

Emergency Nurses' Barriers for Assessing and Managing Pain

Maysa Abdalla Elbiaa¹, Hanaa Abbass Ahmed², Shimmaa Mohamed Elsayed³

1 Lecturer Critical care and Emergency Nursing, Faculty of Nursing, Matrouh University, Matrouh, Egypt.

2 Lecturer Medical Surgical Nursing, Faculty of Nursing, Matrouh University, Egypt.

3 Lecturer, Critical care, and emergency department, Faculty of Nursing, Damanhour University, Egypt.

Abstract

Background: Patients who seek the emergency department frequently require prompt care that may involve giving them treatment to manage symptoms that include pain. Patients are frequently required to wait for long amounts of time without having their pain evaluated or given analgesics, making pain management a frequently neglected part of acute care. **Aim:** To determine emergency nurses' barriers to assessing and managing pain. **Design:** A descriptive research design was included. **Settings:** This study was performed in the emergency units of Damanhour Medical National institute hospital. **Sample:** A purposive sample of 110 emergency nurses who worked in the emergency unit of selected units. **Tools of data collection:** One tool for emergency nurses' barriers to assessing and managing pain was developed. This tool comprised of two parts. Part one sociodemographic data and part two was adopted. **Results:** The mean age of the examined nurses were 42±19. About 59.09% of them were female. The reported nurses related barriers to assess and manage pain were inadequate staff knowledge, inadequate assessment of pain management of barriers to management pain, and lack of education with pain assessment tools. Physician associated barriers were ineffective consideration of pain and pain relief. System concerned barriers were the patient-to-nurse ratio and lack of alternative nonpharmacologic therapy for pain Management. Patient related barriers were difficult to assess patients using a pain scale, inability to communicate with patients and hemodynamic instability. **Recommendation:** Nursing educators need to revise the nursing curriculum in the scope of emergency nurses. Health policymakers need to establish regulations for pain assessment in emergencies. Using administrative strategy and plan to overcome on high nursing workload and patient-nurse ratio.

Keywords: Assessment, Barriers; Critical care nurses, Pain.

Introduction

Pain is characterized as an unpleasant sensory and emotional feeling that is connected to or manifested as potential or existing tissue damage (Akarowhe, 2019). Along with being a common symptom, pain is also frequently a concern in emergency rooms and critical care units (D et al., 2016). The assessment and management of pain is a constant fact that necessitates a variety of therapeutic modalities for pain control with the least amount of side effects (Asimakopoulou et al., 2018). Assessment of pain for patients with the life-threatening situation is difficult. Self-reporting for pain is the golden standard of pain assessment. The inability to communicate due to the presence of an endotracheal tube, disturbed level of consciousness, and using sedation may be a challenge in assessing pain (Alderson & McKechnie, 2016). Not only can the actual disease process itself cause pain, but so can the actual therapy of the illness. Inadequate pain management may lead to slower recovery, an

increased risk of complications, anxiety, disturbed sleep, as well as increase mortality and morbidity rate (Elcigil et al., 2016). Patients who experience severe pain may also have anxiety, sadness, and post-traumatic stress disorder (Alderson & McKechnie, 2016).

At least one acute symptom is present in more than 85% of all presentations, and more than 50% of patients say their pain is moderate to severe (Varndell et al., 2020). According to some research, pain is either ignored or undertreated in almost 70% of patients with life-threatening conditions (Alderson & McKechnie, 2016). Pain management is the practice of minimizing a pain's negative effects or decreasing or overcoming a specific pain that a person feels. The majority of patients seek medical attention primarily due to pain, which is still the most frequent complaint in the emergency department (Sturesson et al., 2017). Patients who seek the emergency department frequently require prompt care that may involve giving them treatment to manage symptoms, namely pain. Patients are

frequently required to wait for long amounts of time without having their pain evaluated or given analgesics, making pain management a frequently neglected part of acute care (Varndell et al., 2018). An essential component of emergency department care and a reflection of care is pain control. The decline in pain and the efficiency and safety with which acute pain is managed can both be used as indicators of patient satisfaction in the emergency department (Sturesson et al., 2017). In emergency medical treatment, reducing pain is a key objective (Rgn et al., 2019). There is an indication that emergency department nurse analgesia is secure and permits quick and an effective pain treatment (Cabilan & Boyde, 2017).

