

Pain management in the Emergency Department: a phenomenological study on nurses' experiences

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ABSTRACT

Introduction: pain is a subjective and complex phenomenon, representing the first cause of access to Emergency Departments. Early management of pain through nurse-led analgesia protocols improves outcomes and patient satisfaction. **Aim:** this study aims to analyse the experiences of triage nurses regarding the pain of adult patients admitted to the Emergency Department, highlighting the main barriers to an objective pain assessment and the strategies adopted to manage it, to improve proper pain management.

Materials and Methods: this qualitative study has an interpretative phenomenological design; data is collected through semi-structured interviews. The study is reported according to the COREQ-32 checklist.

Results: twenty nurses in the Veneto region (Italy) Emergency Departments were interviewed. Seven themes were identified: nurse-led analgesia protocols, pain management in children, non-pharmacological interventions, differences between acute and chronic pain, the role of caregivers of elderly/cognitively impaired patients, nurses' personal experience of pain, and objectivity of nurses' pain assessment.

Conclusions: the interviews revealed a series of factors hindering optimal pain management related to the setting, such as Emergency Department overcrowding, or categories of difficult patients, such as children or elderly people with cognitive impairments. Positive experiences have also emerged, such as the usefulness of non-pharmacological techniques and the participatory role of family members and caregivers, during pain assessment of cognitively impaired patients.

Key words: analgesia; caregivers; emergency department; emergency nursing; pain; pain assessment.

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Introduction

The experience of pain is a subjective, individual, and complex phenomenon. It is the primary reason for seeking emergency care globally, affecting 50% to 79% of patients.¹ Adequate pain management is crucial for effective emergency treatment. The implementation of protocols for pain management by triage nurses has positive outcomes on patient satisfaction, reduction in the administration time of the first analgesic dose, pain intensity, and optimisation of the patient's journey within the emergency department (ED).²⁻⁶ Despite these efforts, oligoanalgesia in emergency settings is still present, with a significant proportion of patients not receiving timely or any pain treatment.⁷⁻⁹ Less than a third of patients presenting to the ED with acute pain receive an analgesic within an hour from admission, with an average administration time sometimes reaching up to 90 minutes, as opposed to the recommended 30 minutes.^{10,11}

Nurses often play a pivotal role in the emergency care pathway, being the first healthcare professionals interacting with patients from admission to discharge. Therefore, the perspective of nurses on pain management in the ED is crucial. Numerous studies have identified obstacles, such as inaccurate assessment, lack of specific tools, ineffective communication, inadequate training, absence of shared procedures, and high workloads.¹²⁻¹⁴ Additional limitations may stem from “myths,” such as opioid safety and the fear that analgesia may interfere with the physical examination or concerns about the risk of dependence, both from patients and healthcare providers.^{15,16} Specific patient groups, such as children or the elderly, especially those with cognitive deficits or depression, are at greater risk of pain underestimation.¹⁷⁻¹⁹ Improved pain management can be facilitated by implementing specific nursing protocols or through effective therapeutic communication with the patient and their caregivers.^{4,20,21}

Given the significance of this topic and the need to deepen our understanding of pain management in ED settings, this study aims to analyse the experience of ED nurses through a qualitative phenomenological investigation. The study intends to highlight barriers and strengths in the assessment and management of pain to ensure adequate treatment.

Aim

This study aims to explore, through a qualitative phenomenological design, the experiences of ED nurses in pain management. The focus is on elucidating challenges and best practices associated with the assessment and treatment of pain.

