Nurses' Perspectives on Pain Management in the Emergency Department

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Nurses’ Perspectives on Pain Management in the Emergency Department

By

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Department of Nursing
Seton Hall University
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SETON HALL UNIVERSITY
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OFFICE OF GRADUATE STUDIES

APPROVAL FOR SUCCESSFUL DEFENSE

Elizabeth Fitzgerald has successfully defended and made the required modifications to the text of the doctoral dissertation for the Ph.D. during the Spring Semester 2021.

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Abstract

Over 130 million people seek care in emergency departments (ED) in the United States annually. Most patients who seek treatment in emergency departments are experiencing a painful condition, and as such, ED nurses should have a deep understanding of pain management in the ED. There is limited qualitative research which explores pain management from the nurses’ perspective. The purpose of this study is to describe pain management from the nurse’s perspective. Thorne’s (2005) method of Interpretive Description guided this qualitative inquiry. New knowledge describing the nature of pain management in the ED provides insight into elements which support and impede the ethical principles of autonomy, beneficence, non-maleficence, justice, and veracity. This knowledge fills a gap in the literature and will inform nursing research, education, and practice.

Key words: Pain, pain management, emergency department, nurse, interpretive description, qualitative
DEDICATION

This work is dedicated to my amazing family
Rory, Liam, Cole, Bryn and Nee

It is also dedicated to all the ED nurses who go to work every day despite the challenges and try to make a difference in their patient’s lives.
ACKNOWLEDGEMENTS

The completion of a doctor program is not possible with the support and understanding of family, friends, and faculty. I would first like to thank my husband, Rory who has supported me every step of the way through this journey, and it has not always been easy, especially while raising three wonderful children. I want to thank my three beautiful and amazing children Liam, Cole, and Bryn. They tolerated my late night and early morning work sessions so I could complete my dissertation. They also understood and maybe liked it a little when we had frozen pizza for dinner instead of a homecooked meal “because I had to write.” I hope the three of you now realize you can accomplish anything if you put your mind to it.

I was lucky enough at orientation for my doctoral program to meet my partners in crime, Katie Horan, and Lisa Foley. The two of you have become such a huge part of my life and without you I am not sure I would have made it. I cherish the memories of our hour-long conversations in SHU’s parking lot after class and all the laughs we shared. My study is better because of the council you provided. You both helped to shape my understanding of not only my topic but what it means to be a nursing researcher. I am forever grateful for your friendship.

I must thank Dr. Bonnie Sturm who taught me so much about nursing research, the purpose of higher education, and life in general. As my mentor and dissertation chair Dr Sturm has been by my side during a global pandemic guiding me and supporting me every step of the way. Words cannot express the gratitude I feel for all the support and understanding Dr. Sturm has provided, she is truly an amazing human being.

Finally, I need to thank all the ED nurses who participated in my study and all those who helped me connect with participants, without you this study would not have been possible.
Nursing is truly an art and a science and to all the nurses who took time out of their busy schedules to sit down and talk to me about their perspectives on pain management, thank you.
Table of Contents

Abstract ................................................................................................................................. iv
DEDICATION ........................................................................................................................... v
ACKNOWLEDGEMENTS ...................................................................................................... vi

Chapter I

NURSES’ PERSPECTIVES ON PAIN MANAGEMENT IN THE EMERGENCY DEPARTMENT ................................................................................................................................. 1

Aim of the Study .................................................................................................................. 1
Phenomenon of Interest ....................................................................................................... 1
  Pain in the Emergency Department ................................................................................. 1
  Phenomenon of Pain ........................................................................................................ 3
  The Nurse’s Role in Pain Management ....................................................................... 5
Relevance to the Discipline of Nursing ........................................................................... 6
Problem and Justification .................................................................................................. 7
Research Question and Design ....................................................................................... 8
Researcher's Perspective ................................................................................................. 9

Chapter II

REVIEW OF LITERATURE .................................................................................................. 11

Pain in the Emergency Department ................................................................................ 12
  Race and Pain Management ......................................................................................... 13
  Patient Age and Pain Management ............................................................................. 16
Nurses’ Perceptions about Patients’ Pain ....................................................................... 17
ED Crowding and Pain Management ............................................................................ 18
Discharging Patients with Pain from the ED ................................................................. 20
Conclusion ....................................................................................................................... 22

Chapter III

METHODS .............................................................................................................................. 25

The Research Approach .................................................................................................. 25
Protection of Human Subjects ......................................................................................... 27
Participants ....................................................................................................................... 28
Setting ............................................................................................................................... 30
# Gaining Access and Establishing Rapport 31

# The Question of Bias 32

# Data Collection 32

# Data Analyses 33

# Rigor 34

## Chapter IV

FINDINGS: OVERVIEW OF NURSES’ PERSPECTIVES OF PAIN MANAGEMENT 36

- Beliefs About Pain Management in the ED as Described by the Participants 36
  - Pain is Subjective 38
  - Pain Management is Provider Specific 39
  - Non-pharmacological Pain Management 40
  - Education about Pain Management 41
  - Nurses Describe Patient Conditions 43
- New Challenges in Pain Management in the Emergency Department 45
- Conclusion 47

## Chapter V

FINDINGS: CONTRIBUTIONS THAT IMPROVE PAIN MANAGEMENT OUTCOMES 49

- The Nurse’s Influence on Pain Management 50
  - Assessment 50
  - Advocacy 52
  - Nurse’s Relationship with the Provider 54
- Pain Medication Administration 55
- ED Environmental Influences on Pain Management 57
  - Time 57
  - Assistive Personnel 59
  - Adjunctive Therapies for Pain Management 60
  - Unwritten Protocols or Policies for Pain Management 61
- Discharge Process 63
- Conclusion 65

# Chapter VI
FINDINGS: CONTRIBUTIONS THAT INHIBIT PAIN MANAGEMENT OUTCOMES

ED Environmental Influences on Pain Management .................................................. 68

Overcrowding ............................................................................................................. 68

ED Throughput ........................................................................................................... 70

Patient Satisfaction ..................................................................................................... 72

Prioritization of Care .................................................................................................. 73

The Patient’s Influence on Pain Management ............................................................ 75

Patient’s Expectations of Care .................................................................................... 76

Patients with Preexisting Conditions .......................................................................... 78

The Nurse’s and the Provider’s Influence on Pain Management ................................. 80

Nurses Describe Being Skeptical about Patient’s Pain ............................................... 82

Chapter VII

DISCUSSION OF FINDINGS ....................................................................................... 86

Ethical Tenets of Pain Management in the Emergency Department .......................... 87

Beneficence and Non-Maleficence ............................................................................ 92

Veracity ....................................................................................................................... 97

Justice ......................................................................................................................... 99

Fidelity and Accountability ......................................................................................... 105

Opportunities for Improvement ................................................................................ 106

Conclusion .................................................................................................................. 108

Strengths ..................................................................................................................... 110

Limitations .................................................................................................................. 110

Implication for Nursing and Research ....................................................................... 111

References .................................................................................................................. 115

Appendix A ................................................................................................................ 122

Appendix B ................................................................................................................ 124

Appendix C ................................................................................................................ 126

Appendix D ................................................................................................................ 127

Appendix E ................................................................................................................ 130
Chapter I
NURSES’ PERSPECTIVES ON PAIN MANAGEMENT IN THE EMERGENCY DEPARTMENT

Aim of the Study

The aim of this study is to explore and describe emergency department (ED) nurses’ perspectives of how pain is managed in the ED. Pain is a common complaint of patients who seek treatment in the emergency department and, as such, ED nurses are familiar with the pain management practices in this environment. They are also accustomed to dealing with obstacles to effective pain management. A more in-depth understanding of how pain is managed is of particular relevance at this time, because of newly established mandates and practice changes taking place in response to the current national opioid epidemic. The perspectives of ED nurses will add useful, pragmatic information about how patients’ pain is managed in the ED and what factors facilitate or impede adequate pain management.

Phenomenon of Interest

Pain in the Emergency Department

United States (U.S.) emergency departments have more than 130 million visits per year with most of those visits related to both acute and chronic pain (Poon, et al., 2016). According to the Center for Disease Control (CDC, 2014), for patients between 15 – 64 years old, when excluding all forms of chest pain, four of the top ten reasons patients sought emergency care were related to painful conditions, such as headache, abdominal pain, back pain or traumatic injury. Patients who present to the ED with conditions associated with significant pain may require continued treatment beyond the ED visit and may be discharged with directions and prescriptions for pain management at home. A retrospective cohort study examining opioid prescribing in emergency departments in the U.S. identified 17% of patients were discharged
from the ED with an opioid prescription (Waszak & Fennimore, 2017). Nationally, emergency physicians are the most frequent prescribers of opioid pain medications to patients under the age of 40 (Hoppe et al., 2015).

A multitude of factors have been identified as impacting pain management practices across all healthcare settings. Barriers to adequate pain management are complex and involve healthcare professionals, the healthcare environment, and the patient (Bergman, 2012; Lewthwaite et al., 2011). Adding to the complexity of pain management is the current opioid crisis which has reached epidemic proportions in the United States and has impacted prescribing practices and attitudes about pain management (Hoppe, et al., 2015; Livio, 2017; NJAFP, 2017). In 2016 the CDC published guidelines for prescribing opioids for chronic pain to address this national crisis and in 2017 the U. S. Department of Health and Human Services (HHS) declared the opioid epidemic a national crisis.

Knowledge deficits about pain and pain management among healthcare professionals have been identified by the Institute of Medicine (IOM) as well as researchers as one of the barriers to effective pain management (Bernhofer, Sorrell, 2015; IOM, 2011; Lewthwaite et al., 2011; Moceri & Drevdahl, 2014). Comprehensive education about pain management has been shown to be lacking in emergency medical education/curriculum (Poon et al., 2016), which may impact pain management in the ED. Nurses’ knowledge also plays a significant role in pain management as they often provide initial and on-going pain assessment, evaluate the effectiveness of pain management, initiate non-pharmacological pain relief measures, and provide education about pain assessment and treatment (Dunwoody et al., 2008; Lewthwaite et al., 2011).
In addition to knowledge about pain, research has indicated that physicians’ and nurses’ personal opinions about patients’ pain influenced their assessment and management of pain (Bergman, 2012; Lewthwaite et al., 2011; McMillian et al., 2000). The gender of the patient can impact opioid prescribing practices by physicians in the emergency department (Safdar et al., 2009). Nurses have expressed frustration with patients who they believe purposely exaggerate their pain levels to receive prompt treatment in the ED (Bergman, 2012). Numerous studies have also documented pain management disparities based on personal factors associated with the patient such as age, gender, race, and socioeconomic status (Dwecki, et al., 2011; Minick et al., 2012; Safdar et al., 2009).

Organizational factors such as ED overcrowding, and the presence of clinical guidelines for pain management can influence timeliness of assessment and treatment of a patient’s pain (Ducharme, 2005; Moceri & Drevdahl, 2014). Further compounding the influence the ED environment and patient priorities have on the management of a patient’s pain is a lack of communication/understanding that can exist between the nurse and those ordering pain medications (Bergman, 2012; Gorawara-Bhat et al., 2017). It has also been suggested that changing healthcare providers’ attitudes about pain management especially in the ED may be difficult (Ducharme, 2005); therefore, understanding ED nurses’ perspectives about how pain is managed could provide guidance on how to improve attitudes about pain management in the ED.

**Phenomenon of Pain**

Pain is a universal phenomenon which transcends age, race, ethnicity, and economic status. According to the American Academy of Pain Medicine (AAPM, 2011), pain affects more people in the United States than diabetes, cancer and heart disease combined. A 2006 National Institutes of Health (NIH) survey indicated back pain, migraines, and neck pain were the most
reported types of pain in the United States (AAPM, 2011). Unrelieved pain negatively impacts a person’s quality of life through a decrease in mood, ability to concentrate, quality of sleep, and overall productivity (AAPM, 2011).

Pain is a subjective multidimensional experience unique to the person experiencing it. Pain and suffering can often be difficult to describe or quantify. Pain description and interpretation depends on a multitude of factors such as: previous experience with pain, psychological, developmental, and behavioral factors, and a person’s culture (Venkat et al., 2013). Pain has biological, psychological, and social implications for those experiencing it and requires those who treat it to be competent in multimodal care (American Nurses Association [ANA], 2016). Clinically, pain is whatever the patient says it is, existing wherever the patient says it does (Gillaspie, 2010). While the patient’s self-report of pain is an important element of pain assessment, it should also be evidenced based, comprehensive, and culturally sensitive.

In 2001, in response to national concerns about the underassessment and undertreatment of pain, The Joint Commission (formerly JCAHO) introduced standards for healthcare organizations to improve their management of patients in pain. The standards were intended to make pain more “visible” by requiring patients’ pain to be documented and to hold healthcare providers accountable for pain management, which resulted in pain becoming the “fifth vital sign” (Baker, 2017). Almost immediately after the implementation of The Joint Commission’s Pain Standards concerns were being raised about the validity of assessing and documenting a symptom (pain) as a vital sign and the possible misinterpretation of the standards leading to overzealous treatment of pain. To date, no national studies have been conducted to determine if The Joint Commission’s Pain Standards have improved pain assessment or control. Opioid prescription use has been steadily increasing in the US since 1991; therefore, no conclusions can
be drawn about the impact the Pain Standards have had on opioid use (Baker, 2017). In early 2018, The Joint Commission implemented revised pain assessment and management standards for accredited hospitals in response to the national opioid epidemic. The standards require hospitals to comprehensively monitor and assess patients for pain, provide non-pharmacological modalities for pain treatment, facilitate access to drug monitoring programs, include patients in decisions about pain management and provide education about opioid use, storage, and disposal (The Joint Commission [TJC], 2018).

**The Nurse’s Role in Pain Management**

The ethical tenets of beneficence and non-malfeasance support the nurse’s role in providing high quality pain management to all patients including those who are at high risk of inadequate pain management such as elderly patients, pediatric patients, cognitively impaired patients, or those with a history of opioid use disorder (Emergency Nurse’s Association [ENA], 2017). Pain management is a multimodal approach that focuses on safe and effective relief of suffering while minimizing both long and short-term complications. Assessment of pain must consider a patient’s age, medical history, surgical history, allergies, social history such as previous or current alcohol and drug use, as well as the suspected reason for pain (ANA, 2016). It is the ED nurses’ assessment and documentation of pain upon the first encounter with the patient that can influence decisions about the overall pain management plan. The ED nurse is also responsible for on-going pain assessment, implementation of non-pharmacologic and pharmacologic pain relief strategies, evaluation of the efficacy of pain treatment, and education about treatment modalities and follow up care. A nurse’s pain management knowledge, attitudes about patients in pain, perceptions of a patient’s physical response to pain and understanding about opioid use and abuse, can all influence the nurses’ pain assessment and management.
(Bergman, 2012; Gorawara-Bhat et al., 2017; Holley et al., 2005; Lewthwaite et al., 2011). As knowledge about pain management continues to evolve, it is the responsibility of the nurse to seek out and utilize current research to provide the best possible care for patients.

**Relevance to the Discipline of Nursing**

Oligoanalgesia, the under treatment of pain, is a common phenomenon in the ED (Neighbor et al., 2004; Pretorius et al., 2015). It has been reported that ineffective management of acute pain can lead to the development of chronic pain, emotional and physiological disorders, increased length of stay, and decreased patient satisfaction (Dunwoody et al., 2008; Gupta et al., 2009). Studies indicate that acute pain can result in changes in central nervous system function which may lead to hyperalgesia (paradoxical response to opioids, increasing sensitivity to certain painful stimuli) and allodynia (the triggering of a pain response from stimuli which do not normally provoke pain) which can impact patients’ subsequent pain encounters (IOM, 2011; Neighbor et al., 2004). On the other hand, the benefits of adequate pain management for the patient include reduced costs of care, faster recovery, improved mobility, and increased patient satisfaction (Jarrett et al., 2013).

Inadequate pain management can also have negative effects on nurses caring for the patients in pain. One study identified that inadequate pain management can create moral distress in nurses who struggle with the suffering of the patient (Bernhofer & Sorrell, 2015). Moral distress can lead to burnout, job dissatisfaction, and turnover (Bernhofer & Sorrell, 2015; Zavotsky & Chan, 2106), therefore further exploration of the impact inadequate pain management has on nurses is warranted.

Although inadequate pain management can be problematic, so can over medication, or distribution of opioids without appropriate education and follow-up. Approximately 11.5 million
adults misused prescription pain relievers at least once in 2015, making prescription misuse only
second to marijuana use as the United States most abused drug. Misuse was frequently
associated with taking more medication then prescribed for pain or taking a family member’s or
friend’s pain medication (Lipari et al., 2017). It is estimated that the cost of the opioid epidemic
exceeds 500 billion dollars per year, with most of the costs being associated with decreased
productivity, healthcare cost, and spending on investigating and prosecuting opioid misuse
(CNBC, 2017).

The literature is abundant with respect to pain management perceptions of patients and
their satisfaction or dissatisfaction with treatment; however, less is known about the perspectives
of nurses about pain management, particularly those who work in emergency care. Given the
paucity of knowledge about how pain management decisions are made in the ED, the serious
nature of health risks for those with untreated acute pain, and the current opioid crisis and
existing directives which limit the use of opioids for the management of acute pain, further
examination of pain management practices in the ED is warranted. An in-depth exploration into
ED nurses’ perspectives on pain management can provide a rich description of this phenomenon,
thereby contributing new knowledge about pain management in the emergency department.

**Problem and Justification**

The assessment and treatment of pain is an integral part of nursing practice, and
therefore, nurses are at the forefront of identifying patients who are being undertreated or over
treated for pain (ANA, 2016). The Institute of Medicine’s (IOM, 2011) report *Relieving Pain in
America* declared pain, especially chronic pain, an undertreated condition across all healthcare
settings, leading to unnecessary suffering, increased healthcare expenses, and decreased
productivity. Hospital accreditation standards dictate patients have a right to adequate pain
assessment and individualized treatment of their pain, suggesting quality pain management is an essential part of quality healthcare (ANA, 2016; Todd et al., 2007). In 2017 the U.S. Department of Health and Human Services declared the opioid crisis a public emergency and developed a five-point strategy to combat this crisis which includes advancing better practices for pain management.

Pain is the most common condition for which patients seek emergency treatment (Poon, et al., 2016). Almost 20% of patients are discharged from the ED with a prescription for an opioid (Waszak & Fennimore, 2017) and ED physicians are the most frequent prescribers of opioids for patients under the age of 40 (Hoppe et al., 2015). The conundrum of how to adequately manage pain in the ED while minimizing the risks of opioid misuse has been minimally explored in the literature. In addition, while studies can be found that describe emergency department nurses’ knowledge and attitudes concerning pain (Moceri & Drevdahl, 2014), disparities in pain management in emergency care (Dwecki et al., 2011), and barriers to caring behavior when managing adult’s patient’s pain in the ED (Bergman, 2012; Gorawara-Bhat et al., 2017), there was limited research on nurses’ perspectives on pain management in the ED. There was also an absence of research on how or if the current opioid crisis has affected ED nurses’ perspective on pain management. In addition, there has been limited research on the nurses’ perspective of non-pharmacological methods of pain management in the ED. Therefore, a better understanding of the phenomenon of how pain is managed in the emergency department from the nursing perspective is merited.

**Research Question and Design**

Interpretive description is the qualitative method that will be used to answer the question "What are the perspectives of emergency department nurses on how pain is managed in the
Interpretive description has provided a “theoretical approach to knowledge development while supporting defensible design variations according to specific features of context, situation, and intent” (Thorne, 2016, p. 30). Interviews will provide sources of data which can be analyzed to address the research question, providing in-depth description of the phenomenon.

The following questions will serve as a guide to explore the experiences of pain management in the emergency department:

a. What values or beliefs do emergency department nurses hold concerning patients’ experience of pain?

b. What do emergency department nurses perceive as obstacles to providing adequate management to patients who experience pain in the ED?

c. What do emergency department nurses perceive as facilitators to providing adequate pain management to patients who experience pain in the ED?

d. What processes and factors are involved in the decisions and practice of pain management in the emergency department?

e. What do emergency department nurses perceive as obstacles to discharging patients from the ED who have pain?

**Researcher’s Perspective**

I became interested in conducting research that may contribute to improving pain management of patients in the ED through both my personal and professional experiences. I have come to realize that patients in pain who seek care in the ED have many unmet needs. As an ED nurse, I have also had to deal with an ED provider who states, “just give them (the patient) Percocet that’s what they came here for”, knowing that is not the best course of action for the
patient. I have left work on too many occasions feeling guilty for over-treating or under-treating patient’s pain.

I am a registered nurse with over 25 years of experience. I have been a staff nurse, charge nurse, preceptor, nurse educator, and nurse manager in a variety of ED settings. I have worked in large inner-city Level I Trauma Centers and small community emergency departments and have developed an in-depth understanding of the ED environment, which will allow me to develop a rapport with the research participants.

My personal bias is that I believe using compassionate care and empathetic concern, patients who experience pain can be managed effectively and efficiently in the emergency department. I believe that when ED personnel become task oriented and forget about the living, feeling being on the other end of the task, ineffective pain management and prolonged suffering can occur. As an experienced ED nurse, I am aware of the fact during this research, I may find myself wanting to justify or rationalize the actions of the emergency department personnel that are reported to me. I will make every effort to be aware of my personal bias, while at the same time remaining open to the points of view and experiences of the participants. I will need to bracket my feelings and be open to discovering caring and un-caring behaviors of ED personnel as they manage patients’ pain. I will also need to maintain an open awareness of the participants’ experiences and perspectives to ensure that I am not justifying inadequate pain management practices or indifference to patients in pain, by blaming the environment (overcrowding, understaffing) or the patient (under or over reporting of pain, opioid use disorder). I remain committed to my role as researcher within this process.
Chapter II

REVIEW OF LITERATURE

This chapter provides an overview of the phenomenon of pain management in the emergency department (ED). To better understand pain management in the emergency department, a search of the literature was conducted. An on-line search engine was used to search the following databases: CINAHL, ProQuest, and Science Direct. Key search terms used either alone or in combination were pain, emergency, emergency department, nurse*, healthcare providers, physicians, discharge, opioid crisis, and pain management. The search was limited to peer reviewed articles that were published in the United States (U.S.) 2000 to the present. Studies were limited as pain management practices are bound by the context of the environment, and the current study will be conducted in the U.S. In countries where studies about pain management in the ED were found, pain standards such as those imposed by The Joint Commission do not exist. In addition, many countries, such as England and Ireland require additional training for ED nurses. Finally, the opioid crisis which has greatly impacted the U.S., is not as prevalent in other countries. Therefore, an extensive exploration of pain management practices outside of the U.S. was not warranted.

