EXPLORING FACTORS INFLUENCING NURSES’ ETHICAL DECISION MAKING FOR POSTOPERATIVE PAIN MANAGEMENT IN THE UPPER EAST REGIONAL HOSPITAL, BOLGATANGA

BY

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Nurses’ ethical decision making for POP management

DECLARATION

I, Tia Moses Banoya declare that, this thesis is my work which was supervised by Dr. Aziato Lydia and Dr. Gladys Dzansi, of the School of Nursing and Midwifery, University of Ghana. This thesis has not been submitted anywhere in any form for the award of a degree or a diploma. I have acknowledged (in the text and list of references) authors and publishers whose work I have used in this study.

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Nurses’ ethical decision making for POP management

DEDICATION

To Jul, Vicentia and Delight for your love and prayer support.
ACKNOWLEDGEMENT

My sincere thanks go to the Almighty God for His grace, love and strength upon me to go through this work. He led me through hard times.

I am so grateful to my supervisors, Dr. Lydia Aziato and Dr. Gladys Dzansi for their immense contributions and guidance throughout the work. Without them, it would have been impossible to complete it. They have been mothers and always encouraged me.

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LIST OF ABBREVIATIONS

ICN - International Council of Nurses
JCAHO - Joint Commission on Accreditation of Healthcare Organisation
POP - Postoperative pain
IEDEM-CD - Integrated Ethically Driven Environmental Model of Clinical Decision
NHIS - National Health Insurance Scheme
ABSTRACT

Postoperative pain (POP) remains a challenge for patients although they have the right to adequate pain management. It is unethical if pain is not managed adequately by nurses. However, there is inadequate literature on ethical decision making by nurses on pain management. Thus, this study aimed at exploring the factors influencing ethical decision making for POP management among nurses. The study employed qualitative exploratory descriptive design. Participants were recruited purposively from the surgical wards of the Regional Hospital, Bolgatanga. Semi-structured interview guide was used for data collection and data saturation was reached at the fourteenth participant through individual interviews. Five themes emerged from the data which was analysed using content analysis procedures. The themes were nurses’ knowledge of ethical principles, influence of unit leadership on ethical decision-making, influence of nurses’ relationship with other professionals, institutional factors influencing nurses’ ethical decision-making and intrinsic motivators of pain management. Findings showed that nurses had adequate knowledge of ethical principles and applied them in the management of POP. Personal commitment and empathy for patients were intrinsic factors for ethical decision-making for POP management. Protocols on pain management, disciplinary and ethics committees, and availability of analgesics were perceived to influence ethical decision-making for POP management. Nurses said institution of an ethics committee could help them know about ethical issues. Constructive feedback from unit leaders was also perceived to influence decision making for POP management positively. The study concluded that, there is the need to place premium on pain management while considering it as a right of patients and an ethical issue. Resources needed to provide ethically accepted management of pain should be provided to enhance pain management.
CHAPTER ONE

1.0 Introduction

This chapter includes the background of the study, statement of the problem, purpose of the study, aims and objectives, research questions, significance of the study, and operational definitions of keywords used in the study.

1.1 Background

Globally, about eighty percent (80%) of the population suffer inadequate pain management (Medrzycka-Dabrowska, Dabrowski, & Basinski, 2015; van Boekel, Steegers, Verbeek-van Noord, van der Sande, & Vissers, 2015). The greatest burden of inadequate pain management is borne by the elderly, pregnant and breastfeeding women, children, persons coping with substance addiction and mentally ill patients (Medrzycka-Dabrowska et al., 2015; Rawal, 2016). In the United States of America alone, a national survey showed that, about 86% of surgical patients suffered postoperative pain while on admission and about 74% suffered pain after discharge (Gan, Habib, Miller, White, & Apfelbaum, 2014; Meissner et al., 2015) which makes pain still a problem, despite the availability of a wide range of management strategies.

About two-thirds of hospitals in Austria lack acute pain services with about 300,000 out of 700,000 surgical patients suffering from moderate to severe pain despite availability of multimodal approaches to pain management (Kinstner, et al., 2011). Kinstner et al. (2011) further reported that only 60.7% of surgical patients’ pain is assessed and recorded, still leaving a great number of patients’ pain inadequately managed. Similarly, Ucuzal and Doğan (2015) reported that only 35.1% of nurses keep record of pain assessment. Patients who underwent minor surgeries such as appendectomy, tonsillectomy, and cholecystectomy reported high pain scores compared to those who underwent major surgeries in Germany (Gerbershagen et al.,
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2013). The perceived minor surgery by nurses accounted for inadequate analgesia administration which subsequently resulted in poor outcomes of pain management (Gerbershagen et al., 2013).

In Ghana, it was revealed that, over 80% of patients with chronic illnesses like Acquired Immunodeficiency Syndrome (AIDS) and cancer suffered and died of moderate to severe pain (Nimako, 2015). It was further revealed that, millions of Ghanaian patients suffered moderate to severe pain without adequate relief. These patients included those with fractures, surgical interventions, and sickle cell crises among others (Nimako, 2015). The unfounded worries on the part of professionals about patients’ risk of addiction to, especially opioid analgesics, have been the commonest reason accounting for undermanagement of patients’ pain. This has been observed by the researcher over time in clinical practice.

Barriers to effective pain management identified by Rejeh, Ahmadi, Mohammadi, Anoosheh, and Kazemnejad (2008) are lack of time to attend to individual patients’ in pain, failure to identify pain cues, limited communication with patients and over reliance on doctors for prescription of pain medications. Aziato and Adejumo (2014b) added that, nurses’ fear of patients getting addicted to pain medications, individual nurses’ subjective views of pain, strict adherence to medication schedules and unsupportive institutional policies contributed to inadequate pain management in Ghana. Also, the perceived need for patients to endure pain to certain levels, views that sleeping patients do not need pain medications (Ucuzal & Doğan, 2015) and knowledge deficit in pain management by nurses (Olmstead, Scott, & Austin, 2010) are other reasons to ineffective pain management identified.

Poor postoperative pain management result in a number of physical, psychological, and economic issues. Some of these are deep vein thrombosis, infection of surgical wounds and subsequent delayed healing, pneumonia, and progression to chronic pain (Meissner et al.,
2015). Insomnia, negative emotional responses, and decreased productivity have also been reported by Aziato, Ohene, Dedey, and Clegg-Lamptey (2016) as some of the consequences of unresolved acute surgical pain. Sinatra (2010) added that, reduced quality of life and high economic costs accompany poorly managed acute pain among surgical patients. Also, poor management of postoperative pain has increased probability of readmission and adversely affects the overall cost of care as well as patient satisfaction (Joshi et al., 2014).

Failure to provide pain relief amounts to human rights abuse no matter the barriers to pain management (Lohman, Schleifer, & Amon 2010). Again, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) pain management standards demand health professionals to recognize that, patients have the right to appropriate pain assessment and management, using acceptable standards and inability to do so is unethical, clinically unsound and economically wasteful (Berry & Dahl, 2000; Phillips, 2000). Brennan, Carr, and Cousins (2007); Gunningberg and Idvall (2007) also supported that, failure to manage pain adequately is unethical practice which amounts to violation of fundamental human rights. The nursing profession therefore require knowledge of nursing ethics to guide performance (Mohajjel-Aghdam, Hassankhani, Zamanzadeh, Khameneh, & Moghaddam, 2013) in order to maintain professional standards. However, registered nurses have inadequate knowledge and poor attitude towards adult pain management, perceiving patients complaints and expression of pain as merely seeking attention from nurses (Hariharan, Jonnalagadda, Walrond, & Moseley, 2006; Manwere, Chipfuwa, Mukwamba, & Chironda, 2015). This could demonstrate inadequate knowledge of ethical responsibility of the nurse regarding pain management. It was also reported by Motov and Khan (2009) that, emergency physicians do not prescribe adequate analgesics to patients because of failure to appreciate patients’ pain, and also failure to properly assess pain. These could be reduced if professional nurses understand the ethical issues
surrounding inadequate management of surgical pain and thus, adhere to their advocacy roles for patients.

Nursing ethics refers to a system of principles concerning the actions of the nurse in his or her relationship with patients, patients’ family members, other health care providers, policy makers, and society (Mallari & Tariman, 2016). Ethics is a necessary element of all healthcare professions including nursing. Ethics is the foundation of nursing practice (Mallari & Tariman, 2016). Ethics has a core role in the moral behaviour towards patients care and their outcomes. The history of nursing is immersed in the duty of attending to the sick, wounded and the destitute in the community (American Nurses Association Center for Ethics and Human Rights, 2015) and its professionals are, therefore, expected to understand ethics and adhere to a certain standard of morality (American Nurses Association, 2015).

Adhering to professional ethical standards depend on the ability of the professional nurse to make sound ethical judgments and decisions. Ethical decision making is the process of recognizing a need, considering alternatives, identifying a morally acceptable option and implementing it (Heyler, Armenakis, Walker, & Collier, 2016). It is also a decision that is both legally and morally acceptable to the larger community (Zeni, Buckley, Mumford, & Griffith, 2016). The standard reference for professional ethical decision making for nurses has long been the International Council of Nurses (ICN) and the various Nations’ code of ethics for nurses that guide nursing practice and research, thus, evidence-based ethical frameworks have the tendency of improving care outcomes and general satisfaction of patients and stakeholders (Mallari & Tariman, 2016).

It was noted that nurses did not observe professional ethical standards in practice, though meeting patient care needs depended on nursing ethics application in making competent ethical decisions (Dehghani, Mosalanejad, & Dehghan-Nayeri, 2015). Borhani, Alhani,
Mohammadi, and Abbaszade (2009) reported that, workload and low staffing levels account for the compromise in quality of care and resultant professional ethics violation. Low support for staff from healthcare authorities and institutions results in decreased ethical sensitivity (Schluter, Winch, Holzhauser, & Henderson, 2008). Also, lack of time on the part of nurses, reduced interest in clinical supervision, an inhibiting medical power structure, institutional policy and legal considerations hinder adherence to professional nursing ethics (Atabay, Cangarli, & Penbek, 2014). This is however, contrary in the United States of America (USA), where about eighty percent (80%) of the population has always voted for nurses in Gallup polls as the most honest and ethical among all other professionals since 2005 (Riffkin, 2014).

It is worth for nurses to understand the famous nursing definition of pain by McCaffery (1968) who explains it as subjective expression of the person (patient) and should be seen as expressed. However, in practice, practitioners’ biases about the patients’ pain limit the realisation of the definition given above. By adhering to the definition, nurses will manage pain holistically, without any subjective attitude towards patients. This could be achieved by understanding and upholding the unemotional, transparent principles of ethics which may provide guidelines for better, more effective pain treatment as argued by Bernhofer (2011). Also, adhering to ethical principles such as beneficence, nonmaleficence, justice, and autonomy will promote adequacy and efficiency in nursing care of pain, since these principles give objective guide and help in ensuring the greatest good is done to patients. This require competent ethical decision making with the principles being the guide, since all biomedical ethics revolve around these principles (Beauchamp & Childress, 2001; Perez, 1995).

A search for literature in the Ghanaian context on ethical decision making by nurses show that, nurses’ approach to ethical issues fall below the ICN code of ethics (Donkor & Andrews, 2011). Donkor and Andrews (2011) revealed that, nurses’ practice is informed by their culture and institutional policies. This is probably because the concept of autonomy,
critical thinking, and decision making are fairly new in nursing education and in the clinical environment, still allowing room for physician-driven model of care which stopped in the high-income countries about three decades ago (Rominski et al., 2011). It was again found in Ghana that, health professionals pay little or no attention to professional ethical principles in practice (Opoku & Addai-Mensah, 2014). This can be true as it was revealed in a qualitative study that nurses approach to patients’ postoperative pain management is based on their individual factors such as the individual level of dedication to patients care, the individual nurse’s discretions and the fear that, patients may become addicted to pain medications (Aziato & Adejumo, 2014b) even though pain management is a fundamental human right (Brennan, Carr, & Cousins, 2007) and should be managed holistically without biases. It should be recognized by all professional nurses that patients have the fundamental human rights to have their pain managed, and thus, take appropriate ethical decisions in managing pain, especially acute post-operative pain to ameliorate the consequences of inadequate management of pain that have been documented.

1.2 Statement of the Research Problem

Effective pain control reduces postoperative morbidity as well as facilitate rehabilitation and speeds up recovery from surgery (Pöpping et al., 2008). Ineffective postoperative pain management on the other hand, alter body functions and can lead to delayed recovery, with subsequent prolonged hospital stay, increased morbidity, and progression to chronic pain (Al Samaraee, Rhind, Saleh, & Bhattacharya, 2010). Empirical evidence show that Ghanaian surgical nurses under-manage postoperative pain for reasons such as individual nurse’s discretion, fear of patients’ addiction to analgesics and institutional laxity (Aziato & Adejumo, 2014a). These studies did not explore how ethical decision making for postoperative pain management influence or contribute to the poor postoperative pain management.

Furthermore, considering that literature reveal patients have the fundamental rights to pain management (Caballero, Collado, Quintosa, & Riera, 2015; Chou et al., 2016; Hall &
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Boswell, 2009), and failure to properly manage a patient’s pain is unethical (Cooper, 2016; Young, 2017), it presupposes that, nurses should take their patients’ pain seriously and attend to them. The reverse seems to be so, unfortunately, especially in Ghana where it was reported that nurses’ approach to ethical issues in clinical situations was substandard (Donkor & Andrews, 2011). It seems there are not enough studies that emphasize the Ghanaian surgical nurses’ perspectives on factors that influence ethical decision making for postoperative pain management, and how ethical decision making contribute to satisfactory surgical pain management. This study therefore, focuses on the Ghanaian nurses’ ethical decision making for postoperative pain management by exploring factors affecting ethical decision making.

The study used the Integrated Ethically Driven Environmental Model of Decision Making (IEDEM-CD) (Wolf, 2012) to guide the organisation of the literature review and general understanding of the phenomenon under investigation.

1.3 Purpose of the study

The purpose of the study was to explore factors influencing nurses’ ethical decision making for post-operative pain management in the Regional Hospital, Bolgatanga.

1.4 Objectives of the Study

The specific objectives of the study were to:

1. Assess nurses’ knowledge of ethical principles in postoperative pain management.
2. Explore the influence of relationship between nurses and other health professionals in ethical decision making for postoperative pain management.
3. Assess the influence of unit leadership on nurses’ ethical decision making for postoperative pain management.
4. Explore institutional factors that affect ethical decision making for postoperative pain management.
1.5 Research Questions

1. What are the nurses’ knowledge of ethical principles in postoperative pain management?

2. What are the influences of nurses’ relationships with other health professionals in ethical decision making for postoperative pain management?

3. What are the influences of unit leadership on nurses’ ethical decision making for postoperative pain management?

4. What are the influences of institutional factors on nurses’ ethical decision making for postoperative pain management?

1.6 Significance of the Study

The findings of the study stand to benefit academia and practice, considering the fact that pain is the commonest manifestation of most health problems. The factors that affect ethical decision making for postoperative pain management will be highlighted and incorporated in curriculum that will enhance the knowledge base of students concerning ethical issues in pain. Clinical nurses will be conscious of the potential factors that may affect ethical decision making in postoperative pain management and implement measures that balance benefits over harm. It will also provide information to hospital management to ensure the provision of resources for optimal surgical pain management.

1.7 Operational definitions

Nurse: male and/or female workers in the surgical units who had a minimum of diploma in general nursing programme and nursing surgical patients.
Ethical decision making: recognizing a need, considering alternatives, identifying a morally acceptable option and implementing it (Heyler et al., 2016).

Post-operative pain: pain experienced by patients after surgical operation.

Unit leaders: ward in-charges or shift in-charges who supervise other nurses in the performance of their duties.
CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

The literature review focuses on overview of the model (Integrated ethically driven environmental model of clinical decision making (IEDEM-CD)) that is used to understand and explore the literature regarding ethical decision making in the study. An overview of some of the ethical principles governing nursing practice is done followed by review of knowledge base of the nurse on ethical decision making, review of influence of unit leadership on ethical decision making for POP management, influence of relationship between nurses and other health team members (doctors, pharmacists, anaesthetists, and physiotherapists), and institutional factors affecting nurses’ ethical decision making for POP management.

Electronic databases such as ScienceDirect, CINAHL, Sage journal online, Scopus and Google scholar among others, of University of Ghana databases were explored using key terms such as “Postoperative pain management,” “nurses’ decisions on pain management,” “ethical decisions in postoperative pain management,” “nurses role in pain management,” “conceptual models of ethical decision making,” and “ethical theories of pain management.”

A number of models such as Greipp’s model of ethical decision making (Greipp, 1992), the contingency model of ethical decision making (Ferrell & Gresham, 1985) and IEDEM-CD (Wolf, 2012) are explored. Greipp’s model of ethical decision making was developed to illustrate the overall conception of the interaction between the nurse and the client within an ethical framework. The model examines all the factors that affect ethical decision-making process, including those factors in the nurse and those of the patients. The author documents the importance of the client’s culture and the nurse’s culture on ethical decision making. The model explains the interactions between the client and the nurse and the multi-factors which
enhance or inhibit the ethical decision-making process by illustrating the ethical knowledge, and professional code of ethics.

The main constructs of the model include: the nurse as a biological essence, the client as a biological essence, learned potential inhibitors of the client and nurse including (which are personal experiences, professional experiences, culture and belief systems), education of both the nurse and the client, and ethical framework.

The model demonstrates that the client and the nurse are unique individuals with physical and mental characteristics that are attributable to parentage, growth and development. The nurse has been educated in a professional nursing programme to plan and deliver health care to individuals and families in an ethical manner. Factors such as personal experiences, culture, belief systems and professional experiences influence the nurse’s decision making. Also, the model indicates that the client, being a biological essence, may also be influenced by his/her belief systems, personal experiences, and culture such that the nurse’s decisions may be affected positively or negatively. Using the model therefore, may require assessing the interplay of the inherent factors in both the nurse and the client in determining ethical decision making which is however, not the focus of the present study to explore both nurses and patients. Nonetheless, the model gives a clue of certain factors that may influence nurses’ ethical decision making in the clinical settings.

The contingency model of ethical decision making (Ferrell & Gresham, 1985) is originally a marketing model which describes factors that come into play to affect ethical decision making in the marketing industry. The model posits that the social and cultural environment will trigger an ethical issue or dilemma and the individual will now make a decision. The decision may be ethical or unethical. The model has three main constructs that affect ethical decision making, namely individual factors (made of knowledge, values,
attitudes, and intentions), significant others (made of differential association and role set configuration) and opportunity variables (made of professional codes, corporate policy and rewards/punishment).

The contingency model suggests or proposes that an individual who is faced with an ethical issue will be influenced by education, and training programmes related to ethics in the professional practice. Also, ethical or unethical decision will be influenced by the cultural background of the person. Furthermore, the management or the leadership under whom the person is working, as well as the peers, will also influence ethical or unethical decisions made. It also proposes that, ethical behaviours are more likely to be practiced when rewards are given and also, unethical behaviours are more likely to be practiced when less punishment for unethical behaviours are given.

It could be suggested that leadership attitudes, and professional relationships as well as the knowledge base and beliefs of the person faced with ethical issue have the tendencies of affecting the decision that will be made. These factors are therefore considered in the review of the literature in relation to POP management.
2.1 Overview of the Integrated ethically driven environmental model of clinical decision making (IEDEM-CD)

![Diagram of IEDEM-CD](http://ugspace.ug.edu.gh)

The integrated ethically driven environmental model of clinical decision making was developed by Lisa Wolf in 2012 to explore the relationship between multiple variables that influence clinical decision making by emergency nurses regarding nursing actions in an emergency unit (Wolf, 2012). It is described as an environmental model to depict that each
element of the model influences all the other elements in determining outcome of clinical decision making for patients’ care. The model has three concentric rings (with broken lines) comprising core elements, immediate elements and influential elements.

The core elements in the model is made of knowledge base of the professional nurse who is caring for the patient. The knowledge base is derived from the experiences the nurse has accumulated from practice over time. The knowledge base refers to professional knowledge of nursing care and responsibilities (Bringsvor, Bentsen, & Berland, 2014), which include knowledge of professional ethics that guide professional practice and decisions. Professional nursing knowledge is obtained from professional training and clinical practice experience (Moule & Goodman, 2008). Other components of the core elements are critical application and moral agency. Critical application refers to the ability of the nurse to identify unmet needs of a patient by critical cues, integrate findings and recognize resources (Laerkner, Egerod, & Hansen, 2015; Wolf, 2012) to solve the health needs using the best available options. It is also the ability to apply knowledge to a situation at hand. Moral agency on the other hand is the conscious and relentless efforts of the nurse to search for information to determine the presence or absence of critical cues. It is also the drive to address a patient needs to enhance the good of the patient. These sub-constructs (knowledge base, critical application, and moral reasoning) are placed in the centre of the model because they are suggested to be the most important or influential in the outcome of the decision making process (Wolf, 2012).

The immediate elements comprise unit leadership and the nurses’ relationship with other health team members. Communication among health team members and their relationships influence accuracy of clinical decision making for patients care (Institute for Healthcare Communication, 2011). Unit leadership consists of leadership attitudes, culture and policies that affect advocacy and accuracy of clinical decision making in healthcare settings (Wolf, 2012).
The last component is influential elements which represent institutional environment and the immediate healthcare environment in general (Wolf, 2012). It encompasses the factors in the institution that enhance or inhibit professional autonomy, support for education, and standards of nursing practice. Other factors that hinder or facilitate effective, safe, and patient-centred care are included in the influential elements. The model suggests that an interplay of the factors within the nurse and the environment influence clinical judgment (Wolf, 2012). It also suggests that a nurse with adequate knowledge base, sound moral agency, and critical cues is most likely to make good clinical judgments regarding patients care.