Because they often give a direct care to patients, nurses are essential healthcare providers for the assessment and treatment of patients' symptoms in a variety of clinical care settings. Nurses must develop their skills in diagnosing and treating pain as well as remove prevalent misconceptions about the pain that prevent efficient pain treatment. However, several studies revealed that nurses' attitudes and expertise surrounding pain are inadequate (Rababa et al., 2021; Salazar et al., 2016).

There are several sources of pain in emergency units such as the cause of admission, medical procedures, invasive devices such as endotracheal tubes, nursing care, and sleep deprivation can worsen the experience of pain (Alderson & McKechnie, 2016). Although there are many contributing factors to the delay in analgesic delivery and inadequate pain management, it is crucial to consider the nurses' viewpoint. The nurse who conducts emergencies is the first caring individual to react with the pain reports at the emergency department, who also initiates the assessment and treatment (Varndell et al., 2018). Understanding and identifying obstacles can aid in promoting the development of pain-reduction techniques that improve emergency patients' medical treatment and outcomes (Holmström et al., 2019). Poor knowledge and abilities, as well as excessive nursing workloads, are obstacles to providing adequate pain assessment and management in many EDs, as recently metnioed (Rgn et al., 2019). Therefore, we aimed at identifying the emergency nurses' barriers to assessing and managing pain.

Significance of the study:

The first step to an effective pain treatment is the contact between patients and nurses to assess the patients' pain. Up to 60% of the patients who seek emergency rooms have acute pain. The most frequent reason for ineffective pain control is the improper pain assessment (Vuille et al., 2018). Emergency nurses are in a prime position to respond to and treat pain as they are the initial and main contact point for patients who are in severe pain. The difficulty of emergency nursing practice, clinical judgment, and the variables affect the identification, evaluation, and treatment of pain (Varndell et al., 2020). The responsibility of emergency department nurses includes dealing with pain, which is commonly recommended. Patients may still experience pain even when nurses have a superior degree of expertise and an extra accepting attitude toward patient suffering because of several additional barriers outside of the scope of nursing practice (Kahsay & Pitkärvi, 2019). Therefore, we aimed at determining the difficulty nurses' barriers to assessing and managing pain.

Aim of the study:

This study seeks to measure the emergency nurses' barriers to assessing and managing pain.

Research questions:

What are the emergency nurses' barriers to assessing and managing pain?

Materials and Methods

Study design:

A descriptive research design was included. This kind of research had no intervention but explore the study variables.

Research settings:

This study was conducted in the emergency units of Damanhur Medical National institute hospital and Kom hamada hospital. These units consisted of four units, where each unit had from 10 to 12 beds. They receive patients in life threatening conditions such as motor vehicle accidents or trauma.

Subject:

A purposive sample of 110 emergency nurses who worked in the emergency unit of selected hospital. Nurses who worked in emergency units were included in the study. About 55 nurses were included from each hospital. The sample size was

done using G. power analysis at a level of confidence 95% and a significant level of 0.05%.

Tools of data collection:

One tool for emergency nurses' barriers to assess and manage pain was developed after reviewing the literature (Ehwarieme et al., 2018; Elcigil et al., 2016; Kahsay & Pitkääjärvi, 2019; Rababa et al., 2021) to collect the data. This tool comprised of two parts. Part one sociodemographic data which included age, sex, education level, marital status, experience years, and previous training in pain assessment as well as management. Part two was adopted from Elcigil et al., (2016). This part included nurses' self-reported questionnaires about barriers to assess and manage pain in emergency setting. These barriers consisted of barriers linked to patients, nurses, physicians, and the system. The patient's barriers consisted of 10 self-reported items. Each question had 5-likert scale, 5 specified strongly agree, and 0 mean strongly disagree. The total score was 50. The nurse's barriers consisted of 10 self-reported items. Each question had 5-likert scale, 5 denoted strongly agree, and 0 imply strongly disagree. The total score was 50. The physician's barriers also consisted of 7 self-reported items. Each question had 5-likert scale, 5 denoted strongly agree, and 0 imply strongly disagree. The total score was 35. The patient's barriers consisted of 12 self-reported items. A 5-likert scale was used, 1 designated strongly disagree while 5 implied strongly agree. The total score was 60. The mean, percent, and total scores for each sub-barrier were calculated.

Validity and Reliability:

The tool was adopted, and the reliability of the tool was ensured, it was accepted (Elcigil et al., 2016). The questionnaire was translated into Arabic to collect the data. The validity was conducted through five-panel experts of emergency and critical care professionals. The necessary modifications were made.

Pilot Study

A pilot study on 11 emergency nurses was done to detect the accessibility of the tool. The needed modifications were done to facilitate applicability of the tool.

