Older people in persistent pain: nursing and paramedical staff perceptions and pain management

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Background. Persistent pain is a common problem for older people. Knowledge about how nursing and paramedical staff perceive these people and what they do to relieve the pain seems scarce.

Aim. To explore nursing and paramedical staff perceptions of older people in persistent pain and their day-to-day management of pain.

Methods. Interviews in Swedish with 52 nursing auxiliaries, Registered Nurses, physiotherapists and occupational therapists were collected from February to May 2000. The analysis was based on their stories ($n = 150$) about older people in persistent pain who received help in their own homes or in special accommodation. A typology of staff perceptions of pain in older people was developed. Activities to manage pain were examined using content analysis.

Results. Respondents perceived the pain as real, exaggerated, trivial, care-related, endured, concealed, self-caused or inarticulate. Older people perceived as exaggerating the pain, those with care-related and self-caused pain evoked frustration in the staff, while those perceived as enduring their pain evoked satisfaction. Various strategies to manage pain were used: no activity, medication, mediating contacts, distracting activities, physical therapies, mobility, work in a gentle way, rest or relieving pressure on body part, and communication concerning pain. The activities differed between the types, as well as between staff with different professional backgrounds.

Conclusion. Care and treatment provided by staff should be based on older people's needs rather than on staff attitudes and preferences. The typology revealed that staff perceived older people in pain as a heterogeneous group and that their perceptions affected the pain-relieving activities that were offered. It seems urgent to address how to handle pain in older people who never complain and those who complain a great deal, as well as how to handle pain in people with impaired communicative ability. Reflective discussions on feelings related to different individuals are needed.

Keywords: typology, qualitative research, content analysis, pain management, older adult, knowledge, gerontological nursing, attitudes

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What is already known about this topic

- Older people in persistent pain are at risk of not having their pain identified or managed.
- Unrelieved pain can be explained in terms of insufficient knowledge among staff concerning pain assessment and/ or management strategies.
- There is under-use of non-pharmacological strategies to manage pain in older people.

What this paper adds

- Staff attitudes and a medicalized view of pain relief exacerbate insufficient pain identification and management in older people.
- Attitudes as well as professional background of staff influence what kind of pain management is provided to older people.
- Findings imply that pain relief to older persons could be improved by raising staff's consciousness about how attitudes interfere with pain management strategies.
- Effects could be evaluated in terms of changed attitudes among staff as well as improved pain relief among older people.

Background

Providing pain management is a common task for nursing and paramedical staff working with older people. In spite of an increasing interest in pain and pain management among older people, pain still remains a common problem among this group. The prevalence of persistent pain, defined as pain more or less daily, has been estimated at 30% of a population of people over 65 years (Brochet *et al.* 1998). Among older people in residential care, pain prevalence as high as 75% has been reported (Ferrell *et al.* 1990, Parmelee *et al.* 1993, Sengstaken & King 1993, Blomqvist & Hallberg 1999). However, little is known about how nursing and paramedical staff perceive older people in pain and how they handle this problem in their everyday work.

The trend in Sweden is that older people, in spite of functional status, should be able to remain living in their own homes as long as they wish. For those who no longer manage to live in their ordinary homes, institutional care in special accommodation is provided (Swedish Institute 1999). The local authority offers home help from nursing auxiliaries (NAs) to those who need support in their homes or in special accommodation. This help comprises, for example, assistance with housework and help with personal care, such as getting out of bed and toilet visits. Health care is provided by Registered Nurses (RNs) in collaboration with NAs. Less frequently, paramedical staff such as physiotherapists and occupational therapists (P/OTs) is involved in the care of older people (Swedish Institute 1999).

The high prevalence of pain among older people has been given different explanations, such as insufficient knowledge among nursing staff about medication usage (Closs 1996, Brockopp *et al.* 1998) and under-use of nonpharmacological management of pain (Davis 1997). Review articles (Helme & Katz 1993, Gibson *et al.* 1994, McCaffery *et al.* 1994, Ferrell 1995, Davis 1997, American Geriatrics Society Panel on Chronic Pain in Older Persons 1998, Klinger & Spaulding 1998, Weissman & Matson 1999, Abraham 2000) suggest a great variety of therapies for managing older people's pain (Table 1). Whether these therapies are used in everyday practice is unknown.