The model was used to establish the relationship between its constructs and accuracy of clinical decision making in an emergency setting where prompt and competent clinical decisions were to be made for critically ill patients (Wolf, 2013). A sample of 200 emergency nurses recruited in the study revealed that higher knowledge, autonomy and supportive leadership correlated positively with accurate clinical judgment in terms of triaging of patients who were critically ill for prompt care.

The model was also used to ascertain emergency nurses’ perceptions on clinical decision making for urinary catheterization of patients (Mizerek & Wolf, 2015). Findings showed that, demographics (such as years of practice, and level of professional nursing education) correlated positively with accurate decisions by nurses on the need for urinary catheterization of patients. It was further established that, hospitals that supported professional nurse autonomy, good communication and collaboration with physicians helped improve the nurses’ independence in clinical decision making on patients’ catheterization. Again, as nurses viewed the procedure as their work, it gave them a sense of responsibility in determining which patient needed catheterisation, and whose catheters needed to be removed at certain times (Mizerek & Wolf, 2015).
The model is grounded in the value that a nurse holds a strong inclination for moral reasoning that may be used to overcome ineffective environment of practice to be able to engage in effective decision making in patient care. Equally, a nurse with weak tendency of moral reasoning in an environment that support effective communication between nurses and other health professionals and ensure accountability and effectiveness in decision making may be effective by virtue of the improved environment (Wolf, 2012). The model also views ethical reasoning as the driving motivation behind the deliberative collection of data and determination of critical cues that allow for clinical judgment and therefore, ethical reasoning and clinical judgment are inseparable.

The model provided a guide to understand factors that influence ethical decision making and to organize the literature. These factors include knowledge base, leadership, nurse-provider relationship, and environment of care. Also, the contingency model of ethical decision making by Ferrell and Gresham (1985) also support that individual factors (such as knowledge, and values), and leadership and organisational environment influence ethical decision making. These justify the use of the models to guide the literature review since the study is focused on factors that influence nurses in ethical decision making for POP management.

The terms “moral reasoning” and “critical application” as relates to the integrated ethically driven environmental model of clinical decision making (Wolf, 2012) have not been considered in the review of the literature. This is because they may be relevant when assessing or exploring ethical decision-making process and nurses’ ethical decision-making skills. The objectives of the current study were not intended to address ethical decision-making process and therefore, these constructs have not been considered.

Permission to use the model was sought from the author of the model through an email and was granted.
2.2 Overview of ethical principles in nursing

The term ethics is derived from the Greek word "ethos" meaning character, and is defined as moral principles that govern a person's or group's behaviour (Petiprin, 2016). Ethics may also simply mean the standards that govern behaviour or conduct of a profession or persons (Fry, 2008). It is commonly defined as the philosophical study of right actions and wrong actions (Beauchamp & Childress, 2001).

Ethics is important to the nursing profession. Ethics guide nurses in their practice on a daily basis; they help distinguish between right and wrong when the correct path is unclear in the nurses’ professional environment (Benner, Tanner, & Chesla, 2009). Nurses are expected to work in an ethical manner in order to meet the individual needs of patients and enhance satisfaction. Nurses who are knowledgeable about ethical theories may be better prepared for ethical nursing practice as they will have a more thorough knowledge of which ethical approach will be most appropriate in a given situation (Petiprin, 2016).

Ethical decisions balance principles of morals and legalities in analysis and usually require moral courage (Dolan, 2017). An important aspect of decision making is preserving moral courage and preventing moral distress associated with controversial practice situations. A nurse’s knowledge and understanding of the Code of Ethics can arm her with the power to be a major influencer in the day-to-day decisions that are made regarding patient care outcomes (American Nurses Association, 2015). The underlying universal principles of ethics important for nursing practice are based on the obligation to do good (Beneficence); do no harm (Nonmaleficence); provide equal and fair care for all without judgement (Justice); defend individual determination (Autonomy) (Fry, 2008; Scanlon & Murphy, 2014). These ethical principles provide a framework for the analysis and resolution of moral problems encountered in the clinical delivery of health care. They form the basis for all Codes of Ethics and also the
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foundation of considerations for all professional groups in healthcare including the nursing profession (Beauchamp & Childress, 2001). Thus, in making decision for POP management, these principles influence the nurse to arrive at the best possible decision.

Nurses are confronted with ethical issues in daily practice. This is evident as a study of 422 nurse participants on the issues of ethics in everyday practice showed that, nurses frequently on a daily basis, faced ethical issues related to protecting patient rights (63.8%), informed consent (61.3%), advanced care planning (41%), challenging staffing patterns (37.3%), difficulty in surrogate decision making (32.5%), and end of life issues (26.2%) (Ulrich et al., 2010). It is in the light of this that understanding the factors influencing nurses’ ethical decision making for POP management is important. Some of the basic ethical principles are explained as follows.

Beneficence is an important ethical principle that underpins nursing care and is basically the duty to do good to patients, while considering the desires of the patient (Quinlan-Colwell, 2013). Beneficence and non-maleficence are closely related; the former is the principle of doing good and the latter is avoiding the causation of harm (Alzheimer Europe, 2009; Andersson et al., 2010; Quinlan-Colwell, 2013). Beneficence involve the active promotion of benevolent acts such as goodness, kindness, charity (Aurelio, 2014). It may also include the injunction not to inflict harm. Nurses are obliged to do good, that is, to implement actions that benefit patients and their support persons. Intentional harm is never acceptable in nursing. However, placing a patient at risk of harm has different facets. A patient may be at risk of a known consequence of a nursing intervention such as adverse effects of medication that is intended to be helpful. Unintentional harm is when the risk could not have been anticipated.
Providing comfort can be deemed as an essential component of beneficence. Comfort needs of patients that are provided by the nurse can be perceived as doing good (beneficence) for patients since comfort involves providing measures to relief pain (Pinto, Caldeira, & Martins, 2016). A phenomenological study conducted by Yousefi, Abedi, Yarmohammadian, and Elliott (2009) to explore nurses’ and patients’ views of comfort needs showed that comfort is indispensable need of human beings whether in illness or in good health. Comfort was seen as a state of being free from suffering and being in a calm environment. This therefore presupposes, that nurses’ efforts to provide comfort for their patients can be viewed as benevolent acts as well as performance of professional duties.

Beneficent actions of nurses could be thwarted when they are confronted with workload and less staffing since time may not be sufficient on their part to perform the core duties of care. A study to evaluate the impact of understaffed nursing shifts on patient outcomes in Australia showed that, patient care quality dwindled with associated effects such as surgical wound infections, urinary tract infections, deep vein thrombosis, pressure injuries, and pneumonia (Twigg, Gelder, & Myers, 2015) suggesting that such patients’ comfort would be compromised.

Autonomy refers to the right to make one’s own decisions. In contemporary discourse it has broad meanings, including individual rights (Filipova, 2009; Tomey, 2009), privacy, and choice (Hinkle & Cheever, 2014). Autonomy entails the ability to make a choice free from external constraints. Patient autonomy is viewed as giving patients the chance to make choices from options that have been made known to them regarding their own treatment. Autonomy involves allowing the patients to decide on what health interventions they wish to be provided for them (Entwistle, Carter, Cribb, & McCaffery, 2010).
Nurses who adhere to the principle of autonomy understand that each patient is unique and has the right to behave differently and make choices and set goals concerning treatment. Honouring the principle of autonomy require that the nurse respect patients’ decisions even if those decisions are not in the best interest of the patient (Berman, Snyder, & Frandsen, 2016). The nurse has to also be considerate. Autonomy is violated in nursing care when a patient’s complaint of pain is considered as exaggeration or demand for attention and thus, is not given the attention deserved. Also, when decision making processes are weak, patient autonomy is easily offended (Dreyer, Førde, & Nortvedt, 2011).

McCaffery (1968) describes pain as subjective phenomenon and is better perceived, assessed and treated just as the individual in pain explains it. This explanation could be better understood in the context of patient autonomy. Aziato and Adejumo (2015a) also elucidated that the subjective nature of pain is best treated when nurses understand and view pain as the patients says it is. By this, patients will feel comfortable since their views are accepted. This in some sense may depict that nurses acknowledge patients’ autonomy regarding their expression of pain.

An important aspect of enhancing autonomy is through patient education. It was found in a study that patients empowerment is best achieved through education so that they are in a position to make informed choices (Anderson & Funnell, 2010). The study further revealed that patients became knowledgeable about their conditions and were better able to carefully make informed decisions when nurses educated the patients. Another study on patient education (empowerment) on hypertension and effects on their lifestyles demonstrated improved healthy behaviours, and decreased blood pressure (Hacihasanoğlu & Gözüm, 2011). These findings buttress the role of empowerment as a form of providing patients with the opportunity to have control of their health. By this, patients may feel they have roles in ensuring their own good health and thus, participate actively towards recovery. Other studies, however,
showed that patients preferred shared decision making rather than being completely autonomous (Deber, Kraetschmer, Urowitz, & Sharpe, 2007; Sandman, Granger, Ekman, & Munthe, 2012). The study further found that older and less educated patients preferred passive roles and shared decision making with nurses. This finding suggests that, in as much as patient autonomy is encouraged, it is good to constantly assess the patients need for autonomous decisions by paying attention to their educational level and age.

Autonomy can also be viewed in the light of the nurse as “nurse autonomy.” A study involving twenty-six (26) participants (nurses) in a semi-structured interview showed that they had good understanding in decision making and also had knowledge of professional autonomy. Nurses identified that autonomy could be enhanced on one hand, through teamwork and that teamwork could at the same time disempower professional autonomy since nurses will lose independence to professional interdependence in decision-making through teamwork (Traynor, Boland, & Buus, 2010). It could be deduced that when nurses gain some level of autonomy in their field of work, they may understand the need to also allow patient autonomy as the patients’ right.

Justice is often referred to as fairness and equality (Berman et al., 2016). Nurses face issues of justice every day as they organize care for their clients: They must decide how much time they have to spend with each client, taking patient needs into consideration, and then fairly distributing the resources accordingly. Justice as an ethical principle in nursing deals with fair treatment of patients and ensuring that the rights of individual patients are upheld (Feinsod & Wagner, 2008). Alzheimer Europe (2010) describes justice as the moral obligation to act on the basis of fair adjudication between competing claims. It is further linked to entitlement, and equality. Justice is also seen as impartiality and objectivity towards patients irrespective of their social status, race, colour (Douglas et al., 2011; Herr, Coyne, McCaffery, Manworren, & Merkel, 2011).
Advocacy can largely enhance justice. Advocacy roles played by nurses is considered as an integral element in ensuring safe practice in health care settings; advocacy for patients help in mitigating risks arising from sudden changes in patients’ conditions and possible harm that may occur from misjudgement in treatment by other professionals (Choi, Cheung, & Pang, 2014). Furthermore, protecting patients’ rights is noted to be an aspect of advocating in the interest of patients (Davoodvand, Abbaszadeh, & Ahmadi, 2016).

2.3 Nurses’ knowledge of ethical principles in postoperative pain management

Pain management decisions are largely determined by nurses because of the length of time spent on patients, therefore, inadequate pain treatment can occur as a result of knowledge deficit about pain (Zhang et al., 2008). It was shown that nurses perceived patients to be in worse pain more than physicians did and were more likely to administer opioid analgesics more than physicians (Phelan & Hardeman, 2015) which could be attributed to the closeness of nurses to patients as well as their focus on lived experiences of patients while physicians focus on healing of the disease (Storch & Kenny, 2007). The closeness could create a sense of compassion and moral obligation to ensure pain is minimised to its barest. Another study revealed contrary findings: nurses’ negative attitude of underestimating patients’ postoperative pain while they relied on their personal judgment based on type of operation or patient appearance instead of patients’ statements about pain influenced adversely holistic and objective pain management (Abdalrahim, Majali, Stomberg, & Bergbom, 2011; Bell & Duffy, 2009). The nurses’ reliance on personal judgment of pain may suggest that nurses may not attend to the patient as needed (amounting to negligence) and harm may be caused as patients may persistently feel pain (Copp, 2006).

Nurses’ Knowledge of pain assessment, management, effects of under treatment, and adverse effects of pain medication is integral in quality surgical pain outcomes (Bell & Duffy, 2009). A study showed that the level of knowledge of nurses on barriers to postoperative pain
manipulation influenced the decisions made towards accurate postoperative pain management (Rejeh, Ahmadi, Mohammadi, Kazemnejad, & Anoosheh, 2009). The study employed purposive and snowballing sampling techniques to and therefore participants had rich experiences to share on POP management challenges. It could be deduced that nurses with better knowledge made decisions that were ethical to improve surgical pain management as opposed to nurses without good knowledge of pain dynamics and thus would have made decisions that adversely affected pain management outcomes.

A cross-sectional study in Uganda on nurses’ knowledge of ethics showed that only 18 (15.8%) of the nurses and midwives obtained a score ≥50% in the ethics knowledge assessment test. Nurses who had attained diploma or higher level of education were less likely to score below 50% in the knowledge test as compared with nurses who had obtained only certificates (Osingada et al., 2015). Chair, Chan, Yu, and Taylor-Piliae (2018) assert that in order to accommodate the growing diversity and complexity in the highly dynamic environment, registered nurses must be well educated and competent in providing patient care. It can be said that those with higher education could make ethically sound decisions with patients regarding their care.

A research conducted to determine nurses’ knowledge and adherence to patient bill of rights using cross-sectional method showed that, nurses’ knowledge of patient rights was 82% of total score (Sheikhtaheri, Jabali, & Dehaghi, 2015). Nurses’ understanding of patients’ rights may place the nurses in a position to better appreciate that patients do not need to be in pain, and will adhere to principles such as beneficence, non-maleficence and justice. Nurses with higher academic degrees obtained relatively higher scores in the assessment of patient’s rights (Sheikhtaheri et al., 2015). Patients’ rights are numerous including those related to ethics, however, the study did not specify which of the patient rights nurses scored highest or lowest in order to inform policy and education. However, since the study included patients as
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participants, objective views about the nurses’ performance with patients’ bill of rights could be obtained to reflect what the nurses said.

Findings of a cross-sectional study on health workers’ knowledge and perceptions of ethical principles by Opoku and Addai-Mensah (2014) in Ghana also revealed that, 217 out of 220 respondents had knowledge about the existence of ethical principles and acknowledged their relevance in healthcare delivery. Awareness of patient’s confidentiality was highest while non-maleficence was lowest among participants. General knowledge of the individual ethical principles was poor. It could be inferred that nurses would generally have poor knowledge of the ethical principles guiding practice though this study did not specify the number of nurses that participated and the specific level of knowledge and perceptions on relevance of the ethical principles in practice. Scores on knowledge of patient confidentiality, especially in emergency cases was rather lower while consent for treatment was well practiced in India (Unnikrishnan et al., 2015). Fantahun, Demessie, Gebrekirstos, Zemene, and Yetayeh (2014) also found that knowledge of patient advocacy was highest while knowledge of autonomy was lowest. In a Brazilian study using mixed methods, professionals perceived that lack of knowledge of ethics and their applicability endanger the profession and clients. Findings were that 60% of intensive care unit nurses had knowledge of ethics but could only resort to applying principles dealing with duties, and patient rights (Santos et al., 2016).

Further, an assessment of nurse educators’ knowledge of ethical principles, professional codes and their implementation showed that, they knew well the professional codes governing them with the older and more experienced ones doing relatively better (Salminen, Metsämäki, Numminen, & Leino-kilpi, 2013). The principle of fairness was rated highest. Those with good knowledge of the principles perceived that they treated others fairly and with respect. Also, a Brazilian case study by Ramos et al. (2013) on the discourse of nursing ethics education noted 38% of teachers, aside 34% teaching ethics related courses, acknowledged that they discussed
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ethical and moral issues in class regularly though their courses were not directly about ethics. Most teachers also perceived their daily duties to evolve around ethics since their lives were expected to serve as examples for students but could not apply some bioethical and ethical theories in daily issues. Moreover, nurse educators’ knowledge of professional ethics can reflect in the clinical area as their students’ practice will be determined by what they are taught. Nurse educators considered justice, honesty and equality as the most important ethical principles that should guide teaching, however, faulted in practical application in Finland (Salminen et al., 2016). Additionally, clinical mentors also self-rated knowledge of ethics as good, though their opinions on the inculcation of ethical values in students was below average (Skela-Savič & Kiger, 2015).

It has also been shown that nurses with long years of work experience, higher educational attainment and belonging to a professional nursing association exhibited high professionalism attributes such as autonomy, accountability, advocacy, collaboration and collegiality (Fantahun et al., 2014). Also, Osingada. (2015) noted that nurses with higher education scored higher in ethics knowledge test. Such nurses are most likely to apply ethics in nursing practice including postoperative pain management as compared to other cadre of nurses who may not have good understanding of nursing ethical principles. Studies further show that baccalaureate nurses demonstrated better skills in documentation of assessment and interventions in patients’ pain experiences (Heikkilä, Peltonen, & Salanterä, 2016; Samuels & Fetzer, 2009), further buttressing that higher education brings about increased nurses’ knowledge of professional accountability and sense of responsibility towards alleviation of suffering (Epstein & Turner, 2015; International Council of Nurses, 2012).

Additionally, more years of experience in the clinical care setting may have positive influence on the nurse’s knowledge and attitude towards pain assessment. Youngcharoen, Vincent, and Park (2017) found that nurses with ten or more years of clinical experience had
highest scores for attitudes towards pain assessment. However, the study did not report the attitudes of nurses with fewer years of experience in patient care to ascertain if attitude has a link with years of clinical experience in patient care. Positive attitude can be inferred from strong moral courage and obligation towards patients’ pain management. Moreover, there is an established positive correlation between professional autonomy and higher education on attitude towards caring for dying patients (Iranmanesh, Razban, Ghazanfari, & Nejad, 2013) which presupposes that higher carrier development and years of experience are most likely to positively influence upholding professional ethical standards in nursing care including ethical decision making for POP management.

Furthermore, Ulrich et al. (2010) assert that nurses with fewer years in practice frequently encountered ethical issues related to patient rights, end of life, resource allocation, organ donation, conflicting professional obligations, conflict of interest, and negative staffing patterns as compared to staff with more years of experience in practice, underscoring the role of experience on knowledge of ethics in nursing. Notwithstanding, 80 percent of respondents felt confident to justify all ethical decisions made while 62.3 percent felt prepared to deal with ethical issues (Ulrich et al., 2010).

A comparative study on nurses and patients by Florin, Ehrenberg, and Ehnfors (2006) also highlighted that majority of nurses perceived that patients preferred a high degree of participation in decision making about treatment. The nurses’ perception of patients’ willingness to participate in decision making however was negatively correlated with patients’ own desire to participate in decision making. The finding could imply that nurses inappropriately involved patients in decisions that were possibly difficult to make or did not know how to properly involve patients in the decision making, underscoring nurses’ insufficient knowledge of how to involve patients. However, Gallagher et al. (2015) realised in their study that nurses knew their decision making roles in the intensive care units and
therefore, through consensus seeking, would coax physicians and other professionals to make decisions on patients with end of life care with relevant stakeholders. According to the findings, nurses who gained respect from physicians over time due to experience always influenced ethical decisions on patient treatment.

Ulrich, Zhou, Hanlon, Danis, and Grady (2014) revealed that Nurse Practitioners’ increased knowledge of professional ethics such as autonomy enhanced their confidence in healthcare delivery decisions and improved quality. This presupposes that as professional nurses know ethics relating to pain management, they may most likely give satisfactory care. Smyth, Toombes, and Usher (2011) also affirms that nurses’ increased knowledge of decision making regarding the selection and administration of analgesics for paediatric surgical patients depended on their personal experience and professional background, use of pain assessment tools, use of behavioural cues of patients and involving children’s parents. It can be that nurses who have higher knowledge are likely to be more autonomous and can in turn empower patients.

According to Valizadeh, Ahmadi, and Zarea (2016), nurses and doctors told parents of paediatric patients that pain was normal following surgery and seldom assessed due to lack of sensitivity and responsibility for the prevention, diagnosis and management of postoperative pain, which is a sign of relegating the supposed right to pain treatment and fairness for patients in pain. A related study shows that nurses considered it as responsibility of parents to detect and notify nurses of their children’s pain rather than depending on nurses for pain assessment of surgical patients (Twycross & Collis, 2013). This is most likely to occur with adult patients as the researcher has noted instances in practice where nurses informed relatives to note patient’s pain expressions and notify staff because of nurses’ lack of time. It presupposes that such nurses overlook the ethical responsibility of nursing care for their clients (Olson & Stokes, 2016) or may not even know that patients have rights concerning pain management.
2.4 Influence of nurses’ relationship with other health professionals in ethical decision making for postoperative pain (POP) management

Quality patient care largely depends on the nurse-physician relationship and collaboration in the hospital setting (Friese & Manojlovich, 2012; Galletta, Portoghese, Battistelli, & Leiter, 2013; Schmalenberg & Kramer, 2008; Sevdalis & Brett, 2009) because these are the two most important healthcare providers in the clinical environment (Schneider, 2012). Nurse-physician relationship depends on the quality of collaboration that exist between them. Nurse-physician collaboration refers to nurses and physicians working cooperatively, sharing responsibilities for solving problems and making decisions to formulate and carry out plans for the patients care (Ushiro & Nakayama, 2010).