Field work:

Preparatory phase: Ethical approval was obtained to conduct the study. After obtaining official permission to collect data from the

hospital administration after the target of the current study was explained. The researcher acquired the tool in the formulated questionnaire. The tool was translated into Arabic. The subject validity and dependability were done. A pilot study was done, and necessary modification was done. **Implementation phase:** the data collection was taken three months starts from March 2021. The researcher collect data at the time break of nurses. The time for fulfilling the questionnaire was 10 min. The researcher collects a questionnaire during the break time of the studied nurses.

Ethical considerations:

Ethical approval was obtained to collect the data after the explanation aim of the study. Nurses' data privacy, confidentiality, and autonomy were ensured.

Statistical analysis

Data record was conducted *via* IBM SPSS software. The normality of distribution was done using the Kolmogorov-Smirnov test. The quantitative data included mean, standard deviation, and median.

Results:

Table 1 illustrated the frequency distribution of the examined nurses concerning demographic and job-related data. The mean age of the examined nurses was 42 ± 19 . About 59.09% of them were female. Approximately 38.18% of studied nurses were single. 40.9% of them also had a technical degree. The total experienced years was 11 ± 36 . In addition, 81.81% of them had no previous education about either pain evaluation or managing.

Table 2 illustrated the frequency distribution of the studied nurses about patients' barriers to assessing pain in an emergency setting. About 55.45% of the examined nurses strongly agree that it is difficult to assess patients using a pain scale. About 46.36% of them also strongly agree that the inability to communicate with patients and hemodynamic instability were common barriers related to patients. One the other hand, about 49.9/5 of them strongly disagree that patients report their pain to the doctor, but not to the nurse and 53.63% of them strongly disagree that patients not intending to interrupt the nurses.

Table 3 represented the frequency circulation of the examined nurses to nurses' barriers to

assessing pain in an emergency setting. About 46.36% of them strongly agree that insufficient time to provide nonpharmacologic pain relief procedures, insufficient staff expertise, inadequate assessment of pain management of barriers to management pain, and deficiency of education with pain assessment tools were barriers related to nurses. About 54.54% of them also strongly agree that nursing workload is one of the barriers facing nurses. On the other hand, 44.54% of them strongly disagree that fear of pain medications since the side effects as barrier for pain estimation and management in emergency setting.

Table 4 indicated the frequency distribution of the studied nurses concerning system related barriers to assessing pain in an emergency setting. The examined nurses strongly agree that system-related barriers were the patient-to-nurse ratio, difficulty contacting or communicating with physicians to converse the treatment of pain in patients and lack of alternative nonpharmacologic therapy for pain management were the most barriers meeting emergency nurses to assess and manage pain (59.09% separately), and about 53.6% of them reported lack of psychosocial support services was barrier for assessing and management pain in emergency setting. Besides, lack of social workers (40.9%) and lack of equipment or skill in using equipment (60.9) were

the least barriers facing emergency nurses to assess and manage pain in emergency setting.

Table 5 indicated the frequency circulation of the examined nurses to physicians' related barriers to assessing pain in the emergency setting. About 59.09% of studied nurses strongly agree that incapable assessment of pain and pain relief was one of the barriers related to a physician. While 60% of them strongly disagree that inadequate acquaintance of pain management and inadequate knowledge of pain management as barriers related to physician. 62.72% also strongly disagree that physicians' reluctance to prescribe opiates since the side effects as barrier that hinder assessing and managing pain.

Table 6 shows the total score, mean score, and percent score of studied nurses' barriers to assessment and management pain. The mean score of patients' related barriers was 4.6 ± 51 , the total score was 35 ± 4 , and the percent score was 55 ± 25 . The mean score of nurses' related barriers was 6 ± 41 , the total score was 60 ± 26 , and the percent score was 39 ± 25 . Regarding system-related barriers the mean score was 4.5 ± 25 , the total score was 45 ± 22 , and percent score was 58 ± 6 . Regarding physician-related barriers, the total score was 29 ± 22 , the mean score was 4.26 ± 12 , and the percent score was 29 ± 42 .

Table (1): Frequency distribution of the examined nurses to demographic and job-related data (n = 110).