A review of the literature that focuses on research reports of how pain is managed in the ED is provided. Particular attention is directed toward nurses’ perspectives on pain management in the ED; however, the perspectives of healthcare providers and research on inequities in pain management in the ED are also discussed. ED nurses carry out orders of various healthcare providers when providing care for patients in pain, they advocate for their patients who are in pain, and are often witness to how pain is managed by healthcare providers. In addition, ED
nurses’ assessment may influence how other healthcare providers treat pain, making the inclusion of healthcare provider’s management of pain in this literature review relevant.

**Pain in the Emergency Department**

The essence of nursing is caring for human beings, and this includes caring for those who are experiencing pain. Pain is the primary reason people seek healthcare (Reznick et al., 2001). Whether pain is from a long bone fracture, a kidney stone, or a simple laceration, it is estimated that almost 78% of patients who seek treatment in an emergency department have some level of pain (Todd et al., 2007). A common misconception is that of the patients who seek emergency care for pain, most have pain that is the result of an injury or trauma; however, Todd et al. (2007) demonstrated only 32% of patients presented to the ED with pain resulting from an injury. Patients seek emergency care for toothaches, headaches, neck, back, and abdominal pain, as well as for chronic pain. It has been reported that approximately 20% of patients with non-malignant chronic pain have visited an ED for their pain (Gauntlett-Gilbert et al., 2015). The variety and complexity of reasons requiring assessment and treatment of pain in emergency care requires ED nurses to have an appreciation for and the competence to address pain with an individualized and balanced approach.

The ED is a distinct work environment. The provision of safe and effective pain management can be challenging within the chaotic nature of U.S. emergency departments. Elements such as the unpredictable nature of the department, overcrowding, potential for exposure to violence, and high staff turnover contribute to this highly stressful environment (Enns & Sawatzky, 2016). These factors may influence ED nurses’ management of and perspectives about pain.
In the ED, nurses encounter patients with a variety of comorbid conditions including opioid use disorders, mental health challenges, cognitive impairments, and disabilities. The complexity of patients’ diagnoses and comorbid conditions further compounds the challenge of pain management in this hectic environment. In addition, pain intensity may not always be a priority in the initial assessment of patients with complex and life-threatening conditions. Other suggested reasons for undertreatment of pain in the emergency department include lack of current knowledge about pain management practices (Moceri & Drevdahl, 2014), patient priorities and overcrowding (Bergman, 2012; Hwang et al., 2006; Hwang et al., 2008), patient anxiety (Craven et al., 2013), patient age (Gorawara-Bhat et al., 2017), patient race (Minick, et al., 2012), and patient history of opioid use disorder (Neighbor et al., 2011). Overprescribing of opioids is also a concern in all clinical settings including the ED. In the ED, there is often limited medical history on patients and a lack of continuity of care which can result in the overprescribing of opioids. ED physicians are the most frequent prescribers of opioids to patients under the age of 40 (Hoppe et al., 2015), although it is not known at this time if this behavior contributes to the current opioid epidemic.

**Race and Pain Management**

Racial disparities in pain management are well documented in a variety of healthcare settings, including the ED (Epps et al., 2008; Minick et al., 2012; Todd, Deaton et al., 2000). However, despite numerous studies exploring racial disparities in pain management in the emergency department, few conclusions can be made as to why these disparities exist. A retrospective chart review at two small Georgia hospitals examined whether wait time differences in pain treatment for long bone fractures existed for minority adults (Epps et al., 2008). A significant wait time difference between admission and analgesia administration was
identified between Hispanic and European-American patients \( (F [2, 196] = 5.6, p = .005) \), with Hispanic patients waiting on average 102 minutes for their first dose of pain medication, and European-Americans waiting on average 62 minutes. In this study Hispanics waited longer than European-Americans for pain medication if they were male, received opioid medication, and were under the age of 50 (Epps et al., 2008). In a similar study using a retrospective chart review, Minick et al. (2012) explored racial disparities in the management of pain for patients with long bone fractures who presented to the ED. In this study a large portion of patients regardless of race did not receive adequate pain management for their long bone fractures while in the emergency department. It was determined that on average patients waited one hour and 45 minutes to receive pain medication and almost 40% of white patients and 30% of black patients did not receive any pain medication. However, there was little difference between the wait time for white or black patients with long bone fractures. These results are incongruent with results from Epps et al. (2008), therefore, no conclusions can be made as to why disparities in pain management exist.

Singhal et al. (2016) reported on racial disparities in opioid prescriptions for conditions commonly associated with drug seeking behavior in the ED. The researchers conducted a thorough evaluation of data from the National Hospital Ambulatory Medical Care Survey (NHAMCS) from 2007-2011, reviewing the odds of opioid prescription during ED visits for conditions such as: back pain, toothache, abdominal pain, long bone fractures and kidney stones. The study population included patients between 18 and 65 with over 16,000 records being reviewed. Long bone fractures and kidney stones were defined as ‘definitive’ conditions as they have objective clinical presentations and can be confirmed with diagnostic tests. Abdominal pain, back pain, and toothaches were defined as ‘non-definitive’ conditions as they are often
associated with drug seeking behavior and often cannot be confirmed objectively or through diagnostic tests (Singhal et al., 2016).

Descriptive statistics revealed that patients in the younger racial-ethnic minority population comprised most of the visits for ‘non-definitive’ conditions (toothaches, abdominal pain, and back pain) as compared to the ED visits for ‘definitive’ conditions (kidney stones and long bone fractures). Results of this study found racial disparities for two of the non-definitive conditions. Non-Hispanic blacks when compared to non-Hispanic whites had 0.67 times the odds of receiving an opioid prescription at discharge, and 0.58 times the odds of receiving opioids while in the ED for back pain after adjusting for other covariates (Singhal et al., 2016). For patients with abdominal pain all racial-ethnic minorities had lower odds of receiving an opioid prescription at discharge. However, non-Hispanic blacks had half the odds of receiving an opioid while in the ED for abdominal pain when compared to non-Hispanic whites (Singhal et al., 2016). Due to the retrospective nature of the data review, several elements which could have impacted pain management practices could not be explored in this study. These include variable clinical presentation, ED overcrowding, patient allergies to or reported adverse reactions to certain medications, and patient preferences.

It has been determined that opioid prescriptions are associated with opioid abuse (Center for Disease Control [CDC], 2017). Evidence demonstrates that non-Hispanic whites have a higher incidence of opioid addiction than minority populations (Singhal et al., 2016). This begs the question as to whether non-Hispanic blacks in this study are being under-prescribed or whether non-Hispanic whites in this study are being over-prescribed and thus contributing to the opioid epidemic (Singhal et al., 2016)?
**Patient Age and Pain Management**

In addition to race, a patient’s age has been shown to impact pain assessment and management in the emergency department. Two studies explored pain management for older adults in the emergency department (Hwang et al., 2010; Gorwara-Bhat et al., 2017). A 2010 retrospective observational cohort study examined the quality of acute ED pain care that geriatric adults received during two points in time; July 1- July 31, 2005, and December 1 - December 31, 2005 (Hwang et al., 2010). An exploration of whether differences existed between pain assessment, pain treatment, and wait time for pain care between older and younger patients was conducted. This study did not identify any differences in wait time for pain treatment between younger patients and older patients. However, Hwang et al. determined older adults (65 – 84 years-old) had a lower reduction from initial pain score to final recorded pain score ($p = .002$) than younger patients. For patients who received analgesics, patients 65 - 84 years-old were less likely ($p = .04$) than patients 18-64 years-old to receive opioid medications (Hwang et al., 2010).

In a qualitative study, Gorawara-Bhat et al., (2017) described the perceptions of emergency department nurses regarding the management of older patients who present with pain. Nurses in this study indicated older patients do not always report their pain, as they are either “stoic, afraid, or they do not know how to verbalize how they are feeling” (p. 234). One nurse stated, “sometimes it’s hard for them (the patient) to comprehend what the number on the scale means” (Gorawara-Bhat et al., 2017, p. 234). In addition, nurses in this study felt there was over-medications for pain in the ED. One nurse stated, “Doctors sometimes over-medicate patients…..they overuse Dilaudid, no matter what’s going on…..they give it to everybody…it does not matter if you are a four out of 10. What do you need Dilaudid for?” (p. 234). This
sentiment was elucidated by several other nurses in the study, some feeling the doctors “give them the highest stuff, and then the patient will leave them alone” (p.235). Other themes illuminated in this study included patient focused themes, such as pain assessment in the elderly, is multi-faceted and complex and there is a mismatch between reported pain and observed behavior, and system related themes such as pain reassessment and protocols are difficult to implement. Gorawara-Bhat et al. (2017), and Hwang et al. (2010), explored pain management in the ED in the elderly; however, neither of these studies explored the ED nurses’ perceptions regarding pain management in other patient populations.

Nurses’ Perceptions about Patients’ Pain

Many emergency nurses rely on their assessment, judgment, and years of experience to determine the severity of patients’ pain, as many pain scales such as the Numeric Rating Scale (NRS) oversimplify pain assessment by attempting to capture the painful experience through a single dimension (Bergman, 2012; Gorawara-Bhat et al., 2017). Nurses admit that in addition to documenting the degree of pain experienced by the patient (as identified with the NRS), they assess and document the patient’s behavior which is reflective of the patient’s experience of pain (Bergman, 2012; Gorawara-Bhat et al., 2017). When describing the complexities of managing older patients who present to the emergency department in pain, one nurse stated, “So, if they’re saying they have abdominal pain and sitting there eating chili cheese Fritos and drinking a soda I say that is the behavior they are exhibiting. But if they are grimacing in pain and crying, that is a reflection of their pain as well” (Gorawara-Bhat et al., 2017, p. 236).

In a grounded theory study that explored perceived barriers to demonstrating caring while managing adult patients’ pain in the emergency department, Bergman (2012) reported that 15 nurses felt frustrated with the NRS used by patients to report their pain. They felt patients
frequently manipulated the NRS. Reasons for perceived manipulation included a lack of understanding by patients of what the numerical rating meant due to educational level, language, or cultural barriers. Other reasons for perceived manipulation included patients wanting to be treated more quickly while in the emergency department and patients who are “drug seeking” (Bergman, 2012, p. 222). One nurse stated, “you can tell when someone is in pain and when the patient’s presentation doesn’t equate with the verbalization. I really don’t believe the patient is experiencing that level of pain” (p. 222). Nurse participants in the Bergman (2012) study also felt frustrated with a perceived lack of cohesiveness with the nurse-doctor relationship. This lack of cohesiveness impacted the nurse’s ability to manage pain in their patients. Some nurses felt it was difficult to obtain an appropriate order for pain medication in a timely fashion, while others reported physicians were “too quick to prescribe narcotic medications” (p. 222). Bergman (2012) explored barriers to caring behaviors when managing adult’s pain in the ED but did not explore other aspects of pain management from the nurses’ perspective in the ED such as non-pharmacological pain management, discharge practices for patients in pain and management of pain in populations other than adults.

**ED Crowding and Pain Management**

Environmental factors may also impact pain management in the ED setting and are important to consider. A unique characteristic of all emergency departments is the inability to control patient volume. There is a finite number of beds on an inpatient unit, and a new patient cannot be admitted until a patient is discharged. This is not the case in emergency departments where patients can continue to arrive despite every bed being occupied. Often patient volume exceeds bed availability in the emergency department which can lead to delays in patient care, especially for those with non-life threatening conditions (Hwang et al., 2008). Nurses interviewed
in a qualitative study examining barriers and enablers to caring behavior when managing adult patients’ pain in the ED reported feeling overwhelmed due to the volume of patients waiting to be evaluated, as well as the volume of patients waiting for an inpatient room to become available (Bergman, 2012). In this study the volume of patients as well as the lack of support staff contributed to the perception of being overwhelmed and impacted their management of patients’ pain. One nurse stated,

“There are times when you are taking care of eight different patients and your name is on 15 different charts at one time….You are pulled in a lot of different directions and sometimes forget (about pain). There is a lack of control. (Bergman, 2012, p. 221)

Prioritizing care of the patients in the ED environment is essential management of life-threatening illnesses and injuries becomes the focus of ED management, as one nurse indicated, “Sometimes the pain just has to wait” (Bergman, 2012, p. 220). Nurses in the Gorawara-Bhat et al. (2017) study also commented on the volume of patients in the ED and its impact on pain management. One nurse recalled, “The ER in not like a controlled environment…. We can’t go back (to reassess pain) right away as promised” (p.234).

ED crowding is a situation that is assumed to have negative effects on patient outcomes, although there is limited evidence of this in the literature. A retrospective cohort review examined the impact of ED crowding on assessment and treatment of pain in older adults with hip fractures (Hwang, et al., 2006). This study demonstrated that greater ED census (more than 120% of bed capacity) was associated with a longer time to pain assessment ($p = .01$), and lower likelihood of having pain assessment documented during initial assessment ($p = .05$) in older adults (range 52-101 years-old) who presented with hip fractures (Hwang et al., 2006).

In a follow-up study, Hwang et al. (2008), conducted a large retrospective study that examined 1,068 charts for adult patients who presented to an academic, urban, tertiary care ED
for conditions which warranted pain management. The purpose of the study was to explore the association between ED crowding and quality pain management (Hwang et al., 2008). The researchers did not explicitly define “quality pain management” but examined as outcome variables: documentation of nurse and physician pain assessment, medications ordered, and times of activities such as assessment, ordering and administration of medications. In this study ED census was converted from a continuous variable to a dichotomous one, with the researchers defining high census as greater than the 50th percentile of occupancy, and low census as less than or equal to the 50th percentile (Hwang et al., 2008). According to Hwang et al. (2008), ED census negatively impacted patient care, with delays in pain assessment (Spearman $r = 0.33$ $p < 0.0001$), medication prescribing ($r = 0.22$, $p < 0.0001$) and medication administration ($r = 0.25$, $p < 0.0001$). When the results were adjusted for patient characteristics, the time of day and type of healthcare provider, patients still waited up to 55 minutes longer for pain assessment and up to 43 minutes longer to receive their pain medication during periods of higher census (Hwang et al., 2008).

At this time, there is no one established definition for ED overcrowding, and it is possible that each ED may have its own threshold level at which ED census begins to impact patient care. This could be related to staffing, ED volume, holding patients waiting for admission or any combination of the three. Therefore, exploring how ED nurses perceive the phenomenon of pain management in the ED and if their perception of overcrowding impacts how they manage patient pain could shed light on this unique characteristic of emergency departments.

**Discharging Patients with Pain from the ED**

Discharge instructions and education are an important part of an ED visit. Discharge education can prevent repeat visits, ensure compliance with treatment recommendations, and
ensure safety for the ED patient. There is limited research on discharge practices for patients with pain from the ED from the nurses’ perspective.

One qualitative study was found that explored ED nurses’ perspective of discharge criteria for patients who received opioids while in the ED. Wolf et al. (2015) examined the perceptions of 19 ED nurses on the discharge process for patients who received opioids for pain management. There were eight different themes identified from the two focus group sessions. Those themes included: time, safety considerations, policies, evidence, physiologic considerations, cognitive considerations, ethical/legal concerns, and nursing impact. Participants in this study expressed concern that there is a lack of evidence-based protocols for discharge criteria after the administration of opioids in the ED. One nurse participant stated, “We don’t even have a policy” (Wolf et al., 2015 p. 224). Discharge time after opioid administration in the ED ranged from zero minutes “gulp and go” to 240 minutes. Most reported wait times to discharge were related to the nurse wanting to assess for a reaction to the pain medication. In general, participants agreed that certain physical assessments prior to discharge after opioid administration were essential and included vital signs, mental status, ability to ambulate, and pain levels (Wolf et al., 2015). This study identified a lack of consistency related to discharge criteria and assessments for patients who received opioids while in the ED. This study did not explore discharge education for patients who received opioids. In 2018, The Joint Commission new standards on pain management require patient education that includes appropriate storage and disposal of opioids to prevent theft or misuse of opioids by others. Therefore, discharge education in the ED for patients with pain warrants further exploration.
Conclusion

The ED is a unique healthcare setting in which specialized treatment is provided to the acutely ill and injured, and vulnerable and marginalized patients who are treated for acute and chronic conditions (Hwang et al., 2006). Research has suggested approximately 75% of patients who seek treatment in the ED are experiencing either acute pain or an exacerbation of a chronic painful condition (Hoppe et al., 2015). The large volume of patients who seek management of painful conditions in the ED as well as the variability of the presentation of the painful condition (acute versus chronic) makes pain management in the ED challenging.

The under-treatment of pain has been identified as a common problem among a variety of ED patient populations, including the elderly (Hwang, et al., 2010; Gorawara-Bhat et al., 2017) and black and Hispanic patients (Epps et al., 2008; Minick et al., 2012; Singhal et al., 2016). The nurses’ perception of patients’ nonverbal behavior may also influence pain management practices in the ED (Bergman, 2012; Gorawara-Bhat et al., 2017; Moceri & Drevdahl, 2014). Research on ED nurses’ perspective of pain management in the ED and what contextual elements play a role in ED pain management decisions may better elucidate the nature of pain management disparities.

Further compounding the complexity of providing pain management to a variety of patient populations in the ED is the variability of the ED environment itself. A unique characteristic of the ED is the inability to control or predict patient volume. Several studies have indicated excessive patient volume can negatively impact pain management practices in the ED (Bergman, 2012; Hwang et al., 2008; Hwang et al., 2006). Currently, there is no established definition for ED overcrowding, nor is it clear how ED nurses perceive ED overcrowding’s impact on pain management. Exploring how ED nurses perceive ED overcrowding, and its
impact, if any, on pain management practices may provide insight into how contextual elements that are unique to the ED influence pain management decisions.

Pain management in the ED does not end with administration of pain medication during the ED visit, but often continues with decisions about discharge after pain medication administration and determination of need for additional pain management at home. One recent study explored decisions about discharge after pain medication administration (Wolf et al., 2015). With limited information on how pain management decisions are made at the time of ED discharge, further exploration of this topic is justified.

Inadequate pain management can lead to negative long-term consequences for patients such as the development of chronic pain, emotional and physiological disorders, increased length of stay, hyperalgesia, and allodynia (Pasero, et al., 2016; Dunwoody et al., 2008; Neighbor et al., 2004). Over-prescribing of opioids can also lead to negative outcomes for patients such as dependency, diversion, and tolerance (Pasero, et al., 2016; Wolf et al., 2015); therefore, research that examines pain management from the nurse’s perspective in the ED is warranted.

While there have been several qualitative studies that have explored pain management in the ED (Bergman, 2012; Gorawara-Bhat et al., 2017; Wolf et al., 2015), these studies have been limited in their scope. The studies have explored pain management in the elderly (Gorawara-Bhat et al., 2017), barriers to caring when managing adults’ pain in the ED (Bergman, 2012), and the nurse’s perception about discharge practices for patients who received opioids in the ED (Wolf et al., 2015) but, did not explore all aspects of pain management in the ED In addition, all of the studies were conducted prior to the opioid crisis being declared a national emergency and prior to the new mandates limiting the use of opioids for acute pain, and the new 2018 Joint Commission Pain standards for accredited hospitals. Therefore, the proposed study is designed to
gain a better understanding of the ways in which ED nurses manage all patients’ pain, their perceptions, and suggestions for improvement of pain management in the ED, the barriers they encounter during management of pain in the ED, and if the current opioid crisis and pain standards have impacted pain management in the ED. This information can be used to offer strategies for interventions and improvement in pain management practices in the ED.
The Research Approach

Interpretive description was the method used to study emergency department (ED) nurses’ perspectives on how pain is managed in the ED. Interpretive description is a qualitative research method that can be especially useful when used by nurse researchers to better understand clinical phenomenon occurring within contexts, thereby addressing what Thorne (2016) refers to as “questions from the field” (p. 30). This naturalist method of inquiry recognizes that truth is comprised of many realities and provides a basis for conceptual linkages that become evident when exploring the specific within the general (Thorne et al., 2004; Polit & Beck, 2012).

Clinical phenomena are frequently studied quantitatively; however, certain phenomenon cannot be measured or are not well understood, and therefore need to be explored qualitatively. Early qualitative studies in nursing employed the methods of grounded theory, phenomenology and ethnography as the researchers attempted to fit the epistemological perspectives and methodological - approaches with those of other fields such as sociology, philosophy, and anthropology to study clinical problems (Thorne et al., 2004). In the interdisciplinary healthcare environment, it becomes easy to forget that each discipline has its own origin with its own intellectual goals (Thorne 2016). So, while ethnography, grounded theory, and phenomenology methods were appropriate for some clinical questions, nursing scholars began to explore other methods to fit their qualitative inquires (Thorne et al., 2004, p. 2). Thorne et al., (1997) developed the qualitative approach known as interpretive description to provide a qualitative method especially suited for discovering new knowledge in the field of nursing. This new
qualitative methodological approach deviated from traditional descriptive approaches in that it assumed nurse investigators were not satisfied with description alone and sought elucidations that could provide clarity and assist with decision making in clinical practice (Thorne et al., 2004).

Interpretive description borrows from other methods of data collection, such as grounded theory, naturalistic inquiry, and ethnography. The product of an interpretive description study does not generate “new truths”, but rather “tentative truth claims”, which inform clinical decisions, and extend current insight into a phenomenon (Thorne et al., 2004, p. 7). The tentative truth generated by interpretive description allows for the discovery of individual variations in phenomenon that are common within the clinical realm. According to Thorne (2016), the integrity of interpretive description is derived from three sources:

- An actual real-world question.
- An understanding of what we do and do not know based on all available empirical evidence.
- An appreciation for the conceptual and contextual realm within which a target audience is positioned to receive the answers generated from the research (p. 40).

Interpretive description presumes that there will be some empirical knowledge and clinical understanding from which studies of human health and illness phenomena are derived (Thorne et al., 2004). It affords the researcher the opportunity to deconstruct what is currently known about a phenomenon. The researcher does not need to start from square one, but rather, can build upon clinical experience and previous empirical work to generate new insight and understanding about a clinical phenomenon (Thorne, 2016).
The available literature was reviewed for the study to determine the current state of knowledge about pain management in the emergency department and if the research question had been adequately answered in a way that was important to the discipline of nursing. A gap in the literature was identified in which researchers recommended further exploration of ED pain management guidelines (Hwang et al., 2006), effective analgesic practices in the ED (Moceri & Drevdahl, 2014), differences in pain management practices for geriatric patients in the ED (Gorawara-Bhat et al., 2017; Hwang et al., 2010) and ED nurses’ perceptions of pain management (Bergman, 2012). Therefore, the use of interpretive description to explore ED nurses’ perspectives on how pain is managed in the ED is appropriate, as the aim of the study was to provide understanding of the complexities of pain management, including the discovery of factors that may facilitate or impede adequate pain management in the ED.