Nurses and physicians value collaboration differently (Brown, Lindell, Dolansky, & Garber, 2015; El Sayed & Sleem, 2011) and each of the professionals have special and unique contribution to patient care but do not often appreciate each other (Miller et al., 2008). A poor collaboration and communication among these professionals have been linked to poor patient outcomes (McCaffrey et al., 2010). A healthy collaborative relationship is most likely to create avenue for nurses to make competent and ethically sound decisions (International Council of Nurses, 2012). There is however, paucity of literature to demonstrate the impact of this relationship on ethical decision making for postoperative pain management among nurses. A study found that professional relationship between nurses and physicians is important. The relationship had a significant impact on satisfaction with the level of involvement among these professionals in patients’ pain management. This reduced ethical conflicts encountered during patients’ pain management (Van Niekerk & Martin, 2002). The study further showed that as nurses perceived that they were allowed to participate in patient care, their level of involvement in decision making was increased. A professional collaborative relationship between nurses and physicians would ensure that ethical conflicts experienced by nurses are resolved in a
Supportive team approach which may further make nurses develop the capacity to formulate decisions that will be ethical in patients’ management.

Also, inter-professional collaboration has a link with job satisfaction and patients’ satisfaction of care. Shen, Chiu, Lee, Hu, and Chang (2011) found that nurses who felt better about nurse-physician relationships perceived they rendered quality care to patients. This study also found that patients rated the nurse-physician relationship to be good and thus rated quality of care given to them as high. The difference in the sample size of nurses and patients in this study however was wide (575 nurses and 220 patients), meanwhile the sampling technique used to arrive at the respective sizes is not clear to aid understanding the similarities of the findings. Similarly, an interventional study on effects of nurses-physician teamwork and their perception of job satisfaction demonstrated that those professionals who worked in the interventional group emergency departments showed significantly higher levels of job satisfaction than those staff in the control group (Ajeigbe, McNeese-Smith, Phillips, & Phillips, 2014). The staff in the interventional group could consider each other as partners in patients care and therefore, had respect for one another.

Also, while nurses perceived that physicians treated them with politeness, respect and dignity, physicians indicated that nurses worked together with them to solve patient problems in a calm and non-hostile manner (Siedlecki & Hixson, 2015). The study further noted that nurses’ decision making on the care of patients was most likely to be affected by negative attitude of the physicians towards the nurses, with less experienced and less educated ones having frequent complains about physicians’ attitudes. It is most likely that nurses with less education could not handle such behaviours of the physicians probably because they might not have the required training to deal with rude behaviours in ethical manner which could result in poor patient outcomes as compared to the more educated nurses.
Another study suggested that negative attitudes among professionals may hinder collaboration as nurses found it challenging in making suggestions to physicians regarding pain management prescriptions for patients in pain. This was because of poor attitudes on the part of physicians towards nurses (Blondal & Halldorsdottir, 2009). The negative attitude reported in this study may adversely affect professional relationship between nurses and the doctors which can hinder collaboration towards patients care. Meanwhile, it was established that good inter professional collaboration was integral in effective postoperative pain management (Zoëga, Gunnarsdottir, Wilson, & Gordon, 2014). Similar findings in Ghana by Aziato and Adejumo (2015b) indicated that effective team work is required by nurses and the other health team members (such as doctors, and pharmacists) for postoperative pain to be properly managed. Collaboration and peaceful teamwork may also allow for detection and reporting of treatment complications and prescription errors (Aronson, 2009).

Again, when nurses know their decision-making roles, they are able to influence decision in the care of patients. A study in Germany showed that nurses played various roles in decision making regarding end-of-life care of patients including coaxing physicians to withdraw or limit treatment for patients considered to have poor prognosis (Gallagher et al., 2015). Also, Smyth, Toombes, and Usher (2011) explicated that nurses used various strategies to determine when to administer “pro re nata” (PRN) analgesia to their patients including their professional background, experience, and involving patients. It could be deduced that when nurses are knowledgeable about their responsibilities in decision making on the medications to be administered, they will endeavour to make decisions that are ethical.

Sharing patient information among nurses and doctors was shown to be collaborative behaviour between these professionals in a study in the United States of America (USA). This was suggested to enhance nurses’ advocacy roles for patients and also reduced potential medical errors (Nair, Fitzpatrick, McNulty, Click, & Glembocki, 2012), even though decision
making occurred less frequently between the professionals. Reduced collaboration in decision making could result in the tendency of working in solitary state (Rosenstein & Naylor, 2012).

Lee, Doran, Tourangeau, and Fleshner (2014) also showed that nurses and physicians rated quality of inter-professional interactions as satisfactory in oncology outpatient clinic. This was shown to improve quality of patient care. Furthermore, nurse practitioners’ and physician assistants’ good collaboration in the intensive care unit imparted positively as acuity and mechanical ventilation rates reduced (Costa, Wallace, Barnato, & Kahn, 2014). Inter-professional interactions could enhance exchange of ideas and decisions on best evidence of care. Reciprocal respect and mutual benefits for other’s profession and views could account for good inter-professional interactions. Also, nurses in general care settings had positive attitude towards inter-professional collaboration in patient care (Brown et al., 2015; El Sayed & Sleem, 2011). El Sayed and Sleem (2011) further explained that, the female dominated nursing and the male dominated physicians, and the traditional subservient role of nurses accounted for the nurses’ willingness to collaborate better. Also, increasing years of experience of both nurses and physicians improved attitudes towards inter-professional collaboration in this study.

According to Hastie and Fahy (2011), midwives and doctors also perceived positive inter-professional relationship to enhance women and their partners’ involvement in birthing process and overall satisfaction. Midwives and doctors who had good relations with one another collaborated ideas in assessment, diagnosis, and management of labour successfully, and patients also expressed satisfaction. Findings further showed that authoritative attitude of doctors prevented midwives from initiating actions relating to patient care, such as patient education and explanation of procedures that physicians planned to carry out on patients (Hastie & Fahy, 2011). It clearly shows that in a practice environment where professionals respect one another coordination of ideas will be effective. This could ensure each professional make suggestions that are clinically and ethically sound so that their colleagues will appreciate.
It may also enhance good outcomes of patients care because, suggestions and decisions will be critiqued well for effective implementation.

Poor nurse-physician collaboration affected nurses’ decisions in teamwork and influenced outcomes of feeding critically ill patients negatively. More experienced physicians had a sense of superiority complex and disregarded suggestions of nurses who were less experienced and less educated. This made nurses perceive a lower collaboration at work as compared to physicians (Mei et al., 2017). Decreased nurse-physician interactions may inhibit quality ethical decisions on patient management since there may not be a platform to share ideas. This could imply that poor nurse-physician collaboration can equally affect surgical pain management, ethical decisions and subsequent outcomes of care.

A qualitative study conducted by Kendall, Deacon-Crouch, and Raymond (2007) revealed that nurses did not value collaboration with pharmacists concerning duties of discharge education on patients’ medication. The nurses limited their responsibilities during patients discharge because of the low desire to work with pharmacists towards patients’ education on their discharge medications. However, Makowsky et al. (2009) found in their study that there was collaboration among physicians, nurse practitioners and pharmacists with benefits such as improved decision making in drug therapy, and patient safety.

2.5 Influence of unit leadership on nurses’ ethical decision making for POP management

Leadership practices are known to influence nurses’ motivation and performance in clinical care settings (Brady Germain & Cummings, 2010; Richards & Edwards, 2012). Effective nursing leadership has also demonstrated to enhance staff retention (Cowden, Cummings, & Profetto-Mcgrath, 2011), job satisfaction, commitment, and client satisfaction (Henriques, 2015; Laschinger, Nosko, Wilk, & Finegan, 2014). Studies show that staff nurses
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rated their supervisors as transformational leaders and were satisfied with the leadership attributes exhibited by the supervisors (Agnew & Flin, 2014). A study in Nigeria also demonstrated that nurses’ perceptions on their supervisors’ leadership styles positively influenced the quality of patient management and that, nurses perceived leaders to use transformational leadership (Olu-Abiodun & Abiodun, 2017). Leadership expectations of higher staff performance was rated highest by nurses on the leadership behaviour domain in that study. This could demonstrate that as staff are challenged to work harder in friendly environment, they will in turn impress leadership by clinging on to ethically sound decisions in patient care.

Effective and constant supervision by hospital management and unit leadership are integral in desirable postoperative pain management outcomes (Aziato & Adejumo, 2015b) because a previous study on Ghanaian nurses’ perceptions and responses to surgical pain management indicated that organisational reluctance and ineffective leadership influenced nurses negatively on their willingness to manage pain (Aziato & Adejumo, 2014b). Constant supervision could therefore be a source of reminder of nurses’ ethical obligations for patients’ comfort needs such as appropriate pain management.

Recognition behaviours of senior nurses’ influence satisfaction of junior staff nurses. Studies showed that positive feedback and positive attitudes of nurse leaders towards junior nurses encouraged them to become confident, motivated and involved in making decisions that supported quality of patient care (Atwater, 2007; Batson & Yoder, 2009; Miyata, Arai, & Suga, 2015). Eneh, Vehviläinen-Julkunen, and Kvist (2012) also revealed that nurses were satisfied with leadership ethics but were not satisfied with feedback and rewards for work they did. It could be possible that the feedback and rewards were not motivating enough to the nurses and therefore, could affect the nurses work output. Conversely, absence of feedback from clinical instructors on students’ performance was viewed by such students as being mentally distressing
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(Maxwell, Black, & Baillie, 2014; Tiwaken, Caranto, & Jose David, 2015) which could translate into poor performance.

Also, as nurse managers allowed nurses to communicate their ideas, plan patient care and to participate in clinical decisions (Miyata et al., 2015; Tsukamoto, Yuki, Funaki, Tanaka, & Yamagichi, 2009), they are most likely to have a sense of responsibility in the care of their patients and therefore, may make ethically good decisions to impart care including pain management. Batson and Yoder (2009) also suggested that nurse managers should take time to know each individual employee, their preferences and concerns through active listening to the subordinates’ concerns in order to improve efficiency of staff. Effective communication is also suggested by Polis, Higgs, Manning, Netto, and Fernandez (2015) as a strong leadership tool to improve teamwork.

A study to assess the impact of supervision on effective work output among primary health care providers in Ghana showed that productivity, including time spent on patient care was higher among professionals who reported being supervised in the last one month (Frimpong, Helleringer, Awoonor-Williams, Yeji, & Phillips, 2011). It was however found that few staff felt that they had little support from supervisors. It was further reported that the effects of supervision depended on whether supervisors were supportive. This imply that supervision should accompany means of empowering and encouraging nurses, especially when they face constraints in the practice environment. Also, an evaluative study to establish nurses’ perceptions of implementing clinical supervision showed that it was effective in improving patient care and ultimately improved standards of work as well as helped in professional development (Davis & Burke, 2012).

Similarly, study to ascertain job satisfaction of navy and civilian nurses in a United States Navy Hospital found that both group of nurses’ job satisfaction was determined by the
supervisors’ support for their work (Zangaro & Johantgen, 2009). Monotonous activities had the strongest significant negative association for job satisfaction for both civilian and navy nurses. This suggests that nurses want to be innovative in the clinical settings. Nurses may also want to be involved and supported by their leaders in decision making in order to feel satisfied.

Also, in a study on factors contributing to nursing teamwork, unit-based leadership effectiveness and openness in communication positively influenced teamwork (Polis et al., 2015). Effective leadership may increase consciousness of staff on their ethical responsibilities to patients. Effective leadership requires knowledge and experience to provide guidance for solving complex problems (Day, Fleenor, Atwater, Sturm, & McKee, 2014) collectively with subordinates where every member is empowered to collaboratively make ethical decisions towards quality patient management. This may be achieved with clear communication of objectives.

A systematic review on the influence of nursing leadership on performance of nurses revealed that, factors that affected the nurses’ motivation and ability to perform were autonomy, work relationships, resource accessibility, and leadership practices (Brady Germain & Cummings, 2010). Nursing leadership may need to ensure that they provide clear guiding principles for their nurses. Nurses also need to feel important in decision making by engaging them.

2.6 Influence of institutional factors on nurses’ ethical decision making for POP management

The general healthcare system has the potential of influencing nurses in their professional practice and how they understand and uphold professional ethics that govern practice. Ethics committees are important establishments in the healthcare facilities that play
critical roles in formulation of policies, educating and handling of ethical issues (Aulisio, 2016; Garrison & Magnus, 2012; Hoffmann & Tarzian, 2008).

It was found that lack of institutional ethics committees and lack of awareness of policies to address ethical issues accounted for 42.6% and 36.1% of barriers to managing ethical issues respectively. The absence of ethics committee and lack of awareness of policies on ethical issues were noted to be the major setbacks to appropriate ethical decision making in the care of patients (Song et al., 2014). In such situations, nurses who may not perform their duties in pain management may not be held responsible since no measures are made available to attend to patients’ rights to appropriate treatment. Additionally, some nurses may not even recognize unethical acts and correct themselves. Samuels and Fetzer (2009) also noted that lack of institutional commitment to newer pain management programmes constrained nurses’ knowledge in efforts to give optimum pain management, highlighting traits of negligence of institutions on their responsibilities to patients in post-surgical pain treatment.

Similar studies in Japan on nurses showed low awareness of ethics committees (83% of 331 respondents either did not know or were not sure of existence of ethics committees). This suggested that ethics committees were not functioning effectively, even if they were available (Nakao, Chishaki, & Obayashi, 2008). It also may be presumed that the absence or non-functioning of ethics committees in hospitals could endanger reinforcement and adherence to professional ethics by nurses which can adversely affect standards of nursing practice including pain management postoperatively.

Adequate staffing is the responsibility of the hospital management. Due to lack of adequate resources, hiring could be reduced. Low staffing impact adversely on time spent by nurses to manage individual patients. Studies showed that some nurses used discretionary measures to attend to patients perceived to be in serious conditions while they ignored others
who were perceived to be in less severe pain. These patients and their relatives complained severally of pain and yet were not attended to due to inadequate time on the part of staff (Twycross & Collins, 2013; Valizadeh et al., 2016). Nurses stand the risk of moral distress when they are aware of their responsibilities such as attending to the individual needs of patients timely and yet are not able to execute them (Mallari & Tariman, 2016) because of institutional forces such as workload and inadequate staffing. Furthermore, reports of shortage of nursing staff in emergency units resulted in over working with its attending effects of constant tiredness, emotional and mental fatigue. It negatively affected the professional practice where medical errors, delayed care, failure to attend to patients and lateral violence became common (Wolf, Perhats, Delao, & Clark, 2017). When professionalism is compromised because of inadequate staffing ethical standards may wane and this implies that ethical decisions and appropriate judgement on patients’ pain management may be compromised.

Failure of health facilities to provide certain diversion therapy resources for patients could also limit nurses to resort to only pharmacological measures of pain relief. This assertion is true as it was established that insufficient and non-functioning play rooms for surgical paediatric patients for diversion therapy limited nurses to resort to pharmacological means of pain management only (Twycross & Collis, 2013; Valizadeh et al., 2016) where even minimal pain experience that could be managed non-pharmacologically by nurses is being controlled with drugs. This may go along with adverse effects and possible addiction, thus causing a breach of the principle of nonmaleficence.

A recent study showed that midwives are proactive because they were able to apply non-pharmacological strategies as well as administered analgesics to women in labour pain based on their experience when doctors were around on the wards (Aziato, Kyei, & Deku, 2017), though no explicit protocols were available for them to use. Designing protocols may
help nurses fully perform their duties of ethical management of pain without the challenges of adverse outcomes of taking interventions based on only experiences.

Clinical guidelines and protocols are important in the provision of evidence-based care (Barr et al., 2013). Studies have shown the importance of the use of multimodal approaches as protocols in the management of hip and knee surgical pain (Parvataneni et al., 2007). Also, functional recovery followed use of the multimodal approaches for pain management, underscoring the importance of standard protocols for pain management. A systematic review done on the impact of nurse-led care in the management of acute and chronic pain found that the use of protocols by nurses could improve pain management and patients’ understanding of their conditions (Courtenay & Carey, 2008). Similarly, Pretorius, Searle, and Marshall (2015) noted that, the use of nurse-initiated analgesic protocols for nurses lessoned the time consuming stress of searching for doctors to attend to patients. Protocols can therefore be perceived to facilitate easy patient education, which is the nurses’ responsibility to ensure autonomy of the patient through education.

A study on the influencing factors to the use of protocols by ambulance nurses in the Netherlands showed that nurses’ adherence to the National Protocol Ambulance Care was high but their complex nature affected their use (Ebben et al., 2015). Also, (Jun, Kovner, & Stimpfel, 2016) found that poor attitude, lack of time, low knowledge or awareness of protocols, unsupportive leadership and organizational culture of resistance to change were barriers to use of protocols. Jun et al. (2016) further indicated that supportive leadership, involvement of nurses in the development of protocols and guidelines, adequate staffing, education on the use and importance of protocols and simplifying protocols may enhance their use in the clinical care of patients to improve pain management.
Other institutional factors such as lack of experienced prescribers, and lack of clear division of labour are known to also influence adequate pain management ethical decisions. This is evidenced by the findings of Blondal and Halldorsdottir (2009) that unclear division of tasks between nurses and prescribers, lack of continuity of care, limited access to physicians and inexperienced physicians, and waste of time in consulting physicians for prescriptions of pain medications that nurses already knew would be administered to patients were perceived to adversely affect prompt pain management. Moral distress is most likely to ensue as nurses’ ethical and professional responsibilities are constrained by institutions’ failure to accomplish their responsibilities. When health institutions take up certain responsibilities such as ensuring availability and accessibility of pain services at all times, ensuring staff adherence to protocols, taking actions on patient-reported outcomes and receptivity to technological advancements in pain management measures, it will help increase staff output in pain management (Gerbershagen et al., 2013; Meissner et al., 2015) ethical decisions.

Workplace violence against nurses can be presumed to be caused by nurse’s poor attitude and unethical behaviours towards patients and their relatives. Hospitals have a role in organising training programmes on how to handle and respect patients’ rights that may reduce the risk of their nursing staff facing violence against them. A pre-test and post-test design was performed to ascertain the impact of a training programme on nurses’ attitudes towards workplace violence in Jordan. The results showed a significant improvement on their attitudes following training (Al-Ali, Al Faouri, & Al-Niarat, 2016). This resulted in a reduction in the prevalence of violence because nurses respected patients and supported each other morally following violence. It can be inferred that nurses could behave ethically towards patients in managing pain through constant in-service training on ethics and pain management, which can eventually reduce risk of workplace violence.
The implementation of effective and evidence-based pain management requires administrative support. In other countries, Magnet standard hospitals support care at the bedside by reinforcing components of evidence-based practice in pain management with standard protocols unlike non-magnet hospitals that have low numbers of baccalaureate nurses, which account for low pain management documentation, reflecting decrease sense of responsibility (Samuels & Fetzer, 2009). A study done to determine factors that influenced nurses to withhold surgical patients’ oral medications identified that nurses made inappropriate decisions because of failure of institutions to provide protocols and guidelines on when and what patients needed to withhold their pain medications (Symons & Mcmurray, 2014). Clear guidelines on administering medications enable nurses make good ethical decisions timely in order to prevent pain from getting worse.

Healthcare system related barriers to effective pain management prevent nurses from giving quality pain management. Some of these include shortage of medications and specialised equipment for pain medication administration (Medrzycka-Dabrowska, Dabrowski, & Basinski, 2015), which put nurses in a state of moral distress.

2.7 Summary of Literature reviewed

Literature was reviewed on the factors that influence nurses’ in making ethical decisions for POP management. It included nurses’ knowledge of nursing ethical principles, nurses’ relationship with other health team members, influence of unit leadership, and institutional influence on the nurses’ ethical decision making for POP management.

The literature showed that nurses’ knowledge of ethical principles is generally obtained from training and years of experience in practice. Knowledge of ethical principles help nurses to make ethical decisions regarding nursing care. Also, reviewed studies show that healthy inter-professional collaboration, and positive attitudes of professionals towards one another
help professionals to participate in making decisions towards patients’ care. Further, effective leadership and feedback on work done from unit nurse leaders enhanced ethical decisions and practice. Again, institutional factors such as absence of protocols, shortage of nursing staff, absence or non-functioning ethics committees in hospitals, among others, also adversely affected ethical decision making and subsequently patients’ outcomes.

Most of these studies were done in middle and high-income countries which have been inferred to the current study because there is paucity of literature that specifically explain the factors that influence nurses’ in making ethical decisions for pain management, especially POP. It therefore calls for this specific study in the Ghanaian context, using qualitative approach to explore what may influence nurses in making ethical decisions for management of surgical pain.
CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter described the research design, study setting, the target population, the sample nature, the procedure in data collection and analysis, methodological rigour, and the ethical considerations.

3.1 Research design

The study employed qualitative descriptive exploratory design. It is mainly employed to study phenomena that have not been studied more extensively in order to unravel experiences of participants. This approach is grounded in the general principles of naturalistic inquiry which deals with the concept of truth; a systematic set of beliefs together with their accompanying methods (Colorafi & Evans, 2016; Lincoln & Guba, 1985). Qualitative research design is used to describe a phenomenon by exploring the thoughts, feelings, actions and behaviours of individuals or groups in context (Colorafi & Evans, 2016; Vinet & Zhedanov, 2010). Qualitative descriptive exploratory design is “amenable to health environments research because it provides factual responses to questions about how people feel about a particular space, what reasons they have for using features of the space, who is using particular services or functions of a space, and the factors that facilitate or hinder use” (Colorafi & Evans, 2016 p 2). This methodology allows for the use of a theory or conceptual framework to guide the study. This design was used to explore, understand and describe what and how factors influence nurses in ethical decision making for postoperative pain management. Also, little is known about the topic, factors influencing nurses’ ethical decision making for postoperative pain management in the Ghanaian context, and therefore, the appropriate design used was the descriptive exploratory method.
3.2 Study setting

The study was carried out in Upper East Regional Hospital which is located at Bolgatanga. Bolgatanga is the capital city of Upper East Region of Ghana. The total land surface area of the region is 729 square Kilometres. Bolgatanga is surrounded by Bongo District to the north, Talensi-Nabdam to the south and east, and Kassena-Nankana to the west. It is dominated by the Frafras, the indigenous tribe. The common religions practiced there are Christianity and Islam.