Demographic and job-related data	No.	%
Age	42±19	
Sex		
Male	45	40.9
Female	65	59.09
Marital Status		
Single	42	38.18
Married	22	20
Divorced	19	17.27
Widow	17	15.45
Academic Degree		
Technical degree	45	40.9
Diploma degree	19	17.27
Bachelor's degree	46	42.81
Total Years of Experience	11±36	
Previous education about pain assessment and management		
Yes	20	18.18
No	90	81.81

Table (2): Frequency distribution of the examined nurses concerning patients' perceived barriers to assessing pain in an emergency setting (n = 110).

Patient-related barriers	Strong Disagree		Disagree		Neutral		Agree		Strong agree	
	No.	%	No.	%	No.	%	No.	%	No.	%
1. Patients' difficulty with completing pain scales.	0	0	2	1.8	18	16.36	29	26.36	61	55.45
2. Consumers not demanding results.	44	40	20	18.18	12	10.9	10	9.09	24	21.8
3. Patients' reluctance to take pain medication for fear of addiction.	43	39.09	11	10	12	10.9	10	9.09	24	21.8
4. Caregiver's indifference.	32	29.09	25	22.72	23	20.9	20	18.18	10	9.09
5. Patients' reluctance to take pain medications since the side effects.	37	33.63	20	18.18	23	20.9	21	19.09	9	8.18
6. Patients report their pain to the doctor, but not to the nurse.	54	49.09	10	9.09	12	10.9	10	9.09	24	21.8
7. Patient's reluctance to perceive opioids.	55	50	9	8.19	12	10.9	10	9.09	24	21.8
8. Patients not wanting to bother the nurses.	59	53.63	9	8.19	8	7.27	10	9.09	24	21.8
9. Patient instability e.g., unstable hemodynamic.	0	0	0	0	20	18.18	39	35.45	51	46.36
10. Patient's inability to communicate.	0	0	0	0	20	18.18	39	35.45	51	46.36

Table (3): Frequency distribution of the examined nurses concerning nurses' barriers to assessing pain in the emergency setting (n = 110).

Nurses' related barriers	Strong Disagree		Disagree		Neutral		Agree		Strong agree	
	No.	%	No.	%	No.	%	No.	%	No.	%
1. Insufficient time for health teaching with patients.	44	40	10	9.09	22	20	10	9.09	24	21.81
2. Insufficient time to convey nonpharmacologic pain relief measures.	0	0	0	0	20	18.18	39	35.45	51	46.36
3. Nurses' indifference.	32	29.09	25	22.72	23	20.9	20	18.18	10	9.09
4. Inadequate staff knowledge of pain management.	0	0	0	0	10	9.09	49	44.54	51	46.36
5. Nursing staff reluctance to administer opiates.	44	40	20	18.18	12	10.9	10	9.09	24	21.81
6. Fear of pain medications since the side effects.	49	44.54	20	18.18	7	6.36	10	9.09	24	21.81
7. Inadequate assessment of pain.	0	0	0	0	10	9.09	49	44.54	51	46.36
8. Nursing workload.	0	0	0	0	1	0.90	49	44.54	60	54.54
9. Lack of education/familiarity with assessment tools.	0	0	0	0	20	18.18	39	35.45	51	46.36
10. Low priority of pain management by the ICU team.	55	50	9	8.18	10	9.09	12	10.9	24	21.8

Table (4): Frequency distribution of the examined nurses about system barriers to assessing pain in the emergency setting (n = 110).

System-related barriers	Strong Disagree		Disagree		Neutral		Agree		Strong agree	
	No.	%	No.	%	No.	%	No.	%	No.	%
1. Lack of psychosocial support services.	24	21.8	0	0	11	10	11	10	59	53.6
2. Patient-to-nurse ratio.	0	0	0	0	1	0.90	44	40	65	59.09
3. Lack of social workers.	45	40.9	9	8.18	20	18.18	12	10.9	24	21.81
4. Shortage of instructions for pain management.	0	0	0	0	1	0.90	44	40	65	59.09
5. Shortage of admittance to professionals who practice specified pain treatment assays.	10	9.09	25	22.72	23	20.9	20	18.18	32	29.09
6. Inconveniency contacting or communicating with physicians to consider the treatment of pain in patients.	8	7.27	15	13.63	13	11.81	8	7.27	65	59.09
7. Inconsistent practices around giving as-needed medications to patient.	6	5.45	5	4.54	59	53.6	11	10	24	21.81
8. Narcotic prescription regulation.	10	9.09	25	22.72	23	20.9	20	18.18	32	29.09
9. Lack of alternative nonpharmacologic therapy for pain management (cold, hot, acupuncture).	0	0	0	0	1	0.90	44	40	65	59.09
10. Not having a authenticated pain treatment plan for each patient.	43	39.09	22	20	15	13.63	10	9.09	20	18.18
11. Lack of medicine in markets.	66	60	15	13.63	13	11.81	8	7.27	8	7.27
12. Shortage of equipment or skill in using equipment.	67	60.90	14	12.72	13	11.81	8	7.27	8	7.27

Table (5): Frequency distribution of the examined nurses to physician barriers to assessing pain in the emergency setting (n = 110).

