

2012

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## Recommended Citation

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Investigating effective methods of pain management in emergency department clients with  
chronic pain

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## Introduction

Effective pain management can be challenging in emergency department (ED) clients with chronic pain. Improper pain assessment by healthcare providers contributes to inadequate pain relief and suboptimal outcomes of clients' conditions. The Bantam Medical Dictionary (2004) defines pain as "a localized or diffuse unpleasant sensation ranging from mild discomfort to agony or distress, associated with real or potential tissue damage, and caused by stimulation of the functionally specific sensory nerve endings" (p.481). ED clients have a diverse number of factors that affect pain threshold and sensitivity to pain medication. The Joint Commission (2011) estimates that approximately 76 million people in the U.S. suffer from pain. "Pain is the most common reason for admission, comprising more than 40% of the over 100 million ED visits annually" (Sinatra, 2010, p.1859). Healthcare providers' attitudes towards proper pain interventions can also negatively affect pain relief, especially in regards to caring for patients with addictive behaviors. Dorsey, Malone, & Simopoulos (2009) state that an ED that sees 75,000 clients per year receives up to 262 monthly visits from drug-seekers alone (p.98).

Pain management is an important component of providing optimum health care. It is the responsibility of healthcare providers to effectively treat and manage pain in order to decrease further complications, increase client satisfaction, and improve the overall health status of the individual. Healthcare providers must be knowledgeable in regards to pain medications, effectiveness of pain control, and the challenges that may present when trying to acutely treat persons with underlying chronic pain. Pain affects all age groups, ethnicities, and populations. Pain can occur because of illness, trauma, and surgery. Clients with chronic pain pose an even more difficult task of controlling acute pain because of higher tolerance to analgesic medications.

Numerous healthcare facilities have established and/or implemented protocols for pain medication that can be utilized by registered nurses (RNs) and licensed practical nurses (LPNs). Professional organizations, such as the World Health Organization and Clinical Standards Advisory Group that have influence over hospital emergency departments, continue to promote effective pain management strategies (Thomas, 2007, p.43). Knowledge and education about effective methods of pain control are vital in the efforts to decrease clients' pain levels.

Factors affected by ineffective pain management include reduced quality of life, impaired sleep and physical function, high economic costs of unrelieved pain, and the development of chronic pain from poorly managed acute pain (Sinatra, 2008). The purpose of this project is to present to healthcare providers working in the emergency department setting effective methods of acute pain management for patients with chronic pain who present in the ED.

## Literature Review

### *Barriers to pain management*

Nurses, physicians, and patients differ in their view of barriers to adequate pain management. Duignan and Dunn (2009) studied the factors that represented barriers to pain management in the ED. Patients' and clinicians' perceived barriers were compared and discussed. Patients' most cited barrier to receiving analgesics was the personal use of alcohol or other recreational drugs. Patients' felt that clinicians would perceive them as a drug-seeker and be less likely to receive adequate analgesic medications. Clinicians' perceived barriers however differed greatly from that of patients. Clinicians felt that the most common barrier was ineffective pain assessment which subsequently leads to inadequate pain relief. In the ED, time constraints and acuity of patients was perceived by nurses as a barrier to proper pain

management. Time constraints for the nurses lead to an inadequate amount of time to assess client's level of pain when caring for their other vital needs such as medication administration, vital sign monitoring, and stabilization of sustained injuries. Caring for other highly acute clients may deter from addressing the pain level of a less-acute client whose only complaint is pain. A large barrier to the adequate treatment of pain occurred when nurses and physicians ignored their client's report of pain and did not find analgesic administration necessary.

Wilsey, Fishman, Ogden, Tsodikov, & Bertakis (2007) evaluated attitudes and beliefs of chronic pain management in the ED. Surveys were given to nurses, physicians, and patients, and included perceived barriers such as belief in pathology, lack of time, fear of opioid dependence, "frequent flyers", no primary care physician, fear of diversion, and non-efficacy of opioids. Of the 15 barriers included in the survey, the top noted barrier identified by all participants was chronic pain having a low priority in the ED. Acute illness and diseases took priority over those who had an established pathology of pain, leading to inadequate analgesic management. Another major barrier is the abuse of opioid drugs and the negative stigma of those on chronic pain management which may occur. Negative attitudes were found in this survey towards treating pain in the ED because providers perceived that patients were only visiting the ED because they lacked a primary care physician and/or insurance. Annoyance and symptom magnification by patients with chronic pain was also cited as a clinician-related barrier. Patients with chronic pain also fear that physicians may label them as "bad patients" or "drug-seekers" and they may not receive the pain relief that is warranted. This stigma can discourage patients to adequately report their pain and thus perpetuate the cycle of ineffective pain management.