Since the functional capacity of older people declines with increasing age, many become increasingly dependent on assistance from staff. Although pain is a common problem among older people, knowledge about how staff perceive their work with older people who suffer from persistent pain seems scarce. Such knowledge could form a basis for developing care.

Table 1 Examples of pharmacological, physical and cognitive methods to manage pain in older persons

Pharmacological methods	Physical methods	Cognitive methods
Acetaminophen	Acupuncture	Biofeedback
Anticonvulsants	Ambulatory assist devices	Control stress
Antidepressants	Balance and fall protection	Counselling
Corticosteroids	Bracing/splinting	Distraction
Local anaesthetics	Chiropractic	Education
NSAIDs	Exercise	Guided imagery
Mild opioids	Heat/cold	Hypnosis
Strong opioids	Hydrotherapy	Life review
	Massage	Music
	Positioning	Pets
	Protect joints	Plan activities, recreation
	Stretch/strengthen muscles	Psychotherapy
	Transcutaneous electrical nervous stimulation (TENS)	Relaxation
		Spiritual support
		Support groups
		Talk to someone about pain
		Visit friends/social support

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The study

Aim

To describe how nursing and paramedical staff perceived older people in pain and the day-to-day management of pain they had administered.

Methods

Sample

For this study, cases reported by a sample of NAs, RNs and P/OTs in a southern municipality of Sweden were assembled. Respondents represented 12 inner-city, suburban and rural areas. They worked in ordinary homes, as well as in special accommodation. Nursing auxiliaries were included using a stratified sampling technique (Berg 2001), where each working team constituted a stratum. All RNs and P/OTs in the area were included. Inclusion criteria were more than 3 months of experience of elder care and experience of older people in persistent pain. Persistent pain was defined as pain more or less daily for more than 3 months. In all, 86 people were asked to participate. Eleven people lacked the experience, 10 did not respond, 13 did not consent to participate, and so the final number of participants was 52 (Table 2).

All cases of older people in pain whom the staff had met during the previous week ($n = 150$) were considered the sample of this study.

Data collection

The interviews were conducted in Swedish and started with a request to interviewees to recount an ordinary day at work: 'Could you please tell me about the older people you have met in the last week whom you know or believe to be in pain more or less daily? If you have done something to relieve the pain, please tell me about it'. This strategy was chosen to obtain concrete descriptions of what the staff had actually done, rather than reflections about possible procedures to relieve pain. Respondents were given the opportunity to choose the place for the interview. One interview was performed in the respondent's own home, while the others were interviewed at their workplace. All but five interviews were tape-recorded and interviews lasted between 20 and 45 minutes.

Ethical considerations

The appropriate officials at the municipality, the local Ethics Committee and the Ethics Committee at the University of Lund (LU 544-99) approved the study. A letter of information about the study was sent to the staff involved, who gave written or oral consent.

Table 2 Characteristics of the nursing and paramedical staff

	NA ($n = 35$) *n*	RN ($n = 13$) *n*	P/OT ($n = 4$) *n*
Gender			
Women	33	10	3
Men	2	3	1
Mean age	46	51	41
Years of experience (years)			
< 10	3	1	1
> 10	32	12	3
Education			
No vocational training*	3	0	0
Nursing auxiliaries training*	23	0	0
Enrolled nurse training*	8	0	0
Registered Nurses†	1	13	0
Physical/occupational therapists	0	0	4
Subjective view of primary assignment			
Personal care	27	0	0
Medical tasks	5	10	0
Teach or supervise	0	2	1
Instrumental care	2	0	0
Assess needs	1	1	0
Other	0	0	2
Number of stories told	94	40	16

*Working as nursing auxiliaries; †one registered nurse worked as a nursing auxiliary.

Data analysis

All data were read through to get a sense of the content. An impression from this first perusal was that cases differed, and so it was decided to explore the differences by constructing a typology (Eneroth 1987, Ruth & Öberg 1996). To do this, the text was analysed in several steps.

As a first step, a manifest content analysis (Berg 2001) by a line-by-line examination of all the cases was performed. This revealed data about the pain, how it was described and how respondents felt when caring for older people in pain.

As a second step, a typology influenced by the work of Ruth and Öberg (1996) was constructed. Each case was read as a whole, cases were compared, and the most startling case and a contrasting case were identified and labelled as 'exaggerated pain' and 'real pain'. A further analysis resulted in six more types, labelled as 'ordinary pain', 'care-related pain', 'endured pain', 'concealed pain', 'self-inflicted pain' and 'inarticulate pain'. Within each type, respondents' views of the pain, how the pain was described and how they felt when caring for the older person in pain was identified.