**Protection of Human Subjects**

There were no foreseen risks to the participants and there were no anticipated adverse reactions. The study participants were adults employed as registered nurses (RN) in an emergency department. Participation was voluntary. The principle of respect for persons was upheld through the process of informed consent. Participants’ written informed consent (See Appendix A for Informed Consent Form) was obtained prior to enrollment in the study and again verbally throughout the study. Participants were informed of the following: a) the aim of the study; b) any foreseeable risks of participation; c) potential benefits to themselves or others; d) confidentiality protections; e) researcher’s contact information for answers to questions regarding the study; and f) conditions of participation, including the right to refuse or to withdraw from the study at any time without penalty. Participants were given the researcher’s cell phone number and email address and were instructed to reach out if they had any questions.
or concerns regarding their interview. None of the participants reached out to express any concerns during the study.

All data was transcribed by the researcher. The data had all identifying factors removed prior to transcribing, and only de-identified data was stored electronically. Only the researcher and the dissertation chair had access to the data. The audio tapes of the interviews and the transcribed data were stored electronically on a USB memory key, were maintained in a locked, secure location within the researcher’s home, and will be retained for at least three years after study completion.

Participants

The sample for this study consisted of 20 registered nurses (RNs) who currently work full-time in an emergency department on the East Coast of the United States. ED nurses with less than one year of experience and who worked less than one day per week were excluded from the study as their experience with pain management in the ED may have been limited. The participants’ experience in the ED ranged from 18 months to 19 years, and all participants worked full-time in the ED at the time of their interview. Fourteen of the participants identified as female, and six identified as male. The educational background of the participants was varied with one participant having a diploma in nursing, 16 participants with a bachelor’s degree in Nursing and three participants with a master’s degree in Nursing. Three participants are certified in Emergency Nursing (CEN). Ten of the participants have experience outside of the emergency department, including several who worked as medical-surgical nurses, two who have experience in pre-hospital care as emergency medical technician (EMT) and as a paramedic, and several who worked in long-term care and with patients with mental health issues. Additional demographics can be found in Appendix D.
Interpretive description sampling is not prescriptive but allows the researcher to seek participants who contribute their experiences with a certain phenomenon (Thorne, 2016). Therefore, a sample of ED nurses from a variety of geographic locations and various size hospital systems was sought. The participants in the study were RNs from 12 different hospitals and four different states: New Jersey, New York, Connecticut, and Florida. The sample was environmentally connected through their shared experiences of managing pain in the ED. The sample shared the commonality of working in the ED and having experiences managing pain in the ED, despite working in various hospital settings and geographic locations. This allowed for the discovery of commonalities amongst ED nurses as well as an understanding of differences among ED nurses’ perspectives on how pain is managed in the ED.

There are three common types of sampling in interpretive description studies which are convenience sampling, purposive sampling, and theoretical sampling (Thorne, 2016). Convenience and purposive sampling were used in this study. Convenience sampling is a technique in which individuals who are “closest at hand” are asked to participate (Thorne, 2016). Purposive sampling is an example of convenience sampling in which individuals are included in a study based on their experiences. Participants were recruited from a variety of hospital systems and types including small community hospitals, for-profit systems, and large urban teaching hospitals to ensure the sample population had a breadth of experiences managing pain in the ED. Snowball sampling is a form of convenience sampling in which early participants in the study are asked to refer other people who meet the eligibility criteria. In this study two participants referred co-workers who met eligibility criteria and were interested in participating in the study.

According to Polit and Beck (2012) there are no fixed rules for sample size in qualitative research, but rather the size of the sample should be based on the question (p. 521).
Thorne (2016) also states, “interpretive description can be conducted on samples of almost any size” (p. 103). Elements that can influence sample size in qualitative research include the scope of the research question, the quality of the data obtained from the participants, the sensitivity of the phenomenon being studied, and the skill and experience of the researcher (Polit & Beck, 2012). Since pain management is a common element of emergency care, and it is not a sensitive phenomenon, 20 participant interviews were conducted for this study.

In qualitative work sampling ends when data saturation occurs, which is when themes and data become redundant, and it is determined that no new information can be obtained from further data collection (Polit & Beck, 2012). Thorne (2016) suggested that data saturation, in which no variation or perspective could emerge in clinical practice, is unlikely and wrote, “the idea that one could stake a claim that no new variation could emerge is antithetical to the epistemological foundations of practice knowledge” (p. 107). Thorne proposed that the applied researcher should in an honest and authentic way discuss what one has discovered through the research process understanding that there may be more to learn. Therefore, for this study 20 participants were interviewed as data collection was completed when, as Thorne suggests, the findings were sufficiently well developed to justify reporting (p. 108).

**Setting**

Individual interviews were conducted in locations that were convenient to both the participant and the researcher and were conducive to a private conversation. Examples of locations in which interviews were held included coffee shops, parks, and restaurants. Fourteen interviews were conducted face to face and six interviews were conducted over the phone. Phone interviews occurred only when geographic location prohibited the researcher and participant
from meeting face to face. Interviews conducted over the phone included those with participants from Connecticut and Florida. All interviews were held in a location that was private.

**Gaining Access and Establishing Rapport**

Participants were recruited from a variety of emergency departments in different geographical locations on the East Coast of the United States. Participants were identified through professional peer contacts and were not known by the researcher. Having worked in acute care settings and higher education for over twenty-five years, I have a wide variety of professional peers who work in many different settings and geographic locations, including New Jersey, New York, Pennsylvania, and Florida. This allowed me to gain access to ED nurses from many different settings. I contacted professional peers and utilized snowball-sampling technique to seek referrals for ED nurses who were willing to participate in this study. Interested ED nurses were contacted via phone and email and provided a Letter of Solicitation (Appendix B). Thirty-eight potential participants were contacted for participation in this study, with 22 ED nurses expressing interest in participating in the study. Two of the interested participants worked outside the geographic location for the study and therefore, had to be excluded. Twenty nurses signed consent and participated in individual interviews lasting from 60 to 120 minutes.

Having worked in the ED in the past lent credence as I interacted with the ED nurses in this study. My experiences as a nurse as well as my experiences managing patients in pain in the ED helped to establish a rapport with study participants. Since I understood the nature of the ED environment, the challenges faced by ED nurses, as well as the complexity of pain management in the ED, I was able to conduct interviews that had meaningful and relevant questions about pain management in the ED.
The Question of Bias

As an ED nurse with extensive experience caring for patients in pain, I needed to be aware of my own bias and perceptions about the phenomenon and be open and receptive to the answers provided by the study participants. According to Thorne (2016), in order to conduct interpretive descriptive research that is relevant and provides meaningful insight into clinical phenomena, the researcher needs to be humble, and ensure their passion and personality do not steer the interactions in a foreseeable direction. I kept a reflective journal which allowed me to identify my feelings and discuss those feelings with my dissertation chair. I was steadfast in my commitment to be as Thorne (2016) states a “neutral facilitator” so the participants in the study could explain their perceptions and perspectives as completely as possible (p. 140).

Data Collection

It is suggested that it is not possible to understand a human clinical problem using one data source, as the one data source could not adequately embody the entire phenomenon (Thorne, 2016). As such, interpretive description encourages the use of collateral methods of data collection to provide multiple angles in which to examine the phenomenon. In this study, interviews with ED nurses from a variety of hospital settings and geographic locations was used to explore the phenomenon of interest from different points of view.

The study utilized snowball sampling, a type of convenience sampling. Willing participants, after signing the informed consent (Appendix A) were interviewed. Interviews lasted from 60 minutes to 120 minutes, with 75 minutes as the average duration of an interview. The interviews were semi-structured using open-ended questions. Open-ended questions fostered elaboration about the studied phenomenon and provided clarification about themes within the interview. All interviews were audiotaped and then transcribed verbatim by the researcher. Field
notes were created immediately after every interview by the researcher to document non-verbal clues and impressions about the interview and participant. Individual interviews began on May 20, 2019 and concluded September 11, 2019. Study participants were given several ways (phone or email) to contact the researcher after the initial interview in case they wanted to provide additional information or provide clarification about something they said. None of the study participants elected to offer additional information or provide clarification after the interviews concluded.

Study participants were asked to discuss pain management policies and procedures from their organization and discuss any mandatory competencies and hospital wide or unit specific education they had received within the last twelve months about pain management. Document review can be used as a collateral data source in interpretive description studies (Thorne, 2016). Although, this was not a structured document review, the description of policies and procedures the ED nurses were aware of and the educational experiences they have had regarding pain management helped to elucidate the phenomenon of pain management in the ED. The absence of policies or educational offerings provided insight as well.

**Data Analyses**

This research used the techniques of concurrent data collection and constant comparative analyses. Concurrent data collection occurs when the researcher gathers the data, reviews the data, and uses the data to develop themes and ideas that will guide future data collection. Using constant comparative analyses the researcher compares one piece of data to another piece of data, to determine what is similar and what is different between the data. The concurrent examination of data and constant comparison of data allowed the researcher to identify patterns,
themes and begin to interpret the data to help explain the phenomenon in a meaningful and relevant way.

According to Thorne (2016), concurrent data collection and constant comparison of data are “fairly central to a way of studying phenomena in which you start with the assumption that at least some aspects of the reality that you are studying are socially constructed” (p. 109). To not only describe the data, but also interpret it, the researcher must continuously engage with the data to check, substantiate, and expand upon the conceptualizations that begin to develop as soon as the researcher enters the field (Thorne, 2016).

The data source for this study was individual interviews. Thorne (2016) supports the use of individual interviews “as a useful core for the development of knowledge in relation to many of the clinical issues we encounter” (p. 87). Each audio-recorded interview was transcribed verbatim. Transcribed interviews were carefully reviewed while listening to the audio-recorded interview to ensure accuracy. To avoid distraction during the interviews written notes were kept to a minimum. Any observations made by the researcher during the interview were noted in a field log immediately after each interview.

**Rigor**

Ely et al. (1999), suggested trustworthiness as a qualitative researcher means that the research is conducted fairly, and that the product of the research represents the experiences of the people who were studied. According to Ely et al. (1999) trustworthiness is more than a set of procedures but rather a personal belief system that shapes the procedures in qualitative research (p. 93). To enhance trustworthiness in this study the research is grounded in the ethical principles of beneficence, justice, and privacy. These principles guided how data was collected and interpreted and how assumptions and conclusions were checked as well as how the research
results will be disseminated. Trustworthiness was enhanced by including study participants from several geographic locations and different hospital types. Analytical notes were utilized to document insights and contextual elements after each interview, adding to the trustworthiness of the interpretation of data. A reflective journal was also kept during data collection. The reflective journal enabled me to bracket my feelings about the emerging data and ensure the findings reflected truths outside of my own biases.

Multiple strategies were used to maximize the credibility of the proposed study’s findings and create a match between the ED nurses’ perspectives on how pain is managed in the ED and my interpretation. Twenty individual interviews were conducted, which lasted between 60 minutes and 120 minutes, and when geographical location permitted, interviews were conducted in person. Six interviews were conducted over the phone to fully explore pain management with participants who lived or worked more than two hours away from the researcher. Collection of data from ED nurses from a variety of hospital settings and geographic locations allowed for cross-site examination for consistency and differences. A frequency log was developed which allowed tracking of concepts, thoughts, and insights from the participants. For example, using the frequency log determined that none of the participants included non-pharmacological pain management practices when discussing pain management in the ED until they were specifically asked about it. Finally, I used peer debriefing with my dissertation chair, who is an expert in qualitative research. This allowed me the opportunity to discuss observations, findings, and methodological steps with an experienced researcher.
Chapter IV
FINDINGS: OVERVIEW OF NURSES’ PERSPECTIVES OF PAIN MANAGEMENT

Research indicates approximately 75% of patients who seek treatment in the ED are experiencing pain (Hoppe et al., 2015), making the concept of pain management a universal phenomenon encountered by all twenty Emergency Department (ED) nurses interviewed for this study. The participants identified pain management as a phenomenon they dealt with frequently and struggled with daily. Pain management was described as contextual and being dependent upon many variables which include the patient, the provider, the nurse, and the environment where pain management occurred. Nurse Stevens describes pain management in the ED,

Pain management is hard; it is why most people come to the emergency department. It’s all subjective, it is based on their perception. I think most people come to the ED because they think it is something they can’t resolve on their own. What’s causing their pain and what their actual pain is, is based on their own experience. (Pause, then said with feeling). Like I said, (sigh) pain management is really hard.

The participants described the interrelated nature of pain management and how the nurse, provider, environment, as well as societal norms and values influence the management of pain in the ED.

This chapter provides an overview of the complexities, nuances, and struggles encountered by the participants as they managed pain in the ED. Chapter 5 and chapter 6 expand upon the findings of the study. Chapter 5 describes the elements of pain management in the ED that were perceived by the participants as facilitating pain management, and chapter 6 identifies those components which were identified as impeding pain management in the ED.

Beliefs About Pain Management in the ED as Described by the Participants

To understand the participants’ answers to interview questions regarding pain management in the ED, it is first important to understand how the concept of pain management
was defined by them. Participants described pain management in the ED as “important” a “priority”, “challenging”, and “changing.” Several nurses described pain management as a balancing act in which the nurse and the provider are trying to treat the patient’s pain but not harm the patient by giving them something that the patient can get addicted to. “I would say we now try to manage pain in the ED therapeutically with the less addictive drugs, we have gotten away from those things that are more addictive” (Nurse O’Brien). Although the current opioid crisis was not a phenomenon specifically investigated at the onset of this study, the subject came up in over 50% of the interviews, adding an important dimension to the overall study findings.

Although I know about the opioid crisis, I think it has been going on since before I started, it is like a catch twenty-two, you know you have to treat the pain because of hospital requirements and the patient is in pain, but you don’t want to just give something (a narcotic) out (Nurse Elliot).

Nurses identified pain management in the ED was evolving and there were a variety of elements that impacted the process of pain management. Participants discussed the subjective nature of pain from the patient perspective and the contextual elements of working in an ED and how those elements such as patient volume and patient acuity impacted pain management. They also articulated that personal qualities such as patient expectations, provider personalities and personal biases influenced pain management in the ED. The nurses identified pain management as an important part of their role in the ED.

The participants acknowledged the complexity of pain management was due to the varied patient populations they encountered and the fluid ED environment. “You see everyone, you don’t know their background, what doctors they have seen, and you see them only for a very short period of time, and you are supposed to fix their pain (laughs)” (Nurse Giordano). Participants recalled caring for patients with acute and chronic pain. “We get a lot of acute pain in the ED, but we also do get a lot of chronic pain” (Nurse Mathews). They described caring for
pediatric patients in pain, as well as adults and geriatric patients with pain. “We don’t use a lot of narcotics in pediatrics, we mostly use Toradol or Tylenol, but on the adult side we use a lot of narcotics” (Nurse Roberts). Whether the participants were describing patients with chronic or acute conditions or patients who were young or old, the participants agreed pain was subjective and based on the patient’s perception of the situation.

**Pain is Subjective**

McCaffery’s concept that “pain is whatever the patient says it is” (ANA, 2016), was supported by 19 of the 20 participants, who identified the subjective nature of pain: “In our mindset in the nursing community we say that pain is whatever the patient says it is” (Nurse O’Brien). The nurses recognized patients responded to pain differently based on the patient’s past experiences with pain and their current state of health. At times, nurses responded in support of the patient’s autonomy and feelings, “Pain is subjective, and if you tell me your back pain is a 10, then it is a 10” (Nurse Peters). Whereas at other times, the sentiment was that some patients handled pain better than others, and some patients were manipulating the system or exaggerating their pain. “I don’t think all the patients that come in have a painful condition (laughs), it is all subjective” (Nurse Stevens).

Due to the subjective nature of pain, participants described needing to individualize the care of patients in pain, as different patients responded differently to treatment. “It depends on the patient, some of them you would give them Tylenol and they would be like ‘Oh my goodness, thank you I feel so much better’ and other patients would need 2mg of Dilaudid to feel better” (Nurse Bishop). Dilaudid is an opioid pain medication used to treat severe pain. Nurse Imada provided an example of the subjective nature of pain and pain management when he described one patient encounter, “I had an 89-year-old woman who broke her hip, and I was like
‘Ma’am do you want anything for pain?’ and she was like ‘No, I’m good’ and I laughed because I had pain just looking at her X-ray.” Participants described the importance of understanding the difference amongst the patient populations seen in the ED. Nurse O’Brien explained, “You need to try to understand the differences in the types of patients you are treating. If you have an elderly patient, the (pain) medications will work differently in their body then it will in a 30-year-old.” Nurse Roberts described it was easier to manage adults who are experiencing pain, “Because they can tell you what is going on” whereas Nurse Adams believed pediatric patients were easier to manage because, “They tell the truth, they are gripping here (points to her wrist) and you know they have a fracture.” Understanding the differences amongst the patients seen in the ED was an important element of pain management identified by the participants because, the preponderance of participants articulated, “Pain is what the patient say it is” (Nurse Collins).

**Pain Management is Provider Specific**

Thirteen of the twenty nurses described pain management in the ED as being provider specific, meaning nurses identified that certain providers always ordered the same medication for patients in pain. Nurses identified they often knew what was going to be ordered for the management of a patient’s pain based on which ED provider they were working with. “Sometimes if a patient is coming in, I just go and grab my meds, I know where to head (because of which provider they are working with), which is bad, it shouldn’t be like that” (Nurse Daniels). The nurses reported they work with various types of providers including residents, attendings, physician assistants (PA’s) and nurse practitioners (NP). Regardless of the type of provider, the participants overwhelmingly reported providers managed pain in their own specific way, based on the provider’s own experiences, knowledge, education, and practice environment. “I don’t find a difference between the types of providers, but two different doctors will manage it
differently, two different PA’s will manage it differently…it is just their personalities” (Nurse Quinn).

Providers with more years of experience were described as more “set in their ways” and had specific ways of managing pain based on their experience. “We have some doctors that are set in their ways and this is the order set for a painful condition that they use, and they are not going to change that, no matter what” (Nurse Collins). Nurse Matthews agreed with this sentiment, “I think the providers give what they want to give to manage pain, it doesn’t matter what we say.” Nurses described how providers with less ED experience were more open to using pain management treatments that did not always include narcotics. “To me it seems like some of the younger doctors are more aware of what narcotics can do to the patients, and they will try other things” (Nurse Thomas). While the participants described using medications other than narcotics to manage pain in the ED, they did not include non-pharmacological methods of pain management as part of their description of pain management.

**Non-pharmacological Pain Management**

When asked to give an overall description of pain management in the ED, none of the twenty nurses initially mentioned non-pharmacological methods of pain management. They described how difficult pain management was, what an important part of ED nursing pain management was, the types of pain (acute vs chronic) seen in the ED and the various medications used to treat pain in the ED, but none of the nurses mentioned non-pharmacological methods of pain management when providing an overall description of the phenomenon. Eight nurses mentioned non-pharmacological methods for pain management when re-counting positive experiences managing pain in the ED. “It helps if you offer them things like ice-packs, shutting the lights off, closing the door, stuff like that, helps make them more comfortable” (Nurse
Thomas). “I do try to do comfort measures, like positioning, hot packs and cold packs, you know stuff like that” (Nurse Collins). The remainder of the participants needed to be specifically asked about non-pharmacological pain management. Seven nurses described adjunctive pain management therapies used in the ED, such as aromatherapy, music therapy and pet therapy. Four nurses when asked about non-pharmacological pain management in the ED laughed, stating none was used. “Non-pharmacological pain management (laughs) I haven’t seen any or used any (laughs)” (Nurse Newman). Another four nurses indicated there was not enough time in the ED for non-pharmacological pain management in the ED. “We really don’t use (non-pharmacological pain management) anything we learned in nursing (school), we really don’t do that in the ED, we don’t really have the time, and I personally don’t even think about that stuff” (Nurse O’Brien). However, all four nurses, when prompted identified things like distraction, ice, and splinting were frequently used in the ED, but they did not consider those interventions pain management, but rather just part of routine care for certain conditions such as musculoskeletal injuries: “I think we do it all the time, but don’t really think about it as pain management. I think it is just part of the treatment for that injury” (Nurse Adams).

**Education about Pain Management**

Management of acute and chronic pain is constantly evolving. With the opioid epidemic being declared a national emergency in 2016, and the development of new and better treatments for acute pain, up to date knowledge about pain management is an important part of evidence-based nursing care (HRSA, 2020). Nurses in this study had on average 4.65 years of ED experience with a range of 18 months to 19 years. Annual education is a requirement for nurses working in acute care settings. Education is provided to hospital staff including nurses to ensure compliance with Joint Commission regulations and provide updates on standards of care and
safety issues within healthcare organizations. The participants reported they receive annual education on topics such as infection control, HIPPA regulations, patient safety and proper restraint usage to name a few, yet 17 of the 20 nurses reported receiving little or no additional education about pain management since they completed nursing school.

Three nurses reported formal education at their place of employment about pain management. Nurse Newman who began working 18 months ago right after passing her NCLEX described a formal orientation with a class on pain management in the elderly. However, Nurse Newman reported, “Unfortunately, I don’t have her (the nurse educator) as a resource at night because she works during the day, but I did receive education about pain management with the elderly, but that is all the education I received about pain.” Nurse O’Brien also described receiving yearly education on pain management in the elderly and for oncology patients. In addition to the two nurses who recalled formal education about pain management, Nurse Daniels who recently completed her master’s degree in Nursing described her formal education on pain management, “I took something on the opioid crisis, and I took a two-day seminar on heart failure and narcotics, so I have learned a lot about narcotics.” Despite Nurse Daniels education about pain management, there was a dearth of formal education about pain management amongst this population of ED nurses.

Seventeen nurses reported they had little to no additional education about pain management since completing nursing school. Five of the nurses reported they had to complete on-line learning modules annually which included some information about pain management. Three of the nurses who described this type of education were from NJ, one was from CT and the other was from FL. All the nurses that described this method of education reported it was ineffective. Nurse Bishop explained, “You know we do those on-line learning modules about
pain management, that you just click through and take the quiz until you pass (laughs). You never really learn anything; you just get it done.” None of the nurses who described this type of education could recall anything specific that was presented in the on-line learning modules on pain. The remaining 12 nurses when asked about pain management education were unable to recall any type of education or as Nurse Imada indicated, “I’m trying to think if we have any education on pain (pause), not really anything that I can think of on pain, not really anything I can recall.” So, despite the nurses in this study describing pain management as important and a priority only one nurse, Nurse Daniels participated in professional development related to pain management.

