard of it before* and she spoke of them withdrawing their support for her:

*I just did the clinical supervision* [professional development course] *and it has really helped me here. I tried to get* [clinical supervision] *put in here, but I just can't* (…) *I have spoken* […] *to people* [nursing unit manager], *but they just don't want to do* [clinical supervision] (…) *people just don't want to do it.*

[RN Georgina interview 1]

#### 8.4.1. Providing education about pain for nursing staff

Three (3) of the nurses in this study related how they provided formal pain education sessions on the unit to their nursing colleagues, which they termed as an *in-service*.

*I mean we are constantly educating, and I mean I educate the* [nursing] *students when they come through, in* [about] *pain, palliative care and death,* (…) [and] *so I educate the nurses here as well.*

[RN Hermione interview 1]

RN Barbara talked about her attempts:

*I would like to give another in-service on pain —we do have sessions that are allotted—my* [last] *allotted time* (…) *I was all ready and prepared* (…) *and it was cancelled!* (…) *due to—insufficient staffing or the ward was too busy.*

[RN Barbara interview 3]

The provision of education by means of an *in-service* also related to compulsory attendance by all unit nurses and its delivery was dependent on staffing levels. RN Barbara used the term *teaching on your feet* to describe her position when in charge of the unit, having a patient allocation and providing bedside education:

*You do that teaching on your feet and it's* [in these] *time constrained* (…) *situation*[s], *you got to keep your eyes and ears open* (…)

[RN Barbara interview 2]

#### 8.4.2. Questioning other nurses pain care provision

Seven (7) study nurses talked about how they asked *lots and lots* of *questions* to junior or newly graduated RNs (whom they referred to by a colloquial term '*new grads*'). RN Barbara questioned the education they had received in relation to pain care for the older person:

*We are trying to educate all the new RNs, the new grads* [junior RNs] *on what you do for pain. There are lots and lots of questions to ask new grads and I begin by looking for something to support that* [numerical] *pain score, look—is it time to get this reviewed or is there pain relief already charted? Is it only PRN* (…) [thumps table] *I question more to guide—to guide them because I don't know what the new grads are learning in so far as pain in older people goes—I think that it has been learnt by them as they go along from us.*

[RN Barbara interview 2]

RN Fran spoke of her distress of being in charge of the unit and, at the beginning of her shift, during bedside handover on finding an older patient with fractured ribs from a fall (Martha) had not received enough pain relief and was in distress. She put this down to the inexperience of the previous RN caring for her:

*Well* [throws both hands in air] *Martha didn't have enough pain relief, so consequently, that new grad* [points finger across table at interviewer] *who is only new to the job, and inexperienced, didn't pick up on that, they will think that Martha's fine* [waves hand in air], *but as they get more experience, they will realise what Martha was like,* [it] *is just not adequate,* [points finger again across table at interviewer] *Martha needed more pain relief even though that new grad* [taps table with her finger] *didn't think she did and I don't know why she thought that.*

[RN Fran interview 3]

When the study nurses spoke of how they focused on providing

education for junior RNs about pain care provision for the older person, their dialog omitted any direct reference to EBP guidelines and/or conferring with others.

### 8.5. Monitoring pain care provision by others

The study nurses spoke of feeling *unsure* at times about the responses provided by junior RNs when they asked them about pain care provision. They spoke of asking for more information and talked of double-checking the bedside chart for the older person themselves, because, as RN Clare commented, *you still have to be very careful*. With RN Barbara speaking of using covert observation:

> *I went and watched* (…)*, they asked the older person if they had pain* [mimics the voice of the older person] *"yes love, oh it's all right"- right then, they wrote zero* [Taps table with finger to emphasis point] *NO, no it's not all right* [points at the interviewer] *and it's not a zero*.
>
> [RN Barbara interview 2]

When asked why some study nurses felt that they had to question junior nurses often and to also check on them, RN Ann responded by stating a need to maintain *high standards* within a *tough ward*. RN Ann further noted it is *important to be seen to meet* those *high standards* that had been set she commented:

> *We, well the more experienced nurses, we like to* (…) *keep things going well. We have high standards, they are difficult to maintain but we do a pretty good job, we do a damn good job actually, but I think with pain we slip a bit sometimes, but no we are a tough ward with high standards and it's important that we are seen to meet them*.
>
> [RN Ann interview 1]

Notably, when speaking of their monitoring of junior nurse colleagues, the study nurses do not speak of their active engagement with the older person to ask if they felt the pain care provision they had received was adequate or if they deemed it safe.

## 9. Discussion

This paper has presented an ethnographic insight into *Nurses' experiences of providing pain care for the older person* and has outlined the experiences of the study nurses within the context and environment of acute care. It provided an understanding of the study nurses' notions of clinical leadership in relation to the culture present in the acute care units. Rycroft-Malone et al. (2004) and McCormack et al. (2002) identified that many factors, including research, the environmental context, the leadership styles present, and the existing culture, can act as either a barrier or a facilitator to the best uptake of EBP.

### 9.1. Nursing culture and clinical leadership

The nursing culture present will guide the behaviour of individual nurses towards the completion of a task, or the development of an approximation of an outcome, and will be based on the internal associations held by the group collective of the nurses present (McFeat, 1974). An outcome shown in this study, has been the placement of an intervention as a 'best possible fit' (McFeat, 1974) and this was perceived as acceptable by the study nurses. Whether or not the multiple nursing interventions in a moment of nursing care provision were best possible adaption based on EBP, are a reflection of the values held of person centred care within the prevailing nursing culture (Lake, Rudge, & West, 2015), and this can be demonstrated as a behaviour used to circumvent issues when they arose (McFeat, 1974). In this study, the culture present emerged at the intersection of the application of the external system (the hospital) and the environment within the unit, and this was evident within the behaviours of the study nurses of a collective group identity.

### 9.2. RN group thinking for shared sense making on pain care provision

The formation of a group identity develops from social interactions within work environments and due to the amount of time spent in that group, having a social position with a sense of membership is important (Bergami & Bagozzi, 2000; Bourdieu, 1985; Meeussen, Delvaux, & Phalet, 2013). By use of Bourdieu's (1977) theory of practice, conceptualisation can occur between the social positioning of the study nurses within the context of the acute care unit. The nurses in this study located themselves within a unique social position when they spoke of being a *senior nurse*. The social position of being a senior nurse for them has resulted from lasting experiences of time spent working within that group as opposed to a formal qualification or a titled position with recognition by the organisation. Being a senior nurse has meant they are able to position themselves to control the capital resources and this has influenced their sense making into the development of a set of formal rules and structural principles to govern the social acts of pain care provision for the older person (Lockett, Currie, Finn, Martin, & Waring, 2014). The social positioning of the study nurses had been acquired by implicit learning within the working environment this allowed them to exert an influence over the formation and prevailing identity of the group.

When the prevailing group identity has a focus on achievement values as the content of the work identity, Benner (1984, pp. 20-21) argues the type of clinical decision making that will emerge will be limited and inflexible. Leading towards what is known as group thinking, as outlined by Janis (1973) and can result in clinical decisions having an ascertainment bias Croskerry (2002, p. 1187) stemming from an adherence to group norms. Previous research has identified when clinical decisions are regarding the presence of pain as a normal part of aging have been influenced by ascertainment bias this can result in a consistent underrating of the intensity of pain in the older hospitalised person (Bartley et al., 2015; McCarthy, 2003).