Established on 13th January, 1953, the regional hospital is located in North-Eastern part of the city, and close to the Ghana broadcasting Co-operation. Participants were obtained from the regional hospital in the capital city. It is the largest hospital in the region and is said to be the final referral hospital from all over the region. The hospital is boarded by Yikene, Nyaria, Bukere, and Tindanmolgo. It has the following departments/units: Outpatient Department, Medical, Surgical, Maternity, Paediatric, Maternal and Child Health/Family Planning, Ear, nose and throat, Physiotherapy, psychiatric, Chest, theatre, and Emergency departments. The surgical ward, from which the study sample of nurses were obtained attends to about 60 patients on a daily basis and is attached to the operating theatre of the hospital.

3.3 Target population

The target population included all registered general nurses and perioperative nurses. The category of nurses mentioned above were expected to understand the core issues with surgical patients, including surgical pain management.

3.4 Inclusion criterion

Registered general nurses who practiced in the surgical departments for a minimum of one year.
3.5 Exclusion criteria

1. Nurses who were on sick leave at the time of study.

2. Enrolled nurses who were in the surgical wards and theatre.

3.6 Sample Size and Sampling Technique

The sample size depended on the number of participants interviewed where continuation would no more elicit any new information (Fusch & Ness, 2015; O’Reilly & Parker, 2013). This means that the information or data obtained become adequate and able to answer the research questions sufficiently. Field notes and concurrent data analysis helped the researcher to identify the moment at which themes were recurring and no new insights, themes or ideas were given by additional sources of data (from participants). The researcher therefore anticipated to interview about twelve (12) to eighteen (18) participants.

Purposive sampling technique was used to recruit participants. It is a technique in which participants are selected because of the belief of their experience or knowledge in the given phenomenon under study (Colorafi & Evans, 2016). The technique was used because the registered nurses who attended to surgical patients had insight and experience in surgical patients’ pain management and might have also encountered ethical issues with patients care, especially in pain management and were, therefore, the appropriate participants.

3.7 Data collection tool and procedure

An interview guide was designed to conduct face-to-face interviews on participants to explore the factors that may influence ethical decision making for postoperative pain management. Interview method is used to collect data from participants through face-to-face interaction which allows for probing (Pokhrel, Reidpath, & Allotey, 2011). The semi-structured interview guide was appropriate because nurses were allowed to express their views
on factors influencing ethical decision making for postoperative pain management since the questions were open ended. It also allowed for follow-up questions and probing further to obtain clarifications and diverse views of participants respectively (Freeze & Kulkarni, 2007).

The interview guide was designed based on the objectives of the study. The interview guide comprises of demographic data of participants and open-ended questions which are followed by probes where necessary. Demographic data such as sex, age, number of years of work, and educational qualification were asked.

Participants were contacted at the ward and they chose a place convenient for the interview. Confidentiality was ensured through one on one interaction without other people coming around to interrupt and hear whatever was said. It was conducted in English language. Anonymity was ensured by assigning codes to participants. Interview was face-to-face and in-depth. Follow-up questions and probing were done to enable participants express their thoughts well and comprehensively to enable the researcher know exactly what participants were saying. Iterative questioning was also employed, that is, re-questioning participants in cases of ambiguous and contradictory comments or statements to elicit clarity. Participants’ comfort was ensured during the interviews by providing conducive seats, and serene rooms, as well as minimising unnecessary delays. Each session of interview lasted between forty-five and one hour.

3.8 Piloting the instrument

The interview guide developed was piloted at the Tamale Central Hospital, which is a regional hospital and a referral centre for other hospitals in the Northern Region. It has surgical units where surgical cases are managed. It also has a good number of nurses. The hospital has similar characteristics as the study setting because it is also a regional hospital as the study setting.
Tamale also has similar sociocultural and economic status as Bolgatanga and was appropriate for piloting the interview guide.

3.9 Data management

Data management is the processes involved in the storage and easy retrieval of the data for use in analysis. Data were managed manually after it was obtained through interviews and recorded (Miles & Huberman, 1994). Participants were assigned codes as follows: MN, and FN with numerals attached to each code. “M” represent male, “F” for female and “N” for nurse and the numerals represent the number of nurses interviewed. All interviews were transcribed verbatim after recording and new files were created for storage of information.

3.10 Data analysis

Analysis was done concurrently with data collection. Data collected was transcribed verbatim. Transcribed data was then analysed using content analysis. Content analysis is used to determine trends, patterns of words used, their frequency, their relationships, and structures and discourses of communication (Colorafi & Evans, 2016; Miles & Huberman, 1994; Pokhrel et al., 2011; Vaismoradi, Turunen, & Bondas, 2013). In content analysis, important themes and patterns that emerge from participants are identified (Vaismoradi et al., 2013). It involves identifying and condensing meaning units of words or texts (Erlingsson & Brysiewicz, 2017). The approach was used to identify emerging themes from the data.

The transcribed data was read carefully over and again in order to be very familiar with the data. In reading through, important points were noted, as well as patterns, and text meaning of words. Features of the data that appeared interesting and referred to the most basic segments of the raw data were organised into meaningful groups as codes. This was done carefully throughout the data sets to ensure all relevant codes were identified. The various codes were then sorted into potential themes and subthemes. The analyst further identified the codes that
could be combined to form some overarching themes and also by merging those that do not stand out, collapsing other themes, or further forming new ones through re-reading the subthemes and codes carefully. The themes were finally defined and named.

Each interview was spaced to allow for analysis, and also for the researcher’s supervisors to assess the results before booking the next interview. This process enabled the researcher to develop better skills in the subsequent interviews.

3.1 Methodological rigour

It is a process used to determine if the data obtained from respondents represent their experiences and thoughts and whether it can be relied upon (Bhattacherjee, 2012; Polit & Beck, 2010; Lietz, Langer, & Furman, 2006). Measures used to ensure trustworthiness in qualitative research include credibility, dependability, transferability, and confirmability (Guba, 1982; Polit & Beck, 2010).

Credibility seeks to address the congruence of the findings to real life situations (Anney, 2014). Credibility ensures that data obtained reflect what respondents are (Guba, 1982). Strategies for ensuring credibility are developing and asking good questions, learning about the research setting, use of random sampling, use of iterative questions, triangulation, and member checking (Anney, 2014; Shenton, 2004). Credibility was ensured in this study through probing, and rephrasing of questions asked earlier to gain clarity from participants, especially in cases where participants gave contradictory statements. This was to ensure that falsehood in the data were identified. Also, frequent debriefing sessions were done with supervisors so that discussions could widen the researcher’s vision and skills to enhance further quality data gathering. Furthermore, transcribed data from participants were given to each participant to read through to ascertain if what were written were what they intended to say. This was done for each participant on the date scheduled to interview the next participants. Rapport was also
established at each session. They were informed that there was no right or wrong response to questions and that they should be free to say only what they knew or have experienced in practice. Participants were also assured of confidentiality and anonymity to enable them feel safe and secure to say what they knew honestly. Each participant was also told of the unconditional right to exit at any time. These helped ensure that they gave as frank information as possible.

Dependability is the consistency of the procedures and processes employed in the study by the researcher. This can be achieved by ensuring that each participant answers same questions from the same interview guide developed, the same method of analysis of data employed (Guba, 1982). Also, code-recode strategy, where the researcher code the same raw data twice with about a week or two intervals to see whether there will be differences is a means of determining dependability of findings (Anney, 2014). Further, stepwise replication can be done to ensure dependability. Stepwise replication is the process where two researchers analyse the same data separately and compared for differences and similarities (Anney, 2014; Chilisa & Preece, 2005). The interview guide developed for the study was used in the interview process in order that participants were not asked different questions entirely. Data analysis was also done using the same methods and same recorder was also used for the audio recording. Ultimately, processes within the study was reported in detail and in context.

Transferability in qualitative study is equivalent to generalizability or external validity in quantitative research in which the results or findings of the study can be generalised. In qualitative study, findings cannot be generalised because of the relatively low sample size and the sampling techniques usually employed. That notwithstanding, the findings can be applicable in other settings when the research setting, participant characteristics and methodology are well described or explained (Shenton, 2004). The methodology has been well explained including the number of participants expected for the purpose of meeting
transferability. Also, data obtained has been well described in context to enable applicability if desired by other researchers.

Confirmability is comparable with objectivity in quantitative research study. In ensuring confirmability, the researcher takes steps to ensure that the findings are the result of the experiences and ideas of the respondents, rather than the characteristics and preferences of the investigator (Chiovitti & Piran, 2003; Shenton, 2004). Information obtained from participants was transcribed verbatim to prevent misinterpretation. Audit trail was developed. This was ensured by keeping all audio tapes, field notes, interview transcripts, and notes on member checking in order to have a track of the entire process of the study.

3.12 Ethical considerations

Ethical clearance was sought from the Institutional Review Board of Noguchi Memorial Institute for Medical Research, an affiliate of University of Ghana, Legon. This was achieved by following the laid down procedures spelled by the institute. Introductory letter was also obtained from the school of nursing in order to seek permission from the Upper East Regional health directorate, and the Regional Hospital authority.

The expected participants were informed of the study and its purpose. They were also informed that no physical or psychological harm was anticipated, and no direct benefit was to come out of the research for them and that they could opt out at any time they wished without consequences. Participants were alerted that the interviews were to be audio recorded just to reduce the delay associated with writing what they said and also to ensure that all what was written actually reflected the participant’s conversations without any alterations. They were also informed that consent forms would be given to them to fill upon accepting to be interviewed. In order to ensure confidentiality and anonymity of participants, codes were used for participants’ identification.
CHAPTER FOUR

FINDINGS

4.0 Introduction

This chapter presents a description of findings obtained from the data gathered that was aimed at exploring factors influencing nurses’ ethical decision making for postoperative pain (POP) management in the Upper East Regional Hospital, Bolgatanga. The chapter also includes demographic characteristics of the participants. The themes and subthemes that emerged from the data analysis are presented in this chapter with verbatim quotations. Five themes emerged from the data including knowledge of ethical principles, influence of nurses’ relationship with other health professionals in ethical decision making for POP management, influence of unit leadership on ethical decision making for POP management, institutional factors that influence ethical decision making for POP management and intrinsic motivators for pain management. Fifteen subthemes emerged from the main themes.

4.1 Demographic characteristics of participants

Fourteen nurses in the surgical units were interviewed in the study. This included seven (7) participants each from the male and female surgical wards. The ages of the participants ranged from twenty-four (24) to forty (40) years. Six (6) were thirty-five (35) years and above, and the rest were between twenty-five (24) and thirty (30) years. Three of the participants were male and eleven (11) were female. Six (6) were married and eight (9) were not married. Five (5) had worked for ten (10) years and above, while nine had work experience of between one and five (5) years and six (6) had work experience of between five (5) and ten (10) years. Five had first degrees and the rest had diploma in general nursing. All participants were general nurses and had a minimum qualification of a diploma. Five had first degrees in nursing and the rest had diploma in general nursing.
4.2 Organization of the Themes

Five themes emerged from content analysis with fifteen subthemes. These are presented on the table below.

**Table 1: Summary of Themes and subthemes**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Subtheme</th>
</tr>
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<tbody>
<tr>
<td>Knowledge of ethical principles</td>
<td>1. Beneficence</td>
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<tr>
<td></td>
<td>2. nonmaleficence</td>
</tr>
<tr>
<td></td>
<td>3. autonomy</td>
</tr>
<tr>
<td></td>
<td>4. justice</td>
</tr>
<tr>
<td>Influence of relationship between nurses and other health professionals</td>
<td>1. Nurses relationship with doctors</td>
</tr>
<tr>
<td></td>
<td>2. Nurses relationship with pharmacists</td>
</tr>
<tr>
<td></td>
<td>3. Nurses relationship with anaesthetists</td>
</tr>
<tr>
<td></td>
<td>4. Nurses relationship with physiotherapists</td>
</tr>
<tr>
<td>Influence of unit leadership</td>
<td>1. Perceived supervisory roles of unit leaders</td>
</tr>
<tr>
<td></td>
<td>2. Feedback from unit leaders</td>
</tr>
<tr>
<td>Institutional factors influencing ethical decision making</td>
<td>1. Ward protocols</td>
</tr>
<tr>
<td></td>
<td>2. Availability of medications and doctors</td>
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<td></td>
<td>3. Ethics and disciplinary committees</td>
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<tr>
<td>Intrinsic motivators of pain management</td>
<td>1. Personal commitment</td>
</tr>
<tr>
<td></td>
<td>2. Empathy for patients</td>
</tr>
</tbody>
</table>
4.3 Nurses’ Knowledge of Ethical Principles

In addressing research question “what is the knowledge of nurses about ethical principles in POP?” the theme ‘nurses’ knowledge of ethical principles’ was identified with four subthemes emerging: beneficence, nonmaleficence, autonomy and justice. General knowledge of the ethical principles was adequate among the nurses. Participants described beneficence as doing good, helping patients, performing one’s duties, and sacrificing for the sake of patients. Participants explained nonmaleficence to encompass preventing pain. It was also found that nonmaleficence (do no harm) was achieved by nurses through forgiving annoying behaviours of patients, seeking clarifications from more experienced colleagues, being vigilant, and avoidance of overdose of medications. Participants also identified patient autonomy and nurse autonomy. Participants saw that while the patient had the responsibility to choose from available treatment options given, the nurse also had the duty to explain to the patients and give them the right to choose. Participants viewed justice in different perspectives such as providing fair treatment to patients, giving individualised attention, non-discriminatory attitude, prioritizing care and making information available to patients. Findings are supported with participants own words in each subtheme.

4.3.1 Beneficence

Participants referred to beneficence as doing good to patients and perceived it as an integral part of nursing and the first principle to adhere to when caring for patients.

“doing good, I should say is part of nursing.” (FN1)

“…usually my first ethical principle is to try to do good for the patient to feel good since it is my first duty, that is to make my patient feel good. Err, for me that is the most important thing in nursing, to ensure that I do good to my patients” (MN12)

Participants further reiterated that beneficence has to do with making patients comfortable by managing their pain:
“You think of doing good for the patient and the first good thing you want to do for the patient is making him feel comfortable and out of the pain through reassurance and administering the prescribed medications.” (MN9).

“…making the patient feel free of pain, that is to avert or alleviate the pain or reduce it as much as I can.” (FN7)

Another participant also described beneficence as actions that produce good results and recovery for patients such as administering pain medications before dressing wounds:

“it is simply ensuring that your nursing actions are intended to produce good results so that the patient can recover fast. Most often a patient who usually complain of pain when we are dressing the wound. Such patient I will give pain killer maybe thirty minutes before I dress. Though his medication is not due, but helping prevent the pain in the dressing is doing good to the patient.” (FN13)

Participants also viewed beneficence as rendering help to patients. Some specified the kinds of help such as, giving patients money to buy medications, food, gauze for wound dressing and many other things the patients could not afford for themselves.

“…in all the nursing intervention that you are doing we are all in one way or the other helping the patient.” (FN11).

“Sometimes we the nurses buy food or even help in other things after discharge, like money for them to settle some bills” (FN7).

“…in this ward some of our patients come and they don’t have anything and these days, insurance doesn’t really cover most, so sometimes as humans as we are, you can come out with help. Some of them come without gauze for even wound dressing meanwhile they have a wound. So, sometimes you have to go out of range to make sure that you get those things for them. I remember a patient complained to me one time that he had not eaten since morning and yet was supposed to take some medication. I felt sad and decided to buy him porridge” (FN3)

Doing sacrificial work especially when there is shortage of staff was also seen as beneficence by participants. A participant mentioned that it was worth stressing themselves to ensure patients’ recovery even at the expense of the nurses’ own health:

“sometimes is just one nurse to about fifteen or thirteen patients and you try to do good as much as possible. So, doing good...yes, it hit the limit and you are about to break down so you don’t want to do it, but then we try as much as possible to do for the sake of just the patient.” (FN11).
Others also saw beneficence as just performing one’s duties, thus going by the job description diligently:

“you just do your work well and basically that is it...doing good” (FN6)

“I think it is just going about your normal work diligently, ensuring you follow the set standards and job description.” (FN14)

4.3.2 Nonmaleficence

Many participants stated that nonmaleficence is avoiding intentional and unintentional harm from occurring in patients. Some mentioned that nonmaleficence constituted preventing various forms of harm on patients such as preventing pain and preventing patients from falling:

“you are to be vigilant in your work to avoid causing harm especially in performing procedures like wound dressing. We try not to inflict more pain on the patient while dressing the surgical wound” (FN6).

“…we must not cause harm, whether intentionally or unintentionally, and that is why we need to read wide so that there is no excuse to say I did not know.” (FN7)

“…and once we have all been through pain in one way or the other it puts us in the position to help, not to cause pain to our patients.” (FN1).

“...Maybe they bring an epilepsy patient. So, you make sure you raise the side rails so that when he gets attack, he won’t fall. That is the kind of harm I think we will prevent. And Then maybe the wound dressing sometimes when you wear the gloves, some of them think maybe you don’t want to get their infection but they don’t know that we don’t want to spread theirs to others and ourselves and even them to re-infect it any longer. So that is the harm we are preventing.” (FN6)

Some of the participants also viewed nonmaleficence to encompass not getting annoyed with patients’ misbehaviours and forgiving them for demonstrating irritating attitudes. They said that by not reacting to the patients, psychological harm is avoided on the patients:

“...certain times they (patients) request things, or they say things that may irritate you in one way or the other. They can say anything that will make you angry but doing no harm psychologically to the patient, you just need to let go, you swallow it. It’s painful to you too but let it go.” (FN2)

“Some of the patients sometimes speak anyhow to us especially when they are in pain and feel we have not done something fast enough. Some of them speak harsh but being a professional we have to reply calmly to them else it may turn out that you should have been able control your temper as a nurse” (FN14)
Participants also viewed preventing medication overdose to be part of nonmaleficence:

“Sometimes over dosage and its side effects is doing harm and to avoid it is by ensuring you monitor what dose of a medication or how frequent you give in order to prevent it. Sometimes we monitor for signs of overdose of some of our analgesics.” (FN1)

“I gave the prescribed medicine which was pethidine. But shortly afterwards this patient required more of it. He told me he was feeling good and shortly the pain had subsided and it is back again. I looked at the possible addiction to the pain medicine that was at hand and the possible side effects as well as the fact that sometimes you are not able to tell the threshold for whom the doctor is prescribing this medicine...in order not to do harm to the patient possibly I just hold on to what the doctor has order, but in this case I had to repeat a half dose of it and called the doctor...” (MN12)

Participants were also of the opinion that harm could be prevented by being sure that one knew exactly what nursing actions to take and to consult for help where there was the need to do so:

“If you want to do something and you are not sure that is really the right thing you have to ask but you don’t just say oh this needs to be done. If you are not sure and you go ahead to do it without confirming it, you can cause harm. So, harm can be prevented by asking for help from other nurses.” (FN3)

“Do no harm means that if you are doubting something you shouldn’t intervene. If you insist and go ahead and a problem comes then you can be held accountable. So, avoiding harm is simply the better thing by not doing it.” (MN4)

Participants demonstrated that going against the principle of nonmaleficence and causing harm intentionally or unintentionally to patients in the course of care could affect their professional lives:

“...it’s obvious because if you cause harm to the patient it will affect you yourself. So usually whenever we are to do anything about the patient we have to be careful, extra, extra careful because you don’t know what will happen.” (Mn9)

“patients who know their rights can report staff who ignore their complain of pain and the management especially, to the matron. The matron can query you and that can remain in your file and affect you in future, like when you want to go to school” (Fn10)
A participant said that a patient who was in labour pain did not warrant midwives to perform episiotomy without anaesthesia as it was practiced earlier. She further said ethics required that no harm is caused to patients:

“there is this practice at first especially the midwives, when they, there is labour they cut the patient. They will say oh its painful enough so we don’t have to inject, but what we learnt in ethics is that we must not cause harm...” (FN7).

4.3.3 Autonomy

Participants saw autonomy to involve giving patients the opportunity to choose and to make input in their care. Others viewed it as rights of the patients and not merely as an opportunity:

“the patient has the right to make decisions on their own and that is why we don’t force or impose things on them.” (FN7).

“this principle has to do with the right of the patient to make his choices without being forced by anyone at all.” (FN10).

“Autonomy is when the patient has the opportunity to make suggestions about himself” (MN4)

Participants also identified that patient autonomy was achieved by empowering the patient with knowledge of their treatment and consequences throughout the time of admission:

“You will try as much as possible to explain to the patient the treatment you are giving and the benefits, err...he or she is going to get at the end of the day but after doing that if the patient still insist he/she doesn’t want the treatment then you cannot force the patient to take it.” (FN1)

“...after admitting the patient and making him/he comfortable, you should explain to the patient what he should know so that he can be involved in whatever you are doing to him well” (MN4).