**Nurses Describe Patient Conditions**

Thirteen of the twenty nurses described patient conditions or diagnoses, rather than actual patients, when describing positive or negative experiences with pain management. When questioned about a positive or negative experience with pain management the nurses spoke in generalizations “patients with kidney stones are managed well” (Nurse Higgins), or “diffuse abdominal pains are not managed well” (Nurse O’Brien). Many of the situations described were broad and lacked specific patient elements or details, and patients were identified based on diagnosis. All the nurses at some point during their interview described conditions, diagnoses, or situations rather than actual patients when describing pain management situations. Commonalities amongst certain painful conditions was discussed: “Gastroparesis patients are difficult to manage” (Nurse Higgins, Nurse Thomas), or “We have a migraine cocktail” (Nurse Collins), or “Kidney stone patients are managed well” (Nurse Daniels, Nurse Peters, Nurse Stevens).
Eleven of the twenty nurses when asked to describe a situation when pain was managed well in the emergency department cited patients with kidney stones. Nurses reported being more comfortable managing a patient’s pain when they could identify what was causing the patient’s pain. “I think I definitely feel more comfortable giving someone with an obvious fracture or kidney stone a narcotic” (Nurse Adams). Nurse Bishop supported this idea when she stated, “If a patient comes in with a kidney stone we do this, (give IV Toradol) it is a standard order that helps the patients…..Um, whereas for pain you don’t have a cause or diagnosis for, you are more cautious.” Ketorolac, brand name Toradol is a nonsteroidal anti-inflammatory pain medication which can be used to treat moderate to severe pain (Drugs.com, 2019). While the participants described being more comfortable administering a narcotic to a patient with an obvious painful condition, the participants also recounted that standards of care for certain conditions were changing. The participants discussed the use of IV Toradol as part of the standard of care for patients with kidney stones and identified it worked well for managing that type of pain. An additional benefit articulated by the nurses was patients who received Toradol did not experience the negative effects of a narcotic which can include sedation, increased fall risk, and prolonged stay in the emergency department. Nurse Peters explained, “So for instance, with a kidney stone patient, Toradol will work much better than Dilaudid or morphine any day of the week. Morphine is an opioid pain medication used to treat moderate to severe pain (Drugs.com, 2019). That is a great one because you can manage their pain and it is not a narcotic.” Nurses reported that management of certain painful conditions was changing based on new challenges, protocols, and knowledge about how pain should be managed. The challenges and changes as reported by the participants were related to a better understanding of the long-term impact narcotic use had on individuals and society.
New Challenges in Pain Management in the Emergency Department

In 2017, the U. S. Department of Health and Human Services (HHS) declared the opioid epidemic a national crisis; it is not surprising that the opioid crisis and its impact on pain management in the emergency department came up in 11 of the 20 interviews conducted for this study. The nurses described the changes that were occurring in the ED and how pain was managed in response to this crisis. Nurses with more than five years of experience had the greatest insight into the changes that have occurred in the management of pain in response to the opioid epidemic. Nurse Collins who has been working in the emergency department for 18-years stated, “Since I began it is a lot stricter.” Another nurse with five years of ED experience, had a similar perspective, “I would say pain in the ER is managed therapeutically with the lesser volatile drugs, we have gotten away from Dilaudid and morphine, those things that become more addictive” (Nurse O’Brien). Nurses described how conditions such as kidney stones, sickle cell crisis and fractures are often treated first with a non-steroidal such as intra-venous (IV) Toradol, and other non-narcotics such as IV acetaminophen (Ofirmev). Nurses expressed using medications other than narcotics was appropriate, provided a safe and reliable way to manage patient’s pain and was becoming more common since the opioid crisis was declared a national epidemic: “I think it is different (pain management), when I first started, they would just give them the hard stuff (narcotics), but now, providers are starting out with Toradol, IV Tylenol, and stuff like that” (Nurse Thomas). Positive experiences with non-narcotic treatments enabled nurses to advocate for this type of treatment with providers, patients, and families. A participant described one such situation when a patient came in with flank pain and the patient’s wife began to demand narcotics for the patient.

I explained to the wife and to the patient that narcotics are not always the answer for pain, that there are other options…. So, when the provider went in, he agreed with my
assessment, and it looked like a kidney stone, and then I was able to explain to the patient and the wife about Toradol and that it actually works better on a kidney stone than a narcotic does. We were actually able to convince her, and he got his 30 (mg) of Toradol and he was better, and she was happy… At least I was able to educate her that narcotics are not always the best thing to jump to (Nurse Imada).

Participants not only described how pain management was changing while the patient was in the ED, but also how the process was changing for patients who were being discharged with pain medications. It was reported that patients were going home with fewer pills than in the past and providers were frequently discharging patients with less “addictive” medications. “I see a decrease in the amount we are giving them, I see we are referring more to pain management and giving them prescriptions for Motrin, Tylenol, Naprosyn” (Nurse Lake). The nurses identified this as a positive change in pain management, although patients did not always agree. “I give them the information about it (their prescription for non-narcotic pain medication), and they are like, ‘this is all I am getting?’ and I’m like you have to follow up with your primary, orthopedic or urologist, but they are not usually happy with that” (Nurse Higgins).

Participants from NJ and FL described the recent changes in legislation related to discharging patients with painful conditions which stipulates prescribing no more than a two to three-day supply of narcotics for a patient. The updated laws were adopted in response to the opioid crisis to minimize the risk of addiction and the accumulation of narcotics in homes. Nurse Higgins explains, “I feel like now the ED provider does not want the liability of getting a patient hooked (on a narcotic) and it forces them (the patient) to follow up for further treatment with their doctor.” In addition to legislation that limits the number of pills patients with acute pain can be prescribed at discharge, participants also identified the availability of electronic medical records as a change that has impacted pain management in the ED.
Eight participants from NJ, NY, FL, and CT described providers using an on-line tracking system when prescribing opioids for patients at discharge. The on-line tracking systems were developed in response to the opioid crisis, and they enable providers to safely prescribe opioids to patients. Each state specific system allows providers to review a patient’s history of opioid use to reduce addiction and diversion of opioids. Nurse Matthews from FL explains,

I think it is kind of fun, I don’t use it because I am a nurse, but I see the providers use it, and you can literally see everything (prescription pain medication) the patient has filled their entire life on this data base and if they get a high score, we won’t give them a prescription (for a narcotic).

Another nurse explained, “They (the doctors) will pull up a website that can tell if the patient has filled any prescriptions for narcotics recently, if they see that they have (filled prescriptions) they will be more stringent” (Nurse Quinn, CT). The availability of the on-line tracking system was viewed as a positive change. This system provided ED providers and nurses the opportunity to obtain a factual pain management history from their patients to ensure patients who were discharged with pain medication from the ED were not chronic users of narcotics.

**Conclusion**

Management of pain in the ED was described as complex, multifaceted, and situational. Pain was recognized as being subjective and based on the patient’s perspective, requiring the ED nurse and provider to individualize their care of the patient in pain. Nurse participants viewed pain management as an integral part of their role in the ED. Participants when asked to describe experiences managing pain in the ED often depersonalized their patient encounters and discussed patient conditions rather than actual patients. Participants dehumanized their patients in pain, when they described how certain painful conditions were managed rather than provide specific details about patient encounters. The preponderance of participants identified medication as the primary way pain was managed in the ED, and often overlooked non-pharmacological
interventions as an integral treatment option for pain in the ED. The evolving nature of pain management in the ED was also discussed. The opioid crisis although not an original concept explored in this study, came up in over half the interviews as a contextual element that has impacted pain management in the ED. Nurses identified the necessary changes in pain management in response to the opioid crisis and described those changes as being beneficial for the patient. The next chapter expands upon the nurse’s perspectives on pain management and those elements that were perceived as facilitating pain management in the ED.
Chapter V

FINDINGS: CONTRIBUTIONS THAT IMPROVE PAIN MANAGEMENT OUTCOMES

The findings of this study identified the complexities of pain management in the emergency department, with the participants describing elements which facilitated pain management and other elements which inhibited pain management. Chapter 5 identifies elements of pain management in the ED, which participants describe as having a positive influence on how pain is managed, whereas chapter 6 identifies those elements described as hindering pain management. Pain management was considered contextual with the nurse, the provider, the patient, and the ED practice environment influencing the outcome.

Nurse participants described contextual elements that facilitated pain management and made the process easier for the nurse, patient, and provider. These aspects were often elements the nurse had some control over and are described under the five themes of assessment, advocacy, discharge, and medication administration. The nurses articulated how important they believed their assessment was to pain management in the ED as it was the first step to understanding what the patient was going through. They reported they often knew their patients better than the providers because as nurses they spent more time with the patients. The nurses described being empowered by those elements of pain management they could control, such as their assessment of their patients. Participants described the importance of advocating for their patients in pain, and how their ability to advocate had a positive impact on pain management in the ED. The relationship between the ED provider and the ED nurse also facilitated pain management. Participants described really knowing the ED providers they worked with and this enabled them to collaborate with the provider to facilitate pain management. They discussed time and how time influenced how they were able to manage patients in pain. An abundance of time
was perceived as a facilitator of pain management, while a lack of time was perceived as a
barrier to effective pain management. Support staff and adjunctive therapies within the ED were
reported to be facilitators of pain management. The preponderance of nurses identified having
support from other disciplines, unlicensed personnel, and access to adjunctive therapies in the
ED resulted in positive patient outcomes related to pain management. Participants also described
standards of care for painful conditions which contributed to positive pain management
outcomes in the ED.

The Nurse’s Influence on Pain Management

Emergency department nurses take an active role in pain management and the care of the
ED patient. The nurse is often the first healthcare provider a patient meets when they seek
emergency care. Nurses in the ED triage patients and determine level of acuity and who needs to
be evaluated by a licensed individual practitioner (LIP) first, and as such nurses influence how
patient conditions are managed in the emergency department.

Assessment

The Nursing Process is a systematic method with five sequential steps with assessment
being the first step. Assessment involves critical thinking and the collection of both subjective
and objective data. Patients present to the ED with various painful conditions, some of which are
obvious, such as a fracture or a burn. Others are more difficult to diagnose, such as chronic back
pain, or abdominal pain, which often require a comprehensive assessment to identify. In this
study, eighty percent of the nurses identified their assessment of the patient and the situation as
an essential aspect of effective pain management. Assessment of pain was described as
multifaceted, normally requiring initial assessment, frequent re-assessment, and final assessment
before a patient could be discharged. Assessment before discharge was a priority for the nurses
in this study. Nurses described important safety measures included in their pre-discharge assessment for any patient who received pain medication; checking vital signs, level of consciousness, responses to pain medication and gait stability were all aspects of safe pain management.

Participants expressed the importance of reassessing the patient frequently to enhance patient safety, but also noted the impact on patient satisfaction and pain relief: “It sounds so corny, but it really works, hourly rounding and hourly vital signs…sometimes even that little conversation so the patient knows you haven’t forgotten about them, that goes a huge way” (Nurse Giordano). Hourly rounds on patients were also described as being beneficial to provide insight into changes in the patient condition and assisted the nurse with being able to identify an increase in pain level, “so it does not get all the way to a ten” (Nurse Thomas). Frequent and timely assessments were an integral part of effective pain management to “really understand” (Nurse Lake) what the patients were experiencing.

Assessment was described as the “bread and butter” (Nurse Daniels) of nursing. Sixteen of the twenty nurses believed their assessment was an essential attribute of effective pain management in the ED. Effective pain management requires the nurse to “understand what you are looking at” (Nurse Quinn). The nurses spoke about paying attention to non-verbal clues, the context of the situation, and avoiding making blanket statements, because a variety of factors may contribute to the patient’s experience of pain during an ED visit. Participants also described listening to family members or friends who were present with the patient in the ED as part of their assessment, as sometimes patients would not admit they were in pain.

Nurse Fleming who worked on a medical-surgical unit before working in the ED relayed that importance of a comprehensive patient assessment, “On the floor you have a diagnosis, you
kind of know what you are dealing with, sometimes in the ED you are trying to figure out why they are in so much pain.” The nurses articulated they knew their patients better than the provider who was ordering the pain medication, “Assessment is key, it is really important, I know we learn that, but assessment (by the nurse) can actually catch something that the provider may not have seen” (Nurse Daniels). Nurses recounted that they were in the patient rooms a lot more than the providers and that they had a better understanding of what the patient needed or did not need related to their pain management. Providers in the ED were described as “spread so thin” (Nurse Jacobs), “The providers are seeing like 40 or 50 patients, whereas the nurse has eight or nine patients over a few hours, so of course we get to know them (the patients) better” (Nurse Collins). The participants’ assessment of their patients’ pain allowed them to understand their patients’ needs and enabled them to support their patients by being patient advocates.

Advocacy

Provision three of the ANA Code of Ethics (2015), states the nurse must protect and advocate for their patients. Advocacy was a common theme among the participants, with 14 of the 20 participants describing advocacy for their patients as an important part of pain management. The nurses described advocating for more medications, for the provider to assess or re-assess the patient in pain in a timelier manner, or for diagnostic procedures they felt were necessary. One nurse described a situation that exemplified how the ED nurses in this study advocated for their patients.

I had a patient last week and she came in because of abdominal pain wrapping around her back, she was getting Fentanyl and nothing was touching her. So, I approached the doctor and was like I think we need to scan (computed tomography scan) her, and at first, he was like ‘No, I don’t want to scan her’. Okay, she is still in pain there is something going on here. So, he finally ordered the scan, and you know what? She had a dissection! (Nurse Newman)
Participants described their ability to assess and advocate for their patients as important in ensuring the patient’s pain was being addressed and treated appropriately. Appropriate treatment according to the nurses meant managing the patients pain safely and effectively. At times, the participants would request the provider start with less medication or something “not as strong” when managing their patient’s pain. When advocating for his patient Nurse Imada recalls saying to the provider, “The patient is complaining of abdominal pain, at an eight, but they are sitting there texting on their phone and having a conversation and are eating and drinking, so, why are we going for Dilaudid.” Nurse Roberts also discussed the importance of advocating for patients in the ED.

Once you assess the patient and assess the vital signs, build that rapport (with the patient), you can tell the doctor, but you have to be the patient advocate, you know if you don’t think the doctor is giving the patient what they need, fight for them.

Participants noted their ability to assess and advocate for their patients in pain was an essential part of the nurses’ role in pain management in the ED.

Several nurses described experiences outside of the emergency department as influencing their perception of pain management and their ability to advocate for patients with certain needs. The nurses reported situations in which their co-workers were not addressing the patient’s pain and they identified that their previous experiences helped them step in and navigate the situation. Nurse Jacobs who started out as a case worker in a mental health unit prior to becoming a registered nurse described her ability to help assess and manage patients in the ED with mental health issues and pain. She describes a situation in which a patient with anxiety and bi-polar disorder was in the ED and the patient was shouting and demanding pain medication, which was increasing tension amongst the other patients in the ED as well as with the ED staff. This nurse
felt her previous experiences helped her empathize and advocate for the patient and step in and address the patient’s concerns and manage the patient’s pain,

She is obviously in pain, I am not doubting that, but I did feel it was a bit exaggerated, certainly, but pain is subjective, so, it is something as providers we have to figure out and then manage based on the pain, not on how they are behaving. (Nurse Jacobs)

Nurse Matthews who previously worked in oncology identified she was more “empathetic” with all patients in pain than some of her colleagues in the ED because of her past experiences in oncology which enhanced her ability to advocate for her patients in pain, “I try to be empathetic with all patients in pain, because I have seen people suffer with cancer pain and, so I try to understand their pain.” Nurse Quinn who was a former travel nurse stated, “No matter who I am working with or where, I absolutely, 100% will advocate for my patients. I have no problem walking up to any provider and asking for pain medication if I think the patient needs it.”

Participants described advocating for their patients in pain as part of their responsibility and further explained the benefit of having a close working relationship with many of the ED providers.

Nurse’s Relationship with the Provider

The participants described their relationship with the providers as a factor that facilitated pain management in the ED. The nurses described having a good rapport with the ED providers, and that the providers trusted the nurses’ assessments and judgement. This allowed for more timely and seamless care of the patients in the ED, “Once you build that rapport, they trust your judgement, things go much more smoothly in the ED” (Nurse Higgins). Twelve of the twenty nurses identified that once rapport and a trusting relationship was developed with the provider, patient care improved. Nurse Elliott explained,
When we have down time, we talk to each other, we get to know each other as people. You are at least more familiar with who you can go up to and say I think this person needs this or that and know they will listen to you.

In addition to developing a rapport with providers, nurses commented on the proximity of the providers in the ED as a positive influence on pain management. It was described by Nurse Fleming, “I think the fact that the physician is right there makes it easier. You can just walk right up to them…..they are at your disposal because they are sitting right there.” Participants described how the nature of the ED environment in which nurses and providers work alongside each other for up to twelve hours, as an enhancement to nurse provider collaboration. Nurses explained how the proximity of the nurse, provider and patient helped them feel more comfortable advocating for their patients; the collegial rapport supported pain management in the ED.

**Pain Medication Administration**

The ED nurse can influence how and when medication is administered in the ED. Five nurse participants described how they or a colleague made individual choices as to how pain medication was given in the ED, or what the patient was told about the pain medication received. While some of the nurses who discussed this practice felt it was acceptable, others struggled to decide if the practice of influencing medication administration was appropriate.

Two nurses in this study reported they administered Dilaudid as an intravenous piggyback instead of how it was ordered by the provider, as an intravenous push. One nurse described the situation and her feelings about altering the route of administration for this medication,

I was with one of the old-time nurses and she would put 1mg of Dilaudid in 50 mL of Normal Saline and run it over 15 minutes, and I was like ‘Where is the order for this? and she was like oh no, no, no, there is no order this is just how you do it, so the patient does not get high, and I am like wait, what?’ As a nurse you are not supposed to do that, so, I
never did, especially with narcotics, I only give them the way they are ordered (Nurse Adams).

Nurse Giordano explained the purpose of giving Dilaudid in this manner was also to prevent the patient from getting high. “When you give it that way, they (the patient) get the pain relief without the high, although I have never read the research on that.” In this example the nurse altered the method of administration with the rationale of providing benefit to the patient, even though strictly speaking a nurse is required to administer medication using the method prescribed. The two nurses who discussed this method of Dilaudid administration indicated it was done to help manage the patient’s pain, while preventing the patient from having an altered level of consciousness, which can occur with narcotic administration.

Three nurses in this study described patient encounters in which they were administering non-narcotic pain medication to their patients in the ED who were in pain but did not tell the patient specifically what they were giving them. The nurses reportedly did this because they believed most patients assumed narcotics were the only way to treat their pain effectively.

“Lately I have found with Toradol, if you tell them it is similar to a narcotic but just a little bit less, and low and behold they think it is the best thing in the world, and they don’t know it is just a nonsteroidal (laughs)” (Nurse Lake). By not telling the patients the name of the medication they were receiving, but also by not lying to the patients, the nurses described being able to manage their patient’s pain safely and effectively. “I didn’t explain to him (the patient) that it was Tylenol - sometimes I think that helps (with pain management)” (Nurse Jacobs). These nurses expressed the belief that they were justified in providing only partial information about the pain medication being administered, as they described it as a method to improve the patient’s perception of the pain management process in the ED.
If you tell them about the medication but don’t use the name specifically like ‘Tylenol’, and tell them it is going to help, or say it is very strong, it will help them more, then if they know it is just ‘Tylenol’ (Nurse Roberts).

Nurses identified having the ability to influence how pain medications were administered and what information patients received about their pain medication enhanced their ability to provide beneficial pain management in the ED.

**ED Environmental Influences on Pain Management**

The ED environment has been described as a unique setting where highly specialized care is provided to the acutely ill and safety net care is provided to uninsured and vulnerable populations (Hwang et al., 2006). ED patient volume often exceeds available resources such as beds and personnel requiring efficient management of patients and their healthcare needs, which can impact pain management outcomes. Participants discussed the influence the ED environment had on pain management and pain management outcomes.

**Time**

While lack of time was considered a limiting factor for effective pain management in the ED, participants reported that when they had enough time to spend with the patient, pain management was improved. Participants were asked to recount situations in which pain management was handled well in the ED, and while many nurses reported on patient conditions which were handled well, such as kidney stones or fractures, several nurses recounted specific patient situations in which they felt management of the patient’s pain went well. The common theme amongst those situations was the nurse had time to spend with the patient because the ED was not busy.

Two nurses described situations in which time was a contributing factor in improving pain management in the ED. In the first instance an 11-year-old patient came into the ED with a
dislocated shoulder and because of, “The experienced provider, and the ED being calm at that
time”, the patient did not need to receive moderate sedation for her shoulder to be reduced.
“There wasn’t like 50,000 other things going on at that moment, so we had a lot of time and a lot
of people in the room helping us” (Nurse Adams). Moderate sedation is a drug induced
depression of consciousness, which requires extensive management of the patient during and
after the procedure. Therefore, by not using moderate sedation to reduce the patient’s shoulder,
the potential complications associated with the procedure were reduced. In addition, the patient
spent less time in the ED, “Which meant she could leave sooner, we didn’t have to monitor her
for so long, there was less risk of losing an airway, less risk and better for the patient” (Nurse
Adams).

Another participant described a specific patient encounter in which she felt pain
management went well. The nurse related she had more time than usual to spend with the patient
and his family during this encounter. “It was one of those nights, I think it was New Year’s Eve,
so there weren’t a lot of people in the ED” (Nurse Daniels). The nurse reported the patient had
appendicitis and was going to go to the operating room for an appendectomy. Nurse Daniels was
able to spend time with the patient and the mother while they waited for the operating room to be
ready. The nurse reported only having to medicate the patient one time with morphine for his
pain while he waited in the ED. “I think that was one of my best experiences, where I was able to
attend to the patient which helped with the anxiety and pain, and the result was a calm patient
and a calm mom” (Nurse Daniels). The nurse who described this encounter received the Daisy®
award for her care of this patient. The Daisy® award is a national award which recognizes
compassionate, caring, and excellent nursing care.
Nurses rarely described situations in which they had, what they perceived to be enough time to manage their patients’ pain. Only two participants recounted situations in which the amount of time they had to spend with the patient was a contributing factor to a positive patient outcome related to pain management. Other elements that participants described as contributing to a positive pain management experience were the relationship between the ED provider and the ED nurse, as well as supportive personnel and adjunctive therapies that were available in the ED.