Materials and Methods

Study design

This study adopts a qualitative approach with interpretative phenomenological analysis of data collected through interviews.^{22,23} This methodology allows a focused exploration of the topic by considering the perspectives derived from the lived experiences of the interviewees, extracting elements directly relevant to clinical practice.²⁴

Ethical Approval

The research, adhering to the ethical principles of the Declaration of Helsinki on clinical research, received approval from the University of Bologna's Bioethics Committee (Protocol

No. 81582, dated 13/04/2022) and authorization from the Health Professions Directions of the involved hospitals. This study is reported following the Consolidated Criteria for Reporting Qualitative research (COREQ-32) checklist.²⁵

Setting

The study involved nurses working in the Emergency Departments of the ULSS3 Serenissima and the Azienda Ospedaliera di Padova, comprising 2 Hub Hospitals (Mestre and University Hospital of Padova) and 5 Spoke Hospitals (Dolo, Mirano, Venice, Chioggia, and Sant'Antonio Hospital of Padova) in the Veneto Region. The data collection period spanned from March to May 2022.

Participants

Participants, selected through purposive sampling to analyse specific experiences and represent the geographical setting uniformly, are ED nurses qualified for Triage activity with more than 6 months of work experience. Participation in the study was voluntary, upon adequate information and consent; no refusals to participate in the study were recorded.

Data collection

Semi-structured, open-ended, narrative interviews were conducted, providing ample freedom for participants to express themselves openly. The participants were put at ease in an informal and interactive context, and the research objectives were explained. The interviews began with the question: “How is pain managed in patients arriving at your Emergency Department?” Subsequently, interviewers guided the discussions with additional questions based on key aspects identified in the literature. The interviews were audio-recorded for subsequent transcription, with no field notes collected. All interviews, except one conducted via video conference for organizational reasons, were conducted outside working hours and in person by two researchers (VS and LM). Both researchers, employed in the ED of two participating hospitals, received specific training in conducting interviews and were consistently supervised by the instructors (SS and GI) of the Master's course in Critical Care Nursing at the University of Bologna. During the interviews, both interviewers and participants adhered to safety regulations for preventing the transmission of the SARS-CoV-2 virus.

Data analysis

Audio recordings of the interviews were transcribed verbatim into electronic documents and analysed to highlight recurring themes until thematic redundancy and data saturation were achieved. The analysis process followed the phenomenological method proposed by Giorgi (1985) and reported by Mortari and Zannini (2017): i) Complete reading of the interviews to familiarize with content and gain an overall understanding of the sense; ii) Careful re-reading and identification of significant content classifiable as “meaning units” relevant to the investigated theme; iii) Analytical examination of the identified meaning units to express their specific contents; iv) Comparison of contents, synthesis, and grouping into common descriptive themes.

The data analysis was conducted without the use of software. To minimize subjectivity and ensure rigour in data analysis, pseudo-anonymized interviews were independently analysed by two researchers not involved in the interview process (CL and LV). The research results (meaning units, themes, and sub-themes) were consistently shared among researchers to achieve consensus.

Data management and storage

Pseudo-anonymized data were collected in an electronic database, assigning each participant a progressive number. The research results were shared with the participating Healthcare Institutions.

Results

Participants

A total of $n = 20$ nurses participated in the study, with an average age of 36.8 years (± 8.0) and an average work experience in the ED of 8.9 years (± 7.9). Each participant was interviewed once, with interviews lasting an average of 21 minutes and 3 seconds

(± 7.18) (Table 1). From the interviews, seven recurrent main themes emerged, with some containing identified sub-themes (Table 2).

Protocols for analgesia administration at triage

Anticipating analgesic treatment in the ED admission phase, following assessment, is facilitated by the availability of specific protocols.

“Everything follows protocols, so it’s not operator-dependent... first, we ask the patient to rate its pain from 0 to 10, and then we administer the therapy” (Nurse 8).

“A patient arriving with pain is assessed for the type of pain... the NRS (Numerical Rating Scale) is applied, and if the patient meets the criteria and consents to pharmacological treatment, we

Table 1. Demographic characteristics of participants and length of interviews.