The findings provide insight into how a social influence can be exerted by an individual for decision making that has been based on social projections on what the other team members are doing, and also becomes a further source of bias for decision making (Jones & Roelofsma, 2000). Meeussen et al. (2013) proposed the formation of a group within a culture will be reliant on the social influences within and often occurs when a convergence of shared sense of identity or group think for the achievement of values is present. Shared sense making will emerge as a common identity that has arisen from the ongoing interactions within the group members as they communicate their personal values or views to the group as a whole (Meeussen et al., 2013). In this study, it can be inferred multiple instances of the presence of 'group think' was observed, namely in relation to how the nurses undertook, interpreted and made sense of pain documentation, how they viewed and mentored the junior nurses on pain care provision and the lack of input or inclusion from the older person in relation to their perceptions on pain care provision.

The presence of group think directing the nurses shared sense making meant the meaning applied by them to the organisational influence present about pain care provision was skewed towards compliance for auditing of completed documentation, as opposed to person centred comprehensive documentation. An audit culture Strathern (2000) argued will incorrectly presume performance can be observed and this resultant publicity will mean visibility has been made to represent transparency of operation and by capturing regularities through propositional statements, then a translation can occur into a set of rules of action. In this study, the meaning had been altered of the documentation undertaken for pain and the performance of pain care provision had become organised into a medium being more amenable to match up to a performance indicator with the documentation being rendered into an objectification of information, but not a subject in communication (Langhof, 2018; Shore & Wright, 2000). Transparency in this manner as a form of accountability within a document has had

an unintended effect and hidden or concealed is the original meaning (Langhof, 2018; Strathern, 2000).

The nurses in this study shared their knowledge of colleagues engaging in work-arounds of fabrication of the numerical pain scores to complete a task as opposed to pain assessment. Here, work-arounds are noted as being a temporary work procedure undertaken to address a block in work flow (Halbesleben & Rathert, 2008). It could be inferred that doubt would be cast on the validity of any audit finding undertaken in relation to the study nurses' documentation of pain scores from each of the study site locations. Also, insight may be gained for explanation as to why some studies continue to report increases of pain documentation without increased patient pain reduction or satisfaction in pain care provision in their findings.

The UK Mid Staffordshire NHS Foundation Trust Public Inquiry (2013) into the Mid Staffordshire hospital trust has already highlighted the dangers of a reliance of measurement of care quality based on positive audit findings. Australian studies by Wang, Yu, and Hailey (2015) Henderson, Willis, Xiao, and Blackman (2017), Henderson et al. (2018) and Blackman et al. (2015) have all commented on missed care for the older person occurring with instances of increased compliance with auditing across hospital and residential aged care facilities. This has led towards the development of a Commonwealth Royal Commission into aged care provision within Australia.

Understanding is gained on how the formulation of a subculture within the acute care units, regardless of the unit type or hospital site, can become reliant on a work-around of how they will provide pain care provision for the older person. It is evident within the findings presented there is a lack of inclusion of EBP for the work-around decisions made, although it is not known if this is a beginning of a progression towards an organisational drift away from person centred care.

Organisational drift can become a norm when conformance is seen to not only increase efficacy, but also to increase legitimacy and, as such, may operate also as a coercive pressure (Kondra & Hurst, 2009). When pressure is exerted to achieve conformity of what delineates acceptable behaviours, this can lead to a social construction of symbolic management. Insight is provided on how the study nurses used this to direct and reward behaviours through shared values, norms and goals, which have pervaded through to the core of each of the nursing groups making up the sub-cultures of each acute care unit (Amalberti, Vincent, Auroy, & de Saint Maurice, 2006; Kondra & Hurst, 2009).

### 9.3. Contribution of nursing socialisation on pain care provision

The study nurses had reaffirmed their position within the group identity by consensualisation of who they are as individual ‘senior’ nurses, and what they are about as a group. This was expressed as a behaviour when pain care was provided for the older person. As noted by Goffman (1967), the way a social organisation is constructed and scaffolded will provide understanding into the views held by the participants themselves. Basically, a persons' experience of the organisational structure will be influenced by their position within it and this will underpin how the individual is influenced when they define and affirm their sense of self through their interactions with others (Goffman, 1967).