Assistive Personnel

Twelve of the nurses discussed how a variety of assistive personnel present in the ED played a part in pain management either directly or indirectly. The nurses who described assistive personnel in the ED, pointed out that patients felt more attended to when there were multiple people going in and out of the room to check on them, “I think the perception of better care can influence how they react to pain I mean getting more updates and having more people in and out of your room can make the patient feel better” (Nurse Adams). Nurse Collins described how the addition of extra personnel in the ED where she works has improved pain management, “Pain is always important, but when it gets busy sometimes the pain has to wait….so they (the patient representatives) can pop their heads in, to buy us some time. It has helped and it works.” Another nurse reported on having pain management specialists in the ED describing how they facilitated pain management for the patients. “We actually have a Sports Medicine Doctor in the ED and he actually did a trigger point injection on a patient, and it worked so well, I was like why don’t we do this more often” (Nurse Matthews)? Licensed and unlicensed staff assisting in the ED (beyond the assigned nurses and providers), was reported to have a positive influence on the process of pain management. At times this was attributed to a specific skill, but at other times
just being looked in on more frequently made a big difference in how patients experienced their pain management.

**Adjunctive Therapies for Pain Management**

Adjunctive therapies for pain are non-pharmacological therapies which have been shown to reduce pain and discomfort such as distraction, aromatherapy, pet therapy, and massage. Adjunctive therapies for pain management are often not available in emergency departments. However, when adjunctive therapies were available the nurses reported they improved their ability to manage their patient’s pain.

Four of the twenty nurses discussed the use of therapy dogs in the ED. The nurses discussed how the use of therapy dogs improved patient’s moods and attitudes while in the ED. “You have these patients that are mean and nasty and are yelling and screaming at you….and the dog walks by and they are a totally different person” (Nurse Imada). The therapy dogs not only improved the patient’s spirits they also lifted the spirits of the nurses. “We have a therapy dog, which you really don’t think would make a difference, but it does. Everyone gets so happy to see the therapy dog, even the staff (laughs)” (Nurse Adams). The improved mood, which resulted from therapy dogs in the ED, improved the patient’s pain management as it provided a means of distraction for the patients. Another adjunctive therapy that was mentioned as a facilitator of pain management in the ED was aromatherapy. Nurse Fleming provided an example of the use of aromatherapy in his facility to augment pain management, “We had a patient who was going for an MRI for a migraine, and we tried a bunch of things (to manage her pain) and nothing was working, so they came and gave her some gauze soaked in essential oils and it helped.” Three other nurses described elements such as snack carts or music therapy, creating a caring environment that facilitated pain management through distraction. Nurse Lake remembered
music therapy being used in the ED where she works. “We have a harp player that comes in once a week, and that helps the patients relax, which helps with their pain.” Nurse Adams also recalled music therapy being used in her ED to augment pain management, “We have a guitar player in the ED sometimes. It helps distract some of our patients.”

Although services such as therapy dogs, music therapy and holistic care teams seemed to improve pain management from the nurse’s perspectives these resources were not available to everyone, “I miss them (therapy dogs), they are so cute, they make everyone so happy, even the nurses. There are fewer resources at night for that” (Nurse Newman). Nurse Fleming stated that the holistic team and aromatherapy used at his hospital for pain management was not available all the time, “The holistic pain management team is only available during the day, which is unfortunate for some of our patients.” The availability of adjunctive therapies served to support the work of the nurses as they managed their patient’s pain. These additional resources provided comfort, distraction, and alternate methods of pain relief for the patients in the ED. Although not available at all facilities and all the time, the participants attributed the availability of these adjunctive therapies as contributing to pain management efficacy.

**Unwritten Protocols or Policies for Pain Management**

Although document review was not part of this study, participants were asked about policies and procedures that were related to pain management. Only two participants were able to recall formal policies related to pain management in the ED. Nurse Fleming stated, “For example we have a standing order for long bone fractures in triage, we can give them 650mg of Tylenol to give them a little bit of relief if they are stuck out (in the waiting room) there for a while.” Nurse Adams recalled a formal policy for management of kidney stones although she could not recall any of the details of the policy. “They have written policies about pain
management for example, for something like kidney stones.” Nine of the participants described standards of care for certain painful conditions. The standards of care varied by the facility and were unwritten protocols that guided pain management in the ED. The protocols were described as unwritten rules that were treatments which the ED staff generally used when managing certain painful conditions. For example, Nurse Thomas recalled a standard treatment for kidney stones where she works, “So, I am not sure why, but we have been giving 15mg of Toradol for kidney stones instead of giving 30mg. That has changed recently - all the doctors are doing it.” Another nurse discussed the standard treatment for kidney stones at the facility where she worked. “We always give Toradol now for kidney stones, which works really well. We used to give a lot of narcotics for kidney stones but not anymore” (Nurse Mathews). Another nurse described the process for managing patients with sickle cell crisis. “The patient will get IV fluid, and oxygen and a non-steroidal until the reticulocyte count comes back. We never give narcotics until that reticulocyte count is back” (Nurse Klein). The unwritten policies were flexible and could be adjusted based on the patient condition or the provider’s preference. Interestingly, the remainder of the participants (nine) could not recall or describe any formal or informal policies or protocols related to pain management in the ED.

Informal protocols that assisted with pain management focused on certain patient conditions such as sickle cell crisis or kidney stones. “The (unwritten) policy was that (for sickle cell patients) your medication at first was to be PO medication….and then based on the reticulocyte count if the patient was really in sickle cell crisis, they would get higher IV medication (narcotics)” (Nurse Quinn). Nurses reported feeling supported and empowered by the unwritten protocols which encouraged certain treatment options, such as nonsteroidal pain relievers, be administered before narcotics. The nurses expressed the need for these unwritten
policies and procedures to become formal policies. They also articulated that standard policies across healthcare settings for the management of common painful conditions, such as kidney stones, migraines, sickle cell crisis and fractures would provide consistency for patients and would also eliminate patients who hospital or provider shop for the chief purpose of seeking a specific medication or treatment. The nurses also discussed informal policies related to the ED discharge process for patients who had been medicated for painful conditions. The participants described that the ED discharge policies were generally informal, and this provided the nurse with a great deal of autonomy in determining when patients were safe to be discharged from the ED and what education patients needed at discharge.

**Discharge Process**

The participants offered descriptions of discharge processes particular to patients who had received some type of pain management in the ED. Six nurses reported their facility had a formal discharge policy for patients who received an opioid while in the ED, while 14 reported there was no formal discharge policy. The formal discharge policies that were discussed by the nurses included elements such as how long the patient needed to wait before they left the ED after receiving a narcotic for pain and how the patient was getting home from the ED after receiving treatment for their pain. “Anytime someone is getting a narcotic in the ED we want to know how they are getting home” (Nurse Peters). Most of nurses reported there was no formal policy or criteria patients had to meet to be discharged. The nurses described they would determine when the patient was safe to be discharged after receiving pain medication in the ED. “I think here it is the doctor, but mostly the nurse who decides when the patient can leave, because obviously if the nurse has some concerns they will speak to the doctor before they let the patient leave” (Nurse Roberts). Nurse Collins identified the discharge process as, “A nursing
thing, a safety thing.” The participants described assessing their patients prior to discharge from the ED to make sure they were safe and able to go home.

The twenty participants worked in 12 different healthcare facilities, indicating some of the participants worked in the same facility as another participant. Participants from the same hospital reported different discharge criteria for ED patients who received a narcotic while in the ED. Nurse O’Brien stated, “There is a hospital policy that they have to wait at least one hour after they are given pain medication.” Nurse Imada who works at the same facility recalled, “So, if they get an IV narcotic, it is a three-hour minimum (before they can be discharged from the ED)….there is nothing I know of for oral medications.” Finally, Nurse Higgins described the discharge process at the same facility, “So, I believe we have a policy (for discharge), I think it is four hours unless they have a ride home.” All three of these nurses who worked at the same healthcare facility had quite a different perspective on the discharge policy for patients who received a narcotic while in the ED.

Most of the nurses reported they had their own standard for when a patient was ready and safe to be discharged after they received treatment for a painful condition. “So there really is no protocol, I discharge based on my standards which are probably different than other people’s standards” (Nurse Stevens). All the nurses in this study reported if the patient received a narcotic while in the ED, they needed a responsible adult to drive them home before the nurse would discharge them. “If someone is getting a narcotic, we want to know how they are getting home, do they have a ride home” (Nurse Peters). The nurses also reported the patients needed to be steady on their feet, able to follow directions and have stable vital signs before the nurses felt comfortable discharging them.
When asked about the discharge process, participants frequently described the education they provided to the patients prior to discharge about pain medication and pain management. Common themes amongst the participants arose regarding education provided to patients and family at the time of discharge. Eighteen participants described educating patients on the potential side-effects of narcotics such as constipation, impairment, and safety issues. “It can cause constipation” (Nurse Matthews), “No driving or alcohol while taking it” (Nurse Giordano), “Don’t make any important decisions while taking it” (Nurse Bishop). Other elements were often included in discharge education by the participants such as, when patients should take the medication. “You should only take them if the pain is really bad” (Nurse Adams). In addition, they identified what alternatives patients should try before taking the prescribed pain medication. “We always tell them to take Tylenol or Motrin first, but if they are having break-through pain then they should take the Percocet or whatever” (Nurse Fleming).

Conclusion

Participants described a variety of elements that had a positive influence on pain management outcomes in the ED. Contextual aspects such as when patients were able to be discharged from the ED, and what information patients received prior to receiving a medication or before being discharged from the ED were elements the nurses in this study could influence to improve pain management. Other elements that the nurses identified they had control over which had a positive impact on pain management were their assessment of the patient in the ED and their advocacy for their patients. Assessment in the ED included initial assessment, ongoing assessment, and assessment before discharge. Nurses commented on the importance of a good and thorough assessment to effectively manage their patient’s pain. Advocacy for their patients in pain was second nature to the nurses in this study who described advocating for their patients.
in a variety of ways to ensure the patient was receiving the best possible treatment of their painful condition while in the ED. The participants described medication administration and discharge procedures as additional areas within the ED that they had some control over. Elements such as additional personnel, adjunctive therapies for pain management and written and unwritten standards of care related to pain management while not within the control of the participants, when present had a positive impact on pain management in the ED. Nurse participants not only described those elements within the ED that positively influenced pain management, but also spoke about difficulties encountered and contextual elements of pain management in the ED that interfered with positive outcomes.

Chapter 6 describes how certain contextual aspects of the ED involving the environment, the nurse or the patient hindered pain management.
Chapter VI
FINDINGS: CONTRIBUTIONS THAT INHIBIT PAIN MANAGEMENT OUTCOMES

The nurse participants identified several challenges to the provision of optimal pain management in the ED. These challenges involved situations particular to the ED environment, the patient and concerns relevant to nursing practice. Themes associated with challenges to the provision of optimal pain management related to ED environment included overcrowding, ED throughput, patient satisfaction and prioritization of care. Participants also identified themes associated with the ED patient and pain management which included patient’s expectations and managing patients with pre-existing conditions. Nurses in this study expressed frustration and disappointment when describing environmental or patient related elements that hindered pain management.

Situations such as overcrowding, patient satisfaction, and patient’s lack of understanding of emergency care, were all areas in which nurses saw little opportunity for influence. ED throughput was another area which impacted pain management. ED throughput is the amount of time between patient arrival and patient evaluation by a Licensed Individual Practitioner, known as door to provider time. The amount of time between patient arrival in the ED and patient disposition, which is either discharge or admission to the hospital is another element of ED throughput. ED throughput time is benchmarked and reported to the Joint Commission and Center for Medicare and Medicaid Services (CMS), which increases pressure on ED nurses to move patients quickly through the ED.

Nurses described patients who had unrealistic expectations about what could occur during an emergency department visit. Patients often expected all their healthcare needs to be met, and the patient was disappointed when they had to follow up or did not leave the ED
completely pain free. Nurses also expressed the challenges they faced managing patients with chronic painful conditions or a history of opioid use disorder. Participants identified difficulty in identifying what was causing patients pain as an inhibitor of pain management. Finally, they described personal elements such as bias and cynicism related to pain management which inhibited pain management in the ED.

**ED Environmental Influences on Pain Management**

Nurses defined a variety of conditions related to the ED environment that had a negative impact on their ability to manage a patient’s pain. In some instances, those conditions were unique to the ED such as overcrowding, hallway beds and ED throughput. In other instances, the environmental factors were related to items not specific to the ED such as prioritization of care and patient satisfaction surveys which are present in all healthcare environments, but in the ED can be impacted by elements such as overcrowding and ED throughput.

**Overcrowding**

Overcrowding is a unique phenomenon that occurs in emergency departments across the country. Overcrowding can occur when there are too many patients for the number of beds within a specific ED. When this occurs patients will often be brought into hallway beds, which are chairs or stretchers placed in the ED hallways where patients can be seen and treated while they await an actual room to be available. Overcrowding can also occur when the number of patients within a specific ED is appropriate for the size of the ED, but there is an insufficient number of staff members to care for the patients within the ED. Overcrowding in the ED was a common phenomenon discussed by participants in this study. There is no standard definition of ED overcrowding and the phenomenon is unique to each ED environment. These nurses
described how overcrowding in the EDs where they worked resulted in lessening priorities for both pain management and pain assessment activities.

Six participants mentioned hallway beds as being part of the ED census. Nurses described how it was more difficult to manage a patient’s pain when they were placed in a hallway bed. Sometimes it is so busy a 12 bed ED turns into 20 bed ED and there are people in the hallway…you can’t even sit down and talk to the patient for five minutes, never mind assess them” (Nurse Elliot). There was little or no privacy for patients in hallway beds and due to the increase in census nurses had less time to interact with their patients. Additionally, patients in hallway beds were frequently unhappy with their circumstances. “With hallway beds, they are unhappy right from the beginning….so, it makes it much harder to manage those patients, because they are not happy where they are” (Nurse Thomas). Placing patients in hallway beds was not within the control of the ED nurse and those that discussed it described how it negatively impacted their ability to manage their patients who were in pain. “

Nurses reported it was “unsafe” managing multiple patients in both the ED rooms and in hallways, thus increasing the stress the ED nurses experienced. One nurse when describing pain management in Florida after a hurricane when patients were placed in hallway beds due to an increase in patient census stated: “It was awful, there were times when I never even saw the patient, never mind assess them or treat them for pain… I couldn’t even find time to medicate them, my God it was horrible” (Nurse Peters). Hallway beds not only increased stress for the nurses in the ED, but they also placed patients at risk, as it was difficult for the nurses to adequately assess and monitor their patients. When discussing hallway beds, the participants were concerned with the safety of all the patients in the ED, “The last thing on my mind when it is busy is pain, I am just trying to keep people alive and safe” (Nurse Peters). Safety during busy
periods in the ED was a concern as was adequate pain management. “When it’s busier and you cannot go and check on them (patients in the ED), to see if their pain is increasing….they get more frustrated which I think makes their pain worse” (Nurse Thomas). Another nurse also reported when it is busier in the ED managing pain is more difficult.

I think as it gets busier you know that patients that you were maintaining at a pain score of four or five and they were tolerating it, it becomes a six or seven when you are busy and then by time you get them their medication their pain level is a nine or 10 and now you are behind the eight-ball. There is only so much you can do in a certain amount of time (Nurse Fleming).

Overcrowding and hallway beds placed an increased burden on the ED nurses as they described how this situation negatively impacted their ability to manage their patient’s pain. This condition also placed patients at risk as the nurses had less time to observe and assess their patients in the ED.

**ED Throughput**

Emergency departments in the United States provide care for a vast number of patients. Improving throughput time, or time from ED arrival to ED disposition, to either discharge or admittance to the hospital is a top priority for most hospitals. Delays in care in the ED can lead to safety issues for patients within the system and can also result in dissatisfaction with care from the patient perspective. Hospital systems frequently try to adhere to industry standards as well as internal benchmarks for the length of time it takes for a patient in the ED to transition from ED arrival to ED disposition.

Fifty percent of the participants commented on the “business” aspect of emergency medicine. Participants described the expectation to “pull till full” as problematic. According to the participants “pull till full” means patients are brought back into the emergency department
treatment area until all beds are full, regardless if the ED nurses and providers are available and ready to manage more patients.

I get you don’t want to have a waiting room full of patients, but you want to give quality care…. Being an ED nurse, you are always pressed for time, you have one patient in, and you have a second patient already waiting for you. (Nurse Daniels).

ED throughput was a common element that the participants discussed. They described how patients were expected to move through the ED quickly and efficiently. The participants described being rushed and unable to provide the care that they wanted to provide to improve ED throughput, “You know they (management) usually want the flow in the ED to be pretty fast, the ED provider will order the patient to get 4mg of Morphine IV, then two minutes later they are discharged, that is a really big problem.” (Nurse Matthews).

Six of the twenty nurses reported that once a discharge order was placed by the provider the nurse had a limited amount of time to discharge the patient. The participants reported a time frame for discharge of as little as “give and go”, meaning the patient received the pain medication then was supposed to be discharge, to ten minutes after pain medication administration. Not all the nurses would adhere to this type of ED throughput and would keep their patients in the ED until they felt like they could safely discharge them. “They want turn over so with these meds (narcotics) they want to ‘give and go’, it’s just not possible. I think legally we should be monitoring them for 45 minutes to make sure they are okay to go home” (Nurse Collins). Participants reported being frustrated with the focus on “metrics” or how quickly things needed to be done in the ED. The nurses indicated their ability to give high quality care was impeded by the need to move patients through the ED in a timely fashion. Seventeen out of twenty participants reported a lack of time needed to address aspects of pain management, whether that was, assessment, follow up, education or discharge in the ED. “With the acuity and
volumes that most ED’s experience I don’t think we can give the kind of care that we want to give our patients to help them manage their pain” (Nurse Stevens). The lack of time was either related to organizational pressures to move people through the ED rapidly or due to an increase in patient volume. Regardless of the cause, the nurses voiced how the frequent lack of time compromised their ability to care for their patients who were experiencing pain. Patient satisfaction with their care and pain management in the ED was another element the nurses identified as being a problematic component of pain management.

**Patient Satisfaction**

Patient satisfaction is an important element in the healthcare industry as satisfied patients will return for more services and will provide recommendations to family and friends. Healthcare facilities want their patients to be satisfied with the care they received and hospital reimbursement for care can be impacted by patient satisfaction scores. Patient perception of the care they received while in a healthcare setting is often obtained through formal, national, standardized surveys such as the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) or the newly developed Emergency Department Consumer Assessment of Healthcare Providers and Systems (ED CAHPS).

Nine of the 20 participants commented on the importance of patient satisfaction surveys and discussed how they believed the surveys drove many of the patient care decisions related to pain management in the ED,

“I mean it is terrible to say, but it all comes down to when they are filling out the surveys. You know they have that question about how was your pain managed, always, sometimes or never, we don’t get credit unless they say always” (Nurse Neuman).

Nurses reported that because patients in pain sometimes had to wait while nurses and providers were managing more critical patients, negatively impacting patient satisfaction. “It’s unfortunate
too, because our (patient satisfaction) scores are going to come from those abdominal pains, our (patient satisfaction) scores don’t come from critical patients” (Nurse Collins).

Participants reflected on situations where they felt providers administered more medications or different medications while the patient was in the ED to garner favorable survey responses or because they did not want the patient to complain. “Sometimes we give people a medication, so that it will shut them up” (Nurse Lake), “It’s sad, it’s the way the providers think is just like give them this (a narcotic) so they (the patients) are not bothering me” (Nurse Daniels). It was also reported that providers were “tired” or “burnt out” and did not want to deal with the patients who were complaining about pain, so they ordered a narcotic for them and then moved on to other patients: “It comes down to the providers, some just don’t care if the patient is there for pain meds, they just want to get them in and out (of the emergency department)” (Nurse Peters). Other nurses reported providers would prescribe more medications for patients at discharge, again to elicit positive patient satisfaction scores: “The doctor would say I am going to give you X, Y or Z, because I want you to receive ‘excellent’ care (said with emphasis), so if anyone asks make sure you tell them you received ‘excellent’ care.” (Nurse Quinn). Words such as disturbing, upsetting, and absurd were used to describe situations in which the participants recalled providers ordered pain medication or narcotic prescriptions to minimize or eliminate patient complaints. An area that participants described as having an impact on patient satisfaction as well as pain management was how care and treatment was prioritized in the ED.

**Prioritization of Care**

While prioritization of care is not unique to the ED, it may be more prevalent in the ED due to the large volume of patients managed in emergency departments. In 2017 over 130 million patients were seen in Emergency Departments in the US (CMS.gov 2020). ED nurses
and providers often need to prioritize care based on which patients require immediate interventions versus those patients that can wait for care. The participants discussed situations where they had to manage patients with more critical conditions over those patients presenting with pain. Participants often identified being conflicted over this choice but described it as a part of what occurs in an emergency department. Nurse Giordano explained,

> I usually come in at 11 (am) and have no patients then, but within 30 minutes I have all new patients, so, I am trying to prioritize what needs to get done and pain management gets lower and lower on the list.

Nurses had to choose between managing someone with a potentially life-threatening condition versus someone with pain. The participants recognized the suffering of the patient in pain, but felt their duty was to the sicker, more critical patient. Patients waiting for pain medication was a common theme that arose. The problem as described by the nurses is the patients’ concern with their situation and their state of health; however, the nurses need to be concerned with all the patients in the ED and therefore, do not always prioritize care in the way patients wish it to be prioritized. Nurse Giordano explained, “That’s the difference when you work in the ED, you have life and death stuff, if you were on oncology, comfort would be a priority, but you can’t always do that in the ED.” Patients in pain often did not understand the delay in care. “They (the patients) are like, I have been here for so long and I still haven’t gotten anything for pain, and you can’t tell them, well next door the patient is dying, and I had to take care of that first” (Nurse Jacobs).

Nurse Daniels described a situation that occurred right after she got off orientation in the ED. She started her shift and was attempting to prioritize care. She went to assess who she identified as a critical patient; an older patient who was experiencing shortness of breath and who was being admitted for pneumonia. She then went to see a patient who had knee pain that
the ED provider suspected was bursitis. The patient with the knee pain according to her account was waiting approximately 20 - 30 minutes for pain medication when she went to assess him. She was unaware that the patient with the knee pain, was a ‘VIP’, which resulted in the nurse participant being spoken to by her supervisor and being reprimanded for a delay in care. The nurse recalled that it was change of shift and she had eight patients that she was responsible for. The incident happened many years ago, yet it still was very emotional for the participant to recall it, and when she spoke about it her voice was filled with emotion.