Thomas (2007) examined previous literature that discussed barriers to providing pain relief in the ED setting. There were a number of named concepts in regards to clinician-related

barriers that affect effective pain management. Interruption of nurses' activities caused delays in the administration of analgesics and other comfort measures. The ED setting is a fast-paced environment that can sometimes pose challenges in time management of patient care. Other barriers include lack of accountability, lack of education, and poor communication and documentation on the part of providers. Lack of accountability meant that healthcare providers may not always be monitored regularly to discern if the client's under their care had received adequate pain management. Providers may feel that pain has to be related to an underlying pathology, and if it isn't present in the diagnostic work then the patient is not really experiencing pain (Thomas, 2007). It is important for healthcare professionals to have good pain assessment skills and recognize when the patient is in pain. Providers may also be hesitant to administer opioids because of side effects such as respiratory depression. Thomas (2007) discusses patient-related factors such as fear of addiction, trying to be a "good" patient, not wishing to "bother" the nurses as significant barriers. Adequate pain management is not only the responsibility of the provider; it is also up to patients to take responsibility for their illness and recovery. Knowledge regarding pain can help empower the patient to make educated decisions in their plan of care. Healthcare providers should be encouraged to empathize with their patients and make pain management a top priority. The practice of effective pain assessment and management is crucial to improving the pain experience of patients.

Attitudes and lack of education on the part of providers and patients can cause barriers to pain management. Sinatra (2010) examined recent literature that discussed the consequences of ineffective pain management and the barriers that needed to be addressed in order to provide sufficient pain relief. Medical school and postgraduate training programs place a low emphasis on pain management which can lead to insufficient physician training and education regarding

opioid use. Lack of knowledge can cause under dosing of opioids and leave patients in pain. Other provider-related factors include physicians having a negative attitude about prescribing opioids, and the fear that patients will become addicted. Knowledge and training can help providers become more comfortable and confident administering opioids to patients in the ED. Noncompliance increases if a patient experiences side effects associated with certain analgesic therapy. Some patients experiencing pain will not accept opioids because fear of abuse and addiction profile. Current research has shown that a multimodal, or combination of opioids, therapy can contribute to treating acute pain in patients with chronic pain.

### *Physiology of Pain*

The experience of pain can vary greatly amongst persons. Healthcare providers are taught to believe the level of pain that the client reports, but many times biased opinions negate a clinician's perception of the client's true level of pain. Understanding the pathophysiology of pain can help aid in more effective treatment. Pain receptors, or nociceptors, are found throughout all tissues except the brain. Their purpose is to respond to painful stimuli (i.e. biological, electrical, thermal, chemical, and mechanical) and transmit signals along the spinal cord to the central areas of the brain. Pain is then perceived and interpreted by the limbic system and the cerebral cortex (Helms & Barone, 2008). Pain usually occurs at the site of insult when tissue damage is induced; such is the case when a person comes into contact with a hot object. It's the body's way of protecting itself in response to a noxious stimulus. As the threat passes or the injury heals, the nociceptive pain resolves spontaneously, unless tissue damage persists (Savage, 2008). When tissue damage occurs, chemical mediators such as histamine, bradykinin, acetylcholine, substance P, leukotrienes, and prostaglandins are released into the extracellular

tissue causing altered capillary permeability, vasoconstriction, and vasodilation. Nonsteroidal anti-inflammatory drugs (NSAIDS) help by blocking prostaglandins, thereby decreasing inflammation and pain. Opioids produce analgesic effects by working with the body's own built-in chemical mechanism to manage pain. Helms et al. explain that fibers in the dorsal horn, peripheral tissues, and brain stem, release neuromodulators (endogenous opioids), that inhibit the action of neurons that transmit pain impulses. Natural opioid-like substances ( $\beta$ -Endorphins and dynorphins) are released into the body and provide the individual with pain relief.

