Voices from the margin: The nurse aide's role in pain management of institutionalized elders

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Abstract

The training and function of Certified Nurse Aides (CNAs) has traditionally focused on safe, hygienic, direct care and concrete, practical task completion. These two basic premises have directed training and job criteria and have evolved without much regard for the personal opinions, desires, and thoughts of the nurse aides themselves.[1] *However, CNA roles are expanding and changing daily, and what this expansion means in terms of patient care has ever-increasing relevance. How and what CNAs think and feel about their role and their training, and how both could be improved to meet the needs of patients and the demands of the healthcare system, are of vital interest to all those who rely upon their expertise.*

Key words: Alzheimer's disease, dementia, long-term care, institutional care, certified nurse aides, pain management

Introduction

Professional nurses train, orient, and supervise Certified Nurse Aides (CNAs) in daily practice. They design and deliver CNA training programs and make recommendations to governing legislative committees who control legal credentialing, competencies, and certification testing.[2] Therefore, CNA credentialing, competencies, and training are a very real part of supervisory nursing and must be of concern to nursing educators. There are many aspects of the changing CNA role that are of importance to nurses. One of these, and perhaps the most immediate, is the role of CNAs in pain management.

Pain control incentives have been initiated globally in response to changing healthcare guidelines, and most health organizations already recognize pain management as a major avoidable public health problem. This is amply demonstrated by the fact that, between 1997 and 1999, fully nine national and international healthcare societies, including the World Health Organization, the American Geriatrics Society, and the Joint Committee on Accreditation of Healthcare Organizations (JCAHO), rewrote and published new pain management guidelines.[3]

Developing a strong, interdisciplinary pain management program in extended care facilities presents a wide variety of problems for administrators. The list of challenges may well be headed by the appropriate use of staff to report pain and the development of training programs that help the entire healthcare team recognize pain needs and deliver speedy, appropriate pain control to residents.

Undertreatment and under-reporting of pain are well-known and often cited problems for institutionalized, cognitively impaired elders.[4] Thus, a good place to begin assessing the needs of this group and how their needs are currently being met (or unmet) is to survey the caregivers closest to the front line of patient contact. In the long-term care facility, this caregiver is the CNA. Consequently, discovering the personal attitudes, interpretive capabilities, and concerns of CNAs with regard to pain management is an important first step in developing an effective program.

Staff CNAs observe patient pain, a subjective symptom with often-subtle signs, on a daily basis. Consequently, CNA viewpoints have the potential to provide

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meaningful insight into successful pain management approaches for this particularly vulnerable population. To date, however, the role of CNAs in this area has been ambiguous or underdocumented.

The focus groups described herein were designed to solidify how the perceptions of aides might assist in recognizing and treating pain in institutional patients, what aides do about it, and what their knowledge needs are concerning pain management in the residents for whom they care.

Method

To obtain direct thoughts and feelings of the aides, a focus group technique was used. This strategy uses small groups of subjects who are guided into open-ended discussions of topics through the use of prespecified, general questions that direct group thought on the discussion topic. A convenience group of 22 (two of whom were male) CNA volunteers at a large multilevel extended care facility were used for the study, and they were asked six general questions about pain.[5]

Subjects were encouraged to speak freely and voice opinions, thoughts, and feelings openly. The facilitator tape-recorded their interactive discussions. To safeguard anonymity, a secretary (who never saw the participants) converted tapes into typed transcripts, and the researchers reviewed only the transcripts. In addition, both researchers who actually had contact with the CNA participants were not involved with the participants in any work capacity.

Five individual focus groups were subsequently assembled. A researcher facilitated each group but, after the first group, four CNA participants were trained as co-facilitators. The co-facilitators actually conducted future groups, while the supervising researcher largely just listened to the group dynamics. In this way, the researchers had as little actual conversational involvement as possible in the conduct of each group setting and could observe the receptivity of the CNA participants to more advanced training concepts.

To assess the naturally occurring randomization of the convenience group dynamics such as age, length and type of CNA service, and training program data were requested from the participants at the outset of each group.

Results

Demographic data

The age spread of the groups represented a wide diversity of worker experience and skills. Ages ranged from 18 to over 60, with a median age of 46. Over 75 percent of the group were over 30, and nearly 50 percent were between 46 and 60 years old. Length of experience as a CNA ranged from 10 months to 40 years, with an average length of service of approximately 13 years. All those participating were certified between 1984 and 1999, and training courses ranged from nine-month community college courses to one-week courses in other states. However, the most frequent training proved to be the eight-week (extended care facility based) certification course. All participants had worked dementia units, skilled nursing units, chronic disease units, or assisted-living units and had substantial long-term care experience.

Questions and responses

The general discussions during group sessions revealed observations that contained many insightful themes:

How do you know when your patient is in pain? This initial question elicited three broad observation categories from participants—verbal, physical, and behavioral responses. Aide observations included a variety of verbal expressions from patients, ranging from just saying ‘ouch’ to cursing or pleading not to be touched. Physical indications ranged from noticeable changes in body positioning and facial expression to changes in vital signs.