I cried, I was upset, I was embarrassed in front of my co-workers….It’s hard for them (the patients) to understand you are just one person and trying to prioritize, I mean yeah (sighs) we try our best to prioritize but it’s hard (Nurse Daniels).

Prioritizing treatment of patients in the ED while trying to provide empathetic pain management was at times difficult for the nurses.

Several elements specific to the ED environment were identified by the nurses as being problematic to pain management in the ED. Those elements included ED overcrowding, ED throughput, and prioritization of care. In addition to environmental elements that were determined to impede pain management in the ED, there were also patient conditions which impacted pain management in the ED.

**The Patient’s Influence on Pain Management**

Pain is a subjective phenomenon. According to the Pasero et al. (2016) pain is what the patient experiencing it says it is. Therefore, the patient influences the pain management process. Participants reported that the patient’s perspective, expectations and past experiences influenced how the patient responded to the painful experience and the management of that experience while in the ED.
**Patient’s Expectations of Care**

The participants reported that patients’ expectations about pain management and the care provided influenced pain management outcomes in the ED. The nurses reported that patient’s expectations could be unrealistic regarding pain management in the ED. It was discussed that patient’s impractical view on pain management in the ED was associated with the customer service element of healthcare. Healthcare systems as well as providers seek high scores on patient satisfaction surveys, which the nurses reported to result in certain patients expecting that all their needs would be met during their ED visit. The expectations of certain patients and the customer service element of caring for patients in the ED frustrated the nurse participants. The nurses described how patients often expected to leave the ED “cured” or with absolutely no pain. One nurse summed it up very well when she said,

> You are taking an emergency situation, where the pain is completely unbearable and trying to get it somewhere where the patient is okay to go home. You know they may not have a pain level of zero, but you are getting them out of the acute crisis and getting them to someplace where they can cope or get to their doctor appointment for follow up (Nurse Giordano).

Nurses voiced that although patients would receive treatment in the ED for their painful condition, the patients were often unsatisfied unless they were completely pain free at discharge: “Sometimes we have to get the doctor, because they don’t want to go home, they want to be cured and the doctor will have to tell them there is nothing else we can give them” (Nurse Jacobs). Four of the twenty participants stated if they could change one thing in the ED it would be the patient’s expectations related to pain management in the ED. One nurse’s statement summarizes the participants’ perspective,

> If I could change anything, you know patients come in and think that they are going to be 100% pain free right away and we know that, that is not always the case…Helping people to understand that we are trying to lessen (said with emphasis) their pain because it is not
going to go away in a couple of hours. So, I think that is really all I would want to change right now (Nurse Thomas).

The participants were quite emotional when discussing the patient’s expectations and reported how it was difficult to meet those expectations. They discussed feeling caught in the middle between what the patient wanted and what they knew was in the patient’s best interest: “A lot of patients think they are going to get a narcotic right away, and you tell them you are giving them Tylenol or Motrin and they are not satisfied with that, they want more, which is not good (Nurse Lake). Many of the participants discussed feeling conflicted between wanting to relieve the patient’s pain, but not wanting to give them so much medication that it became a safety risk. “We can’t take all their pain away, if that were the case, they would all be druggies” (Nurse Jacobs).

The participants described that the role of the ED nurse and the ED provider was to provide preliminary treatment for painful conditions and to prepare the patient for discharge and follow up with a primary care provider or specialist. However, patients often expressed frustration with the need to follow up. “Sometimes patients are shocked that they have to follow up, like we are supposed to cure everything, people need more information about what ED’s do” (Nurse Neuman). The participants also described situations in which patients would return to the ED several days after discharge when their medications ran out complaining they were still “not better.” This caused frustration for the nurses as the described ED resources were being utilized for conditions that should be managed in an outpatient setting. One nurse described it as not only a pain problem, but a problem with insurance and access. “People don’t want to wait weeks or months to see a dentist in a clinic or an orthopedic doctor…they want to be fixed right away” (Nurse Peters). Nurses voiced the need for patients and the public to have a better understanding about emergency care and what can be expected from a visit to the emergency department.
Patients with Preexisting Conditions

The nurses reported caring for a variety of patients in the ED who are experiencing pain. Patients may present to the ED with acute conditions that require pain management or chronic painful conditions that need management. Participants described managing patients with chronic pain as challenging and difficult. The nurses expressed frustration and confusion with how to best handle patients who had chronic pain and were already under the care of another provider for their chronic pain and had come to the ED seeking additional pain medication to manage their chronic pain.

Chronic Pain. Nine of the twenty nurses articulated frustration and conflict with patients who presented to the ED in pain related to chronic painful conditions. Nurse Jacobs expressed the sentiment of the nine nurses in this study about chronic pain when she stated, “There are some instances when people come in primarily for pain management and they have a pain management doctor, so, it does kind of (long pause) get looked at in a negative way.” Nurses described prioritizing other patients in the ED over those with chronic pain, especially if the patients with chronic pain were known as “frequent flyers”, which are those patients who come to the ED on a regular basis for pain management issues. The nurses reported the desire to provide quality care for the patients who came in with chronic pain, emphasizing that they did not want to overlook or miss something that might be occurring with a patient who frequently sought pain management in the ED. One participant recalled a situation when she was trying to manage a patient who was having pain but had a reputation as a frequent flyer,

We just had a patient who is a frequent flyer, and everyone knows he always wants pain medication, and he was having chest pain. So, I called the doctor, like I should have, and she yelled at me for calling her. She said, ‘He always does this, like why are you calling me for this?’, and I was like okay I will just put in my own orders for an ECG, and medications. I know he comes in all the time, but how do we know this time his pain is not for real (Nurse Newman)?
Participants believed the patients with chronic issues were having pain but discussed that the management of chronic pain was not something that is easily managed in the ED.

I think acute pain is managed well, but the chronic pain is a problem, I know there is not always a lot we can do for them in the ED, but I don’t think we acknowledge their pain as much as we should (Nurse Matthews).

Nurses reported the management and treatment of patients with chronic pain was dependent on the provider, with some providers managing the pain while the patient was in the ED, but not providing any additional medication for discharge, and other providers not managing the pain at all. This inconsistency was bothersome, as they described not wanting to enable the patients who demonstrated drug-seeking behavior but were empathetic to the patient’s suffering. “I really think we have to stick to the plan (the patient’s pain management plan), which is you do not give them any other pain medications. I know they are hurting but we need to stick to the plan” (Nurse Imada). In addition to patients with chronic painful conditions, nurses identified the challenges associated with caring for patients in the ED with painful conditions who had a history of opioid use disorder or addiction.

**Patients with a History of Opioid Use Disorder.** Four nurses reported on the complexities associated with caring for patients with a history of opioid use disorder or addiction. Nurses expressed empathy for the patients who are recovering from opioid use disorder and are experiencing pain in the ED. Nurse Higgins recounted how patients will tell the nurse they are allergic to morphine or Dilaudid when they are in recovery, because they do not want to receive any narcotic pain medication.

I always feel sorry for recovering addicts who come in for something like appendicitis and they say they are allergic to morphine, and I’m like are you really allergic? And they are like ‘No, but I don’t want that stuff touching me. You will watch them suffer through it, I always try to give them the lower stuff, so something that gives them relief but not the high (Nurse Higgins).
The nurses reported how they attempted to provide patients with alternate methods of pain relief if they were in recovery. They described talking to their patients about ways to manage pain without the use of narcotics and trying to use non-narcotic pain medication when possible to ease the patient’s discomfort. Unfortunately, patients in recovery did not always get their pain managed in an effective way.

One time I had a patient who used to be addicted to opioids and he came in with severe pain from a kidney stone, and I tried to talk to the Dr about it because he ordered 4mg of morphine and he (the Dr) was like ‘No this is what he is getting’. Then I go to the patient, and the patient is like ‘Get that away from me!’ I think Toradol would have been fine for this patient, but the Dr wanted morphine, and the patient refused, so he never got anything for his pain (Nurse Newman).

Management of patients with chronic painful conditions and with a history of opioid use disorder was challenging for the nurses in this study. Implicit bias related to patients with chronic pain was an element that impeded pain management. A lack of current knowledge and at times provider support about how to manage acute pain with medications other than narcotics inhibited participants’ ability to manage pain in a patient with a history of opioid use disorder.

**The Nurse’s and the Provider’s Influence on Pain Management**

The ED nurse and ED provider evaluate patients who present to the ED with complaints of pain. Based on their evaluation of the patient’s condition, a treatment plan is devised, and in this way the ED nurse and the ED provider influence the process of pain management. An analysis the nurse participant responses identified two themes describing the influences on the pain management process. These themes are recognition of the uncertainty of patient’s diagnoses in the ED and the nurses’ personal views and biases.

**Inaccuracies in Diagnosis**

Nurses and providers in the ED are often faced with situations where they are unsure of what is causing their patient’s pain. This was reported as being different than what nurses “on the
floor” experience, as patients admitted to a medical surgical floor have an admitting diagnosis and often a complete health history available. Six of the participants discussed patient situations in which the patient presented with one thing, or in one way, and after spending time with the patient or getting diagnostic tests back, a different diagnosis or condition was identified. One participant described a situation in which the ED provider and nurse thought the patient was having cardiac chest pain, but nothing they did reduced the patient’s pain, only to find out after diagnostic tests were completed the patient was having a gallbladder attack. “So, I think that is a classic example, we are treating chest pain, and it was an abdominal issue, so of course the nitroglycerine didn’t help because it wasn’t chest pain” (Nurse Roberts). The uncertainty about what was causing the patient’s pain resulted in a delay in care. Nurse Klein described a situation with impact on the management of two patients in pain. Both patients presented to the ED with sickle cell crisis simultaneously, one patient appeared to be in severe pain, while the other patient did not appear to be in “that much distress”. After diagnostic tests were completed, the patient who appeared more comfortable was the only patient with diagnostic tests suggestive of sickle cell crisis.

The second kid who we did not think was in crisis at all…this kid was the real deal. He ended up in the ICU because he needed so much pain management and monitoring, and his care got delayed. But because of the presentation and because of the questions we now have today about people’s pain doctors are hesitant to order narcotics for people until we know what is going on, it’s hard (Nurse Klein).

While patient situations can evolve in any healthcare setting, the participants described the complexity of having to try to determine the underlying cause of the patient’s pain with extreme rapidity and sometimes with so little information as to contribute to a negative impact on pain management. Nurse Elliott described feeling “guilty” because her patient came in with pain and went for diagnostic testing only to determine that the patient had a kidney stone and yet remained
unmedicated for pain. “Because we didn’t know what was going on with the patient - so we made him wait for over an hour, and he had a kidney stone!” The uncertainty about what was causing some patients’ pain impeded the nurse’s ability to consistently manage pain in a timely manner. They identified this was problematic and lead to delays in care that negatively impacted patient satisfaction.

He was in the ED for 16 hours and I guess the resident did not feel like there was anything wrong with the patient, so he (the resident) did not want to order a narcotic. So, the patient was pissed because even if he (the resident) ordered something like Tylenol or Motrin the patient would have been happy, but instead the patient walked out, and we never treated his pain (Nurse Lake).

Doubt about what was causing a patient’s pain was challenging on many levels for the nurses. It impacted ED throughput, patient satisfaction, and frequently put nurses in the middle between the patient who was in pain and the provider who was ordering the pain medication. The varied patient presentations in the ED and the complexities of identifying what was causing a patient’s pain impacted the participants perceptions of patients’ pain.

_Nurses Describe Being Skeptical about Patient’s Pain_

The participants recounted being skeptical of patients in pain. Their skepticism was related to previous experiences with patients in pain. Participants described having extensive experience managing pain. The participants described this experience provided them with an understanding of how patients in pain should present and how their painful conditions should be managed.

Thirteen participants described themselves as being “jaded”, “skeptical” or “judgmental” about patients who presented to the ED in pain. Most of the nurses discussed the subjective nature of the painful experience and how pain is what the patient says it is. However, the nurses reported they spent a great deal of their time managing patients in pain in the ED, and therefore
they believed they could tell when patients were really in pain. Nurse Jacobs articulated this sentiment, “Once you get a couple of years of experience you can pretty much tell when someone is in legit pain and when someone is asking for too much medication.” The nurses would describe how at times they would doubt or become skeptical when a patient did not present in a way that was consistent with their view of a patient in pain. “Some people come in asking for Dilaudid for a headache, you don’t give that, you give Tylenol, relaxation, dim the lights…when someone comes in asking for a narcotic your antennas go up” (Nurse Klein).

Nurses identified things that made them more cautious when managing a patient’s pain. Elements that were concerning included patients driving past other health care facilities for treatment and patients requesting specific pain medications or doses. Three nurses mentioned patients driving past other hospitals or health care settings to seek treatment in their ED as a concern. “A patient just came in the other day with a migraine but took a taxi all the way from Jersey City (laughs). There are so many hospitals on the way, we were like why would they come here” (Nurse Fleming)? Participants described being vigilant with certain patients and in certain situations, especially if the patient requested certain medications or doses to manage their pain. Ten of the 20 nurses recounted situations in which patients requested certain medications to treat their pain. Nurse Bishop provided a generalization about patient’s behavior when they request specific medications for their pain, “The patient will state ‘I need 2mg of Dilaudid, that is the only thing that works for me’, and they would be unhappy if they don’t get that specific type and dose of medication.” Nurse Newman explained an encounter with a patient who complained about the care she received in the ED because according to the participant, “I gave her Dilaudid, which she obviously needed, but we weren’t giving her, her ‘usual dose’ of Dilaudid. So, she complained, and my chart was audited.” Encounters such as this made the nurses cautious and at
times hypercritical with certain types of patients who presented to the ED with painful conditions. “I wish there was something we could do to stop or identify the patient who is drug seeking, trying to stop that behavior would make things so much better for us and them (the patients)” (Nurse Fleming).

Participants described negative past experiences with pain management as having an impact on their current perception of patients in pain.

I am from Ft. Lauderdale and our issue here is the opioid epidemic, it is bad so, you automatically assume someone is pain seeking when they come in the door. I am not proud of that, but that is how it is (Nurse Peters).

The nurses who discussed being cautious or skeptical about patients in pain, were aware their viewpoint was not how they should perceive patients in pain. They tried to treat each patient as an individual and not allow past experiences to influence their current management of pain, but also recognized they were not always successful in that endeavor. Nurse Imada described this conflict when discussing patients who present to the ED with painful conditions that are not obvious like a fracture or kidney stone. “I hate to be insensitive but spending eight years in Newark with a lot of addicts and stuff, it has kind of made me skeptical about those things I can’t see in front of me.”

Participants identified personal elements such as personal or family history with pain as impacting their viewpoint of patients in the ED with pain. Nurse Collins and Nurse Adams described family members who had surgery or chronic painful conditions and who managed with little or no pain medication, and Nurse Lake described her own painful condition but stated “I rarely take anything more than Motrin, and then it has to be really bad.” One nurse described his personal experience with pain and felt if he went to the ED for pain he would not be judged harshly:
I will use myself as an example. I was seen in the ED once for abdominal pain, but that was like four years ago. I think if I went to the ED again for pain, I don’t think people would be jaded about me, because I don’t go the ED that much, but that is not always the case with the patients we see (Nurse Fleming).

Nurses also articulated it was harder to be empathetic to patients in pain when they were tired or overworked. “I am just coming off three 12-hour shifts, and you know when you get to the end of that, you are less likely to believe patients when they report pain, and they don’t look like they are in pain” (Nurse Adams). Personal elements such as previous work history, personal experience with pain, previous negative encounters with pain management and fatigue had a negative impact on the nurses in this study ability to effectively manage pain. The personal experiences and viewpoints of the nurses impacted their perceptions of pain and had an influence on how they managed their patients’ painful conditions.

The findings in the study describe pain management from the ED nurse’s perspective. Pain management was identified as being dichotomous and situational. Nurses recognized the environment, the patient, the nurse, and the provider all influenced the process. A discussion follows which elaborates on the themes, elements and contextual aspects identified by participants and their impact on the ethical tenets of pain management in the emergency department.
Chapter VII
DISCUSSION OF FINDINGS

The goal of this study was to explore and describe pain management in the Emergency Department (ED) from the nurse’s perspective. Pain management in the ED from the nurse’s perspective has not been described in depth in the literature. The literature review (presented in chapter 2) discussed a substantial amount of published research that explored barriers to effective pain management in the ED, discharge from the ED for patients in pain, and nurse’s perspectives on patients in pain, yet no evidence was found that pain management in the ED from the nurses’ perspective was explored in a comprehensive way.

The nurse participants were asked to describe pain management in the ED and describe situations when pain management went well and situations when pain management did not go well. They described elements which facilitated pain management and elements which inhibited pain management. Knowledge of the first-hand experiences of ED nurses adds valuable awareness into behaviors, attitudes, and resources which they consider helpful in the management of a patient’s pain. Moreover, the participants shared their insight and feelings about elements which inhibit effective pain management, and ways to improve pain management in the ED.

Pain management in the ED is a complex phenomenon. Pain is a universal phenomenon and affects more people in the United States than cancer, diabetes and heart disease combined (AAPM, 2011). It has been reported that over 70% of ED visits in the United States are related to a painful condition (Todd et al., 2007). Research exploring pain management in the ED has been primarily focused on retrospective chart reviews, patient, and provider perspectives, with limited research from the nurse’s perspective.
The IOM (2011) report *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education and Research* identified pain as an undertreated condition leading to an increase in healthcare expenses and an increase in patient suffering. The IOM report identified one of the barriers to effective pain management is healthcare provider’s knowledge deficits about pain and pain management modalities. Other suggested reasons for inadequate pain management include ED patient volume (Bergman, 2012; Hwang et al., 2008; Hwang et al., 2010), and patient conditions such as age, gender, race, and past medical history (Gorawara-Bhat et al., 2017; Minick et al., 2012; Neighbor et al., 2011). The IOM report recommended research across healthcare settings and professions as a method to identify gaps in knowledge and improve pain management education. The findings from this study address some of the gaps in nursing knowledge that were identified and address the lack of research on pain management from the ED nurse’s perspective.

The contributions of this study are discussed in three parts through an examination of the findings. The first part describes the participants’ view of pain management in the ED. Although not a topic originally intended to be explored in this study, the opioid crisis and its impact on pain management practices in the ED is described by the participants. The second part discusses the participant’s descriptions of components which facilitated pain management. The third part describes those elements which impeded or inhibited pain management in the ED. It is hoped that the facilitators and barriers to pain management as described by the participants will contribute to a better understanding of pain management in the ED.

**Ethical Tenets of Pain Management in the Emergency Department**

Pain management is a fundamental aspect of emergency department care. This study has identified attitudinal and structural barriers to effective pain management in the ED, as well as
attitudinal and structural facilitators to effective pain management. The difference between effective and ineffective pain management can be related to the subjective nature of pain, implicit biases on the part of nurses and patients about pain management, and the brief, yet intense interactions typical of an emergency department visit. Participants described the struggles they faced when managing patients who presented to the ED with pain. They expressed frustration, guilt, and anger when things did not go well. They also described being jaded, or unsure if patients were ‘really’ in pain. Providing pain management in the ED was described as difficult and filled with uncertainty. The decisions made by the participants in this study about pain management involved moral and ethical elements, which not only impacted the patient but also the participants in the study. A discussion and interpretation of the findings speaks to the professional challenges ED nurses face in their efforts to manage patient pain in the ED. Some behaviors and viewpoints are in harmony with the ethical tenets of the nursing profession and others present challenges to the ethical principles of the nursing profession.

**Autonomy**

According to the American Nurses Association (ANA) the Code of Ethics for Nurses is a guide for the profession and is a social contract with the public (ANA, 2015). Provision 1.4 of the Code of Ethics reminds the nurse that patients have the right to self-determination otherwise known as autonomy. Autonomy denotes the patient has the freedom to make choices about issues that affect one’s life (Burkhardt & Nathaniel, 2013). Patient autonomy is a cornerstone of the nursing code of ethics, although it is one that is often difficult to fully implement, as evidenced by the challenges faced by the nurses in this study.

There was a dearth of evidence in the literature that a patient’s autonomy was considered when their pain was managed in the emergency department. The participants in this study
explained pain was subjective, and that pain is whatever the patient says it is. Participants identified that the patient had influence over the pain management process through their participation in the process and their perceptions about the care received. This contrasts with findings from other studies that focused on the nursing interventions or assessments related to pain management where the patient was a passive participant in the process. In a qualitative study exploring ED nurses’ experiences managing older adults’ pain, the researchers identified themes associated with challenges in managing pain and strategies the nurses promulgated to overcome the challenges in pain management, with no mention of the patient’s influence over the pain management process (Gorawara-Bhat et al., 2017). Bergman (2012) described the ED environment as an inhibitor to the nurses’ ability to care when managing a patient’s pain but was silent on the patient’s ability to participate in the pain management process.

Two overarching themes related to patient autonomy and their right to self-determination were derived from the analysis of the data from this study: (a) patients in the ED have an influence over the pain management process and (b) the nurse supports the patient’s right to self-determination by providing guidance to patients and families about pain management treatment. Participants identified patients contributed to the management of their pain by advocating for themselves. The participants described how patients often understood their pain and would at times request certain medications and doses that the patient believed would alleviate their pain. At times, the nurses were frustrated by the patients requesting certain medications, but in other instances they recognized the patient had a better understanding of their pain than the nurse did. The nurses in this study supported the patient’s right to self-determination. Previous research indicates that ED patients are more satisfied with their care when they perceive staff care about them as an individual (Newcomb et al., 2017). The nurses described the importance of talking to
their patients to really understanding what the patient was going through to effectively manage their pain. They described the influence the patient’s past experiences with pain had over their present circumstances. In addition, they described their frustration when providers treated diagnoses and symptoms rather than patients. Although participants in this study wanted standards of care for certain painful conditions, they identified being uncomfortable when care did not reflect the uniqueness of the individual patient.