### *Chronic Pain*

There are a number of mechanisms that contribute to the development of chronic pain. These mechanisms include alterations in the dorsal root ganglion in response to peripheral nerve injury and neurotransmitters, changes in sensitivity of neurons—lower threshold with peripheral and central sensitization, and loss of pain inhibition in the spinal cord (McCance, K.L. & Huether, S.E., 2006). Clients with chronic pain may have flare-ups and experience acute pain from a new injury that has caused tissue damage. “Acute and chronic pain are due to different physiological mechanisms and thus require different treatments” (Helms & Barone, 2008, p. 38). Acute pain serves the purpose of warning the body that injury or illness has occurred and stimulates the sympathetic nervous system. The experience of discomfort usually occurs for a limited amount of time in a specific affected area. Chronic pain on the other hand, can be hard to understand and is complex. Chronic pain is considered prolonged pain that is either continuous (i.e. arthritis) or intermittent (i.e. migraines) (Helms & Barone, 2008). Pain continues long after the expected recovery time, owing itself to the phenomenon of Windup, which is described by Melzack and Wall (1965) as when repeated stimulation of C fibers causes a buildup of electrical responses in the CNS, which then leads to intensified stimulation of nerve fibers. Over time the

sympathetic nervous system adapts to the persistent pain impulses and the individual with chronic pain does not experience autonomic nervous responses such as sweating, pallor, and nausea. Common chronic pain conditions include cancer pain, chronic postoperative pain, persistent low back pain, myofascial pain syndromes, and phantom limb pain (McCance, K.L. & Huether, S.E., 2006). Health care providers can provide improved pain management by taking the time to understand the physiology and mechanism of chronic pain.

### *Gate Control Theory*

Described by Melzack and Wall, the gate theory explains the body's pain-modulating system in which neural gates that are present in the spinal cord can open and close thereby modulating the perception of pain (Nursing Theory, Gate Control of Pain, 2012). There are three systems that are located in the spinal cord and regulate the transmission of pain. They are the substantia gelatinosa in the dorsal horn, the dorsal column fibers, and the central transmission cells. Noxious stimuli are regulated by a gate mechanism that allows pain signals to be delivered to the brain. When smaller C fibers, which are located throughout the somatic sensory system, are stimulated by noxious stimuli, it causes the dorsal horn transmission neurons to become excited and the gate is opened. The gate is opened by bodily injury, anxiety & depression, and behavior factors of attending to the injury and concentrating on the pain. The large-diameter fibers, more specifically the A beta fibers, transmit nonpainful stimuli and block impulses at the gate, causing the gate to close (Helms & Barone, 2008). The gate may be closed by analgesic medications and somatosensory stimulation (i.e. distraction, meditation, and music therapy) which then promotes relief from pain.

*Pain management*

Pain management can be attained through various types and routes of medication. There have been a number of studies that have strived to evaluate and assess the effective methods of treating pain in the emergency department. Patients' previous opioid use, pain threshold, medication tolerance, clinician's perceptions of pain management, and protocols of pain management established by emergency departments can affect the quality of care.

Patients with chronic pain can have concurrent issues with opioid tolerance and substance abuse. Savage, Kirsh, and Passik (2008) reviewed literature that examined the use of opioids and the challenges of treating pain in persons with chronic pain. Opioids produce analgesic effects by direct inhibition of pain transmission at the dorsal horn of the spinal cord and other pathways that alter perceptual and affective responses to pain. When used appropriately, opioids actually have a lower risk of causing organ damage when compared to other analgesics such as NSAIDS and acetaminophen that can cause hepatic, gastric, and renal toxicities (Savage et al, 2008).

Opioids as a whole, are widely available, generally safe, and relieve most types of pain.

Research and practice has continued to show the benefits of opioid use in persons with pain, such as fast and effective pain relief, but there also a number of adverse affects and precautions that exist. Owing to opioids' high reward mechanism, there is a large risk and incidence of misuse and abuse. Addiction and physical dependence is a huge concern of healthcare providers in the ED. Patients should be monitored for addictive behavior and inappropriate use of opioids.

Patients with chronic pain tend to develop tolerance to opioids and may require higher doses or an alternative opioid to produce an analgesic effect (Savage et al., 2008). This is one of the main issues of trying to treat acute pain in persons with chronic pain. Healthcare providers may be unwillingly to administer opioids or give an adequate dosage which can leave the patient in pain.

Other considerations with opioid use are the dose dependent side effects such as cognitive blurring, respiratory depression, sedation, nausea, urinary retention, and constipation. These side effects can cause providers to be reluctant to administer opioids and also cause a decrease in patient compliance. In clients with a physical dependence to opioids, drug-class-specific withdrawal can occur if the medication is abruptly stopped, dose decreased, blood levels fall, or an antagonist is administered (Savage et al., 2008). Increased knowledge of opioid use is key to effectively treating acute pain in the ED. Patient education and monitoring is beneficial in decreasing the incidence of addiction and substance abuse.

