Interview guide – carers

The detection and management of pain in patients with dementia in acute care settings: Exploratory Study

Interview Topic Guide: Carers

Before start check carer's understanding of the purpose of the research and that they are happy to participate.

1. Could you tell me how long you have been caring for (name of patient)?
2. Are you also caring for other people (prompt: other members of your family, friends or neighbours)?

   [If yes, explain that all following questions are about (name of patient)]
3. Apart from memory loss, are there any other factors that could impact on hospital staff's ability to manage (name of patient)'s pain/discomfort?
4. How can you tell if (name of patient) has pain or is uncomfortable? What sort of signs do you look for? Have the hospital staff asked you if you can tell if (name of patient) is in pain?
5. How do you try to relieve their pain/discomfort when they are at home? How do you tell if they have worked? Have the hospital staff asked you what you do to help them at home?
6. What actions have hospital staff taken that you think have really helped with their pain/discomfort?
7. How do you think their pain/discomfort has been managed?
8. What do you think could have been done better to help with their pain/discomfort?

9. Do you feel that you have been able to provide information to the hospital staff to help them care for (name of patient) effectively? Why? Could things be improved? How could they be improved?
10. What could be put in place to help you feel confident that (name of patient) has their pain/discomfort managed effectively while they are in hospital?
11. What do you think of the care that they have received while they have been in hospital?

Interview guide – ward staff

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Interview Topic Guide: Ward Staff

This interview guide is for interviews with members of the multidisciplinary team, such as doctors, nurses, therapists, and healthcare assistants/support workers.

Before starting, check clinician's understanding of the purpose of the research and that they are happy to participate.

1. To begin with, ask about the interviewee's role and responsibilities, and the types of patients usually under their care
2. Focusing on pain assessment and management in general, ask how is pain recognised, assessed and managed in patients under their care. Invite the interviewee to think of a patient they are caring for at the moment, and to tell how they knew if she was in pain (pain recognition), how they assessed it (pain assessment) and how was it managed (pain management).
   Inquire also on who is responsible for the different aspects of this process.
3. Focusing on patients with dementia, ask whether the process would be any different. Invite the interviewee to think of a patient they are caring for at the moment and relate their answers to this patient.
   Prompt: A patient with dementia may not know how to communicate her pain, or may not remember that the pain is recurrent: how would this affect how their pain is recognised and assessed.
4. Focusing on pain assessment tools, ask about any tools in use in the ward specifically for pain assessment, and if any, for use with patients with dementia.
5. Focusing on the communication and documentation of assessment/management of pain, ask how is activity documented and information communicated.

6. Focusing on the role of carers in the process, ask whether carers are currently involved and how. Invite the interviewee to think of a patient they cared for, and to tell whether the involvement of the carers or relatives changed the recognition, assessment or management of the patient's pain.
7. Invite the interviewee to reflect on the current assessment/management process and if/how they think it could be improved. Invite the interviewee to reflect on existing tools and think how an effective pain assessment and management tool would look like.

   Prompts: for example in terms of format, content, or information resources.

Audit Protocol - drug chart and multidisciplinary notes

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Audit Protocol - drug chart and multidisciplinary notes

We seek consent to access and examine the patient's drug chart and multidisciplinary notes with the aim to document all the types of care that the patient has received related to pain and discomfort, including medications that were prescribed and hospital length of stay. This audit protocol provides a guide on how to carry out the audit of the patient's drug chart and multidisciplinary notes.

As well as the drug chart, *all* notes in the patient record will be examined as potentially relevant pertaining to the current period of hospitalisation (only) – such as, for example, medical notes, nursing notes, bedside notes, intentional rounding, NEWS assessment forms. These can be in paper or electronic form.

The audit will be carried out during or at the end of the observation period, taking into consideration that access to the notes may be impeded after the patient has been discharged, as they may be required by other hospital departments.

The objective is to gather data in relation to:

- documentation of pain assessment
- action taken (or not taken)
- pain reassessment (or not)
- prescribed analgesia.

For each patient, we will identify and record in field notes:

- date of admission to the hospital and to the ward (if different)
- male/female
- age
- reason for admission and primary diagnosis
- additional diagnosis and/or events occurred during hospitalisation (e.g. falls)

From the drug chart, the audit will be done by writing in field notes, for each item prescribed:

- name of item prescribed
- dose
- route
- timing and frequency of administration (dosage regimen)
- whether is was given as prescribed, at the times administration was due

Data will be recorded for items prescribed during the day(s) of our observation of the patient, as a minimum. However, if appropriate, audit notes could be taken from the drug charts for a wider timeframe (e.g. the entire week of the field study).

For all notes, the audit will be done by writing field notes of the documentation examined. For each entry in the field notes, the researcher will write:

- Date, time of entry was written
- Extract of relevant section
- If available, the role of the person authoring the note (e.g. consultant, or pharmacists)

No identifiable information will be copied in the field notes – i.e. patient identifiers and/or name of members of staff/authors of the documents examined.
Each audit will be time-stamped (by recording time/date the audit took place).

This is the minimum set of data to be extracted in the process of auditing. The data needs to be sufficient in order to calculate a score through the Pain Management Index at the stage of analysis.
Researchers will use their own judgement to identify and assess the relevance of the entries in the patient's notes and whether it is necessary to record contextual information pertaining to the above, for a correct understanding of what has been recorded. This is especially the case in trying to capture the *absence* of pain assessment (or action not taken), which, for the purposes of our research, is as important as its presence. For example, pre-designed assessment forms such as the NEWS can include space/boxes about pain assessment; from the record, it may be apparent that sections of this form may have been used, but not the one regarding pain (suggesting pain assessment was not carried out); in this case audit field notes will be written up, recording the date the form was used (e.g. for purpose of intentional rounding) as well as the (apparent) lack of use of the space for pain assessment (the absence of data in the relevant field).

Questionnaire on ward background and contextual information

The ward - Background contextual information

1. **Staffing ratio**:

1.1 Staffing - FT equivalent

	for day shifts	**for night shifts**		**for day shifts**	**for night shifts**
Ward Manager			Consultants		
Sisters			Registrars		
Staff nurses			Foundation Doctors (FY1/FY2)		
HA/Support workers			Junior doctors		
Student nurses			Medical students		
Other (specify)			Other (specify)		

1.2 Is staffing the same during the weekend? If no, how is it different?

2. **Size of ward/Number of patients**

Number of beds:			Bed occupancy:	

3. Patient throughput

throughput counted as per 1000s bed days	
rate of throughput	

4. Patient population (main characteristics):

5. Does the ward hold regular **staff meetings**:

Yes/no	
Frequency (daily, weekly, other)	
Who attends the meeting	
Where does the meeting take place (e.g. day room, staff office, etc)	