**Violation of Patient’s Autonomy.** Nurses in this study supported patient autonomy; however, there were subtle violations of their patient’s autonomy that went unrecognized by the participants. As previously described in chapter 4, participants frequently described patient conditions rather than actual patients when recounting situations about pain management. Participants when asked to describe situations in the ED related to pain management would utter phrases such as “kidney stones are managed well”, or “migraines are hard to treat.” Describing actual patient circumstances was often hard for participants who were “unable to recall” specific situations, this dehumanized the patients they treated. By dehumanizing patients and describing conditions rather than actual patients, the individuality from their narrative was removed and patients became conditions rather than individuals who were in pain. Caring in the emergency department has been defined in the literature as “taking care of my clients physically and emotionally” (Enns & Swatzky, 2016), and being “genuinely concerned” for their patient’s wellbeing (Wiman & Wikblad, 2004). When nurses described patient conditions rather than actual patients, they reduced the patient to a disease or condition, which compromised the nurse-patient relationship and limited the nurse’s ability to individualize the care they provided. Participants in this study provided examples of pain management that was not individualized, but
rather based on a patient condition or pre-determined treatment routine, which negatively impacted patient outcomes.

Another way the nurses in this study violated the autonomy of their patients was when they described the ability to “know when someone was really in pain.” Participants purported they knew when someone was really in pain, based on the patient’s behavior and mannerisms, as well as their experience managing patients in pain. This attitude assumes the nurse, because of their professional knowledge, knows what the patient is experiencing and in turn what is best for the patient (Burkhardt & Nathaniel, 2013). The idea of the nurse “knowing” when the patient in the ED is in “real” pain is not a new phenomenon identified in this study, but rather has been reported in previous qualitative explorations into pain management in the ED. Bergman (2012) reported participants were often frustrated with patients who “manipulated the pain scale”, with one participant stating, “I really don’t believe the patient is experiencing that kind of pain” (Bergman, 2012 p. 222). Gorawara-Bhat et al., (2017) study also reported participants frequently identified a mismatch between a patient’s pain level and the patient’s behavior. This led to the nurses relying on their assessment of the patient’s pain rather than the patient’s reported pain score when directing treatment.

While patient autonomy was an important part of pain management in the ED, there were times when participants described situations that violated patient’s autonomy and were paternalistic in nature. Nurses “knowing” when patients are “really” in pain and dehumanizing their patients by describing conditions rather than actual patients, may inhibit effective pain management in the ED, and can impede the development of the nurse-patient relationship.
**Beneficence and Non-Maleficence**

The principles of beneficence and non-maleficence are related to each other and require the nurse to act in ways that benefit the patient and reduce or eliminate harm. Beneficence and non-maleficence lay the groundwork for the trust that patients place in the nursing profession and in particular nurses (Burkhardt & Nathaniel, 2013). The concept of doing no harm to the patient is an integral to the profession of nursing and it is stated in the ANA *Code of Ethics for Nurses* (2015), which proclaims, “The nurse promotes, advocates for, and strives to protect the health safety, and rights of the patient.”

**Opioid Crisis’ Impact on Pain Management in the ED.** Advocating for patients was a primary consideration for nurses in this study. The participants described advocating for their patients in a variety of situations ensuring the patients they were caring for were receiving the best care. Participants identified the need to advocate for their patients who needed more pain medication, as well as advocating for those who may have required less or different types of pain treatment. The phenomenon of the opioid crisis was not an aspect of pain management that was specifically explored in this study, but its impact on patient care and its influence on changes in pain management came up in over fifty percent of the interviews. This is especially notable as previous studies which explored pain management in the ED from the nurse’s perspective were silent on the impact of the opioid crisis and its influence on pain management practices in the ED.

The preponderance of participants in this study described wanting to protect their patients from the harm associated with the use of opioids and the long-term effects of opioid addiction. Participants described educating patients and families about the deleterious effects of opioid use, and about alternative pain treatment modalities which were deemed effective but not addictive in
nature. Nurses were alert to the harm that the use of opioids could cause their patients and that alternatives to opioid use would be more beneficial in some situations. They recognized that in some instances the use of opioids was necessary and prudent but identified the need to explore the benefits and risks of opioid use in the ED. Consistent with recommendations from Waszak & Fennimore (2017) nurses in this study were mindful of the opioid epidemic but did not instinctively undertreat pain. They also assisted with communication between patients and providers about the safe and effective management of pain ensuring minimal risk of harm to the patients under their care. According to Waszak & Fennimore (2017) ED nurses play an essential role in communicating with providers, patients, and their families in managing pain which facilitates patient-centered pain management.

Previous research has indicated approximately 17% of patients discharged from emergency departments in the United States are discharged with a prescription for an opioid pain reliever, with small pill counts and an immediate release formula (Hoppe et al., 2015). Consistent with the theme of ‘do no harm’ and with previous research, participants recounted how patients discharged from this ED after treatment for a painful condition were less likely to be discharged from the ED with an opioid prescription than in the past. It was explained that if patients were discharged with an opioid prescription, these patients were receiving fewer pills than in the past. Participants also discussed the use of on-line prescription drug monitoring program (PDMP) by providers to ascertain ED patient’s history of opioid use. Participants described the use of the on-line PDMP as a safety feature which mitigated the risk associated with patients leaving the ED with an opioid prescription, supporting the ethical principle of non-maleficence. One study demonstrated the use of PDMPs impacted ED opioid prescribing practices in 41% of cases (del Portal et al., 2015). Another study reported that only six percent of providers use the PDMP for
every prescription they write, although 63% of providers reported being satisfied or very satisfied with the on-line prescription drug monitoring system (Pomerleau et al., 2016). Clearly access to and use of PDMPs can remove some of the uncertainty associated with discharging a patient from the ED with an opioid prescription.

**Discharging Patients from the ED.** Another example of the application of the ethical principle of beneficence was in the discharge process as described by the participants. The nurses described the discharge process from the ED for patients who were treated for a painful condition as variable, depending on not only the location of care, but also the provider and the nurse. Consistent with the findings from Wolf et al. (2015) qualitative study about the discharge process in the ED for patients who received a Schedule II or III narcotic, the determination of patient readiness for discharge was left largely up to the nurses. With no objective or evidence-based measures to determine if patients were safe and ready to be discharged, nurses were left to use their clinical judgement to determine discharge readiness. Previous research has identified how the lack of objective measures to determine discharge readiness could lead to nurses holding onto patients in the ED longer than needed to prevent the influx of more patients into the ED treatment area. Additionally, it has been suggested that nurses might prematurely discharge patients from the ED to improve throughput or empty out the department (Wolf et al., 2015). The findings of the present study accentuated the importance of evidence-based, objective measurements to determine discharge readiness for patients who received an opioid while in the ED.

Nurses in this study commented on keeping the patients in the ED for a longer amount of time than what was ordered by the provider to ensure that the patient was safe to be discharged. Most of the nurses in this study would not allow patients to drive themselves home after
receiving treatment in the ED with an opioid. This public safety concern is consistent with the results from the one previous study that explored the discharge process for patients who received an opioid while in the ED (Wolf et al., 2015). Another commonality amongst these two studies were both groups of participants identified patients needed to have stable vital signs prior to discharge, although neither group provided a concise definition of what “stable vital signs” meant. Concern for the patient’s safety and safety of the public extended beyond consideration of when the patient was safe to leave the ED; nurses in this study described how they educated their patients about the prescriptions given at discharge.

Nursing practice includes educating patients and families about treatments to ensure safety, compliance and to promote self-care. The literature is silent on nursing education provided to patients in the ED about opioid pain medication. Participants in this study recounted the education that they provided at discharge for patients who were leaving the ED with a prescription for a narcotic. The preponderance of participants in this study were concerned with what information the patients received at discharge regarding their narcotic prescription. Nurses instructed patients on the risks associated with taking a narcotic. A 2014 study reported 42% of adults prescribed an opioid at ED discharge self-reported misuse of the opioid and the most common reason of misuse was escalation of the dose, which underscores the importance of the education provided to ED patients at discharge (Beaudoin et al., 2014).

The nurses in this study provided education at discharge about the side effects of opioids such as confusion, constipation, unsteady gait, and risk of falls and accidents. Patients were instructed to only take the prescribed medication if their pain “was really bad” and to try other forms of pain management, such as Motrin or Tylenol first. Patients were also instructed not to drive when taking the prescribed medication. The education provided by participants in this
study is consistent with Waszak & Fennimore’s recommendations for safe delivery of opioid therapy in the emergency department. Interestingly, participants did not educate their patients about what to do if they did not use all the medication prescribed to them. This is a requirement set forth by The Joint Commission 2018 Pain Standards for patients discharged with a narcotic to prevent diversion and misuse. The findings from this study about education provided at discharge can contribute to the understanding of pain management in the ED.

**Non-pharmacological and Adjunctive Methods of Pain Management.** When asked to describe pain management in the ED participants were silent on the use of non-pharmacological pain management and adjunctive therapies. Alternative methods to manage patient’s pain, such as distraction, hot and cold therapy, and splinting while elements of nursing education and easily available to ED nurses was rarely considered by participants in this study as a safe and effective way to manage patient’s pain while minimizing risk of harm. Nonpharmacological approaches to pain management tend to be easy and safe to implement (Barr et al., 2013), and according to TJC (2018) must be offered to patients as part of a comprehensive pain management plan. Research has indicated that cryotherapy, distraction, and breathing and relaxation techniques can decrease pain in adults who have musculoskeletal trauma or a surgical intervention (Drahota et al., 2012; Wong et al., 2010).

There is a dearth of literature exploring the use of non-pharmacological pain management modalities in the ED. One study exploring the triage nurse’s perspective on pain management in pediatric patients noted that nurses with more years of experience were more comfortable with using methods such as splinting and distraction as a means of managing pediatric patient’s pain (Thomas et al., 2015). When questioned about adjunctive therapies and non-pharmacological methods of pain management, years of experience was not a factor for participants in this study.
The use of alternative methods of pain management was related to the availability of adjunctive therapies and the nurse’s personal beliefs about the effectiveness of adjunctive therapies and non-pharmacological pain management modalities. Some participants laughed when questioned about adjunctive therapies such as aromatherapy and non-pharmacological modalities such as distraction and massage. While others stated, they did not have time to use alternatives to medication for the management of pain in the fast-paced ED environment. Although evidenced based methods to reduce pain such as cold therapy (ice packs), distraction or breathing and relaxation techniques could be implemented quickly and easily in most healthcare settings, including the ED, participants rarely identified these methods as feasible options for pain management in the ED. With evidence supporting the use of alternatives to opioids in the management of pain, and the understanding of the deleterious effects of opioid use, under the ethical principle of beneficence it would be prudent for ED nurses to consider alternative methods of pain management when appropriate.

**Veracity**

Veracity refers to the practice of being honest or telling the truth. Being honest and open with patients is promoted in the ANA Code of Ethics (2015). Truth telling promotes trust and a shared responsibility between parties. Lying or avoiding disclosure is paternalistic, implying the nurse knows what is best for the patient, which also violates the patient’s autonomy (Burkhardt & Nathaniel, 2013). In the current study twenty percent of the participants described interactions with patients that lacked veracity. Participants were committed to facilitating the pain management process; however, at times they delivered partial truths. Nurses described telling the patients that they were getting medication that would help their pain, and they were “very strong and almost like a narcotic” when they were administering nonsteroidal anti-inflammatory
medications such as Toradol. The nurses who described this practice felt this method allowed the patient to believe they were getting something strong enough to manage their pain and would enhance their response to the intervention. A 2016 meta-analysis which explored the impact expectation interventions such as verbal suggestions given by a healthcare provider about pain medication demonstrated verbal suggestions reduced pain by 1.39 points on a scale of 1-10 (95% CI 0.85-1.93) (Peerdeman et al., 2016). This study indicates that the practice described by the nurses of suggesting to the patient that pain will be relieved after the administration of “very strong” medication, can be effective for actual pain relief. Although the nurses were not being completely honest with their patients when they did not explicitly tell them what kind of medication they were receiving, they were in fact enhancing their patients’ response to the pain medication and thus improving pain management.

Participants also described situations when the nurse administered pain medications in a manner other than the way the provider’s order read. This occurred when nurses administered Dilaudid, a potent narcotic, as an intravenous piggy-back instead of as an intravenous push medication as it was ordered. The nurses perceived this to be a safer method of medication administration although the nurses who disclosed this admitted they were unsure if their perception of safety was supported by evidence. Currently, references for Dilaudid administration reveal the medication can be administered as an intravenous push over two-three minutes, or as a continuous infusion at 0.5 – 3 mg/hr, there is no mention of administration of this medication as an intravenous piggy-back (IVPB) (Micromedex-hydromorphone, 2020). There is an absence of literature to support the idea that administering Dilaudid as an IVPB is an effective and safer way to manage pain. In addition, by administering medication in a manner
other than how it was prescribed the nurse was practicing outside of their scope of practice. This behavior violates The Joint Commission regulations as well as State specific nurse practice acts.

**Justice**

The ethical principle of justice relates to the fair and appropriate treatment of a patient in a similar situation to another patient (Burkhardt & Nathaniel, 2013; Venkat et al., 2013). Emergency Departments in the United States are a tangible example of the ethical principle of justice as ED’s are required to treat all patients without consideration of ability to pay or other societal factors under Emergency Medical Treatment and Labor Act (EMTALA) (Venkat et al, 2013). Under EMTALA Medicare participating hospitals are required to provide a medical screening to patients who request treatment of an emergency medical condition, including labor, regardless of ability to pay. Hospitals are also required to provide stabilizing treatment for patients who have an emergency medical condition (CMS, 2021). Although the EMTALA law ensures patients who present to an emergency department will be treated regardless of socioeconomic status, the ethical principle of justice was difficult to implement consistently for the participants in this study. Elements such as ED census, ED nurse and provider bias, and special treatment for ‘VIPs’ added to the challenges of providing pain management equitably for the participants in this study.

**Overcrowding in the Emergency Department.** Distributive justice refers to the distribution of good and services, and unfortunately there is a finite amount of goods or services especially in healthcare, which can lead to some patients not receiving the care they require. This is especially true in an emergency department that is required by law to screen and treat any patient who seeks treatment at their facility. Sometimes demand greatly exceeds the supply of resources, such as beds, staff and even supplies. Participants frequently spoke of overcrowding
and hallway beds, which are stretchers or chairs where ED patients can be treatment when all rooms are occupied. Hallway beds and overcrowding in the ED placed an increased burden on the nurses. The participants described ‘caring’ for so many patients when the ED was crowded, that they never even saw some of the patients they were responsible for. They recalled diagnostic tests being completed and patients being ready for discharge before the nurse even had time to assess the patient. They recalled not even having five minutes to sit down to talk to their patients. As one participant stated, “The last thing on my mind during times like that is someone’s pain, I didn’t care, I was just trying to keep people alive and safe” (Nurse Peters). Participants expressed remorse and frustration when they were unable to provide the care, they thought their patients needed or deserved, due to the volume of patients in the ED. On the other hand, two nurses recalled having time to spend with their patients especially when the ED was quiet enhanced their ability to manage their patients’ pain. Participants identified having time enabled the nurse to provide high quality care which resulted in better patient outcomes and improved patient satisfaction with their ED visit. The participants recognized they could not control patient volume and ED overcrowding was an element of the ED environment that was unlikely to change.

Overcrowding is a phenomenon specific to emergency departments and there is no universal definition of what constitutes overcrowding. It has been suggested that each ED may have its own threshold at which patient volume begins to impact patient care. One study found that at an ED census level of 120% hip fracture patients were less likely to have an initial pain assessment ($p = .05$) and waited longer for pain medication ($p = .01$) (Hwang et al., 2006). Another study identified that during periods of high ED census patients were less likely to receive any pain medication and specifically NSAIDS. This study also identified during periods
of high ED census there was a delay of more than 60 minutes for pain assessment and analgesic administration when compared to periods of low or normal ED census (Hwang et al., 2008). Previous research has identified ED nurses feel overwhelmed by the volume of patients being treated in the ED (Bergman, 2012), and this increase in workload inhibits the nurse’s ability to provide the care their patients deserve. “Sometimes you can just provide very minimal care and sometimes not even that” (Enns & Sawatzky, 2016). The findings from the current study support previous research and provide insight into the impact ED overcrowding has on both the patient and the nurse.

**Patients with Comorbidities.** Patients who present to the ED for treatment often have underlying health issues. When caring for patients who are in pain in the ED underlying health issues and pre-existing conditions need to be considered. Nurses described inequities in the management of two specific groups of patients who present to the ED with painful conditions, those with chronic pain and those with a history of drug use/abuse. Participants often referred to patients with chronic pain as “frequent flyers”, which are patients who use the emergency department on a regular basis for care. This term is not unique to the population in this study, as participants in the Bergman (2012) study expressed frustration with “frequent flyers” who use the ED for their pain management needs.

Nurses recounted patients with chronic pain being treated differently from those with acute pain, violating the ethical principle of justice. There was both an implicit and explicit bias identified in this population towards patients with chronic pain. “Patients with chronic pain are looked down upon” (Nurse Imada). Nurses discussed that patients with chronic painful conditions exaggerated their pain and manipulated the system to get treatment. They stated there was doubt about the severity of a patient’s pain when they had a history of a painful condition.
This doubt would lead to delays in care and skepticism on the part of the healthcare team, who often wanted “proof” of the patient’s pain by diagnostic tests. Nurses described situations where providers would not order any treatment for ‘frequent flyers’ who presented to the ED for pain. One nurse recalled getting yelled at by an ED provider when requesting orders for a frequent flyer who was presenting to the ED for cardiac-type chest pain. This suggests patients with a chronic painful condition were treated differently than those who presented to the ED with similar symptoms or conditions but did not have a history of pain. Previous research that explored ED nurse’s attitudes and beliefs towards people with chronic pain suggests ED nurses have negative beliefs and attitudes towards people with chronic pain (Martorella et al., 2019). Interestingly this study identified ED nurses who had a history of chronic pain were associated with better beliefs and attitudes towards patients with chronic pain. However, in this study this was not the case. One participant described having chronic pain but discussed her frustration with ED patients who have chronic pain and are unable to manage their symptoms effectively at home. Another nurse in this study whose mother suffered from chronic pain but only uses holistic treatments for pain management identified that she “doesn’t believe” in narcotic use for chronic pain treatment. The findings from this study may assist with identifying the determinants of the stigma associated with chronic pain and provide additional insight into ED nurse’s attitudes and beliefs about patients with chronic pain. This could facilitate education and interventions to reduce the ED nurses’ negative feelings towards patients with chronic pain.

**Patients with Opioid Use Disorder.** Another sub-population of ED patient that participants in this study recalled being treated differently when presenting to the ED for a painful condition were patients who were in recovery from opioid use disorder. Nurses recalled the challenges associated with caring for patients who were in recovery and who presented to the
ED in pain. Some of the challenges were associated with the patients not wanting to receive pain medication for fear of becoming addicted again. This resulted in patients claiming they were allergic to certain medications and being undertreated for their painful conditions. Nurses expressed empathy for the patients and would often advocate to the ED provider for alternates to narcotics when managing the patients in pain who had a history of opioid use disorder. Unfortunately, providers were often unwilling to alter their standard orders for the patients who were in recovery, leading to undertreatment of the patient’s pain and unnecessary suffering. The ethical principle of justice is based on the idea that people with similar diagnoses should be treated in a similar manner; however, patients may have different analgesic requirements despite sharing the same diagnosis (Pasero, et al., 2016). Therefore, the lack of pain management treatment for patients with a history of opioid use disorder is a violation of the ethical principle of justice, and with so many alternatives to opioids for the management of pain is unnecessary.

The challenges associated with caring for patients in recovery from the ED nurse’s perspective has not been explored in literature. The findings of this study identify some of the barriers to providing effective pain management to patients who are in recovery in the ED. The ASPN 2016 Position Statement on Prescribing and Administering Opioid Doses Based Solely on Pain Intensity suggests that prescribers extend analgesic choices beyond opioids and include the use of non-pharmacological interventions in the patients’ pain management plan (Pasero et al., 2016). Implementing these suggestions into ED pain management plans for not only patients in recovery, but for all patients in pain would be beneficial. In 2016, St Joseph’s Regional Medical Center in Paterson, NJ launched the Alternate to Opiates (ALTO) Program in which opioids are used as second-line therapy for many conditions including kidney stones, headaches, and musculoskeletal injuries (Waszak & Fennimore, 2017, St Joseph’s Health, 2018). This program
has been successful in managing pain without the use of opioids and should be expanded to other hospitals around the country.

**Injustice in Pain Management Leads to Moral Distress.** Stories about how patients were not treated equitably were common in this study. One example which exemplifies the emotional toll inequities in pain management had on the participants was the story told by Nurse Daniels about the VIP with knee pain who expected treatment before the elderly patient with pneumonia and shortness of breath described in chapter 6. While recounting the story Nurse Daniels was visibly upset and often had tears in her eyes and her voice would crack, she also had a difficult time maintaining eye contact during that portion of the interview. The emotional toll and long-lasting effects that incident had on Nurse Daniels was evident when she stated,

> I was very upset. I cried; I was embarrassed. You want to believe in yourself, that you can be a great nurse, and then that happens, and you feel bad and doubt yourself. It made me step back and figure out how to handle the situation the next time. The first thing I do now is figure out if anybody is going to yell at me. That was the learning lesson there. (said with sarcasm and rolling her eyes).

While this story exemplifies the emotional toll injustice and inequities in care had on the participants, there were other reports of participants being frustrated, angry, upset or feeling caught in the middle, when patients did not receive the care the nurses thought they deserved.

Moral distress has been described as a unique moral conflict that occurs when a person knows the right thing to do, but institutional constraints make it difficult to pursue the appropriate course of action (Zavotsky & Chan, 2018). Although not specifically labeled moral distress many of the nurses recounted situations in which the emotions described were indicative of moral distress. Others describe situations that contained morally distressing conditions. Varying degrees of moral distress in ED nurses can lead to work dissatisfaction and burnout (Zavotsky & Chan, 2016). In addition, the attitudes and behaviors of some of the participants in
this study related to patients with chronic pain, may indicate disengagement which is an element of burnout (reference). Although moral distress and burnout were not specific phenomenon discussed by participants in this study, the stress described when managing patients’ pain in the ED provides insight into elements that contribute to both burnout and moral distress in this population.

**Fidelity and Accountability**

The ethical principle of fidelity is multifaceted and refers to the concept of faithfulness. The nurse is called to be faithful to the profession by upholding the profession’s code of ethics, to practice within the established scope of practice and to remain competent in practice (Burkhardt & Nathaniel, 2013). According to the ANA (2015) “Accountability is judgement and action of the nurse for which the nurse is answerable to oneself and others for those judgements and actions” (p. 44). Professional accountability is a cornerstone of the nursing profession and accountability is grounded in the moral principle of fidelity. To remain faithful to the profession of nursing, the nurse must remain competent in practice. The ANA *Code of Ethics* (2015) Provision 5.2 requires the nurse to maintain competence and continue professional growth. This provision expects nurses to continually evaluate their practice and to engage in life-long learning.