Nurse number	Hospital category (Hub or Spoke)	Age	Gender	Qualification	Years of service in the Emergency Department	Interview duration (minutes and seconds)
1	Spoke	47	M	Regional nursing diploma	7 years and 9 months	33' 35"
2	Spoke	35	M	Nursing degree	12 years	23' 42"
3	Hub	31	M	Nursing degree	4 years and 10 months	30' 54"
4	Hub	32	M	Nursing degree	4 years and 6 months	14' 23"
5	Hub	29	F	Nursing degree + Master degree in nursing	4 years	11' 16"
6	Hub	35	M	Nursing degree	1 years and 11 months	21' 26"
7	Hub	45	F	Nursing degree	20 years	15' 44"
8	Hub	30	F	Nursing degree	6 years	19' 37"
9	Spoke	45	F	Nursing degree	6 years (2 on pregnancy leave)	18' 32"
10	Hub	35	M	Nursing degree (qualification course in progress)	5 years	22' 29"
11	Spoke	33	M	Nursing degree	6 years	30' 33"
12	Spoke	32	F	Nursing degree	2 years	16' 35"
13	Hub	27	F	Nursing degree	4 years	20' 07"
14	Spoke	33	M	Nursing degree	3 years and 6 months	9' 41"
15	Spoke	28	M	Nursing degree	4 years	10' 22"
16	Hub	30	M	Nursing degree	2 years and 6 months	28' 58"
17	Spoke	48	M	Regional nursing diploma	23 years	20' 18"
18	Hub	37	M	Nursing degree	11 years	34' 22"
19	Spoke	49	F	Regional nursing diploma	30 years	15' 55"
20	Spoke	55	M	Nursing degree	21 years	22' 30"

Table 2. Main themes and sub-themes emerged from the interviews.

Main themes	Sub-themes
1. Protocols for analgesia administration at triage	<ul style="list-style-type: none"> - Logistical aspects - Cultural aspects and patients' beliefs - Fear of analgesia interfering with physical examination
2. Pain management in paediatric patients	
3. Non-pharmacological techniques for pain management	
4. Differences between patients with acute and chronic pain	
5. Caregivers and elderly or non-cooperative patients with communication deficits	<ul style="list-style-type: none"> - Providing information - Delegation of tasks and patient surveillance - Interpretation of Signs and Symptoms in Case of Communication Deficits
6. Personal experiences of pain by nursing staff	
7. Objectivity of nursing assessment of pain	

fill out a form and then we administer the therapy” (Nurse 3).

The interviews revealed significant heterogeneity in the structure and application of protocols.

“We’ve had protocols for pain management for about 10 years. We administer therapy based on the physician’s indication... in agreement, the protocol is applied, and then we proceed to reassess the pain after some time” (Nurse 19).

“Generally, we ask the doctor before administering a drug, except for paracetamol for ‘low’ pain” (Nurse 14).

In other cases, the absence of protocols for triage analgesia is described as a critical element, resulting in a series of disadvantages and potential issues.

“We feel the lack of a pain management protocol, especially when the waiting list is long. It could be a valuable tool and should valorise the triage nurse... currently, there is no protocol... if I administer a drug independently, I am not protected from potential issues” (Nurse 2).

The analysis identified factors hindering adequate pain management in triage.

Logistical aspects

Constant ED overcrowding, organizational or structural problems, and staffing shortages can delay or lead to inadequate pain management in triage.

“It’s important not to let the patient suffer... advanced triage is not done due to lack of space” (Nurse 20).

“Reassessment is necessary, but not all colleagues do it. I sometimes struggle to do it; unfortunately, we are not ubiquitous. I find it challenging when there is a high number of patients” (Nurse 11).

Cultural aspects and patients’ beliefs

In some cases, pain is not treated due to the patient’s expressed will, as stated by Nurse 15:

“Personally, I always suggest therapy, but most of the time they say ‘no, I’ll hold the pain.’”

Fear of analgesia interfering with physical examination

The belief that pain treatment may interfere with the physical examination and diagnostic evaluation persists. This attitude was common in many interviews and is particularly prevalent in patients with abdominal pain, as expressed by Nurse 8:

“We don’t administer any analgesic therapy to patients with abdominal pain because it’s useful to conduct the examination with the presence of pain; otherwise, the physical examination could be distorted.”