As a third step, questions about the trustworthiness of the typology were considered. Confirmability means that steps need to be taken to assure that the reality under investigation

is not distorted by the researcher. In qualitative studies, there is usually an intention to make the research process visible by presenting quotations from interviewees. The quotations were translated by a native speaker of English who has worked as a professionals translator in Sweden for 20 years. Quotations were carefully checked by the author to ensure that subtle nuances of the original Swedish texts were correctly and consistently rendered in English. Each quotation is presented with its case number and with information about the narrator's occupation (NA, RN or P/OT). Confirmability (Guba 1981) was investigated by having a co-investigator provide a view of the typology and categorize a randomised sample of 30 cases (20%) under the eight types. Twenty-eight cases (93%) were categorized under the same label as the original assignment. In cases of disagreement, cases were discussed and new ways to interpret findings were reconsidered whereupon the most reasonable interpretation was chosen. Transferability refers to whether the results have relevance and could be transferred to other contexts. In order to investigate the transferability of the typology (Guba 1981), it was presented to a group of experienced gerontology nurses from other municipalities who easily could relate them to their own experiences.

As a fourth step, activities to manage pain were analysed by manifest content analysis (Berg 2001). All text concerning pain management was identified, preliminarily coded, compared and re-coded, gathered into categories with similar content and counted. A repeat coding gave 89% agreement. For the remaining 11% the author and a co-investigator jointly decided what was the most reasonable categorization. Finally, management activities were related to the professional background of the staff and to the eight types.

Findings

Types of older people in persistent pain

A majority (67%) of cases concerned women. Musculoskeletal pain was frequent, with the most common locations being limb and back. Accidents due to falls, leg ulcers, cancer and degenerated joints were the most commonly described causes. Based on the 150 cases described, eight different types of perceiving the pain of older people were identified.

Real pain

The largest group ($n = 37$, 25%) concerned older people whose pain was seen as obvious and expected. In these cases, the origin of the pain was well known and visible, for example cancer, accidents and leg ulcers. In their stories, staff related how pain affected the daily lives of the older people. Pain intensity was described by words such as 'great pain', 'troublesome ache' or 'enormously painful':

> There is a woman with great pain in her legs. In the last few months she has started to fall, she's dizzy and she has hurt herself. She was in the emergency ward two weeks ago and had her arm X-rayed. She has a vertebral compression in her back. And we can't relieve her pain. (No. 41, RN)

Although older people often complained about the pain, the complaints themselves were not considered problematic. What made caring difficult and caused frustration was when staff felt they had limited ability to help, when side-effects restricted the choice of pain management or when they felt that the pain problems were not given adequate attention by nurses or physicians. However, feelings of satisfaction were evoked when staff felt that their own efforts to relieve pain made a difference for an older person in pain.

Exaggerated pain

The second largest group ($n = 25$, 17%) concerned older people who complained a great deal. These stories were the most detailed of all. Older people complained of pain in multiple locations, as well as in the entire body, for example, 'he is in pain from his head down to his toes' (no. 20, RN), and the pain was present all the time or was fluctuating. Older people were described in negative terms such as 'complaining', 'demanding' or 'fixated on the pain', and they were perceived as exaggerating their pain:

> They keep on about it the whole time…it's a different problem, you could say. The mental side has to be tackled a different way. Of course, she says that too, she's in such pain. But, of course, she's obviously in pain…but it's something different…It's as if she has it here in the head, it's there all the time. Of course she has some discomfort, she did break her hip. (No. 23, NA)

Medical diagnoses were unknown or diffuse for people who were perceived to exaggerate their pain. In cases where staff knew the diagnoses, neurological disease was common. Complaints perceived as exaggerated evoked staff frustration and made them doubt the pain: 'If he was in tremendous pain, I don't think he'd be able to dress himself' (no. 23, NA). Although caring was perceived as frustrating, caregivers mostly tried to understand the behaviour by considering the older person as lonely, sad or bored.