Chumbley (2010) explored the use of ketamine in uncontrolled acute and procedural pain. Ketamine's pain relieving effects are owed to its effects on the N-methyl-D-aspartate (NMDA) receptors. NMDA receptors become active and intensify pain impulses or signals when pain becomes persistent. Ketamine works by blocking the NMDA receptor, which in turn helps stop the pain signal (Chumbley, 2010). It should be noted that when ketamine is given intravenously (usually 2.5mg q 5 min up to 10mg), that it is only effective if the NMDA receptors are active and should not be routinely given to patients. It has however been shown to be effective in managing pain in those who are opioid tolerant. Ketamine can be given not only IV, but oral and subcutaneous as well. Less opioid administration is required when ketamine was given in conjunction with other opioid analgesics (Chumbley, 2010). It is also relatively safe because at sub-anesthetic doses, ketamine does not affect vital signs, though patients may experience lightheadedness. Criteria for the use of ketamine include those clients with neuropathic pain (including phantom limb pain, hyperalgesia or allodynia), poor response to opioids, and history of high opioid consumption preceding injury or surgery (Chumbley, 2010). In conclusion, Chumbley (2010) states that ketamine is safe and effective for treating

uncontrolled pain, as long as administered in low doses, there is a reduction in dosing when discontinuing, and administered by trained persons.

Campbell-Fleming and Williams (2008) examined the use of ketamine as an adjuvant to opioids in management of severe pain. Using ketamine as an analgesic adjuvant can help decrease the need for additional opioids because of its ability to potentiate opiates and other analgesics. Ketamine has been in use since 1970 and has analgesic, dissociative, sedative, and amnesic properties (Campbell-Fleming & Williams, 2008). Fitzgibbon and Viola (2005) conducted a 12-month protocol audit involving 16 patients in a palliative care unit (PCU) who were terminally ill and had uncontrolled pain with their current use of opioid and analgesic medications. The study found that when ketamine was used in conjunction with opioids, 15 out of the 16 patients' pain level were decreased by at least 4/10 and the use of breakthrough opioid medications in a 24-hour period was reduced by at least 50% for 12 patients (Fitzgibbon & Viola, 2005, p. 52). Management of pain with ketamine is appealing to healthcare providers because it rarely causes respiratory depression or other changes in vital signs. Side effects are noted as being nausea, vomiting, apnea, and sedation, which are dose-dependent. Ketamine potentiates the effects of opioids, so it is vital for patients to be checked for opioid toxicity if the medication is not reduced (Campbell-Fleming & Williams, 2008). Ketamine's drug profile and proven efficacy appears to be positive and beneficial in treating severe pain. Campbell-Fleming & Williams concluded that ketamine should be strongly considered by healthcare providers who are attempting to acutely treat clients with a high opioid tolerance.

Fentanyl citrate is an opioid agonist used to manage persistent pain (moderate to severe) in opioid-tolerant patients, treat breakthrough cancer pain in patients, and as an adjunct to general anesthetic (Nursing Drug Handbook, 2011). Grape, A. Schug, Lauer, & Schug (2010)

investigated the different formulations of fentanyl for the management of acute and breakthrough pain relief, post-operative pain, and chronic pain. Routes of administration include transdermal, transmucosal, intranasal, and intravenous. Fentanyl is a synthetic, highly selective opioid agonist that is highly potent (100- to 300-fold more potent than morphine), has a large volume of distribution (3.5-8 L/kg, average 6 L/kg) and a high total body clearance (30-72 L/h) (Grape et al., 2010). The mechanism of action depends on the route of administration. Transdermal fentanyl is not practical to treat acute pain in the person with chronic pain because of the delayed onset of action and the 48 hour time period that is required to determine if the dose amount is adequate (Grape et al., 2010). The pharmacokinetics and clinical efficacy of oral transmucosal fentanyl citrate (OTFC) makes it a promising method to treat acute pain, but is specifically contraindicated in opioid-naïve patients, so there must be a documented history of chronic pain and opioid use (Grape et al., 2010). Grape et al. (2010) found that oral transmucosal fentanyl citrate (OTFC) when compared to oral morphine, demonstrated in patients a 33% improvement in pain relief and produced analgesic effects within five minutes. Fentanyl buccal tablets (FBTs) have an enhanced absorption across the buccal mucosa and an increased early systemic uptake. The use of intranasal fentanyl was studied using eight healthy volunteers and results proved that the mean maximum drug concentrations were reached in 5 minutes and there was an overall decrease in breakthrough pain (Grape et al., 2010). Grape et al. (2010) performed a study that focused on the use of FBTs and involved four randomized, placebo-controlled trials in opioid-tolerant cancer patients and in patients with chronic, non-cancer-related pain. The study showed that 65-81% of the patients identified improvements in breakthrough pain after receiving FBTs as compared with the placebo, proving this to be an effective formulation for the treatment of acute pain.