> “They may point at it. They might not be able to talk but they show you . . . Sometimes they yell when they are otherwise quiet, you know, when you’re washing them or something . . . Some get quiet and don’t talk like usual; but if they can, they tell you. Each one is different, but you get to know them.” (Aide responses, Group I & II)

All groups were particularly sensitive to a variety of behaviors that might be important pain indicators, including lack of movement, inability to settle down, not participating in activities, increased irritability, decreased eye contact, fetal positioning, wincing, clinging to caregivers, resisting care, and displaying stoic attitudes.

> “If you listen good, you start to understand. Everything, the whole body will transmit what they feel, but you have to be focused and tuned in on it. It’s like raising children and when they’re babies you know the different cries for the different needs; patients are the same way.” (Aide response, group II)

What tells you when a patient is not in pain? These answers could be categorized according to the same broad categories noted in question one and in many ways reflected a converse of the indicators for pain. Verbal affirmations of comfort from the patients when asked about pain and physical indicators such as good body alignment, sleeping well, taking nourishment without hesitation, and freedom of motion were all mentioned.

> "They have a happier attitude, more outgoing. One guy gets angry when he is in pain, you can't make him satisfied with anything! But he never actually complains. You know he's hurting, though. When he is not in pain, he jokes with you, then he's okay." (Aide response, Group IV)

Aides characterized residents who were not in pain as cheerful in demeanor and generally appearing happy and smiling on approach. They indicated these patients usually participated freely in activities and were able to socialize readily within the resident community of the facility or, if physically confined, socialized well within the confines of their physical capabilities.

What do you do when you recognize your patient is in pain; and *What are some of the things you do to ease the pain?* These questions were answered simultaneously by most participants and, because of the blending of responses in all the groups, they are also addressed together here. Two main pain categories emerged from these questions. Aides indicated they recognized both spiritual or emotional pain and physical pain, or a combination of both of these, in their patients. Analysis of the data from these questions pointed to a unique sensitivity of this staff to the fact that pain is experienced both physically and emotionally. Most group members recognized their responsibility to notify a licensed nurse of all patient pain experiences, but none felt this was necessarily the first or only response they should have to these situations.

The majority agreed physical pain could be addressed in a variety of ways and that nursing intervention should be prompt when physical pain was evident. Medication, whirlpool baths, voiding, and bowel evacuation were all strategies mentioned as helpful methods of physical pain relief.

> "I know I'm getting on now and my legs hurt sometimes, and my arthritis starts to ache up, but sometimes it helps me see these residents different and I'll say, 'Oh, I know it hurts today' and they smile and I know they know that I understand . . . When the pain medicine needs time to work is when they sometimes need us to help them forget for awhile." (Aide responses, Group III)

Comfort measures they could personally provide for reduction of physical pain included repositioning, massage, back rubs, distraction, and providing drinks or nourishment.

However, most aide responses addressed emotional or spiritual pain. Relief of emotional pain by aide intervention was remarkably evident and, in some group discussions of this, outweighed references to physical need. In addition to reporting patients' impaired emotional status to nurses, aides related they could do much to assist patients with this type of pain themselves.

> "One lady said, 'I'm not so good because I just lost my son.' So all I did was say I was sorry and would she like to tell me about it. I think she had lost him but not last night . . . It's like they keep repeating things over and over and that's a painful memory to remember all the time. That I cared made her feel better. I asked if she wanted a drink and sandwich . . . It makes them feel better if they are still loved and cared for. Yeah, that's important."

They described encouraging patient venting, offering verbal assurances of belief and advocacy, making physical contact such as holding hands, and a variety of other empathetic gestures. They regularly provided distraction for patients by playing music and spending time with patients in need of comfort. Aides readily recognized that emotional pain often accompanied physical pain, and the presence of one usually led to the presence of the other. The importance of CNA empathy and patient advocacy with both families and other staff clearly presented itself in all groups in relation to these questions.

What do you do to make pain worse? Acting in a harmful way, inadequate communication, and knowledge deficit were the three broad themes that characterized aide responses to this question. Most comments in this category were repeated many times and led by multiple references to the negative effects of moving patients, unknowingly touching them in ways that hurt them, improper application of devices, and inept equipment usage that caused pain. Turning patients in bed was repeatedly mentioned, but most considered this a necessary discomfort-causing action because it also provided relief from discomfort in the long run. Participants indicated numerous times that they were given inadequate instruction regarding how to move or handle patients. Dealing with patients with injuries or recent surgeries and having instruction unequally provided to all three shifts were just a few areas they mentioned as continuously problematic.

> "Uh, huh. This morning we pulled up somebody

> who we didn't know had his hipbone redone. And he's yelling he knows it's going to hurt. And I said we would be gentle. Then when we did it and he screamed, I felt bad."

They expressed anger at these situations and a strong desire not to be associated with causing unnecessary pain during their care to patients.

They expressed concern at pain medication delivery delays or inadequacies of the medications used. They noted that these caused increases in and/or extended existing pain in their patients. They cited multiple situations where nurses did not respond to reports of patients in pain until after that nurse completed another more pressing task. They also spoke of nurses who delayed medication due to dose timing restrictions and/or inability to change dosing perimeters readily because of communication problems with physicians.