Nurse 9 adds that:

“If you administer pain relief therapy, it’s difficult to define the diagnosis because sometimes you mask the symptom.”

Conversely, Nurse 18 reports that:

“The doctor doesn’t necessarily have to assess the patient based on suffering... in my opinion, administering therapy in triage helps the examination because the patient relaxes and allows for a more thorough assessment.”

Pain management in paediatric patients in the emergency department

“Children are a sensitive subject...” (Nurse 9)

The management of pain in paediatric patients in the ED is described as particularly challenging, both concerning assessment and treatment.

“Children are very difficult to manage, akin to the elderly with dementia... pain is very difficult to assess, almost impossible” (Nurse 11).

Some interviewees highlighted the absence of dedicated procedures for paediatric patients’ analgesia.

“There’s a gap in protocols; we cannot administer any analgesics to paediatric patients” (Nurse 5).

Often, ED organization tends to expedite the care of children and their families by directing them to paediatric units:

“In general, the child has a sort of priority; you never make them wait, so they are taken care of immediately and directed to paediatrics” (Nurse 2).

Non-pharmacological techniques for pain management

All respondents reported that current triage pain management protocols involve pharmacological therapy and do not include the use of non-pharmacological techniques, which were found to be operator-dependent.

“Probably it’s always operator-dependent... in a simple fracture, especially in triage, you could use a splint, which certainly, by immobilizing the limb, already alleviates the pain a bit; and I think this is sometimes done based on personal work experience” (Nurse 17).

Creating a comfortable environment in a chaotic setting like the ED is challenging, but when achieved, it benefits the patient.

“Personally, I try to create a comfortable situation... I lower the volume of the monitors, dim the lights, use a pillow if possible. I’ve seen an absolute improvement in comfort and, consequently, pain... because patients can rest and calm down... Music therapy... but here in the adult ED, it’s almost impossible, the numbers of patients are too high...” (Nurse 16).

Sometimes, for patients presenting with acute pain, where immediate pain relief is not possible, nurses facilitate pain-relieving positions or apply localized heat. The role of communication, as a distracting technique or to alleviate anxiety, is described by Nurse 3:

“Finding two minutes just to talk, to find an empathic way to connect with the person, but often, due to haste, this is lacking, and the patient suffers.”

Certain aspects related to non-pharmacological pain manage-

ment techniques are hindered by the context and organization, such as the high workload, especially in Hub hospitals, which may not always allow for adequate and comprehensive care, perhaps...

“due to lack of time, probably also due to knowledge and dedicated environments that should be available there but aren’t” (Nurse 5).

Differences between patients with acute and chronic pain

Differences in the treatment of acute and chronic pain emerged, contextualized in the ED. Despite literature indicating that nursing assessment tends to underestimate pain compared to what patients perceive, especially in case of chronic pain, the interviews clearly showed general attention to situations of acute-on-chronic pain:

“The main thing noticed is the intensity of pain, whether chronic or acute, it doesn’t matter much” (Nurse 20).

Or

“Usually, someone with chronic pain comes for an acute problem, so even the acute-on-chronic pain is still treated as newly onset acute pain... chronic pain that flares up and no longer responds to therapy becomes more complex from a therapeutic point of view...” (Nurse 6).

Caregivers and elderly or non-cooperative patients with communication deficits

A significant portion of elderly individuals visit the ED accompanied by their family members. Interviewees shared their experiences regarding the role and behaviours of family members and caregivers, revealing three sub-themes:

Providing information: family members/caregivers play a key role in providing basic information to healthcare providers.