Physician related barriers	Strong Disagree		Disagree		Neutral		Agree		Strong agree	
	No.	%	No.	%	No.	No.	%	No.	%	No.
1. Insufficient assessment of pain and pain relief.	0	0	0	0	1	0.90	34	30.9	65	59.09
2. Physicians' reluctance to prescribe opiates since the side effects.	69	62.72	12	10.90	13	11.81	8	7.27	8	7.27
3. Physicians' reluctance to prescribe sufficient pain.	66	60	15	13.63	13	11.81	8	7.27	8	7.27
4. Physicians' denial of trust in the nursing assessment of pain.	43	39.09	22	20	15	13.63	10	9.09	20	18.18
5. Inadequate knowledge of pain management.	66	60	15	13.63	13	11.81	8	7.27	8	7.27
6. Physicians' Fear of Addiction to medicine.	56	50.9	25	22.72	13	11.81	8	7.27	8	7.27
7. Doctor's indifference.	32	29.09	25	22.72	23	20.9	20	18.18	10	9.09

Table (6): Total score, mean score, and percent score of studied nurses' barriers for assessment pain (n=110):

Item	Total score	Mean score	Percent score
Patients' barriers			
Min. – Max.	1-50	5.30 – 4.11	44.60 – 88.81
Mean ± SD.	35 ±45	4.6 ±51	55 ±25
Median	25.25	2.53	55.6
Nurses' barriers			
Min. – Max.	1-50	5.62-25	59.6-90.5
Mean ± SD.	39 ±25	6 ±41	60 ±26
Median	30.9	4.26	68
System barriers			
Min. – Max.	1-60	6.78-30	30.2-60.9
Mean ± SD.	45 ±22	4.5 ±25	58 ±6
Median	46	6.19	55.9
Physician barriers			
Min. – Max.	1-35	4.25	10-50.25
Mean ± SD.	29 ±22	4.26 ±12	29 ±42
Median	27	7.98	28.9

Discussion:

Emergency care is a specialized area of medicine that deals with the interdisciplinary treatment of patients who have acute, sometimes fatal organ malfunction or illness. These patients require a certain physical region, monitoring equipment, and specialized human resources, which the emergency department delivers. One of the main causes for patients to seek emergency care, whether through Emergency Departments (ED) or pre-hospital services, is pain. In the emergency room, where pain can make it difficult to treat and manage diseases that cause it, pain management is a crucial element of patient care. Even while pain frequently goes unrecognized, unassessed, and untreated, it remains to be one of the main causes patients seek emergency medical attention (Hachimi et al., 2020).

Since nurse practitioners are the medical professionals that interact with patients most frequently, they play a crucial part in controlling pain (Cahyani et al., 2018). In the evaluation and treatment of pain, nurses are mandatory. They often act as the patient's primary observer of pain and discomfort and serve as a liaison between the doctor and the patient (Elcigil et al., 2016). The present study discusses emergency nurses' barriers to assess and managing pain. These barriers may be multifactorial, the barriers included in our study were categorized into patient, system, physician, and nurse.

Regarding the nurse-related barriers to assessing pain in the emergency department. Most of the studied nurses reported that inadequate time to deliver nonpharmacologic pain relief measures, inadequate staff knowledge, inadequate assessment of pain

management of barriers to managing pain, nursing workload, and lack of education with pain assessment tools were the most affected barriers in assessing and managing pain in emergency units. This can be interpreted due to the nature of the emergency department, the patient was admitted with a life-threatening condition, and a distributed level of consciousness unable to verbalize the presence of pain. A strategy for prioritizing patients in emergency rooms is known as triage. Consequently, even though nurses are aware that every patient's main precedence *via* an emergency visit is pain, awkwardly, according to the triage method, the nurses' urgency is not always pain (Kahsay & Pitkääjärvi, 2019).