Some also noted that making patients aware of nurses’ desire to attend to their needs was key to enhancing patient autonomy. A participant ensured this by letting patients know that the nurses were obliged to them as stated:

“...let him (the patient) know that you are here because of him and you will like to do what is good for him and you still go by what he will say.” (FN3).
Participants also noted that making treatment options available for patients was part of enabling patient autonomy:

“The patients, you would probably have to give him options or her options to choose what he/she has to, what he/she wants.” (MN12)

“The patient is supposed to be aware of all the things that may happen to him so that he can choose whatever he wishes.” (MN4)

Seven of the participants considered that the subjective nature of pain was better managed by allowing patient autonomy:

“I do consider patient rights about pain and that is how come we do have times we give them medications according to what the patient says his pain is, and what time the patient says it exists. I do respect that they are in pain.” (FN10)

“The patient has the right to express his pain and request for medication because he alone can tell how severe the pain is. For me I think it is important we even allow or tell them to inform us when they are in pain. They are even helping us by telling us how they feel” (FN14)

“the patient should still be given that chance to have his voice and then made to know their voice really counts especially when they are complaining of pain. They know best how their pain is like. From there we can further assess to confirm certain things and continue” (FN3)

Only one participant noted the need to document patient’s refusal of procedure when they express their autonomy:

“…if you are going to do something for the patient, if the patient does not want it, he doesn’t want it. You can’t force the patient to take it. Yours is that you have to document it: patient refused this, patient says you should not do this.” (MN9).

Other participants mentioned the need to make a senior staff aware of patient’s wilful refusal of treatment:

“Like a patient can say I don’t like this medication, maybe he just does not like it. You can’t force him to take it. You only explain that it could help relieve the pain and he decides to take or not. If he still goes ahead to refuse then you may let your in-charge know that you did your best but patient refused” (FN1)

“So, if you want to carry a procedure on him and he insist that, you upon the education and reassurance and he still say no, probably you have to inform the in-charge and when you all come to agreement so you let him be. like as he still insists like you still keep on educating and reassuring, hoping to change his mind, but until you be able to change the mind you can’t do anything about it. You just document it.” (FN13)
Some participants restricted patients’ autonomy when they felt patients made unfavourable choices such as continuous request for pain medications that the nurses felt it could result in addiction:

“When you give the patient a medication so many times and the patient still goes ahead to say give me morphine, give me morphine, then you tell the patient oh no, for morphine now the way you have taken it is enough...So we just sometimes don’t serve, then we tell the doctor to talk to the patient, no morphine and that is it.” (FN2)

“If a patient makes an option and you feel that is not the right thing you will explain to him and let him understand why what he wants cannot be done.” (FN3)

Four participants mentioned about nurse autonomy. They said that nurse autonomy is being able to make decisions independently as a nurse, and implementing without being coerced by other professionals:

“When we even explain to them what we have done already they listen and take it in good faith and also write it in their order sheet. Other times too we make decisions on patients’ treatment together” (FN1)

“When the doctors are not around sometimes you just know that oh if I do this it will work so sometimes you just do it. You just take your own independent decisions and it help the patients, especially when they (doctors) are not around” (FN7)

“Sometimes we are able to assess and score patients’ pain, especially those with acute pain and write medication. We go to the pharmacy and explain and by seeing the pain score they serve us and we give to the patient and document. The doctors come and they are ok with us” (FN14)

“Sometimes I ask myself whether I need to call the doctor for any complain a patient make? I assess the situation and manage the patient and document what I have done. If I exhaust all my skills in solving it the nursing way including diversion therapy, then I call the doctor to also come in.” (FN10)

FN7 and FN14 further said that making decisions with doctors concerning patients treatment was considered teamwork which showed that the doctors recognised nurse’s autonomy in decision making.

“sometimes on rounds we make inputs and decisions with the doctors. They appreciate nursing is autonomous body and also can make suggestions and decisions” (FN7).
“sometimes we make the doctors understand that we also have our responsibility in
decision making and also have to contribute our voices or ideas in the patients care.
They know we don’t just take orders from the doctors like that. But we weigh it and
make inputs as we collaborate with them” (FN14).

4.3.4 Justice

Many participants viewed justice to be fair treatment of patients, such as being attentive
to patients’ needs and non-discriminatory attitude:

“you should make sure you treat them equally. Don’t say because this one’s father is a
minister should get that and this one should get that... I think being fair sometimes
could be giving them the kind of attention they need” (FN3).

“If you are not attending to them don’t attend to them at all. If you are doing stuff do it
but if you attend to one call if the next person calls, you are supposed to go or else they
will start saying something.” (FN10)

A participant said that non-discriminatory attitude towards patients was achieved by
showing them respect and treating them equally:

“Me for instance I consider them all as equal and so I respect and treat them without
discrimination. They are given their medications as they deserve especially the pain
medications” (FN11)

Some participants indicated that attending to patients should not be on the basis of
patients’ social class, or race:

“we treat them equally despite their colour, race, whatever... So far as you are working
with the individual and as it says, you should treat all of them equally, so you will work
on that” (FN13)

“...if you you’re treacherous with your patient just because err you show some people
are upgraded than some others you are going to have trouble with your patients
because the next thing they will do is to report you for being selective” (FN14)

A participant linked justice to medication administration where patients are expected to
be given prescribed medications due them and not withholding it:

“we do justice because if their drugs are there, the pain killers is there, you have to
administer, give it to them because you will not say oh because you are not in pain I
won’t do it, I won’t attend to you. Oh, we are not doing that, we, I mean we administer
what is supposed to be done” (MN9).

Participants reiterated that they tried to be generous with patients’ prescribed medications:
“We try to ensure that we are generous with medications that are prescribed and treat them fairly without discriminating.” (FN7).

“I don’t withhold their drugs for them to suffer before I give.” (FN11).

Some participants also viewed justice to involve advocacy or defending of patients in situations where they may not have the ability to do so.

“I remember we had a patient who came here and the patient had road traffic accident (RTA) and for just some few hours of stay in the hospital, they billed him about seven hundred cedis which he had nothing to pay, it was only paracetamol that we gave and the paracetamol too he bought so we said no to this injustice. We had to send the folder back ourselves and explained to them and the bill was corrected to forty-seven cedis (GHC 47.00) and he paid and left.” (FN2)

“sometimes you realise that some patients have no say because maybe they do not have money to afford certain things for their treatment. We have to step as advocates for the patients so that they feel a little better” (FN14)

Participant considered severity of patients’ condition to determine who to attend to, especially when staff were few:

“when you are not enough, ensuring that the one who needs the most attention is always hard to achieve. But we have to try as much to identify those who may not be able to cope when you don’t attend to them first, and later handle the others. Prioritizing care is part of justice.” (FN3)

4.4 Influence of relationship between nurses and other health professionals

The research question “what is the influence of the relationship between nurses and other health professionals in ethical decision making for POP management?” was asked and the main theme “influence of relationship between nurses and other health professionals” was identified from the analysis. Four subthemes emerged. These subthemes were: influence of nurses’ relationship with doctors, influence of nurses’ relationship with anaesthetists, influence of nurses’ relationship with pharmacists and influence of nurses’ relationship with physiotherapists in ethical decision making for POP management.

Nurses described their relationship with doctors as cordial or friendly. Also, doctors were perceived to pay attention to nurses’ opinions and assessment of patients pain related
issues, accepted nurses’ suggestions, and related well with nurses. Regarding nurses’ relationship with the pharmacy staff, it was also described as cordial. Nurses were most often given prompt attention when they needed medications at the pharmacy, though there were few reported instances of queuing for medications. It was also found that pharmacy staff sometimes brought certain medications earlier requested by nurses to the ward in order for nurses to administer. The subthemes are supported with verbatim quotations as follows.

4.4.1 Nurses relationship with doctors

Participants stated that they had friendly relations with the doctors.

“on the whole we do have a good relationship with the doctors because they are friendly. We interact well with them” (FN1)

“The relationship here is friendly between doctors and nurses because they come and ask us how we are doing and we exchange pleasantries.” (FN14)

“I quite remember I once brought my relative for treatment. The next day I called him on phone to see a patient and this doctor asked how my relative was fairing. I felt like he was being friendly to me” (FN11)

Nurses also reported that they and the doctors respected each other at work:

“respect is reciprocal, so you respect me, I respect you. Some of them respect we nurses and so we also respect them and the work is going smoothly” (FN13)

“The doctors don’t react badly to us when we make mistakes. They will say that oh, when a patient comes in similar situation, do what you can as a nurse for the patient and call us (doctor). For me I see that its respect they show us with that attitude” (FN2)

The participants further stated that the doctors benefited from the cordial relations because they relied on the nurses for information about patients on the wards:

“They (doctors) can’t be going round almost every time, so they rely on we the nurses to tell them when they have patient on the ward” (FN1)

You know the doctors ask us how the patients did over the night because they do not go on night duties and so they rely on us if the patient had complained over the night. If he is not fine with you he may not even be free to ask, but because we are cool with each other that they ask us.” (MN9)
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“I have the phone numbers of almost all the doctors in the various departments. So anytime a doctor makes a refer I make a call or look for the one on duty at that moment and call the person to come and see the patient” (FN1).

Participants reported that their suggestions on the ward in relation to pain management and other activities were mostly welcomed by the doctors they worked with:

“The doctors also show us that respect because our views are appreciated when we go on rounds with the doctors...Yesterday like this somebody came with an accident, fracture. They ordered diclofenac tablets. So, I sent the folder back to them that from the way we see the pain this one will not do anything, so he now prescribed morphine.” (FN10).

“sometimes you expect that looking at the extent of injury or surgery the person has undergone, they will prescribe a strong analgesic to take care of the pain but they don’t do that and when we are going on rounds we try to suggest to them to change and they do change the prescription. You can’t direct them to do anything, but you suggest because you are with the patient always...we do make decisions with the doctors” (MN4).

“You the nurse you can just make a suggestion, oh doctor this one we should do this and that, and that the pain will go off. The doctor will accept. He will also bring his views and you will help each other.” (MN9).

They also said that doctors asked of their inputs and were allowed to make decisions on the management of patients, especially during ward rounds where they interacted with the doctors:

“Certain times we talk a lot with the doctors. So, when they come they ask, ok this patient, what can we do? Doctor do you see... then he will also ask ok you people what do you think we should do for this patient? Then we all bring our decisions then we will make it. At the end of the day the patient benefits our collective decisions” (FN2)

“...they sometimes ask of how we want to approach certain patients’ pain and we bring our ideas and they respect it. Yes, because they know we are always with the patients” (FN10)

Participants also reported that because of the cordial relationship with the doctors, they (nurses) assessed patients’ pain and reported to doctors and medications were written for such patients. Other times too they were able to prescribe for the patients and the doctors agreed with the prescriptions when they came later for ward rounds:
“The doctors respect us in the sense that they always feel that we too we know what we are about. Mostly they take our assessment of the patients’ pain and order the pain medications. Sometimes we go ahead and make some orders and send to the pharmacy especially when the doctors are not there. Then we serve and when the doctor come we tell him, oh I gave this medication for pain.” (FN3)

“Sometimes they prescribe a pain killer and we think this one will not do, you can alert them that from the way we see the patient’s pain this other drug will do, so they change it because they know that we also are able to assess the patients” (FN13).

“Sometimes in the absence of the doctors, maybe during night shift, we have nothing to do than just assess the pain and make a prescription for the pharmacy to supply. The thing is that can’t say the patient should wait till day break for doctor to come. Then the next morning the doctor is informed about what we did.” (MN9)

Two participants mentioned that they could detect or avoid medication errors and also identified and reported adverse reactions of medications that patients encountered to doctors to take actions:

“if say they order a medication and we know that the patient reacts to it or did not find it easy with the drug, we alert the doctor and they change it” (FN7)

“we detect and prevent some medication errors, like over dose. We inform the doctor and they make changes. Some of them say ei, you saved me from trouble” (FN14)

Participants said that in situations where their suggestions were not agreed upon by doctors, polite language was used by the doctors in communicating to the nurses, explaining why their suggestions were not accepted. This brought a sense of togetherness and smooth collaboration:

“If they don’t accept our suggestions, they show us that respect by explaining the reason and why that drug cannot work for the patient” (FN3)

“Sometimes we ask and depending on the doctor you are dealing with, some of them are flexible they will listen to you and even if they are still maintaining what they have prescribed they will give reasons to convince you” (MN4)

Participants reported that when they made mistakes, some doctors prompted or corrected them politely:

“Sometimes we even make mistakes as, not necessarily pain management. But sometimes our management sometimes we skip certain things and the surgeon or doctor will come and do it himself or call us to just remind us to do it” (MN12)
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“When we also make mistake, they correct us calmly and you can tell that they respect us. I remember one time I was supposed to give morphine to a patient postoperatively and I forgot. The doctor came and saw it and reminded me politely to administer it” (FN7)

Some participants however, reported that some of the doctors were rude and bossy to them and were not willing to accept suggestions and questions from nurses:

“….unlike others who are rude and shout anyhow as if they had quarrelled with you earlier or something. (FN6)”

“But other doctors are the bossy type so when they do something and you question them you open fire” (MN4)

“Sometimes we have hitches because some of them feel too big to be corrected when they make mistakes. When you want to correct them and you are not careful they get angry” (FN7)

Some participants mentioned that good relationships with the doctors made them work freely, efficiently and they felt valued:

“The nice relationship makes us able to tell the doctors our assessment findings. We are…(pause) also err, willing to and eager to contribute our knowledge and decisions in the pain management of our patients” (FN13)

“it will help you learn more. It will broaden your learning skills. Depending on the condition it broadens your mind on the condition we are discussing about. So I think it really helps when we do the interaction” (FN8)

Another participant said that the cordial relationship with the doctors was not taken for granted. There was the need for joint consultation in decision making since pain management is a multidisciplinary approach:

“…. I will say that our good relationship does not warrant that we take their decisions for granted. You have to still consult when taking a decision to treat pain. Also, you have to document it legibly for the person to see what you have done afterwards.” (MN9)

4.4.2 Nurses’ relationship with Pharmacists

Participants reported that they had cordial relationship with the pharmacy staff in the health care environment. There were friendly relations between these two professionals:
“the relationship is cool because when a doctor prescribes a drug for forty-eight hours and the pharmacy mistakenly supply twenty-four-hour dose, they correct it calmly and peacefully without arguing when we draw their attention” (FN6)

“There is that understanding with the pharmacy because we work as a family for the common good of the patients’ recovery” (FN7)

“When they prescribe something and pharmacy give under dose we alert the doctor that this is what they have supplied, what should we do. Then the doctor speaks with the pharmacy or inform us to settle it with the pharmacy. Often our in-charge get involved and the pharmacy clarify the order amicably” (MN4)

A participant further illuminated that there were times when nurses were confused as to whom to go for clarifications when prescription errors occurred:

“sometimes when they prescribe pain killers and we go to the pharmacy, sometimes they don’t supply all of the drugs… Sometimes they say they are also trained or they are even trained more on the drugs than doctors, so when the doctor prescribe and they see that is not the correct order they will give what they want. So sometimes we are now the middle men. We don’t know whether to go with the doctor or to go with the pharmacists” (MN9)

Many of the Participants also reported that the Pharmacists always served them their medications quickly since they were aware that the nurses were coming from the surgical wards. This they said helped them to promptly attend to the patients in pain:

“…mind you the Out-Patient Departments (OPD) are also coming to the pharmacy for medications, but because of the good relationship with them, when we get there they know we are from the surgical ward and quickly they will serve us our medication so that we can come and administer before they serve the others.” (FN7)

“When we get there (the pharmacy), they do everything so fast for us then we come then we go on with everything we do to relieve our patients of pain” (FN2)

“Err, with the pharmacist certain times when the patient is in pain, severe pain when we go to them they understand us especially when we need the drug so urgently we walk to them ourselves and then they give us the drug and we come back.” (FN11)

Few participants reported delays with collecting prescribed pain medications at the Pharmacy due to overcrowding and the need to follow certain protocols before being served some medications like morphine:

“In the pharmacy you have to sometimes be in queue, especially on busy days. Sometimes by the time you return from the pharmacy the patient has already suffered severe pain if no medication is found in the emergency box to give in the meantime.
Sometimes you can be lucky and someone inside the pharmacy will see you and help you out, other times too you struggle like that.” (FN13)

“there are at times we follow the protocols of documenting morphine at the pharmacy and end up delaying while the patient is in pain. Sometimes I put myself in the patient’s shoes and I ask myself if someone is doing all this delay tactics and I am in pain how will I feel? Sometimes I feel unhappy, but the pharmacy will also say they are doing the right thing and protecting their heads from trouble.” (FN10)

Participants indicated that they sometimes noted omission of some prescribed drugs and they alerted the pharmacy staff:

“Sometimes they underserve us our patient medications. We draw their attention and they don’t argue us. They cross check and correct it.” (FN1)

“At times we may copy the medication wrongly to the pharmacy and they take the pain to correct to come and correct us or give us phone call to tell us the mistake and how it should have been written.” (FN13).

It was also reported that the Pharmacy staff always informed nurses when certain medications were out of stock and also did not hesitate to send such drugs or call the nurses anytime these drugs were available:

“They call to tell us that oh the drug you needed is now available, or when it comes they will inform us.” (FN1)

“Other times too they take the pain to come and check if our emergency drugs are well stocked. Some of them even bring it later when they procure, especially if we went earlier with our list of emergency drugs.” (FN14)

A participant said she took advantage of the cordial relationship with the Pharmacy staff as an opportunity to learn the literature of some medications:

“At times too, we go and ask them questions about some drugs and they explain to us.” (FN14)

Some of the participants said that the cordial relationship with the pharmacy made things easier in the management of patients’ surgical pain. Some explained that once the pharmacy understood them, they did not always need a prescriber to order some medications before being served. Participants said it reduced delays in the management of surgical pain:
“once some of the doctors trust our, err, ability to also assess pain and request appropriate pain medications, at times I usually feel the obligation to do something for the patient who is in pain before calling the doctor” (FN8).

“The good relationship give me the confidence that even if I take an action to write a prescription and it is wrong, there is somebody who can see it and correct me. It gives me the urge, that courage to also exhibit my knowledge on patients who are in acute pain and a doctor is nowhere near the ward.” (FN11).

4.4.3 Nurses’ Relationship with Physiotherapists

Participants indicated that there was some cordial relationships with the physiotherapists. The physiotherapists responded to nurses’ call to perform physiotherapy on patients, and that, the two professionals shared ideas in the relieve of patients’ pain during physiotherapy sessions:

“hmm we have a cordial relationship with the physiotherapists too, because whenever we call on them to help especially with amputees they come easily. And when we go there we say oh, we have this and we have that, then they come into the ward then together we help the patient to exercise then they go back” (FN2)

“...they also tell us certain things we have to do for the patients, especially the amputees, how to manage the leg and make it comfortable for fast healing.”(FN5)

“When the physiotherapist comes and they do their exercises on the patients and they are in pain, I let them know right from there that the exercise you have just finished doing on the patients they can’t take it. The pain is severe on them. We (nurse and physiotherapist) then suggest to the doctors to prescribe pain medications to administer before and after procedure to minimise the pains”(FN10)

A participant said physiotherapists always informed the nurses of their schedules on the ward. Nurses in turn decided to give pain medications to patients due for physiotherapy at least 30 minutes prior to the physiotherapy sessions. These minimized severe pain during exercise sessions.

“...the physiotherapist when they are coming in they will give you time, by 10am we will come for our rounds so because of that I want to give my patient medication around 9am or 9:30am.” (FN7)
4.4.4. Nurses’ relationship with Anaesthetists.

Participants indicated that anaesthetists were always found in the theatre and hardly came to the wards. Nonetheless, two of the participants said that there were cordial relationships with them during the few times they were on the ward.

“we have nice relations with the anaesthetists because there are several times we call them over when we think we are managing some patients’ pain and we are not seeing improvement. They come in if they don’t have any case in the theatre. They will quickly come in to help. even if it is some medication like intravenous (IV), and you can’t fix it they will quickly come in and secure the line so that we can manage the pain.” (FN7)

“We are cool with the anaesthetists, though we don’t have them coming around like that. Sometimes we call them to assist us with patients who have prolonged unrelieved pain” (MN12).

You know these people are good at pain management. So sometimes we fall on them to help us with some stubborn surgical cases. (FN13)

4.5 Influence of unit leadership on ethical decision making

The research question “How does unit leadership influence nurses’ ethical decision making for postoperative pain management?” was asked and the major theme that emerged was “influence of unit leadership on nurses’ ethical decision making” with two subthemes. These subthemes were “Perceived supervisory role of unit leaders” and “Feedback from unit leaders.” It was found that unit leaders ensured that nurses performed their duties well and also made sure emergency medications were available on the wards. It was also identified by nurses that unit leaders provided feedback to nurses on the work the nurses did. The unit leaders also served as motivation to nurses.

4.5.1 Perceived Supervisory Role of the Unit Leaders

Nurses said that their unit leaders scrutinized their work, made corrections on mistakes committed by nurses and wanted nurses to do the right thing in the management of postoperative pain:
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“the in-charge we have is very keen in managing postoperative patients. She makes sure that we do the right thing at the right time.” (FN2)

“she comes to go through what you have done like medication administration, assessment of our surgical patients and then make corrections.” (FN10)

“The In-charge serves to coach and prompt us on what we are supposed to do. Sometimes too they bring in disciplinary measures to put us on track.” (FN11)

“One of the supervisory role of the in-charge is when the doctor has made orders, the in-charges come and see as to whether you have done it or not and if you haven’t done it why it wasn’t done. So, before doctor comes everything is set.” (FN14)

Nurses consulted their unit leaders who were considered as experienced for assistance and advice when faced with challenges especially patients care:

“Mostly it’s the ward in-charges you turn to because they are those that have the experience more than we the younger ones coming up. We consult them then you take their advice on how to deal with certain situations.” (FN6)

“Anytime we manage a patient’s pain and we don’t get results we inform the in-charge and she also assess and bring input to help us. When that fails she calls the doctor, please we did this and that and still the patient is not fine. Then the doctor will also come in to add something.” (FN7)

Participants also said that unit leaders (in-charges) tried to make sure that emergency drugs were available and as well ensured that nurses managed patients pain properly:

“They always want to make sure the emergency drugs are there so that they can take care of the urgent situations.” (MN4)

“She (the In-charge) will make sure that all the pain medications will be available in the emergency box so that in case of any emergency you will attend before calling the doctor.” (MN9)

“The in-charge make sure the people don’t come in pain and continues in the pain by ensuring that the patient’s pain medications are collected and served always” (MN12)

Other participants said the unit leaders gave them opportunity to make decisions regarding patients care and at the same time ensured standards of care was maintained:

“certain times you tell in-charge please I want to do this for this patient, I want to do this and that, then she will say, oh you go ahead” (FN13)
“she gives us the chance to make decisions to help the patient, she doesn’t strictly tell
you do this do that, she make you open up yourself because she know she cannot always
be there.” (FN2)

“Our ward in-charge gives us the free will to flow and work but will as well make sure
that the standards are kept.” (MN12).

