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Nurses' perceptions of pain management for older-patients in the Emergency Department: A qualitative study

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ABSTRACT

Objectives: 1) Identify themes arising from nurses' perceptions of assessing older-patients' pain; 2) use themes to guide development of optimal interventions to improve quality of pain assessment in the emergency department (ED).
Methods: Nurse interviews (n = 20) were conducted until theme saturation. They were transcribed, coded, and analyzed using qualitative methodology.
Results: Two major themes—nurse 'challenges' and 'strategies' to overcome challenges, and their subthemes – classified as 'patient-related' or 'system-related,' were salient in nurses' perceptions. Strategies nurses reported for managing challenges were based in their own professional lived experiences.
Discussion and conclusion: A 2 × 2 framework was developed to conceptualize challenges, strategies, subthemes and their classifications, yielding 4 typologies comprising challenge types matched with appropriate strategy types. While emergent challenges and strategies are corroborated in the literature, the present study is the first to develop a scheme of typologies beneficial for guiding the development of optimal interventions to improve the quality of assessing pain in older-patients.
Practice implications: The typology framework can guide the development of pain assessment tools and the needed combinations for assessing multidimensional pain in older-patients. Using the present findings, a new clinical intervention was shown to significantly improve pain management for older-patients in the ED.

1. Introduction

Pain is the most common symptom reported by older-patients (≥65 years) entering the Emergency Department (ED) [1]. Older patients expect pain relief during ED care, yet they often receive minimal relief [2,3]. Relieving pain is important because pain can have deleterious effects such as, impeding daily functioning [4,5], leading to depression and decreased quality of life [6,7]. The present study is part of a larger Quality Improvement (QI) project on pain management for older-patients in the ED [8].

Nurses are front-line ED providers, "caring" for older-patients–assessing and alleviating pain. In contrast, physicians' major role involves "curing," i.e. prescribing. From patients' perspectives–during assessing, nurses are communicating directly with them; and, in conveying physicians' directions, they are communicating indirectly for physicians. Thus, nurses play a pivotal role communicating with ED patients, and hence are the focus of this study. Their communication surrounding pain management is highlighted for several reasons.

First, studies show that despite guidelines to assist in assessing [3,9–11], documenting [12,13] and treating pain [14,15], older adults are at high risk for underassessment and inadequate pain treatment [16–21], and compliance with pain scale use has yet to become a norm in nursing practice [13,22–26]. These studies assume that adequate pain treatment is based in congruent exchange–between provider and patient–of the meaning of pain experienced, and conversely, lack of congruence in communication leads to under-treatment. Second, there are no biological markers or vital signs that correlate with the existence or intensity of pain, making nurses' communication with patients central to pain assessment. Third, frequent discrepancies between patients' verbal self-report of pain, and nurses' observed nonverbal pain behavior in the same patient [27–29], can cause conflict in nurses trained to use the 0–10 Numeric Rating Scale (NRS) as the gold standard for

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pain assessment [6]. This underscores the vital need for understanding older-patient verbal and nonverbal communication during pain assessment [30–33]. Fourth, in capturing pain as a one-dimensional rating, and excluding patients' sensory and/or affective discomfort [34,35], the NRS oversimplifies the complexity of patients' pain experience [34,36].

In contrast to the above research, the Social Transaction Model (STM) [27] highlights patient-clinician communication on pain assessment as a gestalt rooted in physiological, psychological, and social factors. While the STM refers to all clinician providers, for this study "providers" refers only to ED nurses. The STM model comprises three factors: 1) "contributing factors" for patients' include biologic, developmental, sociocultural, contextual factors and previous experience with pain; for nurses they include staffing, workload issues, and interdisciplinary communication. 2) "pain assessment process," is dependent, not merely on patient subjective "self-report," but ALSO on nurses' behavioral observations and evaluation of physiologic symptoms to interpret severity of patient pain, leading to varying degrees of "consensus," with patients. Since the meaning of pain is inherently different for nurse and patient [37], when consensus is achieved, outcomes are positive; conversely, lesser consensus results in more negative outcomes. 3) "Intervention"—treatment and its effectiveness – ranges from positive to negative, with consequences for patients.