“When they [relatives] come, they are helpful. Now, with the COVID issue, they cannot enter. When we have doubts or inadequate information, we call them on the phone” (Nurse 1) or *“... we look for relatives and ask them about the previous conditions of the patient, or drugs they take at home even in case of pain”* (Nurse 6)

Delegation of tasks and patient surveillance

“We [nurses] tend to let them in [family members/caregivers], especially when dealing with the elderly or agitated patients... knowing them, they understand what they might need. They are resources we should use, helping us manage agitated patients” (Nurse 7).

Interpretation of signs and symptoms in case of communication deficits

In the absence of adequate tools for assessing pain in elderly individuals with cognitive deficits, the caregiver represents an important resource.

“A family member can be a helpful element, able to pick up on pain signals, especially since the NRS scale is not always applicable” (Nurse 4).

In consideration of these testimonies, family members/caregivers play a fundamental role. In other cases, however, they are perceived as problematic elements that sometimes interfere with

the clinical-care pathway, causing confusion and anxiety.

“The presence of a family member is always excessive; I tend to send them home because I’ve noticed that patients become anxious if they know their relatives are waiting outside” (Nurse 2).

An effective relational approach could strengthen the relationship with family members, involving them in care and making them part of the decision-making process.

“It always depends on how you approach [the family]. Explaining that the patient has been taken care of, that they can see them as soon as possible, alleviates the patient’s agitation but also that of the family” (Nurse 17).

Personal experiences of pain by nursing staff

During the interviews, it emerged that nurses who have suffered from pain similar to that for which a patient comes to the ED have a greater predisposition to listening, empathy, and immediate pain management. They prioritize patients with particularly acute pain, proposing immediate pain relief.

“I feel very connected to those suffering from renal colic because I’ve experienced it. I had a bad personal experience, and yes, it can influence you... you shouldn’t... you always have to remain objective and critical, but it’s not always easy” (Nurse 3).

Nurse 6 reports:

“For example, I’ve had renal colic problems, and if I see a patient with the same problem, I know how they feel. I try to let them go ahead by giving them priority due to the pain, because I’ve experienced it, and I know what it means.”

Only a small percentage of nurses expressed that they objectively assess pain without being influenced by personal experiences, like Nurse 2:

“For me, personal experience comes as personal experience and not as work experience.”

Objectivity of nursing assessment

The use of tools allowing nurses to objectively assess what the patient reports, using validated scales appropriate to the patient’s age and cognitive level, is not always implemented.

“There’s a protocol based on the NRS scale reported by the patient... I never actually ask for the NRS scale because it’s usually very subjective.” (Nurse 13).

In some situations, the objectivity of nursing assessment regarding the intensity of pain experienced by the assisted person can be hindered. Specific categories of patients are more challenging to assess due to different cultural approaches to pain than those of the evaluating healthcare provider.

“We’ve seen young people of 18, 35, or 40 years from Bangladesh die of a heart attack because we’ve somewhat underestimated them. They have a pain threshold of zero and don’t know how to explain it.” (Nurse 18).

Another challenging category to evaluate seems to be people with psychiatric conditions, with recurrent visits to the ED:

“They are difficult patients with continuous requests... it’s challenging to understand whether they have a problem or if it’s

related to their pathology” (Nurse 10).

From the conducted interviews, it emerged that some nurses do not rely on the NRS scale but on observation and the patient’s subjective perception, as Nurse 13 states:

“I quantify the pain on how I see the patient’s appearance.”

According to other interviewees, scales must be applied methodically to allow for an objective assessment:

“All patients should be treated the same. It is crucial to collaborate with colleagues and use protocols” (Nurse 1).

The fast-paced work rhythms and the substantial number of people accessing the ED can impact the objectivity of the assessment:

“When there are many people, you need to work faster, and sometimes [pain assessment] is based on the visual impact” (Nurse 17).