Trivial pain

The third most common type ($n = 24$, 16%) was older people whose pain was unfamiliar to the carers. Stories gave an impression that staff perceived the pain as trivial or as not being the cause of their visits: 'And then, in passing, they tell

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you they're in pain too' (no. 59, RN). The stories were the most fragmented and included a minimum of details about the pain or the cause of it:

There is a man who sometimes has aching legs. (No. 10, NA)

I have a woman up there in the forest. She has pain in one arm. It aches. (No. 31, NA)

Pain was described as 'hurt' or 'ache' and was located in the legs or back. The staff expressed uncertainty about the pain or its management: 'I don't know what kind of tablets he has, we call [the nurse] and they decide' (no. 87, NA). Sparse visits, limited care needs or a personality that made interaction difficult explained their insufficient acquaintance: 'it's a little difficult to get close to him' (no. 4, NA).

Care-related pain

This type concerned older people ($n = 22$, 15%) whose pain was evoked by the daily care activities or even by light touch. Typically, the origin of the pain was unknown. If known, it was considered to be due to neurological disease such as stroke, contractures or leg ulcers. Pain was perceived as intense when described in words such as 'terrible pain', 'gigantic problem', 'pain everywhere'. Older people expressed their pain loudly by screaming or whining or by being resistant:

[He's] suffering from some paralysing disease. He has pains, he hurts all over, you can hardly touch him he's in such pain. He complains of course and then he has to be harnessed to be hoisted into bed. And when you undress him, his shoulders and neck…hurt. He's in pain all over, I think. (No. 90, NA)

Caring became difficult because staff felt they had to perform daily care in spite of hurting the older person. They expressed frustration in statements such as 'one is afraid of being too rough' (no. 58, NA) or 'it's a tough job, one has to exert oneself to be careful' (no. 29, NA). Not knowing how the older person experienced the care, as well as not knowing how to relieve the pain, brought distress.

Endured pain

Stereotypical statements were made about older people who endured in silence ($n = 16$, 11%). As in the cases of exaggerated pain, stories were usually long and included many details:

Then we have the tough women who are in terrible, terrible pain, but never really complain. You know, they're in pain, but they fight all the same. They're like a little ray of sunshine. She can hardly see, finds it hard to walk. Needs a walking frame. Great pain, has fallen several times. She's been to hospital. Like, you don't believe she'll come back, but now she's out walking again, although with our help. It's people like that who make it fun to work in a way. The ones that fight. Our little ray of sunshine. She keeps us all going. Fights, fights, fights. (No. 92, NA)

The pain in this group was perceived as episodic. The origin of the pain was well-known and visible, such as rheumatoid arthritis or leg ulcers. Older people were characterized as 'content', 'patient' or 'a fighter'. Non-complaining behaviour was interpreted in terms of the person having a great need of independence or successful coping ability. Staff expressed positive feelings in relation to the older person by statements such as: 'having a good time together' (no. 23, NA) or 'it's people like that who make it fun to work, so she's absolutely fantastic' (no. 92, NA).

Concealed pain

Some stories ($n = 11$, 7%) were about older people who were considered deliberately to hide their pain. Staff described situations where the body language or diagnosis indicated pain but the older person denied it:

He got a new wound, and it hurts a bit. You dress it sometimes, he says, 'No, it does not hurt'. He does not want to admit the pain. He keeps a stiff upper lip. They are quite, what would you say, resistant, many old people. They don't whine in a hurry. (No. 42, RN)

Descriptions of the pain were fragmented since staff were not sure whether the person was in pain or not. They tried to understand the concealing behaviour in terms of fear, repression or as a need for independence. Situations where staff felt afraid of hurting the person's integrity or when their help was refused made them feel distressed or offended. Also, feelings of challenge were experienced, as when a caregiver strove to be allowed to come closer and become a friend.

Self-inflicted pain

Although fairly uncommon ($n = 9$, 6%), some stories were about older people whose lifestyle was considered to cause the pain. Factors such as inactivity, noncompliance, overweight, smoking or 'not trying' rather than diagnoses explained the pain:

Anyway she's paralysed from the waist down, her back is sore. When she's lying it's OK, it's when she sits. She's fairly big, this lady. It's when she sits, her back, bottom, hips, all of her. She has a nice big electric indoor wheelchair, she could adjust it herself so that she could sit comfortably. But she just sits where she is. She is, as I said, very big. (No. 18, NA)

Pain was mostly located in the chest or musculoskeletal system and was expressed in terms of 'sore'. The care was

considered physically and psychologically demanding, as expressed in statements like 'difficult when they can't help' (no. 29, NA) and 'encourage and nag' (no. 61, NA). Irritation was evoked by those who were considered able but unwilling to move themselves, as well as by those with a sturdy bodily constitution: 'I have a man who's fairly stout, that's what he is, and he's rather difficult' (no. 29, NA).