Chaplin and Zeppetella (2010) reviewed literature and clinical trial studies that examined the use of Instanyl, an intranasal fentanyl used to treat breakthrough pain. The recommended dose of Instanyl is one spray of 50, 100, and 200 µg, which can be repeated after 10 minutes up to four times a day. The medication is licensed for the management of breakthrough pain in adults who have already been on opioid therapy for chronic cancer pain (Chaplin, S. & Zeppetella, G., 2010). There are a few limitations of the use of Instanyl. It is contraindicated in persons who are opioid-naïve, have severe respiratory depression or obstructive lung conditions, the elderly, or those with moderate-to-severe renal or hepatic impairment. Clinical trials showed that 30-60 % of clients obtained pain relief (pain intensity rating decreased from 6/10 to 4/10) after only 10 minutes of administration and the analgesic effects lasted up to one hour (pain intensity rating decreased to 2/10). Medium onset of symptom improvement is 11 minutes (Chaplin, S. & Zeppetella, G., 2010). There were a few adverse effects that the authors addressed which are similar to other fentanyl formulations including nausea, vomiting, and constipation. The efficacy and clinical data of Instanyl suggests that this medication would be effective in treating persons with chronic pain who are experiencing acute pain in the ED.

### Literature Summary

There are various components that contribute to effectively treating clients with chronic pain who present to the ED with episodes of acute pain. It is important for providers to understand the barriers to pain management, methods of pain treatment, and how to assess and evaluate the effectiveness of treatment. Understanding the physiology of chronic pain and pharmacokinetics of medications helps contribute to managing the client's level of pain. It is the role of the provider to weigh the benefits and risks of using specific analgesics with certain

clients. Opioids have shown to have great efficacy in decreasing acute pain. Ketamine is a relatively safe medication to be given in the treatment of acute pain in clients who are opioid tolerant because of the drug's effect on NMDA receptors (Chumbley, 2007). Various preparations of fentanyl, especially intranasal, have also been shown to treat breakthrough pain and provide fast-relief of acute pain (Grape et al., 2010). As with most medications clients need to be monitored for side effects and any adverse reactions. Clients should be equipped with current knowledge regarding side effects and abuse potential of opioids. Analgesic regimens can also be used in order to improve tolerability of the medication as well as maintaining analgesic efficacy. The following case study provides an example of how barriers to effective pain management can be overcome through proper knowledge, assessment, and treatment.

### Case Study

Mr. K has a history of chronic back pain following an injury and subsequently had spinal surgery two years ago. He is also currently in pain management and his pain regimen includes Lortab 10/500 mg three times a day as needed and Valium 5 mg three times a day as needed for muscle spasms. His pain has continued to increase over the past month to an intolerable level. Despite his pain he decides to try and paint the bonus room in his home. While on the ladder he loses his balance and falls on an outstretched arm and began having excruciating pain. After taking an additional dose of his home medications, Mr. K receives no relief from pain and decides to drive himself to the local emergency department.

### Usual procedure

On arrival to the emergency department he is triaged and rates his pain 10/10 and requests pain medication. The attending physician is very familiar with Mr. K and considers him