Concerning the patients-related barriers to assessing pain in the emergency department. It was found that difficulty to assess patients using a pain scale, inability to communicate with patients, and hemodynamic instability were most reported barriers to assessing and managing pain in the emergency department. About the system-related barriers to assessing pain in the emergency department. Patient-to-nurse ratio and lack of alternative nonpharmacologic therapy for pain management were the common system-associated barriers. Regarding the physician-related barriers to assessing pain in the emergency department. It was reported that insufficient assessment of pain and pain relief and insufficient knowledge of pain management is considered a physician barrier.

The current finding is in line with Rgn et al. (2019) ED nurses' perceptions of obstacles to efficient pain treatment. These obstacles are multifaceted and include physician dominance in pain management, workplace violence, staff deficiencies, and multidisciplinary working relations. Nurses may also face violence from patients' family which decrease their ability to assess pain. Kahsay & Pitkääjärvi, (2019) also reported that frequently mentioned challenges identified by nurses in the current study included a deficiency of instruments for measuring pain, a deficiency of protocols and standards for dealing with pain, and an absence of guidelines and procedures for evaluating pain. According to the pathology of the pain rather than its degree of severity, emergency patients may receive priority care, which

further delays the start of medications and lengthens the suffering of patients.

Kahsay & Pitkääjärvi, (2019) also reported that frequently mentioned challenges identified by nurses in the current study included a deficiency of instruments for measuring pain, a deficiency of protocols and standards for dealing with pain, and an absence of guidelines and procedures for evaluating pain. According to the pathology of the pain rather than its degree of severity, emergency patients may receive priority care, which further delays the start of medications and lengthens the suffering of patients. The finding is proved by Rababa et al. (2021) who reported that a lack of standardized pain assessment tools and protocols was the most common system-related barrier.

Inadequate educational preparations given to nurses throughout their education may be the cause of their lack of proficiency in pain evaluation and management. Nursing educators, however, must be proficient in instructing and preparing students in these areas (Démeh & Rosengren, 2015). To improve nurses' expertise about pain assessment and management, nurse educators need to revise courses recounted to pain assessment and management. Démeh & Rosengren, (2015) found that nurses performed poorly in pain assessment and management knowledge. This may be due to inadequate school preparation, a deficiency of instruments for pain assessment, and a deficiency of continuing education programs on pain evaluation and management.

Kahsay & Pitkääjärvi, (2019) also reported that system-related barriers were related to health policymakers, lack of regulation, and documentation systems in emergency settings. The nurse-patient ratio also was a barrier need to consider by the health care system. Elcigil et al. (2016) also found that system-related barriers were the common barrier compared to other present barriers. The most prevalent barrier respondents observed was a lack of psychological support services. To deliver high-quality pain management in hospitals, collaboration is crucial. It is a key to foster a collaborative team environment between physicians and nurses. High nurse-patient ratios and heavy nurse workloads are viewed as

key obstacles to providing patients with the best pain management (Alotaibi et al., 2018).

The key to successful pain treatment is the use of pain assessment tools, and regular use and documentation of these tools is one of the keys to successfully managing pain (Ehwarieme et al., 2018). As a first step to ensuring safe and efficient critical nursing care, healthcare institutions, professional groups, and academics might work also together to identify and agree on national nurse-patient ratios in critical care. This would reduce the nursing burden. Nurses' awareness of and understanding of pain management in critical care has a substantial impact on nurses' perceptions of obstacles to pain treatment (Wang & Tsai, 2015). Nurses' views and concepts about pain may affect how effectively they treat patients' pain.

Conclusion and recommendation:

From the current findings, it can be concluded that a lack of pain assessment and management guidance in the emergency unit can be a barrier to a valuable pain management. Nurses' knowledge and education about pharmacological and non-pharmacological pain management need to improve. Patient hemodynamic stability and inability to use a pain scale in emergency patients may hinder effective pain management. Nursing workload and nurse-patient ratio affect the assessment and management of pain as soon as possible.

Recommendation: Nursing educators need to revise the nursing curriculum in the scope of emergency nurses and focus on tools of assessment and alternative pharmacological and nonpharmacological interventions. Regulating the evaluation of pain in crises is a task for health officials. Utilizing an administrative strategy and plan to deal with the high patient-nurse ratio and nursing workload. Future studies on nurses' attitudes and knowledge in relation to pain management barriers in emergency settings need to be considered. Developing continuing educational programs for emergency department nurses to advance their knowledge and treatment delivery strategies, including pain monitoring and management. Integrating pain assessment tools into educational programs to increase nurses' understanding of pain management and

to encourage them to utilize them when providing daily patient care. Include the instruments for assessing pain in the curriculum for nursing students so that they may utilize them when they graduate.

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