Inarticulate pain

The smallest group ($n = 6$, 4%) concerned older people about whose pain the staff were unsure and therefore had to presume. The uncertainty was due to the older people's lack of ability to express themselves verbally:

> Then there's a woman I've had for many years, but she's in such a bad way she can't speak about anything…The poor thing is in such pain but she can't say it. But I understand that she is. Just as an example when she's sitting up in a wheelchair and has to sit for a long time…(No. 16, NA)

People in this group had a diagnosis of neurological disease or were severely motor or communicatively impaired, with contracted joints. The origin of the pain was believed to be sitting or lying in the same position for too long. Pain was described in terms of 'I think it hurts' or 'he might be in pain'. In order to discover pain, staff relied on their ability to read nonverbal language and on their own empathetic ability: 'I can imagine that she is in pain. For even someone who doesn't have pains would be. You get sore if you sit and don't move…' (no. 16, NA). Not being sure about whether pain was present or not was considered demanding. However, in spite of this, staff derived satisfaction from knowing that their actions were beneficial to the older person: 'I can see what she needs, I can. I see everything she needs, better than anyone else' (no. 16, NA).

Activities to manage pain

Based on the 150 identified stories about older people in persistent pain, nine categories of actions were identified, and these were unevenly distributed between professional groups (Table 3).

No activity

In most of the cases ($n = 42$, 28%) staff could not recall having done anything specific to relieve pain during the last week. The nonactivity was explained as reliance on medication as the primary way to relieve pain, lack of time, feelings of resignation or stereotyped attitudes that ageing inevitably brings pain.

Table 3 Activities to manage older people's pain

	NA cases ($n = 94$) n (%)	RN cases ($n = 40$) n (%)	P/OT cases ($n = 16$) n (%)
No activity used	34 (36)	8 (20)	0 (0)
Medication	23 (24)	15 (38)	2 (13)
Mediating contacts with health care	12 (13)	16 (40)	4 (25)
Distracting activities	15 (16)	4 (10)	4 (25)
Physical therapies	16 (17)	3 (8)	3 (19)
Mobility	8 (9)	1 (3)	11 (69)
Working in a gentle way	16 (17)	0 (0)	3 (19)
Rest or relieving pressure on body part	8 (9)	4 (10)	4 (25)
Communication concerning pain	5 (5)	8 (20)	0 (0)

Numbers are based on 150 stories by nursing auxiliaries (NA), Registered Nurses (RN) and physiotherapists/occupational therapists (P/OT).

Medication

Using medication ($n = 40$, 27%) was the most common way to relieve pain. Acetaminophen and mild opioids (for example dextropropoxyphen) were most frequently used, while nonsteroid anti-inflammatory drugs (NSAIDs), strong opioids (such as morphine) or adjuvant analgesic drugs such as antidepressants or corticosteroids were rare. In most cases, medication was viewed as stopping or alleviating pain, but it was also described as ineffective.

Mediating contact with the health care system

Helping the people to contact a physician or other health care professional ($n = 32$, 21%) was considered a way to relieve pain. The contact could mean leaving the problem to the other person to solve, starting a discussion about the pain problem or actively proposing or persuading physicians to prescribe pain management.

Distracting activities

Planning and supporting an older person to engage in something other than pain was considered a way to manage pain ($n = 23$, 15%). Mostly, however, distraction was performed in daily interactions, where staff noticed and seemed surprised that joking and having fun brought distraction or alleviation.

Physical therapies

Physical therapies ($n = 22$, 15%) included massage, bandaging and changing dressings, transcutaneous electrical nerve stimulation (TENS), heat or hot bath and acupuncture. Some physical procedures such as acupuncture or deep massage were considered to bring temporary painlessness. Mostly, the effect of physical therapies was alleviation.

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Mobility

Statements about mobility ($n = 20$, 13%) meant helping older people to get out of bed, go for a walk or carry out passive movements. Mobility was considered as a way to alleviate or prevent pain, or prevent it from getting worse.