a “frequent-flyer” and “drug-seeker”. On examination of Mr. K, the physician determines that he does not appear to be in acute distress and there is no obvious deformity to his right arm. The physician orders an X-Ray of the right arm and for the nurse to administer Ultram 50 mg by mouth. Mr. K continues to complain of pain 45 minutes after administration of pain medication and uses the call light to ask the nurse for additional pain meds. Mr. K states “I am in so much pain, I cannot take this pain anymore, please ask the physician for more medication!”. The nurse notifies the physician, but the physician states “Mr. K will not be receiving any narcotics, the only thing he will be getting is Toradol 60 mg intramuscularly”. The nurse administers the injection to Mr. K and he is transported to the X-Ray department. At this time, Mr. K is in so much pain he can hardly even remain still for the procedure. Mr. K is returned to his room while awaiting the results and rates his pain 9/10. The nurse knows that the physician will not order any more medication and does not want to bother him, so she decides not to report his level of pain. The X-Ray results post and indicate that Mr. K has a closed, non-displaced ulnar fracture of his right arm. The physician discusses the results with Mr. K and after having a final diagnosis for the pain, orders the nurse to administer Fentanyl 50 mcg intravenously. Five minutes later, Mr. K now rates his pain at 5/10 and less agitated. Mr. K is able to remain still for the orthopedic technician to apply a splint to his arm. Mr. K thanks his nurse for taking care of him and for having finally received some relief from his pain. He is discharged from the emergency department and instructed to follow-up with an orthopedic physician.

#### Application of Current Research

The triage nurse recognizes that because Mr. K is in pain management and takes narcotics on a regularly basis, that he is at increased risk for being tolerant to opioid medications.

Mr. K visits the ED frequently, but the nurse and physician decide to treat him with the same compassion and respect as any other client that presents to the ED. The nurse is aware of some of the barriers to pain management and knows that it is important to take time to accurately assess the patient's level of pain and acknowledge the patient's report of pain (Duignan & Dunn, 2009). The nurse documents Mr. K's level of pain as being 10/10 on the pain scale and notifies the attending physician. The physician is familiar with Mr. K, but does not want to have any biased opinion against him because of frequent visits to the ED. The physician is aware that because Mr. K has a higher tolerance to opioids that he may require a higher dose of medications or an alternative medication as compared to Mr. K's home medications (Savage et al., 2008). After an IV is established, the physician orders Dilaudid 1 mg IV. Mr. K states that his pain is now 6/10 on pain scale and also reports being nauseated. Dilaudid, or hydromorphone, is an opioid that has a quick onset and is known for having a high reward value but can also cause nausea, so the physician also orders Zofran 4 mg IV (Savage et. al, 2009). While Mr. K awaits the X-Ray, his pain starts to increase again. The physician decides that instead of ordering an additional dose of Dilaudid, he will order Fentanyl 100 mcg IV. Fentanyl is a highly potent opioid medication with a fast onset and works extremely well in opioid-tolerant patients (Grape et al., 2010). Mr. K now rates his pain 2/10 on the pain scale. The X-Ray is complete and the results show that he has a closed, non-displaced ulnar fracture of his right arm. The physician is relieved that he did not wait until a diagnosis confirmed Mr. K's level of pain and instead decided to use evidence-based research to properly assess and manage his pain. Mr. K is glad that he accurately reported his pain and received adequate pain management while in the ED. Mr. K is able to tolerate the orthopedic technician applying an arm splint without experiencing any discomfort and is discharged with follow-up care instructions.

## Conclusion and Recommendations

The client's pain issues were not appropriately addressed in the usual procedure scenario. Ineffective pain assessment skills and inadequate knowledge of chronic pain was evident by the actions of the nurse and physician. The nurse was reluctant to report the client's pain to the physician and the physician in turn allowed biased opinions to affect sound judgment in regards to pain management. Instead of believing the client's report of pain, the physician made personal conclusions as to the level of pain the client was experiencing. The physician also waited for a diagnosis to confirm the source of pain prior to administering narcotics, which does not follow best practice and is considered a barrier to pain management (Duignan & Dunn, 2009). Instead of the physician prescribing non-opioids, such as Toradol and Ultram, opioid medications such as Morphine, Dilaudid, and Fentanyl would have been more appropriate for an opioid-tolerant client (Savage, Kirsh, & Passik, 2008). The client experienced pain from triage to discharge. Although the client's health status was addressed and his injuries were identified and stabilized, pain management was not a priority. Providers and nurses can overcome this barrier by making pain management more of a priority while caring for clients with chronic pain (Wilsey et al., 2007). Effective pain management requires providers to take an evidence-based research approach to administering analgesics and formulating standards of care. This was achieved in the second scenario through the actions of the nurse and physician understanding the barriers to pain management and applying appropriate methods of treatment. Pain management requires a multidisciplinary approach that places the patient's pain experience as a top priority. Acute pain services that monitor regular pain assessments and documentation can also increase the likelihood of effective pain management in the ED. Awareness of attitudes and biased opinions towards clients with chronic pain is vital to overcoming barriers to pain management.

Healthcare providers should always follow best practice and use a safe approach when treating clients with pain.

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