Therefore, to develop the evidence basis for implementing quality medical care in the form of compassionate and competent pain relief [38–40], we focused on nurse perceptions of communication surrounding pain management in this study. The aims of this study are to: 1) understand, in their own words, ED nurses' perceptions of assessing older-patients' pain and, 2) use emergent themes to guide optimal interventions for improving the quality of pain assessment in the ED.

The most appropriate way to understand nurses' perceptions was to conduct a qualitative field study using in-depth interviews with nurses in the ED [41]. This method could also help generate hypotheses about ways to improve pain management [42].

2. Methods

To develop the evidence basis for communication of pain assessment in older-patients, we used in-depth, semi-structured interviews with ED nurses in an urban location in Midwest US. Interview questions were descriptive, comprising lead questions and probes (Appendix, Interview Guide). Specifically, questions asked about assessment of musculoskeletal/abdominal pain, medication administration protocols, nurses' perceptions about managing pain–including assessment/reassessment, and unique geriatric care issues.

2.1. Sample

A convenience sample representing the ED nurse population, (n = 20), comprising approximately 30% of nurses employed at an academic urban adult ED was used. See Table 1 on Nurse Demographics. IRB approval and nurses' written consent were obtained.

2.2. Recruitment

The study was introduced to potential participants at a regularly scheduled nurses' meeting (65 were present) where they were invited to sign written consent if interested in participating. They were informed that interviews would be conducted during their shift hours at a quiet ED location. Interviews were conducted at the convenience of those nurses present when the Interviewer team (RGB, AW) was present in the ED.

Table 1
Nurse Demographics, N = 20.

Variable	Total (%)
1. Age	
<26	0 (0)
26–35	9 (45)
36–45	6 (30)
46–55	5 (25)
2. Gender	
Female	19 (95)
Male	1 (5)
3. Race/Ethnicity	
Caucasian	14 (70)
African American	2 (10)
Asian	3 (15)
Biracial	1 (5)
Hispanic or Latino	0 (0)
American Indian or Alaska Native	0 (0)
Native Hawaiian or Other Pacific Islanders	0 (0)
4. Education	
ADN	3 (15)
BSN	15 (75)
MS	2 (10)
ER Tech	1 (5)
5. Years as a Nurse	
<5 years	4 (20)
5–10 years	4 (20)
11–20 years	7 (35)
>20 years	5 (25)
6. Experience in current ED	
<5 years	13 (65)
5–10 years	6 (30)
11–20 years	1 (5)
>20 years	0 (0)

Legend: ADN = Associate's Degree in Nursing; BSN = Bachelor's of Science in Nursing; MS = Master's of Science in Nursing; ER Tech = Emergency Room Technician

2.3. Interview methodology

In–depth, semi-structured, face-to-face interviews, were conducted in June–July 2012. Interviews lasted 20–40 min, were audio-recorded, and subsequently transcribed verbatim. Written transcripts were compared against audiotapes for 10% of interviews to assess their accuracy. Data collection continued until theme saturation was reached on all emergent themes and subthemes, and no new patterns emerged from the data (n = 20) [43].

Our four-member team – consisting of two physicians – a geriatrician/professor (WD), an ED physician/professor (TH)–a pre-medical student (AW), and a social psychologist/qualitative researcher (RGB) had ongoing discussions on reflexivity [44]. One team member (AW) conducted participant observations in the ED, shadowing nurses during their interactions with older-patients. This parallel qualitative methodology elucidated the degree to which nurses reported 'perceptions' of managing pain matched their actual pain-managing 'behaviors,' and helped triangulate the validity of our data. Further, we had two informal meetings with the ED administrator to learn about pain management and charting policies for ED nurses (also used to triangulate our data). To minimize bias in the interviewer-nurse dyad, the interviewer team included the qualitative researcher (RGB) (conducting interviews) and the pre-medical student (AW) (taking field notes and recording nonverbal signals). As a reflexivity check, upon completion of the manuscript, we elicited reactions of interested nurse interviewees to our report; there was universal agreement that we had captured their "real situation." In fact, one "strategy" from our data ("Reassess, A Reminder" computer

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