Work in a gentle way

Working in a gentle way ($n = 19$, 13%) was done by performing care at the older people's own pace or according to their instructions, helping them to avoid unnecessary walking or carrying heavy objects for them. Working in a gentle way was believed to minimize pain.

Rest or relieving pressures on body part

Rest and relieving pressure on the body ($n = 16$, 11%), was supported when staff tried out and procured aids or helped older people to change position. By resting or relieving pressure on parts of the body, they perceived that pain was alleviated or prevented from getting worse.

Communication concerning pain

By talking and listening to problems concerning pain ($n = 13$, 9%) staff had an opportunity to help older people relieve pain. The staff informed older people about pain, persuaded them to perform activities believed to be healthy and encouraged and strengthened their self-confidence.

Relationship between types and activities to manage pain

The activities that had been used partly related to how staff perceived the pain of the older person (Table 4). Most activities were performed in relation to the group with 'real pain' and the smallest number in relation to those with 'concealed pain'. Doing nothing about the pain was the most common strategy with 'trivial pain', 'endured pain', 'concealed pain' and 'self-inflicted pain', while working in a gentle way was the most frequent activity among those with 'care-related pain'. Supporting medication and mediating contacts were frequently used activities among those with 'real pain', distraction among those perceived as 'exaggerating pain' and rest in relation to those with 'inarticulate pain'.

Discussion

The nursing literature presents 'pain in older people' as if it concerned a fairly homogeneous group and problem. However, the present study showed that the staff perceived older people in pain as a heterogeneous group. The typology demonstrated that everyday care for older people was a

Table 4 Description of nursing activities and professional background in relation to types of older persons in pain

	Real pain ($n = 37$) *n*	Exaggerated pain ($n = 25$) *n*	Trivial pain ($n = 24$) *n*	Care-related pain ($n = 22$) *n*	Endured pain ($n = 16$) *n*	Concealed pain ($n = 11$) *n*	Self-inflicted pain ($n = 9$) *n*	Inarticulate pain ($n = 6$) *n*
Utilized nursing activities								
No activity	5	4	12	4	5	7	3	2
Medication	14	7	4	9	4	1	1	0
Mediating contacts with health care	13	7	2	4	3	1	2	0
Distracting activities	7	13	1	1	0	0	1	0
Physical therapies	11	2	4	3	1	0	0	1
Mobility	9	2	1	3	1	0	3	1
Working in a gentle way	1	2	1	11	1	0	2	1
Rest or relieving pressure on body part	6	0	0	3	3	0	1	3
Communication concerning pain	4	3	0	2	1	1	2	0
Mean no of nursing activities	1·8	1·4	0·5	1·6	0·9	0·3	1·3	1·0
Professional background of story teller								
Nursing auxiliaries (63%)	12	19	23	16	10	4	8	2
Registered Nurses (27%)	17	5	0	2	6	7	1	2
Physio-/occupational therapists (11%)	8	1	1	4	0	0	0	2

complex task that not only embraced the performance of actions to manage pain, but was also based on the interpersonal relations between older people and the staff. Findings revealed how groups of older people evoked various feelings in the staff and also indicated that perceptions and professional background influenced the managements that was given. For instance, those perceived as exaggerating their pain and those with self-inflicted pain evoked frustration and irritation in the staff. In previous studies (Lorber 1975, Fagerhaugh & Strauss 1977, Salmon & Manyande 1996), the problem with patients perceived as problematic, demanding or unpopular has been highlighted. As in the present study, problematic people were considered uncooperative or coping less well and lacked visible indicators of pain. Salmon and Manyande (1996) suggest a need for research to investigate whether being perceived negatively by staff influences the level of analgesia administered. Results from the present study indicate that those who were viewed as exaggerating the pain did not receive any less medication than others. The difference was rather the high use of distracting activities in relation to this group.

Although the staff utilized distraction, efforts to distract in a more deliberate way were seldom used. In a phenomenological study of pain, Leder (1984–1985) showed that people in pain may direct their attention inwards, towards the pain, or outwards, towards the world outside. The staff in the present study registered a similar shift in older people's attention. Rather than viewing it as a natural process, it seemed to surprise them and made them doubt the presence or intensity of the pain. Madjar (1999) points out the need for carers not to doubt the reality of a person's pain but to acknowledge its existence. The findings imply that the care of older people in pain might be improved if the staff created distracting milieus for older people. Systematic studies of the effects of such interventions are an issue of importance for nursing practice.