Meeussen et al. (2013) indicates how, over time, a group identity can be directed into a coherent and consistent representation of how individuals will think, feel and act. This can extend into the development of consensus-based social rules for how other members will behave in the group and this is then taught or passed on to the others within the context of the group (Schein, 1992). In this study, consensus-based social rules were present in relation to pain care provision information for the older person and how it was passed on and governed by the study nurses as a whole - thus ensuring replication and perpetuation by a process of socialisation under a guise of mentorship. The nurses in this study had developed consensus-based group goals as part of their group identity and these served as guidelines or rules for action in relation to pain care provision, and rules for inaction.

The study nurses took external and internal factors into account, and transformed them into personal and social contextual factors that worked to their advantage towards maintaining their own social capital (Bourdieu, 1985, 1989). For them, their social capital was held as an important role in their socialisation of other nurses into the norms of behaviour that they had developed (Goffman, 1967). It was noted the study nurses' social capital was homogeneous within the group boundaries and they were accepting of them as norms of behaviour that were associated within the existing nursing subculture present (Bourdieu, 1990 [1980]). Being viewed and accepted as a ‘senior nurse’ by other nurses placed the study nurses in a high social position within each unit and meant the interpersonal interactions between the study nurses and the older person had little impact on the attitudes and actions within the group collective as a whole (Goffman, 1967). The study nurses' processes of socialisation in relation to pain care provision was, at times, suggestive of maintaining their own social status rather than for an optimal outcome for the older person and driven by socialisation as part of their mentoring behaviour (Eller, Lev, & Feurer, 2014) towards their colleagues. Being available and open to questions noted Eller et al. (2014) is desirable in a mentor. However, the study nurses use of covert surveillance posing as supervision, overt questioning, checking, and their lack of goal setting in their mentoring processes belies the process. Honesty and trust are known to be key to mentoring for an exchange of knowledge to occur (Eller et al., 2014).

Within this study was an absence of reference by the study nurses to current EBP for pain care, the older person and pharmacological knowledge, as well as a lack of conferral with experts in the field, either for peer review or reflection. A solution proposed based on Mannion and Thompson (2014) is for clinical mentoring whereby external experts from those outside of the unit are available to provide input and critique or challenge group decisions and quality of care issues.

### 9.4. Limitations

The researcher noted an excessive use of neologisms and/or slang by the study nurses with a lack of uptake and/or use of appropriate medical terminology when they spoke in the interviews. Electronic patient records were not in place and all documentation was paper-based. A limitation of using focused ethnography on nursing practices meant there was a narrow focus of enquiry and did not include input from family members nor other health care providers. Although those older persons with cognitive and communication impairments were included in the observational aspect of this study, their voices are silent as they were not interviewed.

## 10. Conclusion

This paper presented an ethnographic insight exploring the influences of nursing culture and this emerged as a major barrier towards effective pain care provision for the older hospitalised person. It provided insight into aspects when present, may contribute towards a lack of change when pain care provision for the older person continues as less then optimal.

This study provides some understanding as to when negative aspects of nursing culture around clinical leadership can occur to influence the meaning of care processes, where this results from shared sense making stemming from socialisation based on group think. The study has identified the presence of consensus based social rules on ‘how things are done’ for pain care provision. Insight has been gained on how organisational drift stemming from work-arounds can develop and contribute towards a movement away from person centred pain care provision. A main recommendation from this study is for clinical nurses, who are in positions of power within clinical settings to be required to engage in reflection on their individual needs in relation to further education and seek out organisational support. Furthermore,

improvement of quality of pain care requires openness for discussion for input from other disciplines who are outside of the unit as well as input from the older person themselves.

## Acknowledgements

The author wishes to thank and acknowledge both the RNs and older person participants in this study for providing their time and input. Many thanks to the acute care units who also took part in this study. The author also wishes to acknowledge the support for this study from Dr Erica Southgate and Prof Sian Maslin-Prothero.

## Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.apnr.2019.05.010.

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