4.5.2 Feedback from unit leaders

Participants indicated that the unit leaders pointed out the mistakes nurses made in the
discharge of their duties:

“She (in-charge) comes to you and she tells you, you see this thing you did, it is very
bad, you did this you did that. Then you are cautious. The next time you won’t repeat
it.” (FN2)

Other participants stated that the unit leaders equally would not hesitate to applaud and
compliment them whenever they did very well in the care of surgical patients’ pain:

“Some of the in-charges will encourage you and say you are doing your best when they
come and see that a patient’s pain is well managed. They will tell you that keep it up,
you are competent in the work.” (MN4)

“If the in charge notices that you are serious and hardworking she applauds you. That
gives you the confidence to work and know that you are on the right track.” (FN10)

Participants also said that the in-charges always served as source of inspiration for them
and that made them also had the urge to work harder:

“If you have somebody behind you inspiring you all the time and you see that your work
input is recognised you feel good to do more. So that alone makes me willing to try to
be sure my patients are free from pain before even my in-charge comes to see.” (MN4)

“It is just like when a son is standing by the father and the father ask him to fight. He
will fight with all his strength because you know that there is somebody behind you who
is willing to help you in case of anything. So, they being behind us is a solid support for
us. You think well and also try to impress them the more.” (FN13)

The staff said that the feedback unit leaders gave them motivated them to find solutions
to unmet needs of patients, identified their mistakes and made them learn better. The feedback
was also found to be satisfying to the staff:
“The positive feedback they give us means they are trying to find the solutions to certain problems and so at the end of the day it helps me to take care of the patient’s pain better especially with the decisions taken to manage them.” (FN7)

“The in-charges feedback helps you to know whether you have done the right thing or you did the wrong thing. Then it will help you also do your things correctly.” (FN8)

“If you do something for a patient and then there is a positive feedback, you are satisfied at the moment. That means what you did helped the patient so that way next time maybe when you are confronted with a situation like that or a similar thing, you try to apply what you did.” (FN6)

Nonetheless, a participant mentioned that she found it demoralizing and discouraging if she managed a patient and there was no improvement in the condition:

“Sometimes you do maybe you manage the patient and it’s not improving, sometimes it discourages or demoralizes you in a way if the feedback is negative because you will ask oh after all what you did there wasn’t still any improvement and next time you wouldn’t be confident using those same techniques and management in a similar case. But I think it will push you to learn more and know more.” (FN6)

4.6 Institutional factors influencing ethical decision making for POP

The research question asked was “what institutional factors influence nurses’ ethical decision making for POP management? The major theme dentified was “Institutional factors that affect nurses’ ethical decision making for POP management” with three subthemes including Ward protocols, Availability of doctors and medications, and Availability of ethics and disciplinary committees. Participants viewed protocols as integral in pain management ethical decisions. It was noted that, there were not enough explicit protocols, yet protocols were viewed as making the nurses able to independently make decisions. It was also found that there was frequent shortage of prescribed medications which caused delayed pain treatment. Knowledge of the existence of disciplinary committee in the hospital contributed to the seriousness in pain management by nurses.
4.6.1 Ward Protocols.

Three of the participants stated that they had a tool for assessing pain. They mentioned
that there was a numeric rating scale which was used to assess surgical pain and then proceed
to manage based on the score obtained:

“We have protocols in the ward for assessing pain. We have our pain ruler which we
use in assessing pain in the ward.” (FN1).

“most of the time, we have protocols of taking care of postoperative patients. So, pain
for instance we are able to give some medications like morphine for severe pain when
the doctor is not around because per the scale, if the pain score high you go ahead and
give.” (FN2).

“based on our rule we know that patients must have their medications based on the
protocols that are put in place. So, it also helps us to know that oh, okay when patients
come from the theatre, every 4 hours or every 8 hours they must be on pain medication.
So, there is nothing like you forgot because it’s a rule that is there, established by the
hospital and as a policy.” (FN7)

One participant mentioned that following doctors’ orders was a protocol for most of the nurses:

“So, the protocol is we follow doctors’ orders in medications. So, when a doctor has
not ordered, you have no right to give. Only when it is an emergency you give then you
record.” (FN2)

Some participants however, said that there were no clear protocols for them to use. They said
it sometimes led to confusion about what action to take for patients with pain where prescribers
were not readily available:

“For protocols for pain management in the hospital, we don’t really have a clear cut
one, and for me it is kind of a challenge sometimes. That is where it brings the confusion
of beneficence, maleficence and all those ethics because in one way you want to help
but you are hesitant because you probably cannot tell if the end product is going to
yield the benefit between you and the patient; what you and the patient will desire”
(MN12).

“Sometimes some of us sit down helpless when patients present with pain because for
me I don’t see clear protocols around. There are some of our doctors that when you
take an action by giving some pain relievers especially the strong ones like morphine
and they come, they are like, who asked you to do that. While others will commend you,
others will have problems with you. Some even say the day you have problem they will
look at you suffer. Yet these doctors will not always be around to prescribe. So, we
sometimes have the dilemma of what actions to take for our patients when you don’t
have the protocol written down.”(FN7)
Protocols were perceived to be of help to nurses. FN12 said that making decisions on what nursing interventions to give after assessment of patients is easy as compared to the absence of protocols on the wards. She narrated:

“Protocols make our work easy. We are able to decide on what nursing interventions to take based on the protocols available. Though I don’t see protocols written especially pain protocols but what I know is that it could be easy making decisions on what treatment to give without any doubt.” (FN13)

Participants also mentioned that protocols were beneficial because it made the nurses work easy, and prevent waste of time looking for doctors:

“….it even make our work easy, because we know what to do. But we are not always allowed. It is a waste of time waiting for doctors when we know what they will come and prescribe” (FN2)

“If the protocols spell out what actions to take, it becomes easy to decide on the medications to give for the patient to be relieved of pain. I then document and avoid wasting time to call them (doctors). At times you call on phone and they don’t pick or they delay in coming which places the patient in long suffering of pain. But if protocol is there that becomes simple.” (MN9)

Two participants added that protocols could reduce the workload on the few doctors available since protocols give a clear direction of the steps to take in patient management:

“Simple protocols wean off the few doctors from being called frequently to the ward. With the protocols you know what exactly to do for the patient if the doctor is not there” (MN9)

“if there are protocols on what to give patients in pain, we can easily attend to the patients and document This way, the few doctors we have, when they come later we tell them” (FN2)

Some were also of the view that protocols help nurses know what to do for patients postoperatively, such as immediate management after surgery, and steps to take when doctors were not on the wards:

“Protocols are good because some of them help us know what to do when doctors are not readily around in the wards to order pain medications for patients.” (FN11)

“I think that also helps because maybe like… we have protocols guiding maybe, if someone comes out from the theatre, how you are supposed to manage the client, what you should be doing, especially, the very important thing you should be looking out to do for that patient.” (FN6)
Other participants stated that protocols help staff identify salient nursing activities to accomplish when constrained with time:

“...when you really follow them and like at the end of the day even if you can’t do everything for the patient, you do the most important things the patient really need.”  (Fn11)

“Since protocols are kind of summarised, and inform us what critical areas one must do, it helps us able to perform at least, let me say the life-saving procedures and maybe continue with the others when there is time later. For me that is how I see protocols impact on the work.”  (FN3)

Another participant indicated that protocols facilitate free flow of communication:

“if there is a clear-cut protocol and the whole or all the units of the hospital especially the clinical field are aware that there are these protocols, I think there will be free flow of communication and it will help us.”  (FN12)

Further probing revealed that nurses learned from their seniors certain routine practices and considered them as protocols. A unit leader of male surgical ward who had worked for ten years said:

“Our seniors we came to meet in the ward used to say that when a patient is in pain and the doctor is not around, you have to use your skills to assess and write for medication for the patient and document what you did for the doctor to see when he comes. We eventually learned some of these things and are now using to help our patients”  (FN7)

Another senior staff who had practiced for thirteen years on the female ward and was a shift leader in the ward said that some of the things they did were really protocols written and posted sometime back but were no more available on the wards’ notice boards. He said these were, however, still in practice.

“You see we used to have some rules of pain management in the ward but just that the papers are not there again. Once everyone has come to see what we do as normal and accepted, it becomes a protocol. Just that sometimes we have challenges with some new colleagues and doctors”  (MN9).
4.6.2 Availability of doctors and medications

The availability of doctors and pain medications can determine how ethical decisions made by nurses will be executed for the benefit of the patient in pain. Most of the participants reported that prescribers were very few. The few doctors available were not always on the wards especially during the afternoon and night shifts to perform assessment and prescribe medications for patients with surgical pain:

“Sometimes the nurse will be looking at the patient in pain and is helpless until when the doctor is around to also do assessment and get to the root cause of the pain.” (FN1)

“They (doctors) are not available, because most often its one doctor that is around for morning rounds but in the afternoon and evening, if there is emergency, you have to manage them yourself (the patient).” (FN6)

“The prescribers’ unavailability at sometimes surely bring a problem when you are attending to the patient because you want to hear from them (the doctors) bring their ideas also on what to do.” (MN4)

“...if it is a weekend and the doctors are nowhere to be found you probably have to find alternatives of managing the patients’ pain. Most often than not, some surgical patients’ pain just need pharmacological therapy and sometimes you don’t get good results...” (MN12)

Findings showed that for the few doctors available, nurses had to make phone calls to reach them to review patients. Sometimes they responded to the calls and came to review or they sometimes gave telephone orders. Other times too, the doctors would not respond to the calls, leaving the nurses to make decisions:

“You are not able to reach the person, other times too you call, the person has just gotten to the house and he’s very tired, coming back becomes a problem. So, he has to be on the phone and talk, which if you see the patients face to face you are able to know what is wrong with the patient but we have to call and then they talk.” (FN3)

“we have to call the doctors phone in some cases, and if the network doesn’t permit, you will not be able to get the call through” (FN7)

“when we call them, they will come and if they know that they are in a very far place, they will ask us the problem of the patient and they make telephone orders” (MN9)
Participants reported that frequent shortage of pain medications at the pharmacy affected management of pain of surgical patients. Patients had to resort to buying their pain medicines from pharmacy shops outside the hospital. This was perceived as waste of time since patients had to be in pain while waiting for the medications to be brought:

“sometimes too, you go to the pharmacy and the drugs is not there. You can imagine the patient is in pain wailing, then you rush to pharmacy, pharmacy does not have morphine. you now have to write morphine for the patient to go to town and buy the drug” (FN1)

“Most at times the drugs are not available in the hospital. Certain times patients will come and go back to town to buy the drug for us to administer” (FN2)

“sometimes the dispensary staff will not be there. Other times too the drugs they will write like morphine or tramadol, it will not be the. The dispensary will write nil. That means the patient has to go and buy. So, if we don’t have the drug in our emergency box to give to them, the patient will be in pain until the drugs are purchased from town...” (FN5).

Unavailability of doctors and some pain medications resulted in a number of effects that nurses battled with, including delayed treatment of patients’ pain and subsequent prolonged pain experience. Some of the nurses could not do much to help patients in such situations and thus entrusted it in the hands of God. Other nurses eventually lost the interest to attend to patients when they complained of pain

“Sometimes you want a particular drug. Maybe the patient is in severe pain and you request for morphine, they go to the pharmacy and it is not there. The patient suffer the pain until the relatives go and buy from town.” (FN6)

“Sometimes we have a doctor on call and they are far away from town. So, you have to just do the little you can and leave the rest for God.” (FN8)

“...and the zeal to treat the patient’s pain earlier will be lost because a patient complains of pain and you know that the same problems of no pain killers will be told” (FN2).

Nurses often relied on non-pharmacologic management as well as borrowing medications from other patients to help those in acute pain when they faced challenges of shortage of drugs and unavailable doctors:

“...if the pharmacy is not having the drugs they will mark it nil on the folder...
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if the patient is in severe pain we just move to a nearby patient who may have the drug to borrow for the patient in severe pain.” (MN9)

“Hmm sometimes we just wish there was a doctor around to also do something to help because sometimes you reassure, give medicine and do everything you can as a nurse but it’s like it’s not helping the patient and you only tell patient to exercise patience and the doctor will come later. ” (FN6)

“...sometimes when they are not around, you borrow from a different patient and give it out to the patients in pain and replace later when the doctors come and prescribe...When we don’t get to borrow we reassure and use other non-pharmacological measures like diversion therapy and sometimes it helps a little, other times too it does not help ” (FN13).

4.6.3 Ethics/disciplinary committees

All the participants said there was no ethics committee in the hospital:

“We don’t have ethics committee in the facility. If they have then I don’t know about it.”(FN1)

“I have not heard of ethics committee in the hospital”(FN2)

“We do not have an ethics committee in the hospital as far as I am concerned. It has not been mentioned anywhere at all about the existence of ethics committee.”(FN7)

“I have no idea whether we have an ethics committee within my facility. ”(MN12)

Participants mentioned that ethics committee could help staff to exhibit the standard practice behaviour, handle patients with dignity and respect.

“If we had an ethics committee it could be of great value because it could create awareness or remind us that nurses are supposed to act in a certain format and follow certain strategies not just based on their own ways of doing things and we don’t just manage the patients just as they are.” (MN12)

“I know if we had ethics committee it would help us put up our best to meet the standards of practice behaviour. Sometimes patients come with pain and we treat them as if they are not supposed to express themselves. We tend to shout at them and disrespect their feelings which is not good at all.” (FN13).

A participant also said that ethics committee’s presence could be of help because the committee would weigh the wrong and the good that nurses did as well as the intention of the act so that fair judgement could be made:
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“Sometimes I feel demoralised after going an extra mile for the sake of the patients and in the end when an error is committed the authority just hammer on the mistake and take us on while forgetting the good intentions we had for the patients. Hmm, I believe ethics committee could properly look at our plight sometimes and also make us feel that at least we had good intentions just that the unfortunate happened.” (FN14)

Participants doubted if the disciplinary committee was effective, though they acknowledged that disciplinary measures were taken when staff went wrong in their line of duties:

“Well for here I don’t think we have an effective disciplinary committee aside from the fact that maybe when you do something wrong during the day the in-charge comes around to correct you or the one taking over will notify you and correct you” (FN3)

“We have disciplinary committee in the hospital” (FN7)

“I don’t know if they have effective disciplinary committee or not but I know that if you do something that go contrary to what you are supposed to do you will be disciplined” (FN11)

While some participants doubted its vibrancy, FN2 stated that she has not heard of disciplinary committee in the hospital. She said:

“I have not heard about disciplinary committee in the hospital but I know there are some people that discipline staff, especially our matron.” (FN2)

Participants enumerated the importance disciplinary committees had in their practice, such as making staff to have a sense of accountability and responsibility:

“It will push you to work out your maximum because you will not want to be held accountable for wrong doing. If something happens to a patient and you are asked, this patient was in pain what did you do? If you know you will be asked questions like that you won’t just sit and do nothing. You will find yourself doing something.” (FN6).

“We do have to work massively for the patients because you don’t want to involve in the disciplinary committee because if you involve yourself in the disciplinary committee later it may affect your documents or your promotion. So we don’t want anything that we will do and then it will go to the disciplinary committee” (MN9)

“Being aware of disciplinary committee makes you act fast than just being relaxed. If a patient is complaining of pain and you just ignore the patient and if anything happens you will be held responsible, you will be audited and you will outline whatever you did for the patient and will be held responsible.” (FN11)
4.7 Intrinsic motivators of pain management

Another theme, “Intrinsic motivators of pain management” emerged from the data analysis with two subthemes namely, Personal commitment and Empathy. It was found that nurses looked beyond certain challenges such as tight work schedules and limited resources as they desired commitment to their core duties to the patients. Also, the nurses exhibited compassion and sympathy for their patients with reasons such as the nurses’ own experience of pain, respect for patients’ dignity as humans, and views that pain is unpleasant experience.

4.7.1 Personal commitment

The study revealed that personal commitment to one’s duty was integral in the management of patients’ pain amidst other challenges they faced such as inadequate staff and logistics. Participants mentioned that they were committed to patients’ wellbeing and that the patients were the reason for their work:

“I commit myself to the patients and make sure that the pain is gone because the patient is the reason why I am here and when a patient comes I tell the patient we are capable of making you fine and free of pain. Because I have already assured the patient so I must make every move to make sure the patient is fine and feel comfortable.” (FN2)

“When you are committed to the work you make sure that all orders are carried out and also with your nursing knowledge, skills and experience you are able to tell what exactly to do for your patient’s pain to subside and that basically is my duty to the patient: to make him comfortable” (FN14)

Some participants also noted that workload due to higher numbers of patients and understaffing could make them only stick to only routine nursing duties but for the spirit of commitment, they always had to do extra work:

“The thing is that commitment to work also counts because sometimes you get to the ward and the ratio of patients and nurses is very bad so if you are not committed and you want to do routine nursing care you might be tempted to ignore some of the patients’ complaints. So, it takes commitment to really stand and listen to the patients’ pain complains and you give the intervention that is needed” (FN5)
“Sometimes our staff strength is so poor that if you are not the committed type of person you will ignore some patients. You know, when you are few and the patients are many, you get overwhelmed that you can be angry easily but it takes commitment and patience to listen and attend to all the patients’ problems” (MN9)

Other participants said that some patients did not return from the operating theatre with their folders immediately for nurses to attend to them. They said they could refuse attending to the patients until the folders were brought but because they were committed to the work they had to attend to the patients while waiting for the folders:

“Here sometimes a patient may come from theatre and for about an hour the folder may still not come. When the patient is in pain we go ahead and do something about it. You won’t say because the folder is not there yet let me sit and wait while the patient is in pain. The doctors may still be writing in the folder. It takes commitment to do something to avert the pain while you wait for the prescription.” (FN3)

“Like I said if you are committed to your work you know that I have to do this for the patient. So, once they come out from the theatre you will be quick to do whatever that is expected of you and it only take commitment to do the right thing to ensure the patient is comfortable on bed.” (MN4)

FN14 indicated with joy that it was fulfilling when she worked hard and a patient recovered from pain. She mentioned that commitment to her duties was basically rewarding:

“The patient will be happy when he recovers from the pain and I will also be happy that I have come to work and I didn’t only come to walk up and down and go but I have come to do something. I have come to really work, so with that if you’re collecting your salary you know that you have worked for it.” (FN14)

4.7.2 Empathy

Participants showed empathy for patients when they were in pain for various reasons. Some of the participants said that their own past experience of similar pain made them feel the need to attend to their patients with empathy:

“When they express this pain at that moment I will want to manage the pain if I can at that moment because we have been through it in one way or the other and we know how it feels like. So anytime a patient complains of pain the next thing I feel like doing is to try and manage the pain” (FN1)
“I feel for them also because you know how it is when someone has a wound. Some of us have had wounds before and wound goes with pain. So, you feel for the patient because I do remember how I felt when I had surgery.” (FN13)

Others also showed empathy for patients who were in pain because they said the patients are also human beings and were only unfortunate to be sick:

“You don’t want them to undergo that kind of pain because we are all human beings, only that the patient is unfortunate to be in pain and the thing is that you can also be a patient any moment from now or even in the next one minute you can be a patient.” (MN4)

“Because I am a human being and I have sympathy and empathy, so if your fellow human being is in pain and you do as if you don’t care, it is not good.” (FN14)

FN 14 had the belief that as a human being it was good to do to others what one expects them to do to you and that informed her to attend to patients in pain. She narrated:

“When the patients are in pain we feel for them. The world is round and the way you care for the patient is the same way others will care for you. You just put yourself in the shoes of the patients and show them compassion if you wish others to do same to you when you are also in the same shoe.” (FN14)

Others also viewed pain as an unpleasant experience and that made them feel bad when their patients expressed it:

“you just know that they are in a situation that they need help because pain is one thing anybody at all that experiences it would not want to experience it again so it’s something that as a nurse you will not be happy to see your patient in this unpleasant state.” (FN6)

“No health worker or a nurse will be happy that their patients are in pain because it will mean that they are not doing well or what they are doing is not good enough. So, you won’t feel ok about that when the patient is allowed to go through this unbearable situation” (MN12)

It was also noted by the nurses that by being empathetic they were able to better understand the patients and acted promptly when they expressed pain:

“Emotionally you will feel sorry for the patient because you are thought to show empathy. So, you put yourself in the shoes of the patient at that moment and then you try to feel what the patient is feeling. That helps you give the necessary intervention that you need to unmake the pain of the patient.” (FN5)
“That is when you are even able to call the doctor. If you are not disturbed definitely you just have to leave it there but if you feel something for them that’s when you will know what to do by even calling the doctor to come and check while you do your nursing intervention.” (FN11)

4.8 Summary and conclusion of findings

In order for nurses to be able to make professional ethical decisions, nurses must have adequate knowledge of the ethical principles that guide practice. The findings have shown that nurses had adequate understanding of these principles. Furthermore, nurses also acknowledged the roles protocols, ethics and disciplinary committees played in decision making for surgical pain management. However, disciplinary committee was reported to be ineffective while ethics committee was reported to be unavailable in the hospital. Frequent shortage of analgesics and patients resorting to buying medications from outside the health facility was also a concern for nurses.