Caring for older people in persistent pain may produce an ethical dilemma for the staff. The staff described how they sometimes inflicted pain and distress through everyday caring activities. Although this made them frustrated, they felt that inflicting pain was unavoidable. A number of nursing studies have highlighted the paradox that nursing requires nurses' participation in acts that inflict pain and cause suffering to other human beings (Fagerhaugh & Strauss 1977, Schroeder 1992, Madjar 1999, Nagy 1999, Allcock & Standen 2001). Madjar described how nurses who inflicted pain entered a process that made them feel helpless and powerless. In order to protect themselves from this feeling, they interpreted the pain as temporary and inevitable. The staff in the present study continued to perform painful caring activities although the pain had been present for more than 3 months. They tended to interpret the pain as inevitable and 'only' present during caring activities. Schroeder (1992) argues that inflicting pain is a morally ambiguous act and that although it might be unavoidable, it must never become a routine part of nursing practice. Previous studies have shown how care could be improved by allowing the staff to verbalize and reflect on situations they experience as demanding (Edberg & Hallberg 2001). Although this study indicates that this could be a way to decrease pain among older people, more research in this area is needed.

The results indicated that different professions focused on varying activities to manage pain. Registered Nurses emphasized medication and helping older people to get in touch with a physician. Physiotherapists and occupational therapists concentrated on how to maintain a proper balance between rest and mobility. The main strategies used by NAs were working gently and ensuring that the older people were given their medication. One interpretation could be that the different professions complemented each other. However, such an interpretation seems unlikely. The care of older people in this study was organized as a consultant system, that is a system where RNs and paramedical staff were situated in a central office and were contacted by NAs only in problematic cases. Thus, the everyday responsibility for identifying and managing pain lay with the NAs. A more reasonable interpretation, therefore, is that pain in most cases was not managed multidimensionally. Sorkin *et al.* (1990) argued that treatment planning must move away from single modality treatments and rather be built upon the complex relationship between physical and psychological factors. Intervention studies indicate that group activities such as walking (Ferrell *et al.* 1997, Ross *et al.* 1999) or physical therapies (Grant *et al.* 1999) might be useful in reducing pain in older people. This study demonstrated that the predominant part of the management of pain was based on conventional methods such as analgesic medication. The majority of the activities suggested in the professional literature (Table 1) about pain management for older people were not used, and in one quarter of the cases the staff had not performed any activity to relieve the pain during the previous week. Everyday caring strategies may need to be complemented with active strategies based on recent knowledge about which pharmacological, physical and cognitive therapies are effective and safe in this age group.

The aim of this study was to illuminate what the staff said they had done to relieve the pain, not what they actually had done. Thus, the findings must not be taken as the 'true' story of how the pain was managed and what pain relieving activities was performed. There is reason to believe that some

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activities were used far more often than the numbers indicate and that an observational study might have given a different picture. What numbers really reveal is the activities the staff had deliberately performed with *the intention* of relieving pain. With this in mind, there is reason to believe that the findings are trustworthy. Another possible limitation of this study is its transferability (Guba 1981). However, professionals from other municipalities with different ways of organizing care recognized the types and the activities to manage pain and could easily relate them to their own experiences. The findings also seem trustworthy in the sense that they are consistent with findings from other studies (Fagerhaugh & Strauss 1977, Walker 1994).

Conclusion and clinical implications

This study resulted in the identification of eight types, describing how staff perceived older people in pain. Through identifying the types, it became evident that caring for older people in persistent pain is complex. Older people with 'real pain' due to life-threatening diseases or accidents were common cases. However, this study shows other types of pain that require attention. Since a precondition for pain management is awareness of the pain, the primary intervention should be to perform structured and regular assessments of pain in all older people who do not manage their daily living independently. In particular, this concerns silent and noncomplaining people and people with impaired verbal communication. Findings also imply that staff attitudes concerning older people considered as demanding constitute a barrier to proper pain management. In everyday practice, there is a need for reflective discussions among staff on feelings related to these people and if attitudes affect what pain management is offered. The application of a variety of approaches, pharmacological as well as nonpharmacological, to relieve the pain is another important area. Finally, although this study provides insight into the perspective of the staff, it provides no answer as to how older people in pain perceive their situation or what kind of pain management they prefer. Since care and treatment should be based on the older people' needs and wishes, further research to explore their perspective is needed.

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