Three nurses in the current study had advanced degrees (MSN) and an additional four were enrolled in graduate school. Three nurses were members of the Emergency Nurses Association (ENA) and were Certified Emergency Nurses (CEN). However, despite almost fifty percent of the participants in this study being actively engaged in professional growth, there was a dearth of knowledge about pain management. Eight nurses were able to recall they received some education about pain management. All the nurses lacked up to date information about non-pharmacological pain management practices for the management of acute pain. Nurses in this
study recounted that most of the education they received was on-line learning modules and provided by the organization they worked for. Most of nurses were passive when it came to learning about pain management with only one nurse participating in an independent educational activity about pain management.

Participants were competent in pain management, but competence is just meeting acceptable practice. None of the nurses in this study sought professional growth related to pain management, yet all the nurses identified they encountered patients in pain daily. It is the nurse’s responsibility to have current knowledge relevant to current standards of care as well as changing issues within the healthcare setting (ANA, 2015). Nurses in this study were knowledgeable about the opioid crisis and changing regulations related to opioid use, they lacked understanding about evidence-based care of patients in pain. As one nurse stated, “I don’t really think about pain management as much as you do, I just give them what the doctor orders” (Nurse Stevens). With the changes in pain management practices and the emergence of the opioid crisis to maintain competence and professional growth nurses should seek opportunities to improve their understanding of pain treatment options.

**Opportunities for Improvement**

Participants described several opportunities for improvement in the practice of pain management in the ED. The areas included patient expectations, standard protocols for management of painful conditions, standard protocols for discharging patients who received pain medication while in the ED, and a decrease focus on the ‘business aspect’ of the ED care environment.

The impact patient expectations had on pain management in the ED was described by eight participants in this study. The nurses identified patients had expectations about the care
they were going to receive while in the ED, and those expectations were often viewed as unrealistic by the participants. Participants often described patients wanting to be pain free when discharged from the ED, and most nurses felt this was an unrealistic expectation. A 2006 study explored patients with abdominal pain and their expectations about pain relief in the ED. Forty-four percent of the patients reported they expected complete relief of the abdominal pain while in the ED (Yee et al., 2006). Participants in the Bergman (2012) study also indicated that patient expectations related to pain management “are too high”, and patients need to be more accepting of what the nurse can do for them during their short ED visit. The findings from this study are consistent with the previous research which describes the frustration ED nurses experience with their patient’s expectations of complete pain relief. This impeded their ability to effectively manage their patient’s pain. Nurses in this study suggested patients be better educated when they arrive to the ED for care about what they can expect from their visit. The information provided would include information about pain management modalities, length of stay, and need for follow up care. Participants in this study believed improving patient’s understanding about emergency care would improve patient satisfaction and the nurse’s ability to effectively manage their patient’s pain.

Seven participants described the need for standard protocols for pain management in the ED as a method to improve care. Nurses expressed dissatisfaction with variations amongst providers when managing certain painful conditions. Previous research has demonstrated inconsistencies in pain management for trauma patients in the ED (Neighbor et al., 2004) and ED patients with long bone fractures (Minick et al., 2012). Disparities in pain management in the ED have also been documented in the elderly (Hwang et al., 2006) and amongst racial-ethnic groups (Epps et al., 2008; Singhal et al., 2016). Although participants in this study did not discuss
disparities in pain management, they did express concern over the lack of consistent protocols and guidelines to manage painful conditions in the ED.

Clinical guidelines and protocols are meant to aid in decision making and are aimed at promoting evidenced based care (Ducharme, 2005). Participants in this study described wanting standards of care and often did not understand how pain management decisions were made. One nurse expressed concern about a change in practice that in her opinion resulted in less effective pain relief for her patients. Previously patients with kidney stones were medicated with 30 mg of Toradol, recently however, the standard changed to 15 mg, which to this nurse seemed to be less effective. Including ED nurses in the decision-making process when establishing guidelines or protocols for management of painful conditions in the ED is important. A 2015 study from New Zealand which surveyed 172 ED nurses found 97% of the respondents thought having pain management protocols was an important nurse-empowering facilitator of pain management (Pretorius et al., 2015). The absence of pain management protocols in the ED and the lack of consistency amongst providers and facilities when managing painful conditions was an element that impeded the pain management process. The nurses in this study recommended establishing evidenced-based guidelines for the management of pain in the ED and identified the lack of these guidelines as an impediment to quality pain management.

Conclusion

Despite existing literature that has examined pain management in the emergency department, research describing all elements of pain management from the emergency department nurse’s perspective is absent. Previous published qualitative studies have explored the ED nurse’s perceptions about pain management in the elderly (Gorawara-Bhat et al., 2107), pediatric pain management in the ED (Thomas et al., 2015), and barriers to caring when
managing adult patients’ pain in the ED (Bergman, 2012). This study used interpretive
description to explore and understand pain management from the nurse’s perspective. With the
current opioid crisis and today’s complex and changing healthcare environment this study sought
to understand how pain is managed in the ED, and more importantly what barriers and
facilitators are associated with pain management in the ED. As the nurses described their
experiences and offered insight into pain management in the ED, the researcher was able to
identify and interpret common patterns that assisted with pain management in the ED.
Assessment, advocacy, time, and a collaborative relationship with the ED provider all resulted in
improved pain management for the patient. The participants described overcrowding, personal
biases of nurses and providers, and patient expectations as some of the elements that impeded
pain management. Despite the challenges and obstacles faced in the management of pain, the
participants in this study, tried to individualize their care and were genuinely concerned for their
patients in pain. They recognized that pain was often a symptom of a larger problem that needed
to be identified and addressed. As the nurses described their approach to effectively managing
their patients’ pain while functioning in a stressful and chaotic environment, the researcher was
able to extract and interpret common and distinctive patterns in their views about pain
management that can contribute to a deeper understanding on the phenomenon. These findings
contribute to a deeper understanding of pain management in the ED. They offer specific
strategies and elements that contribute in a positive way to pain management in the emergency
department and can impact pain management in the future. The findings also identify elements
that impede pain management in the ED and offer insight into how those elements can be
mitigated.
Strengths

This is the first qualitative interpretive description study from the nurse’s perspective on pain management in the ED. This is also the first study to explore pain management from the nurse’s perspective since the opioid epidemic was declared a national crisis. Participants who had various experiences and worked in different ED environments were targeted to provide insight into the phenomenon of pain management. The participants represented the perspective of 20 emergency department nurses with 18 months to 19 years of ED nursing experience. Participants in this study identified as male (5) and female (15), were from four different states (NJ, NY, CT, and FL), and worked in 12 different healthcare systems increasing the transferability of the findings. The diversity of the sample served to strengthen the data, provide different perspectives, and contribute to the trustworthiness and credibility of the findings. The participants provided clarity on how pain is managed in the emergency department and how pain is prioritized in the ED. They added new and detailed information about how pain management is evolving and what elements facilitate and inhibit effective pain management in the ED.

Limitations

There were some limitations to this study. Participants were obtained through a convenience sampling method; nurses who felt they had something to contribute to the study may have been more likely to participate. Document review was not a part of the research design. Participants were asked about documents such as policies and procedures and educational offerings on pain management, which were described when present. However, having actual documents to review would have added a dimension to the data not available with this study. A consideration for future studies would be to pre-select several healthcare systems and request through their individual IRB the ability to review documents related to pain.
management in the ED. Additionally, the study did not provide the perspectives of other healthcare providers, such as physicians, nurse practitioners, and unlicensed personnel on pain management in the ED. Finally, data collection for this study concluded six months before the Covid-19 pandemic impacted ED management of patients in the United States, which limits its applicability during unprecedented pandemic conditions.

**Implication for Nursing and Research**

The findings from this study that are of value to emergency department nurses have several implications for pain management. As pain management is a common phenomenon encountered by ED nurses, the insights, approaches, and areas of concern may contribute to evidence-based changes to pain management. Through the identification of the ethical principles associated with pain management in the ED, targeted interventions can be developed to promote patient autonomy and patient justice. As distress over pain management in the ED has implications for the nurse, further examination of this phenomenon and its association with moral distress, and burnout is warranted. Although document review was not part of this study, participants described both written and un-written pain management practices in the ED. Most participants described informal or unwritten practices. The findings of this study can guide emergency department leadership to develop policies and procedures which support effective pain management practices. Suggestions by participants also included the development of evidence-based protocols for management of common painful conditions encountered in the ED, such as migraines, kidney stones, and sickle cell crisis. Additionally, findings suggest the need for clear and concise discharge criteria including time frames to discharge for patients who received opioid pain medication during treatment in the ED.
Participants described an abundance of time as a facilitator of pain management in the ED, whereas elements such as ED throughput times and ED overcrowding as inhibitors of effective pain management. Considering the current COVID-19 pandemic and the vivid description of an increase in ED patient volume in the main-stream media, a further exploration of the impact an increase in ED census has on pain management should be considered. These findings suggest consideration for some decrease in the emphasis placed on ED metrics. Given the changes in pain management practices and the need for continuing education in nursing, the findings from this study identified a need for nursing education on updated pain management practices which are unit specific and include elements on non-pharmacological pain management practices. The participants in this study reported on-line learning modules were an ineffective method of providing education. Continuing education about pain management should be targeted sessions that include in-person or virtual sessions with opportunities for participants to engage in a meaningful way in the learning process. Additionally, evaluation of learning should occur not only immediately after educational offerings, but also at three or six months to determine if long-term retention of content has occurred.

An exact duplication of this study should occur after the Covid-19 pandemic abates to determine if the themes identified in this study remain consistent after an event such as the pandemic. Additionally, replication and expansion of this study to a national web-based survey may further elucidate elements that facilitate and inhibit pain management in the ED and enable those findings to be transferable. Considering the Covid-19 pandemic and its impact on ED patients and nurses, including elements such as comfort care in future studies are warranted. Gaining the perspectives of ED nurse educators, ED providers, assistive personnel, and ED managers may provide a greater understanding of pain management in the ED. It would be
interesting to compare the perspectives of all those that assist with pain management practices in the ED.

Future research could be designed to determine if education about pain management changes ED nurse’s knowledge and behaviors related to pain management. ED nurses could be provided education about up-to-date pain management practices including assessment, discharge education and use of non-pharmacological modalities to manage pain. A pretest and posttest could be used to evaluate knowledge before and after education. Observations of interactions between nurses and patients in pain could be documented to determine if behaviors, not only knowledge would change. Other future research could be designed to determine the effectiveness of pain management in the ED. Patients who were treated for a painful condition and discharged could be sent a survey asking them to describe their pain management while in the ED. This survey would not explore how satisfied a patient was with pain management, but rather what elements contributed to a reduction in their pain. Finally, a future study could explore if patient and family education on what to expect during an emergency department visit improved patient satisfaction with their pain management. One example might be to study two groups of emergency department patients. A simple pamphlet could be provided to randomly assigned patients when they present to the ED for treatment of a non-life-threatening illness which would explain what to expect during their visit. Information provided would include items such as how their pain would be managed, what type and the amount of medication they would receive at discharge, and what would be expected of them after discharge, such as follow up with a specialist or primary care provider. The other group of patients would not receive any information at the beginning of their ED visit. Both groups would be provided with standard ED care and discharge instructions which include information about follow up and medications.
prescribed at discharge. A simple questionnaire would be provided to each group of patients to
determine if the pamphlet provided improved the patient’s satisfaction with the care they
received during their ED visit.

Given today’s rapidly changing healthcare environment and the continued reliance on the
emergency department to provide care to acutely ill patients and safety-net care to those without
access to other means of healthcare it is critical for nursing research to uncover how to provide
effective pain management to patients in the ED, while supporting and empowering ED nurses.
This study is an initial step in that direction.
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Appendix A

Informed Consent Form

Consent for Participation in Research

Title of Study: Nurses’ Perspectives on Pain Management in the Emergency Department

Investigator: Elizabeth Fitzgerald, MSN, RN

1. **Researcher’s Affiliation:** The researcher is a doctoral student in the College of Nursing at Seton Hall University.

2. **Purpose of the Research:** The purpose of this qualitative research study is to explore and describe the perspectives of emergency department nurses on pain management in the emergency department.
   
   a. **Duration:** The duration of the study’s interview process is approximately 60 – 90 minutes.

3. **Procedure:** After signing informed consent, the study participant will be asked open ended questions about their experiences and perspectives about pain management in the emergency department (ED). The interview will be audio taped. Patient’s names should not be used in the interview. If a patient’s name is used it will not be included in the written transcript of the interview. Study participants will be given a phone number to contact the researcher in case there is any information the study participant would like to add to the interview. The phone call will be audio taped. Study participants will also be provided with an email address in which additional thoughts or comments may be emailed to the researcher.

4. **Typical Questions:** Typical questions that study participants will be asked during the study will be directly related to the study participant’s experiences managing patient’s pain in the ED.

5. **Voluntary Nature of Participation:** Participation in the study “Nurses’ Perspectives on Pain in the Emergency Department” is completely voluntary. The study participant may choose to withdraw without giving a reason from the interview and the study at any time and not be penalized in any way. Study participants do not need to give a reason for ending participation in the study.

6. **Anonymity:** Data will be collected without any identifying information. The researcher will be aware of the participant's identity, but except for the signature on the consent form, names will not appear at any point in the research study. The consent form will be kept in a secure locked site in the researcher's home, separate from the interview and will not be able to be linked to the study participant.

7. **Confidentiality:** No names, addresses or other identifying information will be attached to the information that the study participant provides. All recorded data will be stored on a USB memory key and kept in a secure, locked site in the researcher’s home. The recorded data will be kept for a minimum of three years after the completion of the study.

8. **Confidentiality of Data:** A typed transcript of the data will be kept for a period of at least three years after completion of the study. The typed transcripts will be kept in a separate, locked, and secured site in the researcher’s home. Only the researcher and the dissertation chair will have access to the typed transcripts.

Page 1 Participants initials: ________
9. **Risks:** There are no anticipated risks for participating in the study. The questions that will be asked are related to perspectives about pain management in relation to work experience in the emergency department.

10. **Benefits:** Direct benefit may not be experienced by participating in the study, however; potential benefits to participating in the research project include providing insight on the management of pain in the emergency department (ED) from the nurses’ perspective. Participation in the study may help improve the quality of pain management in the ED. In addition, this is an opportunity for ED nurses to voice their individual perspectives and personal ideas on this important concept.

11. **Financial Renumeration:** There will be no financial remuneration for participation in this study.

12. **Compensation:** There is no other form of compensation for participation in this study.

13. **Alternate Procedures:** Participation in the study is voluntary.

14. **Contact Information:** Participants with questions can contact the primary researcher, Elizabeth Fitzgerald, MSN, RN at the PhD Nursing Program at the College of Nursing, Seton Hall University 973-542-6200, or by cell phone at 973-255-7255, or by email at [elizabeth.fitzgerald@student.shu.edu]. The researcher's faculty advisor is Dr. Bonnie Sturm at Seton Hall University, College of Nursing and can be reached at 973-761-9762, or by email at [bonnie.sturm@shu.edu].

15. **IRB:** The Institutional Review Board (IRB) at Seton Hall University can also be contacted for answers to any pertinent questions about the research and the study participant's rights. The IRB can be contacted by calling the director, Dr. Concetta Beale at 973-761-9401, or by email at [irb@shu.edu].

16. **Audio Tapes:** The interview will be tape recorded and listened to only by the primary researcher, her faculty advisor, and the transcriber. All data will be transcribed by either the researcher or by a transcriptionist who has obtained a certificate in the protection of human subjects and has been approved by Seton Hall’s Institutional Review Board. The audio tape will not be labeled by name but will be identified by a code number. The tape-recorded interviews will be stored in a locked cabinet in the researcher's home for a minimum of three years after the completion of the study.

17. **Copy of Consent:** The study participant will be given a copy of this signed and dated Consent Form.

By Signing this consent form the study participant agrees to participate in an interview for the qualitative study "Nurses’ Perspectives on Pain Management in the Emergency Department." It is understood that the interview will be audio taped. It is also understood that no financial remuneration will be received for participating in the study.

Study Participant ___________________________ Date________________________
Investigator___________________________________________Date_______________
Participants initials: __________
Appendix B

LETTERS OF SOLICITATION

Letter of Solicitation for Nurses’ Perspective on Pain Management in the Emergency Department

You are being asked to participate in the qualitative study “Nurses’ Perspective on Pain Management in the Emergency Department” because you are a nurse in the emergency department who has personal first-hand experience with the research topic.

Affiliation

My name is Elizabeth Fitzgerald, and I am registered nurse with over 25 years of emergency department and ICU experience, and a doctoral student at Seton Hall University College of Nursing. I am the Nurse Researcher who designed the study “Nurses’ Perspectives of Pain Management in the Emergency Department” under the guidance of Dr. Bonnie Sturm, Associate Professor at Seton Hall University, College of Nursing.

Purpose of the study

The purpose of this study is to explore and describe the emergency department (ED) nurses’ perspectives about pain management in the ED. As an ED nurse caring for patients who present with pain, you have a valuable and unique perspective to share on the topic.

Participation time

60-90 minutes

Study procedure

After signing informed consent, you will be asked open ended questions about your experiences and perspectives about pain management in the emergency department (ED). The interview will be audio taped. Please do not use any patient’s names when speaking about your experiences. If you do use a patient’s name, it will not be included in the transcript. Typical questions that you will be asked during the study will be directly related to your experiences managing patient’s pain in the ED. The interview will be audio taped. Your name and all names mentioned in the interview will be eliminated from the typed transcript of the interview.

You will be given a phone number to contact the researcher in case there is any information you would like to add to the interview. The phone call will be audio taped. You will also be provided with an email address in which you may email your thoughts to the researcher.

Participation is voluntary

Participation in the qualitative study “Nurses’ Perspectives of Pain Management in the Emergency Department” is completely voluntary. If you do decide to participate, you may
change your mind and end your participation in the research study or the interview at any time. You do not have to give a reason for ending your participation.

**Anonymity**

Data will be collected without any identifying information. The data collected from each study participant will not be anonymous to the researcher. The researcher will eliminate all names and identifying factors connected to the interview so that it will not be able to be identified by anyone else. Except for the signature on the consent form, your name will not appear in the research study. The consent form will be kept in a secure locked site in the researcher’s home, separate from your interview and will not be able to be linked to your interview.

**Confidentiality**

No names, addresses or other identifying information will be attached to the information that you provide. All recorded data will be stored on a USB memory key and kept in a secure, locked site in the researcher’s home. The recorded data will be kept for a minimum of three years after completion of the study. A typed transcript of the data will be kept for a period of at least three years after completion of the study. The typed transcripts will be kept in a separate, locked and secured site in the researcher’s home. Only the researcher and the dissertation chair will have access to the typed transcripts.

If you have any questions or would like to participate in the study, you may email me at elizabeth.fitzgerald@student.shu.edu
Appendix C

Interview Guide

Interview Guide: Nurses’ Perspective on Pain Management in the ED

Introductions & Explanations: “Thank you for meeting with me. I am hoping to learn as much as I can about how pain is managed in the ED. I am interested in how nurses are involved in pain management and what nurses observe others to do in terms of managing patient’s pain”.

1. Before we get started, please tell me a little bit about yourself and your experiences as a nurse.
   a. ask about years of experience
   b. ask about other areas worked

2. Please tell me about your experiences managing patients’ pain in the ED.
   a. ask about the nurses
   b. ask about observations of others.

3. Please describe any non-pharmacological methods of pain relief that you have used, or seen others use in the ED.

4. Does your institution have any protocols or policies re: pain management? What is your perspective on how these are used or not used in the management of pain in the ED?

5. What are the biggest concerns or obstacles that you encounter in your experiences of pain management in the ED?

6. Please describe your experiences in discharging patients who have received pain medication while in the ED.

7. What are your experiences connected with discharging patients who are going home with prescriptions for pain medication (opioids)?

8. Pain management is constantly evolving; how has pain management in the ED changed since you first began working in the ED?

9. Can you describe ways in which you have maintained (updated) your knowledge about current pain management modalities?
   a. Ask about formal (undergraduate or graduate) education related to pain management

10. Can you describe a situation, which you would call successful pain management in the ED? What about a situation that you would call a failure?

11. Is there anything else you would like to add about pain management in the ED?
## Appendix D

Demographics of Sample

<table>
<thead>
<tr>
<th>Identified Gender</th>
<th>Years of Experience in ED</th>
<th>Highest Degree</th>
<th>National Certification (CEN)</th>
<th>State</th>
<th>Type of hospital as described by participant</th>
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<tbody>
<tr>
<td>Female</td>
<td>Three</td>
<td>BSN</td>
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<td>NJ</td>
<td>Small community hospital with two locations</td>
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<td>BSN</td>
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<td>NJ</td>
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<tr>
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<td>Primary stroke center, urban area</td>
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<tr>
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<td>MSN (NP)</td>
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<td>Highest Degree</td>
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<tr>
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<td>NJ</td>
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<tr>
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<td>BSN</td>
<td>No</td>
<td>NJ</td>
<td>Suburban hospital in an affluent area</td>
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<tr>
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<td>Highest Degree</td>
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<td>Type of hospital as described by participant</td>
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</table>
Appendix E

IRB Approval

April 24, 2019

Elizabeth Fitzgerald

Dear Ms. Fitzgerald,

The Research Ethics Committee of the Seton Hall University Institutional Review Board office has reviewed and approved as submitted under expedited review your research proposal entitled “Nurses’ Perspectives on Pain Management in the Emergency Department.”

Enclosed for your records is the signed Request for Approval form.

Reflecting the process for federally funded research, there will be no longer be a continuing review. Informed Consent documents and recruitment flyers will no longer be stamped.

Thank you for your cooperation.

Sincerely,

Mary F. Ruzicka, Ph.D.
Professor
Director, Institutional Review Board

cc: Dr. Bonnie Sturm

Please review Seton Hall University IRB’s Policies and Procedures on website (http://www.provost.shu.edu/IRB) for more information. Please note the following requirements:

Adverse Reactions: If any unreported incidents or adverse reactions should develop as a result of this study, you are required to immediately notify the Seton Hall University IRB Director, your sponsor and any federal regulatory institutions which may oversee this research, such as the DHHS or the FDA. If the problem is serious, approval may be withdrawn pending further review by the IRB.

Amendments: If you wish to change any aspect of this study, please communicate your request in writing (with revised copies of the protocol and/or informed consent where applicable and the Amendment Form) to the IRB Director. The new procedures cannot be initiated until you receive IRB approval.