Nurses also demonstrated that cordial relationship with the doctors, pharmacists, anaesthetists and the physiotherapists allowed for peaceful work, and encouraged decision making to help improve patients’ pain management amidst the few doctors available. Again, supportive unit leadership and provision of feedback from leaders was found to motivate nurses to put in more efforts in their responsibilities. Even though nurses enumerated challenges such as workload, shortage of staff and frequent shortage of analgesics to have the potential of affecting ethical decision making for POP management, they still had the motivation to be committed to patients. This is because the nurses had empathy for the patients due to their own past experience of pain, and their respect for human dignity.
CHAPTER FIVE

DISCUSSION OF FINDINGS

5.0 Introduction

This chapter discusses the key findings of the study relative to the wider literature. The main themes were Nurses’ knowledge of ethical principles, Influence of relationship between nurses and other health professionals in ethical decision making, Influence of unit leadership affecting ethical decision making, Institutional factors affecting ethical decision making for POP management and Intrinsic motivators for pain management.

5.1 Nurses Knowledge of ethical principles

The study revealed that most of the nurses had adequate knowledge of the basic ethical principles. Nurses were able to explain principles such as beneficence, autonomy, nonmaleficence, and justice which supports the findings of Santos et al. (2016). They were able to demonstrate how these principles relate to pain management. All the nurses had a minimum qualification of a diploma, possibly depicting the role of higher education on knowledge of nursing ethics. This also supports studies conducted by Osingada et al. (2015); and Fantahun et al. (2014) where they identified that nurses with diploma and higher degrees had good understanding of the ethical principles. Contrary findings were revealed in a study by Opoku, and Addai-Mensah (2014) who found that, health professionals including nurses had low knowledge of ethical principles. Similarly, Fantahun, et al. (2014) found that nurses had inadequate knowledge of patient autonomy, an important basic ethical principle. It could be deduced that incorporating ethical principles in surgical nursing curriculum could enhance the provision of ethically acceptable nursing care and improve overall quality of nursing care as supported by Osingada et al. (2015) including surgical pain management. Previous studies have
also underscored the importance of higher education on high quality nursing care (Aiken et al., 2016; Chair et al., 2018).

The nurses in this study demonstrated knowledge of the principle of beneficence. Beneficence was seen as doing good to patients. Nurses helped patients who could not afford food and some medications by giving them money to buy. Nurses said that such acts were beneficent to the patients which is supported by Aurelio (2014) who noted that, beneficence encompasses acts of mercy, and charity. The inability of some patients to afford certain things while on admission identified in the study could be a reflection of the poor socioeconomic status of the region (Cooke, Hague, & McKay, 2016; Ghana Statistical Service, 2010) where access to quality healthcare is difficult. Even though the National Health Insurance Scheme (NHIS) is available, some medications and treatment are not covered under the NHIS and thus, patients have to pay for such treatment. The burden of poor economic problems could be minimised if the NHIS is extended to cover all treatment for all categories of disease conditions in the region.

The nurses also said that, sacrificing their efforts to make patients comfortable is part of the principle of beneficence. Nurses spent more time outside of their duties and worked extra hard for their patients’ wellbeing. Similarly, Andersson et al. (2010); Quinlan-Colwell (2013) explain that beneficence is doing good, sacrificing for patients and not inflicting harm to others. Compensating the efforts of nurses who provide extra support for patients may encourage other nurses to emulate. It was also found that nurses sacrificed their energy and time to care for overwhelming high numbers of patients at the expense of their own health. They indicated that it was a form of doing good to the patients. This finding may signal understaffing with its accompanying effects of low quality of patient care, resulting in adverse effects on patients such as surgical wound infection, and urinary tract infection as suggested by Twigg et al. (2015). Furthermore, nurses’ feeling of being overburdened with work could lead to a state of
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moral distress as the nurses sometimes could not do everything required of them amidst their knowledge of expected duties as supported by Schluter et al. (2008).

Providing comfort for patients through actions that produced good results for their recovery was also seen as beneficence in this current study. Administration of prescribed medications and engaging patients in diversion therapy were some of the things nurses did to ensure comfort of the patients. Comfort is an indispensable need throughout human life, whether in illness or in good health, and it is a major responsibility of the nurse to provide means and processes to ensure the comfort of patients (Kolcaba, 1995; Yousefi, Abedi, Yarmohammadian, & Elliott, 2009). Previous studies reported that patients expected hygienic hospital environment, caring health workers, and absence of suffering (pain) in order to experience comfort in hospitalisation (Pinto et al., 2016; Yousefi et al., 2009). This implies that nurses need to reassure and provide hospitalised patients with competent care to facilitate comfort and subsequent recovery.

Nurses explained nonmaleficence as preventing harm on patients while taking care of them. Examples mentioned were preventing patients from falling and ensuring minimal pain during wound dressings. These findings are consistent with the definition of nonmaleficence by Bernhofer (2011) who said it involves refraining from harming patients by considering safety of the patients in caring for them. American Nurses Association (2009) also views nonmaleficence to be avoiding harm as the study participants stated. When nurses have adequate knowledge on their duties and perform according to the standards, patients’ safety may be guaranteed and harm may be reduced. There is certainly risk in every nursing action is carried out for patients. Nurses should therefore be cognisant of that and always weigh the benefits and risks of procedures to be sure that the patient stand to benefit the greatest good.

Another important principle that the nurses identified was the principle of autonomy. Nurses further distinguished patient autonomy from nurse autonomy. Patient autonomy was
viewed as the right and opportunity given to patients to make decisions regarding their treatment. This finding is consistent with the assertion of Entwistle, Carter, Cribb, McCaffery (2010) who also noted that, autonomy is allowing or enabling patients to make decisions about what health care interventions they will want to receive or not wish to receive. Furthermore, nurses in the current study said that the subjective nature of pain was best treated when autonomy of patients was upheld which is supported by an earlier study that found pain experience as subjective and need to be given individualised attention by nurses (Aziato & Adejumo, 2015a). If patients’ autonomy is viewed as a right, then it can be deduced that nurses will respect patients’ views. This is because it may place an obligation on nurses to appreciate patients’ autonomous decisions. Quality nursing care will therefore, be enhanced (Traynor et al., 2010) and that, patients will feel valued.

The study also established that, empowering patients through education on their conditions and making treatment options available were effective tools for enhancing patient autonomy. This finding is supported by findings from earlier study which showed that patients empowerment began when professionals recognised that patients were in control of their conditions and were able to make informed decisions after educating them (Anderson & Funnell, 2009). This may imply that patient education not only provides knowledge, but also serves as a form of empowerment (which can be viewed as providing autonomy) of patients to take part in their care which can reduce morbidity as it was found that patients with hypertension had improved healthy lifestyle behaviours and decreased blood pressure after they were educated (Hacihasanoğlu & Gözüm, 2011).

Nurses in this study stated that they sometimes restricted patients’ autonomy when the patients made unfavourable choices. This finding is contrary to findings of Berman, Snyder and Frandsen (2016) who noted that autonomy involve respecting the views and decisions of patients even if the choices are not in the best interest of the patient. Other findings further
showed that many patients preferred shared decision making with their care providers rather than complete autonomous roles (Deber, Kraetschmer, Urowitz, & Sharpe, 2007; Sandman, Granger, Ekman, & Munthe, 2012). Entwistle et al. (2010) also added that, placing so much emphasis on patient autonomy may be problematic when too much emphasis is placed on importance of patients’ independence. Nurses need to demonstrate respect for patients’ autonomy even if the patients’ decisions may not help their treatment and comfort. Further explanations to patients and involvement of other professionals such as doctors in difficult patient decisions may help boost understanding of consequences of certain options that are not fit for good treatment outcomes. This may likely reduce risk of ethical and legal issues arising for nurses.

Also, the nurses said that professional nurse autonomy is when nurses have the right to make decisions independently. Tomey (2009) also identified nurse autonomy to be the nurse having independence to make judgement and the freedom to function. This may imply that the nurses in this study knew their decision making roles as Gallagher et al., (2015) found in their study about nurses knowledge and awareness of their decision making roles. Some nurses confirmed that they had autonomy since they made decisions with doctors and collaborated in the care of the patients. It may imply that, teamwork between nurses and doctors has the potential of increasing nurses’ autonomy which is consistent with a previous study by Traynor et al. (2010). It can also be deduced that providing measures that enable nurses to participate in decision making and collaboration in the healthcare environment will enhance nurses’ autonomy and thus, help improve quality patient care since nurses’ confidence will increase (Ulrich et al., 2014).

Nurses also explained justice as being non-discriminatory and ensuring fair treatment of patients which agrees with that of Alzheimer Europe (2010); Feinsod and Wagner (2008); Aziz, Saeed, and Roufael (2018). Nurses further said that justice is being impartial irrespective
of the patient’s colour, race or social status as also indicated by Douglas et al. (2011). It was also found that being impartial to patients could be achieved through paying attention to their respective needs, and respecting their rights to treatment (Alzheimer Europe, 2010). As nurses are impartial towards their patients and acknowledge their rights to have their pain treated, it will enable them to be generous with their prescribed analgesics in order to minimise the severity of pain experience.

Nurses also explained that advocating for patients and defending vulnerable ones were also aspects of ensuring fair treatment of patients. Nurses serving as patient advocates will help in safeguarding patients interests and well-being (Choi, Cheung, & Pang, 2014). This will go a long way to enhance fair treatment of patients and also help prevent harm from being caused by other health workers who may be incompetent, especially in the wards. Previous study by Davoodvand, Abbaszadeh, and Ahmadi (2016) also found that protecting patients’ rights was part of advocacy which is consistent with the current study. A recent study also concluded that advocacy roles played by nurses may enhance patient autonomy (Dadzie, Aziato, & Graft Aikins, 2018), implying that patients who are advocated for may end up having knowledge of their rights to treatment and therefore, will expect fair treatment from nurses.

5.2 Influence of relationship between nurses and other health professionals

The study found that there was friendly relationship between nurses and doctors. This enabled the nurses to call the doctors to the wards whenever there were patients to care for. It was also reported that nurses and doctors had mutual respect for one another. The finding is contrary to that of O’Connor et al. (2016), who indicated that poor teamwork and collaboration between nurses and doctors placed patients at risk of poor outcomes. Team work may thrive where there is respect for all team members. There will also be a feeling of belonging because members will feel as equal partners of patient care which will lead to improved interpersonal
relationships (Ajeigbe et al., 2014) and subsequent quality of patient care (Shen et al., 2011). However, Bergman (2012) had contrary findings; there was non-cohesiveness and lack of team work between nurses and doctors, which made nurses unable to make suggestions to doctors to prescribe analgesics. Healthcare institutions may need to put in place measures to identify disrespectful and intimidating behaviour of professionals and processes of disciplinary actions for offenders (Siedlecki & Hixson, 2015) since it was found that some of the nurses reported instances where the doctors exhibited rude and bossy behaviours towards them which is supported by Çelik, Çelik, Ağirbaş, and Uğurluoğlu (2007). Some of the effects of verbal abuse of nurses reported are headaches, disturbed mental health (Çelik et al., 2007) and decreased job performance (Roche, Diers, Duffield, & Catling-Paull, 2010) with its attending impacts on patients. Policy formulations towards identifying and reduction of abuse among professionals and fostering collaboration may help.

Nurses reported that the doctors they worked with accepted their suggestions during ward rounds as also found by Gallagher et al. (2015) that, nurses knew their decision making roles and influenced doctors regarding end of life care for patients. It however, contrasts with an earlier study in the United States of America (USA), which found that the nurses and doctors seldom made decisions together in the care of patients even though nurses frequently shared patients’ information with doctors (Nair et al., 2012). Also, Wang et al. (2018) asserts that nurses perceived that their collaboration with doctors was good, especially with sharing information on patients with doctors. The tendency of nurses and doctors to work alone instead of together as a team is high when decision making is lacking among these professionals which may result in poor patient outcomes (Rosenstein & Naylor, 2012). Furthermore, non-cohesion between these two groups of professionals may hinder nurses’ ability to care for patients’ pain as suggested by Bergman (2012). Efforts to enable collegial relations between these
professionals may be helpful since they are expected to collaborate effectively to provide quality care for patients (Wang et al., 2018).

The study findings also show that nurses were able to make prescriptions of pain medications based on their assessment of the patients’ pain levels and documented it. Nurses assessed pain using the numerical pain rating scale and showed the results with prescriptions they felt were safe to the pharmacist to be dispensed for the patients to take. Nurses took these actions mostly when the doctors were not around the wards to prescribe analgesics. This is supported by a previous study where nurses used strategies such as pain assessment tools to determine when to give analgesics to patients (Smyth et al., 2011). It was reported that the doctors eventually agreed with the nurses’ prescriptions when they came to the wards. This suggests that, when nurses know their roles in ethical decision making for pain management they will be able to implement proper treatment for patients (Davis & Kimble, 2011), which could be perceived by the doctors as appropriate. Prescription role is, however, not part of Ghanaian nurse’s job description and therefore, may pose a risk of abridging professional duties. Standard protocols in human resource constraint facilities may cover the nurses in situations where doctors are not available and nurses need to intervene in prescribing for patients’ pain management.

In a clinical context where punitive actions are seldom used, nurses may likely report potential and actual problems such as medication errors. The study found that nurses were able to identify potential medication errors and adverse effects and reported for appropriate actions. This may imply that nurses were not rather accused of these potential errors and adverse effects, and therefore, were comfortable reporting for appropriate actions. Aronson (2009) noted that practice environment where medication error reporting is encouraged by ensuring blame free and non-punitive environment, staff may feel at ease reporting for prompt actions. By this, nurses may have the courage to think critically and make ethically sound decisions aimed at
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preventing and managing common medication issues. Nurses should therefore be supported and encouraged by hospital authority to monitor patients closely for medication errors as well as adverse effects and also pay attention to medication administration.

Nurses had opportunity to learn about certain medications and their uses from the pharmacists. The reason could be because the nurses had cordial relations with the pharmacists which permitted the establishment of learning environment. The current study is contrary to an earlier finding that nurses were not willing to be in collaboration with pharmacists especially regarding patient education on their discharge medications (Kendall et al., 2007). Meanwhile another study found that collaboration with nurse prescribers and pharmacists facilitated positive patient outcomes, improved decision making and patient safety (Makowsky et al., 2009). A previous study also said that difficulty in accessing appropriate drug dosing information leads to knowledge-based medication errors (Nichols, Copeland, Craib, Hopkins, & Bruce, 2008). The attitude of nurses in the current study may help in reducing such errors as supported by Frush, Hohenhaus, Luo, Gerardi, and Wiebe (2006). This could go a long way to improve the nurses’ understanding of the medications and thus reduce errors.

5.3. Influence of unit leadership on ethical decision making

This thematic area discusses the major findings which include perceived supervisory roles and the feedback from the nursing unit leaders as reported in the findings.

Unit leaders (nurse managers) were perceived to pay particular attention to the nurses’ duties to ensure that they did the right things on the wards. Nurses were corrected in areas they made mistakes. This is supported in a study by Choi, Kim, and Kim (2018) where it was found that the nursing unit managers provided guidance and information to staff which improved the effectiveness of the staff. Close supervision and monitoring of staff can therefore be said to be an effective means of increasing productivity of the professionals (Aziato & Adejumo, 2015b;
Frimpong et al., 2011), ensure improved patient care (Davis & Burke, 2012) and ethical standards of work since workers get to know that their efforts are being monitored. This may suggest why the junior nurses consulted their unit leaders who were considered experienced for advice on issues they did not understand on pain management. Constant consultation with more experienced nurses and other health professionals may reduce the risk of making avoidable mistakes in patient care as suggested by Seiden and Barach (2006).

Nurses also perceived that their unit leaders also gave them opportunity to make suggestions on patient care which is consonant with Atwater (2007); Batson and Yoder (2009); Miyata, Arai, and Suga (2015) where they found that positive attitudes of senior nurses towards the junior ones made them confident and drove them to participate in decision making which improved quality patient care. However, contrary findings were recorded by Azaare and Gross (2011) where staff nurses reported that their nurse managers intimidated them. Findings of the present study suggest that the leadership of the units motivated the junior nurses to be proactive in their duties because they felt recognised in the clinical care environment. It may be suggestive of good leadership attitudes because Giambra et al. (2018) noted that in order to make the best decisions to enhance patient satisfaction, those professionals involved in the area of practice should be actively involved in the decision making. Therefore, nurse leaders need to understand the need to create environment that allow for participation of junior staff in decision making to foster quality care.

The study also found that unit leaders always wanted to ensure that analgesics and other emergency medications were available on the wards for the nurses to administer to patients despite report of frequent shortage of the analgesics. It may imply that the unit leaders were committed to the welfare of their patients and therefore felt obliged to ensure the provision of resources such as medications for patient care. The effort of ensuring the availability of medications could result in both patients and staff satisfaction as suggested in previous studies.
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(Hayes, Bonner, & Pryor, 2010; Henriques, 2015; Penz, Stewart, Arcy, & Morgan, 2008; Zangaro & Johantgen, 2009). It is not surprising that in the advent of the National Health Insurance Scheme (NHIS) there are still shortages of certain medications. This is because of systemic challenges such as non-payment of claims, and non-coverage of some medications. However, considering the core purpose of the NHIS, thus to ensure access to healthcare by all Ghanaians especially the poor, there is the need to re-strategize the health system to ensure appropriate treatment of all patients. This is because, it was also found that due to the shortage, patients were compelled to buy analgesics, which usually become a burden for the poor patients.

Nurses said that unit leaders commended them when they did well in the management of patients’ pain. Staff motivation in the form of encouragement makes staff feel that their efforts are being recognised and may increase work output (Cummings et al., 2010; Eneh, Vehviläinen-Julkunen, & Kvist, 2012). This may explain why some of the nurses reported that they sacrificed their time and energy for the sake of the patients. The finding corroborates with previous study, where nursing managers provided encouragement to junior nurses (Choi et al., 2018). Conversely, some nurses in the current study felt demoralised when their efforts to manage patients’ pain did not help the patients. This calls for nursing unit leaders to identify efforts of such nurses, though futile, and motivate and inspire them alongside those who do well in the management of their patients.

Again, nurses perceived their unit leaders to provide them with feedback on the work they did. Seeking and providing feedback inform nurses with a sense of how well they are doing their work (Smither, Brett, & Atwater, 2008). Polis et al. (2015) also indicated that provision of feedback to staff is an attribute of effective leadership which is the result of openness in communication with staff. Openness and constructive feedback from nurse unit leaders may have the potential of eliminating or reducing repeated errors committed, thereby
enhancing quality care which may explain why unit leaders provided feedback to their subordinates immediately they identified some. However, providing feedback to nurses in embarrassing manners such as correcting or condemning openly should be discouraged among nurses and their leaders.

5.4 Influence of institutional factors on ethical decision making

Nurses indicated that they had pain rating scale which was used to assess pain as a protocol routinely. Others also said that carrying out orders of doctors was a protocol. It is clear that these may not be sufficient to use in the management of surgical pain. After assessment of pain there would be the need to identify what protocols to apply in management which, however, was not available for nurses as found in a previous study in Ghana (Aziato & Adejumo, 2015b). Meanwhile, previous study showed that the use of assessment tools and multimodal protocols for pain management after total knee and hip arthroplasties resulted in excellent pain control and functional recovery of patients (Parvataneni et al., 2007). Similarly, Barr et al. (2013) found that guidelines and protocols provide evidence-based patient centred treatment of pain. Also, a systematic review by Courtenay and Carey (2008) found that use of protocols improved patients understanding of their conditions and pain control. Interestingly, Sommer et al. (2008) found that pain protocols use did not significantly improve outcome of pain management. Ebben et al. (2015); and Jun, et al. (2016) further said that, the use of protocols was acknowledged by nurses, however perceived that complexity of guidelines and protocols and low knowledge or awareness of the protocols affected their use by the nurses. Thus, simplified protocols and guidelines may give clear direction on the strategies to employ in the management of post-surgical pain as suggested by (Aziato & Adejumo, 2015a).

It was also identified that protocols helped save time and reduced workload on the doctors since nurses could determine actions to take in preventing and managing surgical pain.
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Blondal and Halldorsdottir (2009); Pretorius, Searle, and Marshall (2015) also reported that the presence of nurse-initiated analgesic protocols lessened time spent in attending to patients without necessarily searching for doctors to review patients. Evidence has also been established that initiating pain management before surgical review reduces risk of severe pain (Macintyre, Scott, Schug, Visser, & Walker, 2010). This can be achieved by the nurses when there are evidence-based protocols for pain and through consensus with the doctors. When nurses are also abreast with knowledge of the available standard protocols and are motivated, they may likely use them to improve their decision making towards pain management.

The study found that doctors were few and therefore could not come to review patients regularly, especially during afternoon and night whenever a patient was in pain. Nurses often reached doctors to review patients using phone calls. Other times too nurses scored patients’ pain using the numeric rating scale and administered medications on their own when they could not reach a doctor to consult. It supports a recent study where midwives gave pain medications to patients in labour pain based on their experience whenever doctors were not available (Aziato, Kyei, & Deku, 2017). This suggest that nurses know what to do for patients in pain when doctors are not available. More empowerment such as the provision of protocols to enhance-evidence based practice is needed, especially in human resource limited health facilities. By this, nurses may be able to make better decisions that are ethically driven on the management of pain while using the protocols as guide.