Discussion

The analysis of the interviews has brought to light various critical aspects of the management of pain in the ED, highlighting the diversification of practices among healthcare professionals despite the existence of available protocols. Pain assessment emerged as a crucial point, with variable use of validated scales and reliance on subjective evaluations based on the patient’s appearance and the nurse’s perception, potentially contributing to delays in analgesic intervention and oligoanalgesia.^{6,26}

The limited use of opioids in Italy was identified as a critical issue, with the so-called “opiophobia” potentially stemming from a lack of training for healthcare professionals and concerns among patients regarding side effects and dependency.²⁷ The timely introduction of opioid analgesics has been suggested as a potential solution to improve the management of severe pain, although some nurses believe that delaying analgesia, especially in patients with acute abdominal pain, is useful to avoid interference with the physical examination.²⁸

Pain management in children patients poses intricate challenges due to their clinical peculiarities, communication difficulties, and the anxiety often experienced by parents and healthcare providers.^{19,29} The role of parents, though occasionally marginalized, can significantly contribute to establishing an effective collaborative relationship in recognizing and assessing pain in children, planning treatments, and reassessing their effectiveness.³⁰ The absence or underutilization of specific tools for the paediatric population adds another layer of complexity. A 2010 survey in Italian paediatric or maternal-infant hospitals revealed that 31.6% did not use validated scales for pain detection at triage, and 47.4% lacked protocols for pain management.³¹ Similar to children, individuals with cognitive deficits and non-cooperative patients have specific needs that the ED’s organizational structure may struggle to meet, lacking adequate support for their caregivers.³²

Nurses report considerable challenges in accurately assessing pain in certain patient categories, such as those with psychiatric conditions, language barriers, or cognitive impairment. In the latter, the support of caregivers or family members, present in over 64% of patients, proves to be a valuable resource for interpreting the state of distress or managing the waiting period.^{33,34} Some basic caregiving tasks can be delegated to family members or

caregivers,³² particularly in contexts with limited staffing or excessive patient influx.^{35,36} Contrary to this perspective, a low percentage of respondents considered family members or caregivers as obstacles, transmitting their anxieties and fears not only to the patient but also to healthcare providers. The relationship between caregivers, patients, and healthcare providers in pain management should be viewed as an integral component of the care process rather than an impediment.

Nursing assessments may underestimate pain compared to the patient’s perceived level, as nurses tend to evaluate pain based on their perception, overlooking the value reported by the patient on a numerical NRS scale.²⁶ Nurses who personally experience chronic pain exhibit more favourable attitudes toward patients.¹⁶ According to respondents, personal pain experiences do not affect the assignment of colour codes, but nurses are more inclined to promptly address pain, having undergone a painful experience similar to that of the patient they are assisting. In contrast to some literature reporting the underestimation of chronic pain compared to acute pain,³⁷ no distinct attitudes were observed in the assessment and treatment of acute pain versus chronic pain in the studied context.

The implementation of non-pharmacological interventions in the ED results in a clinically relevant reduction in pain in over 40% of cases; despite acknowledging their importance, only a small percentage of patients receive non-pharmacological interventions.³⁸ Protocols for managing waiting room analgesia undervalue the efficacy of non-pharmacological treatments, such as the application of heat/cold, distraction, immobilization, limb elevation, and emotional support. This area of intervention represents a domain where nurses can autonomously operate, leveraging their professionalism for the well-being of the individual. Cultural preferences, often inclined toward pharmacotherapy, or time constraints within the working context hinder the sufficient implementation of these interventions, although they could prove highly beneficial in enhancing patient comfort and compliance during the waiting period.

Limitations

This study has some limitations, including the potential influence of the socio-demographic reality of the analysed geographic area (encompassing both urban and rural contexts) on the experiences reported by the nurses. Additionally, the fact that interview transcriptions were not returned to the participants may limit the opportunity to obtain feedback and corrections from them.

Conclusions

The management of pain in the ED is intricate and subject to diverse practices. Pain assessment, the limited use of opioids, challenges in paediatric pain management, and specific patient categories, along with the necessity to implement non-pharmacological interventions, emerge as key areas for improvement. Educational interventions, specific protocols, and increased awareness of the importance of pain management could contribute to a more uniform and timely approach in the ED.

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