The aides directly identified knowledge deficit or lack of good communication among staff as causes of increased or initiated pain situations. They specifically identified cases in which new equipment was delivered to a unit but nobody told them how to use it. If there was not adequate regular staff available to provide inservice to them, a breakdown of communication was experienced at the resident's expense. The issue of communication with and between physicians and nurses was cited numerous times. Frequently, this was expressed in terms of the CNA not having input, their suggestions not being acted upon, or their opinions not being valued.

What do you need to know to provide the best care for patients in pain? The last question brought a wide variety of comments depending upon whether the question was interpreted as related to desired additional knowledge, role expansion, or deficit knowledge of tasks aides already performed. Themes focused on patient advocacy, education to assist them with both identification and treatment of pain, and improved communication as part of the caregiving team.

Participants recognized their need to know the backgrounds of the residents for whom they cared. They understood that many times the solutions for spiritual and emotional pain issues are hidden in the patient's social history. They expressed concern that, as a profession, nursing often seeks to make the patient "look good" and that perhaps it is okay to dress the resident in ways that provide comfort as opposed to a nurse's or family member's desire for the patient to look a certain way. They stressed that, as direct caregivers, they must speak for what is best for their patients even when that advocacy is in direct conflict with family desires. They strongly voiced their patient's right to be treated as an individual and the aide's responsibility to support this.

Aides universally indicated they felt their education was not adequate. They recognized a need for better and expanded basic training, more consistent and continuous inservice, and improved situational instruction on special patient care needs as they arise.

The group participants also indicated they knew these residents better than many others on the caregiving team and, in many instances, even the patient's families; and they felt their opinions should be considered more carefully. The CNA groups as a whole felt strongly that they wanted more education, and they desperately voiced the need to be contributing members of the healthcare team.

Results summary

This study revealed an articulate, proactive group of men and women who, although they may somewhat lack sophistication in voicing their opinions, are highly capable of appropriate, insightful thinking. Participants demonstrated a highly developed sense of commitment to quality of care and patient welfare. The majority voiced significant concerns and desires that left clear impressions with this research group. Among these were:

- A significant desire to be heard;
- Frustration that they are often an ignored population;
- Strong desire for more training and inservice education; and
- A desire for inclusion in the decision-making process concerning situations and issues surrounding their job role.

Discussion

In the institutional elder, cognitive capability and short-term memory are in many instances compromised and sometimes absent altogether.[6] In these cases, lengthy, knowledgeable observation of these patients can mean the difference between adequately controlled pain and undertreated pain. This is especially true in chronic conditions where objective signs of pain are usually absent.[7]

The American Pain Society and the United States Public Health Care Agency both earmark failure to assess and provide timely treatment of pain complaints as the most critical factor in undertreatment of pain among all populations. They also target confused elderly as one of the most problematic populations. This is largely attributable to lack of frequent assessment and the poor communication status of the patient. In both instances, they recommend improved observation and helping the patient to report, recognize, and describe pain more adequately as the best methods for alleviating these problems.[8] The specific pain recognition criteria recommended for clinicians and caregiver family members include:

- Listen to the patient's descriptions about the quality of the pain;
- Describe the location;
- Describe the intensity;
- Describe the aggravating and relieving factors;
- Report cognitive responses to the pain; and
- Continue follow-up assessment of the effects of medications used for relief .[9]

In the confused elderly, many of these criteria become distorted or absent when nurses with busy care schedules attempt to quickly address pain issues among their patients, and family members become distant because of lack of daily contact.[10]

Data obtained from these focus groups support the fact that aides are not only aware of patients in pain, but they are highly skilled at precise description of that pain. In every instance, they ably related detailed descriptions of every aspect of the recommended clinician's observation criteria[11] and that of patient self-reporting criteria of both initial and follow-up 'relief from pain' reporting. In addition, this did not appear to diminish when patients were confused or demented.[12]

CNAs were able to give detailed descriptions of subtle behavioral and physical changes that indicated to them patients were experiencing increased or decreased pain symptoms. When verbal self-reports were not possible from the patient, CNA staff still recognized patient pain experiences. When patients were unable to communicate their needs to nurses or families, significant attempts at advocacy were repeatedly described. Since accurate pain assessments in confused mental states represents a significant pain management problem not currently addressed well at any level of patient care, these results were particularly thought provoking.[5]

CNA staff can and do recognize pain in their patients in close conjunction with the patient self-reporting criteria of the American Pain Society. Strong desires for more and better education and a more significant voice in both their own and patient care situations were also heard. The information gleaned from this study could provide the basis for several more studies with CNAs. How do both nurses and patients view the role of the CNA in pain management? How can this worker group be better trained to perform a significant reporting role in pain management? Can they be used in more responsible roles than presently allowed? What is the future of the CNA in extended care or home care situations? Significant indications for further study of training programs, job roles, and suggestions for new role responsibilities in pain management systems were amply supported by this study. In general the most significant result may be the awareness that more studies are needed and that CNA workers need a voice of their own in the healthcare system.[4]

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