Frequent shortage of pain medications in the hospital also affected POP management adversely as nurses reported that patients resorted to buying such medications from the community, which resulted in delayed treatment of pain. Nurses eventually lost interest and zeal in attending to patients. Interestingly, other nurses borrowed medications from patients who were able to buy to administer to those who needed it, and also relied on non-pharmacological management of pain at certain times. Non-pharmacologic measures of pain
management such as music has been shown to be effective for surgical pain, chronic pain, and labour pain among others (Aziato et al., 2017; Huang, Good, & Zauszniewski, 2010; Vaajoki, Pietilä, Kankkunen, & Vehviläinen-Julkunen, 2012). Therefore, it is prudent to combine the non-pharmacologic strategies with pharmacologic measures to treat acute surgical pain. Nurses may need to liaise with hospital authorities to understand the stress patients go through when proper pain management modalities are not available. This may result in constant monitoring for shortage and prompt replacement of such medications.

Ethics committees are indispensable in healthcare facilities as they play roles such as policy formulations, education and handling of ethical issues (Aulisio, 2016; Garrison & Magnus, 2012; Hoffmann & Tarzian, 2008). However, it was found that there was no existing ethics committee at the hospital of study. The absence of ethics committee may mean that nurses may not get sensitized about professional ethics issues in order to be abreast with current acceptable trends. Furthermore, nurses may not be able to identify ethical issues and how to resolve them by taking appropriate ethical decisions because of the absence of ethics committees to help guide the nurses (Song et al., 2014). The nurses reiterated that ethics committee could help improve standards of nursing practice and ensure nurses’ respect for patients’ rights and dignity.

5.5 Intrinsic motivators of pain management

Nurses expressed commitment to treat their patients’ pain despite numerous challenges they met in their line of duties such as shortage of staff, medications, and overwhelming workload. This finding is confirmed by an ethnographic study which found that nurses’ personal dedication to the comfort of their patients influenced their interventions for the patients (Aziato & Adejumo, 2014b). Strategies to improve nurses’ commitment to their work such as staff engagement, setting objectives with staff (Ashraf, Mehdi Jaffri, Tariq Sharif, &
Asif Khan, 2012), and leadership support for nurses (Miedaner, Kuntz, Enke, Roth, & Nitzsche, 2018; Orgambídez & Almeida, 2018) are needed. Even though, these strategies are extrinsic motivation, implementing them may make staff feel that authorities have concern for their efforts. Furthermore, constant encouragement of staff may help improve their efforts.

Nurses said that it was fulfilling to work hard and see patients recover. It was realised that nurses perceived that they rendered quality care when their hard work was recognised by their unit leaders and as well contributed to patients’ recovery. A recent study also found that nurses view of quality delivery of care impacted positively on their commitment to work (Miedaner et al., 2018). Helping nurses to recognise their efforts in the care of patients may boost intrinsic motivation and thus enhance their commitment towards patients care. Furthermore, providing the needed resources for nurses and ensuring peaceful work environment may also increase staff motivation since they may feel safe and satisfied at work. Justifiably, Cerasoli, Nicklin, and Ford (2014) in a meta-analysis study found that job satisfaction, and provision of resources for workers are intrinsic motivation factors. Moreover, it was recently established by Choon Hee, Kamaludin, and Ping (2016) that, intrinsic motivation of nurses directly influences job performance of nurses, further buttressing the need to provide measures for intrinsic motivation of nurses.

Nurses’ past experiences of pain influenced their empathy for patients to promptly manage their pain. The nurses also viewed pain as unpleasant experience which agrees with findings of Aziato et al. (2016); Kumar and Elavarasi (2016) and that they did not wish even their enemies to experience pain. Being cognisant of ones’ own past experience and remembering its unpleasant nature are important elements that may influence the nurse’s empathy for patients in pain (Aziato et al., 2016). That is however, not to suggest that nurses should also experience pain in order to be empathetic but those nurses who have experienced
pain in their lives can reflect on how it was when patients are in pain. This may help the nurses empathise with the patients and thus attend to them.

5.6 Conclusion

The discussion covered the key findings of the study. The thematic areas discussed were nurses’ knowledge of ethical principles, influence of nurses’ relationship with the other professionals, influence of unit leadership, institutional factors and intrinsic motivators of pain management. Understanding the ethical principles guiding nursing practice is key to adequate pain management. Also, nursing leaders need to constantly supervise and provide constructive feedback to junior nurses on their performance since it could influence positive decision making that enhance pain management. The provision of adequate resources such as simplified pain management protocols will also enhance nurse autonomy in making ethical decisions, especially in limited human resource health facilities. Also, leadership efforts to encourage nurses who are intrinsically motivated to make ethical decisions for surgical pain management could further ensure their satisfaction with work. These efforts would subsequently improve quality of surgical pain management.
CHAPTER SIX

SUMMARY, RECOMMENDATIONS AND CONCLUSION

6.0 Introduction

This chapter presents the summary of the entire study, and implications of the findings to nursing, education, practice, research and policy. Limitations and suggestions for future research are also presented in this chapter. It ends with a general conclusion.

6.1 Summary

Postoperative pain remains a challenge for patients with various reasons accounting for its inadequate management. The consequences of this unrelieved pain could lead to immediate or delayed complications. The study therefore aimed to explore factors influencing nurses’ ethical decision making towards POP pain management. The study employed exploratory descriptive design. Semi-structured interview guide was designed using the objectives to obtain the data from participants. Thematic content analysis was used to analyse the data and five themes emerged: Knowledge of ethical principles in POP management, Influence of unit leadership on POP ethical decision making, Influence of nurses’ relationship with other professionals in ethical decision making for POP management and Institutional factors influencing ethical decision making for POP management.

In exploring nurses’ knowledge of ethical principles in POP management, it was found that nurses had fairly adequate knowledge of the basic nursing ethical principles. Nurses explained beneficence to be doing good to patients such as taking measures to relief pain, helping patients with food and money. It was also perceived as making patients comfortable. Nurses also explained nonmaleficence as avoiding harm to patients in caring for them. Again, nurse autonomy and patient autonomy were identified. The former was explained as giving patients the opportunity and rights to make choices from options concerning their treatment.
Nurses also indicated that empowering patients with knowledge of their treatment and consequences could make patients autonomous. Nurses acknowledged that the subjective nature of pain could be best treated by allowing patient autonomy. Nurse autonomy was also explained as nurses having the independence and freedom to make decisions on patient care. Justice was viewed as being fair and showing non-discriminatory attitude towards patients irrespective of their race, colour, or social status. It was noted that nurses need to be fair to patients by administering their prescribed analgesics.

Nurses described their relationship with the other professionals as cordial. Nurses were involved in decision making concerning patients’ pain management. Nurses perceived doctors to have time to listen to their views about patients’ pain management and there was also reciprocal respect. However, a few of the nurses reported instances of rudeness by doctors towards them. Nurses often found it easy getting medications from the pharmacy especially in emergency situations. Also, nurses reported that they made assessment of patients’ pain and prescribed for the pharmacists to supply them when doctors were not around. Nurses’ relationship with the physiotherapists and anaesthetists was also cordial, even though they did not often work together because these professionals scarcely came to the wards.

Nurses perceived that their unit leadership involved them in decision making on patients care. Unit leaders were also seen to monitor nurses’ performance and always gave feedback on work done. The nurses were commended whenever they did well which motivated and inspired them to work hard towards surgical pain relief.

Institutional factors that affected nurses’ ethical decision making were protocols, availability of doctors and medications, and ethics and disciplinary committees. Standardised protocols for POP management were not available in the wards. However, nurses had analogue rating scale for assessment of pain. Nurse acknowledged that protocols would help them make
good decisions on pain management even when doctors are not around to assess and prescribe medications. Frequent shortage of analgesics was an issue that prevented nurses from doing their best in the management of surgical pain. Even though there was no ethics committee in the hospital, nurses acknowledged that such body could help enhance their knowledge of ethical issues and thus help them make ethical decisions.

6.2 Implications for nursing practice

The findings of the current study bring to bear the issues that need to be addressed in order to improve the quality of nursing care for POP. Understanding the factors affecting ethical decision making for surgical pain management will enable nursing unit leaders provide the necessary encouragement and support to nurses at the ward level to attend to patients’ pain, while holding on to the ethical principles guiding pain management. Nurses increased knowledge of professional ethical principles and their applications in pain management will better equip them to present holistic nursing care of surgical pain. Also, the provision of standard and simplified protocols and guidelines such as nurse-initiated pain management protocols will empower nurses to adequately assess and manage surgical pain in situations where doctors are few. These protocols should be posted on the wards to always guide the nurses. Moreover, creating the awareness of the impact of cordial relationship among the multidisciplinary professionals involved in the management of surgical pain will further enhance ethical decisions and pain management outcomes.

6.3 Implications for nursing education

The study showed that nurses had knowledge of ethical principles and that they demonstrated how these principles are important in the management of surgical pain. The nursing curriculum should therefore, place more emphasis on ethical principles specifically guiding pain management. Again, there could be a component for teaching students and
practicing nurses on how to establish interprofessional relationships and maintain collaboration in caring for patients.

6.4 Implications for nursing management

Nurses who are prepared to take up leadership or managerial positions should be taught the leadership skills that will enable them to understand and motivate their subordinates to put up their best in the clinical setting. Nursing management should also carry out constant supervision and provide nurses with feedback on the work the nurses do. This will make nurses know their strengths and weaknesses and be able to address the challenges. Nursing management should also play a role in the procurement of medications and other equipment that can help in the provision of diversion therapy to patients. This will enable nurses have the chance to use all acceptable avenues to manage surgical pain successfully.

6.5 Avenues for future research

Further research can be conducted on the following areas:

1. Nurses Ethical decision-making processes on POP management

2. Knowledge and application of ethical principles of registered nurses and enrolled nurses.

3. The impact of nurse-initiated guidelines and protocols on pain management ethical decision making and outcomes.

4. Comparison of knowledge and application of ethical principles of registered nurses and auxiliary nurses

6.6 Limitations of the study

The study has increased knowledge of the factors that influence nurses in making ethical decisions for pain management. It however, has limitations. One limitation is the fact that only registered general nurses were recruited in the study. It is possible that other category of nurses
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could have different views on the factors that influence their ethical decisions. Another limitation of the study is that the researcher could not assess the entire process of ethical decision-making process for surgical pain management. This could have helped in identifying nuance factors affecting arrival at appropriate decisions.

6.8 Recommendations

The following recommendations were made to help regulatory bodies and the management of the health facility:

A. Nursing and Midwifery Council of Ghana (N&MC): The curriculum should integrate ethical principles and applications to pain management in the existing surgical nursing curriculum. Also, the interprofessional team work and collaboration should be incorporated so that nursing students have the opportunity to learn about teamwork.

B. Ghana Registered Nurses and Midwives Association (GRNMA): consensus efforts to provide regular professional development on nursing ethics and professional relationships in nursing care. They should also advocate for the provision of the required human and material resources for nurses to use in the management of surgical pain.

C. The Regional Hospital management: should consider pain management as a priority and ensure that they provide the needed resources for nurses to use for the patients. Management should also consider establishing ethics committee that will serve to help nurses understand ethical issues in patient care.
6.9 Conclusion

Nurses in this study had adequate understanding of the ethical principles that underpin all biomedical ethics. Their knowledge of these ethical principles helped guide the management of surgical pain, especially the understanding that patients’ choices have to be recognised and also the awareness that patients have the right to report their pain. Nurses also saw the need to balance good over harm when performing invasive procedures on surgical patients and being fair to them in terms of administration of analgesics.

Nursing leadership attitudes also impacted nurses’ ethical decision making since it was shown that nurses had positive feedback on their nursing duties. This could help nurses understand their weaknesses and strengths in clinical care of patients and address the weaknesses. Also, the provision of resources such as simplified pain management protocols may improve patient outcomes since the nurses were able to initiate pain management, especially in cases where doctors were not around.

It was also established that good interprofessional relationship was key to ethical decision making for patients’ care since effective pain management hinges on a multidisciplinary approach. All the factors identified that had influence on ethical decision making in this study depend on the professional nurses’ motivation and willingness to care for the patients. The need for nurses to be committed to their duties and the feeling of empathy for patients can therefore be further promoted among nursing leaders.
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Appendix A: Interview Guide

Data Collection Instrument: Interview guide

Demographic Information

1. Code
2. Sex: male [ ]; female [ ]
3. Age
4. Marital status: Married [ ]; Divorced [ ]; Not married [ ]
5. Religion
6. Level of education
7. Years of clinical experience

Interview

1. Tell me how patients express pain on your ward
   Probe
   Verbal expressions
   Non-verbal expressions
2. How do you feel when patients express pain on your ward?
   Probe
   Worried?
   Disturbed?
   Indifferent?
   Why do you feel that way?
3. What do you do for the patients?
   Probe
   Pharmacological
   Engagement in conversation
   Engagement in games/TV programmes
4. What inform your choice of pain management?
   Probe
Nurses’ ethical decision making for POP management

Patients’ expressions of pain
Personal commitment
Patient rights
Family influence
For ethical reasons

5. What do you know about nursing ethics?

6. Tell me about nursing ethical principles

7. How do you apply ethical principles in your patients’ pain management?
   Probe
   Fairness
   Do no harm
   Self-sufficiency
   Do good

8. What do you think are the institutional factors that affect your pain management decisions?
   Probe
   Ward protocols
   Doctors’ availability/ prescription
   Drug availability
   Ethical committee
   Disciplinary committee

9. How does your unit/ward leadership affect your pain management ethical decisions?
   Probe
   Ward in-charges’ influence
   Feedback from nurse leader
   Positive; How?
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10. How is your relationship with other health professionals concerning surgical patients care?
   
   Probe
   
   With doctors
   
   With pharmacists
   
   With physiotherapists
   
   With anesthetists
   
   How cordial are these relationships?
   
   How does your relationship with the professionals relate to ethical principles?
   
   How do the relationships influence your ethical decisions for postoperative pain management?

11. Do you have any other thing you wish to share? Thank you.
Appendix B: Consent Form

Consent Form

Title: Exploring factors influencing nurses’ ethical decision making for postoperative pain management in the Bolgatanga Regional Hospital.

Principal Investigator: Moses Tia Banoya, Telephone: 0202698074 Email: mbtia@st.ug.edu.gh

Address: Department of Adult Health, School of Nursing and Midwifery, College of Health Sciences, University of Ghana, Legon, Box LG 43, Accra

General Information about Research

The study aims to explore your perspectives on factors that influence you in making ethical decisions for postoperative pain management. I will like you to provide me with information on how you understand nursing ethics, your relationship with other health staff, influence of unit leadership and institutional factors have played roles on your ethical decision making when caring for surgical patients’ pain. I will use English language in the conversation. You will be required to sign a consent form before the start of the interview to show that you have willingly decided to participate. You have the right to withdraw at any time in the interview process and not face any problem. The interview will be recorded with your permission and that will not include identifying information about you such as name, age. The recorded tape will be given to you to listen to be sure it is what you intended saying. Also, recorded information will be transcribed and given to you to read through to ascertain if what is written is really what you said. It is expected that the interview will last for about forty-five to sixty minutes.

Possible Risks and Discomforts

No harm is anticipated in the process of the interview. Physical tiredness and emotional distress may be expected. In that event, the interview will be paused and continued at a later time or another day when you are ready to participate.

Possible Benefits

There are no direct benefits that you will get from participating in the interview. Study may benefit you later when policy makers initiate change with findings, especially organizing in-service training on ethics in pain management.
Confidentiality

Every information obtained from you will be kept from the reach of all persons except myself and my supervisors. In the event that other school authorities need to have the recorded tape, permission will be sought from you. You are also assured that every bit of information made known to me by you will be for academic purposes only and nothing more. The device that will be used to store your taped voice will not be shared with any other person. Your demographic information will not be audio taped. Your name will not be used in the whole process and no document shall contain your name. You will be given Codes such as FN1, MN2, FN represent male nurse and MN represent male nurse. The recorded data and transcribed data will be stored in a folder in the researcher’s personal computer. The folder will be password protected. Field notes, consent forms, and other hard copies of data will be placed in folders and locked in researcher’s personal cabinet. After five (5) years, all hard copies of documents containing information obtained from you will be burned while the soft copies of information obtained from you will be deleted permanently from the computer. The interviews will be done at a place of your convenience and free of interruptions by others. Other persons will not be allowed at the place of the interview except myself (the researcher) and you. When the need arise for my supervisors to be present in the interview or interview you, permission will be duly sought from you.

Compensation

You will be given a bottle of soft drink, pie and water for refreshment.

Voluntary Participation and Right to Leave the Research

The decision of participation and withdrawal from the study is solely your right and thus depend on you to decide at any given time in the course of the study. There will not be any risk of withdrawing from the study at any time you wish.
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Notification of significant findings
Significant new findings will first be forwarded to the appropriate authorities of the hospital and then disseminated to the staff for use.

Contacts for Additional Information
For any information regarding the study, kindly contact the following:
Tia Moses Banoya. Email: mbitia@st.ug.edu.gh
0202698074
Dr. Lydia Aziato (Ag. Dean), School of Nursing and Midwifery, University of Ghana, Legon, Accra
Phone number: 0208552719, Email: aziato@yahoo.com

Your rights as a Participant
This research has been reviewed and approved by the Institutional Review Board of Noguchi Memorial Institute for Medical Research (NMIMR-IRB). If you have any questions about your rights as a research participant you can contact the IRB Office between the hours of 8am-5pm through the landline 0302916438 or email addresses: nirb@noguchi.ug.edu.gh
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VOLUNTEER AGREEMENT

The above document describing the benefits, risks and procedures for the research title "Exploring factors influencing nurses' ethical decision making for post-operative pain management in Bolgatanga Regional Hospital" has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

_________________________  ______________________________
Date                                                Name and signature or mark of volunteer

If volunteers cannot read the form themselves, a witness must sign here:

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

_________________________  ______________________________
Date                                                Name and signature of witness

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

_________________________
Date  Name Signature of Person Who Obtained Consent
Appendix C: Introductory Letter

UNIVERSITY OF GHANA
SCHOOL OF NURSING

SONM/F:11
Ref. No.: .............................................. December 13, 2017

The Regional Health Director
Upper East Region

Dear Sir/Madam,

INTRODUCTORY LETTER

I write to introduce to you Tia Moses Banoya, an MPhil second year student of the School of Nursing and Midwifery, College of Health Sciences, University of Ghana, Legon. He is seeking your permission to collect data for his research on the topic “Exploring Factors influencing Nurses’ Ethical Decision Making for Post Operative Pain Management in the Bolgatanga Regional Hospital.”

I should be most grateful if you could kindly assist him with the information that he may require.

Thank you.

Yours faithfully,

Dr. Lydia Asiato
Ag. Dean

COLLEGE OF HEALTH SCIENCES
P. O. Box LG 43, Legon, Accra, Ghana.
* Tel: +233 (0) 302 513 250 / 0299 531 213
* Email: sonf@chs.ug.edu.gh
* Website: www.nursing.ug.edu.gh
Appendix D: Ethical Clearance letters

1st November, 2017

ETHICAL CLEARANCE

FEDERALWIDE ASSURANCE FWA 00001824
NMIMR-IRB CPN 016/17-18
IRB 00001276
IORG 0000908

On 1st November, 2017, the Noguchi Memorial Institute for Medical Research (NMIMR) Institutional Review Board (IRB) at a full board meeting reviewed and approved your protocol titled:

TITLE OF PROTOCOL : Exploring factors that influence nurses’ ethical decision making for postoperative pain management in the Bolgatanga Regional Hospital.

PRINCIPAL INVESTIGATOR : Moses Tia Banoya M.Phil Cand.

Please note that a final review report must be submitted to the Board at the completion of the study. Your research records may be audited at any time during or after the implementation.

Any modification of this research project must be submitted to the IRB for review and approval prior to implementation.

Please report all serious adverse events related to this study to NMIMR-IRB within seven days verbally and fourteen days in writing.

This certificate is valid till 31st October, 2018. You are to submit annual reports for continuing review.

Signature of Chair: ____________________________

Mrs. Chris Dudzie
(NMIMR – IRB, Chair)
Nurses’ ethical decision making for POP management

GHANA HEALTH SERVICE ETHICS REVIEW COMMITTEE

In case of reply the number and date of this Letter should be quoted.

MyRef. GHS/RDD/ERC/Admin/App 936
Your Ref. No.

Moses Tia Banoya
University of Ghana
School of Nursing and Midwifery
Legon, Accra

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your Study Protocol.

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<th>GHS-ERC: 012/10/17</th>
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<td>15th November, 2018</td>
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This approval requires the following from the Principal Investigator

- Submission of yearly progress report of the study to the Ethics Review Committee (ERC)
- Renewal of ethical approval if the study lasts for more than 12 months,
- Reporting of all serious adverse events related to this study to the ERC within three days verbally and seven days in writing.
- Submission of a final report after completion of the study
- Informing ERC if study cannot be implemented or is discontinued and reasons why
- Informing the ERC and your sponsor (where applicable) before any publication of the research findings.

Please note that any modification of the study without ERC approval of the amendment is invalid.

The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Kindly quote the protocol identification number in all future correspondence in relation to this approved protocol

SIGNED

DR. CYNTHIA BANNERMAN
(GHS-ERC CHAIRPERSON)

Cc: The Director, Research & Development Division, Ghana Health Service, Accra
### Appendix E: Demographic characteristics of participants

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