Original Article

Nurses' Report of In-hospital Pediatric Pain Assessment: Examining Challenges and Perspectives

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Abstract:

Pain is a symptom pediatric nurses commonly encounter in the hospital setting. Untreated pain can lead to adverse physiologic and psychological effects. This study examines in-hospital pain assessment methods nurses report using and assesses challenges, difficulties, and barriers nurses report to assessing pain in hospitalized children. Cross-sectional study of 82 pediatric nurses from all pediatric departments of a tertiary hospital in Israel. A self-report questionnaire was developed to examine how nurses assess children's in-hospital pain and barriers to in-hospital pain assessment. Nearly all nurses (90%) reported having enough knowledge to assess children's pain in the hospital, relying on child's self-report (86%) and being familiar with commonly used validated pain scales (90%). However, a majority (75%) reported not using pain scales recently and only half (58%) reported using an alternative method involving the child. Most nurses (86%) reported relying on their own overall impression of the child's pain and only a third (34%) reported involving the parents in their pain assessments. Nurses included comments stressing the importance of pain assessments and their frustration with the current validated measures available. This study adds to a growing body of literature demonstrating a gap between recommended pediatric pain assessment guidelines and reported practice, with nurses showing a resistance to relying on single-item or unidimensional measures to assess and evaluate the rich and complex pain experience. A multidimensional approach involving child self-report, parent report, and nurses' own overall impression based on clinical assessment skills of pain is discussed.
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Pain is among the most commonly experienced complaints nurses encounter in the pediatric hospital setting. This pain can be due to illness, trauma, or medical procedures (Drendel, Brousseau, & Gorelick, 2006; Finley, McGrath, Forward,

McNeill, & Fitzgerald, 1996; Fortier, MacLaren, Perret-Karimi, & Kain, 2009; Kankkunen, Vehvilainen-Julkunen, Pietila, Kokki, & Halonen, 2003; Zisk, Grey, Medoff-Cooper, & Kain, 2007). There is growing evidence that the untreated pain of children can have adverse physiologic and psychological short- and long-term effects. These include prolonged hyperglycemia, increased inflammatory response, respiratory complications, and delayed healing. Untreated pain can also lead to intense focus on the painful memories, poor adaptive responses to future pain, attention deficits, chronic pain syndromes, and behavioral disorders (Brennan, Carr, & Cousins, 2007; Kennedy, Luhmann, & Zemsky, 2008).

In-hospital pediatric pain management must begin with an accurate assessment of the child's pain. Few studies have examined reported or observed nursing pain assessment practices for children. Several studies have demonstrated that nurses find pediatric pain assessments challenging and that nurses in all types of pediatric hospital settings underperform pediatric pain assessments (Franck & Bruce, 2009; Hamers et al., 1998; Simons & Moseley, 2008; Subhashini, Vatsa, & Lodha, 2009; Twycross, 2007,2010).

In light of our growing knowledge about the importance of detecting and treating children's pain and the increased awareness of the difficulties nurses face performing this task in the hospital setting, this study had a dual purpose:

1. To examine the pain assessment methods nurses report using in pediatric hospital settings
2. To assess barriers perceived by nurses and why they find it hard to assess pain of hospitalized children.

LITERATURE REVIEW

The American Academy of Pediatrics (2001) recognized both the prevalence and significance of pain among the pediatric hospitalized population and subsequently published guidelines for pain assessment and management. These guidelines include assessing pain as the fifth vital sign, anticipating pain and intervening before onset, and ongoing monitoring and assessing of pain using appropriate tools. Nurses, however, continue to report barriers to pain assessment and management (Czarnecki et al., 2011; Twycross & Collins, 2013), and the Royal College of Nursing in 2009 still found that children are not receiving optimal pain relief (RCN, 2009).

Nurses have different ways available for detecting and assessing children's pain. Many children can provide a self-report of the existence and intensity of their pain. Bauman and McManus (2005) state that children as young as 2 years old can provide some information about their pain and should be believed. Numerous structured pain measures using assorted methods of assessment have been developed to assist children in reporting pain. When the child cannot provide a self-report pain assessment, the nurse may also ask the parent to provide a pain assessment. Studies have shown relatively high correlations between child self-reports and parent observational pain reports, while emphasizing that only the child can provide an actual expression or assessment of his or her pain and that the assessments provided by parent or nurse are only estimates (Rajasagaram, et al., 2009; Zhou, Roberts, & Horgan, 2008).

Although the past few decades have seen the development and validation of many pediatric pain self-report and observational measures for the hospital setting, research shows that nurses have difficulty performing and documenting pain assessments. Reasons nurses report for this lack of performance include workload burden, inadequate medication orders, health care providers giving low priority to pain management, and difficulties with documentation format, including lack of resources to provide guidance for how to use pain assessment tools (Drendel et al., 2006; Twycross, 2010; Van Hulle Vincent, 2005). Moreover, some nurses may have a personal belief that children exaggerate pain for secondary gain, and they rely on the presence of observable manifestations of pain, such as crying (Drendel et al., 2006; Twycross, 2010; Van Hulle Vincent, 2005), for pain assessment. Byrne, Morton, and Salmon (2001), in their qualitative study of how nurses interpret and communicate with children about their postoperative pain, reported that nurses may defend themselves emotionally against children's pain. The authors conclude that these factors may lead to underassessment of children's pain and subsequently lead to inadequate and inappropriate pain management planning and practice.

Additionally, studies show that even when a nurse obtains a child's report of pain, the nurse still looks for external validation either by corroboration from the parent or by the existence of pain cues considered convincing by the nurse, such as crying. Without this external validation, the nurse often ascribes a lower pain score than that reported by the child (Bauman & McManus, 2005; Byrne et al., 2001; Hamers et al., 1998; Rajasagaram et al., 2009; Simons & Moseley, 2008; Subhashini et al., 2009; Van Hulle Vincent, 2005).

In Israel in 2001 the Ministry of Health defined pain as the fifth vital sign, thereby mandating its assessment. The professional guidelines state that pain should be measured as with all other recognized vital signs (temperature, pulse, respiration, blood pressure), and the measures used should be sensitive to changes in pain intensity and character and compatible

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