Introduction

The aim of this paper is to analyse a critical incident, which occurred during an acute care placement. The discussion will be based on the communication needs and assessment of pain in a confused 74-year-old male patient, who will be referred to as Mr Jones to maintain confidentiality (Nursing and Midwifery Council: Code of Conduct 2004). The rational for choice is due to the writer believing the implications related to not relieving pain are contributing factors to delayed recovery and become detrimental psychologically to both the patient and the nurse. Plus the cost of additional resources required when pain is unresolved. Also the knowledge gained form this experience will be transferable to all aspects of patient care in all areas of nursing.

Critical Incident

Mr Jones was brought into the accident and emergency department by ambulance after being found on the floor of the residential home he resides. The patient was assessed by a nurse and presented with confusion, weakness, a wound above his left eye and multiple contusions to his right arm and leg, as well as a skin tear to the upper left wrist. Staffs from the nursing home were unable to accompany the patient to A & E, even though he was uncompliant with all treatment and the paramedics struggled to transfer him. The patient's son was called to come straight to A & E. Staff were unable to assess the patients Glasgow coma score accurately due to the confusion, as they were unaware of how the patient normally presented. Any attempt to assess the patient's wounds was repelled. One nurse expressed that pain assessment was causing difficulties as the patient complained of pain even when the oxygen saturation probe was put onto his finger and concluded this could not possibly have caused him pain. Mr Jones was left alone for most of one hour while waiting for his son to arrive.

Unfortunately the cubicles in A&E were full and Mr Jones was treated in the clinic room, were only a curtain divides patients. Unfortunately there was another patient having a head wound sutured after a fight in a pub. Some of the language used by this patient was offensive and Mr Jones appeared to become agitated and frightened. He started to shout he wanted to go home and his body language showed increased anxiety. Hinchliff, Norman &Schober (2003) explain that anxiety is an expression of nervous energy and a confused patient will be extremely fearful when entering the busy hospital environment with clinical surroundings. When Mr Jones son arrived he looked distressed at the sight of his father and articulated that the confusion was not usually as bad and his father was normally approachable and not aggressive.

Cognitive impairment is characterised by a deterioration of one or more of the following factors, memory, attention, visual spatial skills, language or behaviour (Forrest 1995). Cognitive impairment is exacerbated by pain and may also mask pain; it is associated with behaviours such as aggression and disruptive vocalisation Ferrell & Ferrell (1996). Parke (1998) believe pain in older adults is poorly assessed and managed and even more so if they are confused. Carers of confused adults often assume they are unable to identify appropriately their pain. Patients with short-term memory loss may be unable to recall resent painful experiences and can result in carers overlook any complaints of pain (Chibnall & Tait 2001). However, studies have shown that pain reported by cognitively impaired patients are reliable and valid (Weiner & Herr 2002).

Staff roles

Once the paramedic had handed over all the information he had gained to the staff nurse, Mr Jones became the responsibility of the nurse and the A & E department. The staff nurses role was to triage, coordinate care and assess pain levels she appointed the doctor to see him next, due to the confusion not being

normal for him as well as the physical state he presented in. Mr Jones was at first left with his son but due to his fathers increasing confusion was finding it extremely upsetting and difficult to cope with alone. Mr Jones was constantly trying to leave the clinic room. I was assigned to stay with Mr Jones; I assisted with his physical care and also became an advocate for him and his son. Davis, Aroskar, Liaschenko & Drought (1997) emphasis advocacy is important nurses have an ethical responsibility to protect patients rights, it gives both the patient and their family a voice and assist with understanding, communication, relaying information between all parties involved. I assisted by interpreting between family, patient and doctor. I was also to contact Emergency Medical Admissions to assess if there would be a bed available on the ward, before the government target time for being in A & E of three hours 59 minutes was breached (Department of Health 2003).

Negative aspects of care

Unfortunately Mr Jones had arrived at A & E when it was extremely busy and in retrospection it would have not exasperated his anxiety had he been put straight into a cubical and not had the upset of being in the vicinity of an abusive drunk man, this would be in line with (Hinchliff, Norman &Schober 2003). Perhaps a patient who was not confused could have been swapped from a cubical into the clinic room. The doctor assessing was of Indian origin and not easy to understand he introduced himself but spoke little to Mr Jones asking where the pain was as he examined him. Mr Jones did not answer and looked quite anxious at this point one considered that it might have eased the examination had a clearer speaking doctor been available.

The doctor was to gain an understanding of the patients' mental state and attempt to diagnose the reason for Mr Jones fall and the condition he was in. There was very limited non-verbal communication used by the doctor and he

examined Mr Jones very quickly. Bephage (2000) explains that communication and interaction with this patient group should be clear, concise and at a pace suitable so as not to cause further agitation and confusion. The student used basic terminology when repeating what the doctor had said to aid in easy understanding for the patient and his son. Bephage (2000) advocates the use of simple verbal communication in such incidents along with eye contact and facial expression to aid understanding and provide the patient with reassurance that both patient and family are being listened to and cared for, this builds trust between those involved.

Analysis of Incident

The nurse was to assess Mr Jones pain and any injuries that had been sustained. This proved very difficult due to his confusion and agitation. Ferrell (1995) recognises the importance of accurate assessment and management of pain in this group and stresses it is a priority in their care. Due to confusion Mr Jones was finding it difficult to describe and express his pain. Brochet (1998) articulates that ineffective identification of pain put confused patients at higher risk of poor pain management, under treatment of pain in patients with cognitive impairment is concerning as this will impede their quality of life, through lowered function, increased dependency and increase the length of their stay in hospital.

The nurse spoke to Mr Jones son and explained how they were to proceed with his father, after this she tried to reassure Mr Jones himself and used therapeutic touch to assist in relieving anxiety. Mr Jones was asked if he had any pain on a scale from 0 to 10, 0 being no pain, 10 being the worst pain he had experienced to evaluate his pain with no effect. He became withdrawn not answering and closed his eyes. The patient's son identified an unusual lack of speech, withdrawal and tension adding that his father was normally able to articulate his wishes

much better. The patient continually through one leg over the rail and worked his way down the trolley, making groaning noises and wincing. It was difficult to interpret whether this was due to pain, anxiety or confusion. Mr Jones son was asked to assist interpreting if his father was in pain as it was assumed he was more familiar with his father.

Feldt (2000) stresses when a patient is confused and unable to verbally respond assessments must rely on observations of behaviours. Herr & Garand (2002) identified such behaviours including wincing, vocalization, body movements, and changes in interpersonal interaction. MacCafrey & Pasero (1999) believes patients with confusion report fewer complaints of pain and that failure to report pain should not be assumed to mean the absence of pain. Ferrell (2000) consider that some cognitively impaired patients exhibit little or no specific behaviours associated with pain. Horgas & Dunn (2001) found that family and caregivers underestimate pain in confused patients. However, Cohen-Mansfield (2002) suggests relatives who visit frequently are able to give more accurate estimations of pain. Weiner & Herr (2002) noted that it is important to consider other causes of behaviours when relying on observation to assess pain, such as infection, constipation, bladder problems and primary mood disorders.

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