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Pain management in hospitalized children: unveiling barriers from the nursing perspective

Manejo da dor de crianças hospitalizadas: desvelando barreiras sob a perspectiva da enfermagem

Manejo del dolor en niños hospitalizados: desvelando barreras desde la perspectiva de enfermería

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ABSTRACT

Objective: To understand nursing team perceptions about the barriers in pain management in the care of hospitalized children.
Method: Descriptive-exploratory study, with a qualitative approach, conducted with eight nurses and seven nursing technicians. Data were collected at the *Universidade de São Paulo* University Hospital, between June and September 2022, through individual interviews, analyzed from the perspective of thematic content analysis and in the light of Symbolic Interactionism.
Results: The following categories emerged: 1) Knowledge translation: is pain management actuallyperformed? and 2) Reflecting changes: how to achieve the potential of pain management? Professionals have theoretical knowledge about pain management, however, they listed numerous barriers at each stage, mainly related to institutional routine, and, when reflecting on this context, they indicated the need for an institutional protocol.
Final considerations: Barriers stand out from theoretical knowledge and make pain management for hospitalized children disregarded. Knowing this context is relevant forimplementing change strategies.
Descriptors: Pain. Pain management. Child hospitalized. Barriers to access of health services. Pediatric nursing.

RESUMO

Objetivo: Compreender as percepções da equipe de enfermagem sobre as barreiras no manejo da dor na assistência às crianças hospitalizadas.
Método: Estudo descritivo-exploratório, com abordagem qualitativa, realizado com oito enfermeiras e sete técnicas de enfermagem. Os dados foram coletados no Hospital Universitário da Universidade de São Paulo, entre junho e setembro de 2022, por meio de entrevistas individuais, analisados sob a ótica da análise temática de conteúdo e à luz do Interacionismo Simbólico.
Resultados: Emergiram as seguintes categorias: 1) Tradução de conhecimento: o manejo da dor de fato é realizado? e 2)Refletir mudanças:como atingir a potencialidade do manejo da dor? Os profissionais possuem conhecimento teórico sobre o manejo da dor, porém listaram inúmeras barreiras frente a cada etapa, principalmente relacionadas à rotina institucional, e, ao refletirem sobre esse contexto, indicaram a necessidade de um protocolo institucional.
Considerações finais: As barreiras se sobressaem ao conhecimento teórico, e tornam o manejo da dor às crianças hospitalizadas desconsiderado. Conhecer esse contexto é relevante para aplicar estratégias de mudanças.
Descritores: Dor. Manejo da dor. Criança hospitalizada. Barreiras de acesso aos cuidados de saúde. Enfermagem pediátrica.

RESUMEN

Objetivo: Comprender las percepciones del equipo de enfermería sobre las barreras en el manejo del dolor en el cuidado de niños hospitalizados.
Método: Estudio descriptivo-exploratorio, con abordaje cualitativo, realizado con ocho enfermeros y siete técnicos de enfermería. Los datos fueron recolectados en el Hospital Universitario de la *Universidade de São Paulo*, entre junio y septiembre de 2022, a través de entrevistas individuales, analizados en la perspectiva del análisis de contenido temático y a la luz del Interaccionismo Simbólico.
Resultados: Emergieron las siguientes categorías: 1) Traducción del conocimiento: ¿Se realiza realmente el manejo del dolor? y 2) Reflejar cambios: ¿Cómo alcanzar la potencialidad del manejo del dolor? Los profesionales tienen conocimientos teóricos sobre el manejo del dolor, pero enumeraron numerosas barreras en cada etapa, principalmente relacionadas con el cotidiano institucional, y, al reflejar ese contexto, señalaron la necesidad de un protocolo institucional.
Consideraciones finales: las barreras se destacan del conocimiento teórico y hacen que se desestime el manejo del dolor en niños hospitalizados. Conocer este contexto se vuelve relevante para aplicar las estrategias de cambio.
Descriptores: Dolor. Manejo del dolor. Niño hospitalizado. Barreras de acceso a los servicios de salud. Enfermería pediátrica.

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INTRODUCTION

The experience of pain in hospitalized children is a frequent phenomenon. It is estimated that approximately 95% of these children present pain, at some point during hospitalization, due to invasive procedures, diagnoses and the course of the disease[1]. Furthermore, studies indicate that, on average, 55% have an intense score, and 78.6%, a moderate score[2,3]. Results from qualitative research show that children cite pain and discomfort as the worst aspects of hospitalization[4]. Children are considered a vulnerable group to unrelieved pain, with a directly proportional relationship between age and pain relief[5].

Recognizing this aspect, international organizations have listed pain relief as a goal of the last decade, a child's right and a healthcare professional's responsibility, establishing it as the fifth vital sign[1]. There is no doubt that pain has become a relevant public health issue. In recent years, numerous investigations have focused on innovations in assessment and intervention methods[1,4,6]. However, integrating pain management into goals, rights and policies does not guarantee that it will occur, with pain still being a research phenomenon in nursing. Here, pain management is understood as the cyclical stages of assessment, intervention (with pharmacological and non-pharmacological interventions, jointly) and reassessment[7].

In child and adolescent health, pain assessment and reassessment are conducted using validated scales, depending on the stage of development and cognitive status, such as: Neonatal Infant Pain Scale (NIPS), for newborns up to 2 months old ; Face, Legs, Activity, Cry and Consolability (FLACC), for children between two months and seven years old; Wong-Baker FACES Pain Rating Scale, for children over three years old; Numerical Verbal Scale (NVS), gold standard for assessment, with self-reports by children over seven years old; and the Comfort-Behavior Scale (COMFORT-b), for children under continuous sedation[8].

The World Health Organization (WHO) recommends that the intervention be multimodal, integrating pharmacological and non-pharmacological interventions. Pharmacological intervention is chosen using the analgesic pain ladder, guided by two steps: 1) Mild pain, using dipyrone, paracetamol, or ibuprofen (depending on the child's age); and 2) Moderate to severe pain, using opioids at different therapeutic doses. The non-pharmacological intervention has different possibilities, such as nutritious or non-nutritive sucking, distraction (playing, storytelling, music and virtual reality), cuddling, among others[8].

In addition to the aforementioned steps, a concept analysis recently recommended that the family be included at the center of the pain management steps, with the with a collaborative communication, in a trustworthy environment, with a genuine partnership[9]. The recognition of the family in this process aligns with the premises of Family-Centered Care, a philosophy that guides the work of pediatric nurses[10], and their presence is considered as a non-pharmacological intervention for pain relief[11].

Along this path, nursing team professionals, with an emphasis on nurses, have an active role in managing pain management, being responsible for the assessment, implementation of pharmacological intervention, autonomy in the use of non-pharmacological interventions, reassessment and inclusion of the family in this process[7]. However, recent studies demonstrate that these steps are undervalued and remain below ideal standards[7,11,12].

In Brazil, in a cross-sectional, retrospective study conducted with the medical records of 1,251 hospitalized children, it was noted that 11.2% were not assessed for pain; 481 had pain validated by scales, but the absence of analgesia occurred in 18.3%, even with prescription; 99.6% had no documentation of non-pharmacological interventions; and 59.7% required reassessment[7]. Furthermore, in a qualitative investigation conducted with nursing team professionals in Brazil, it was reported that in clinical practice there is no family inclusion in painful procedures, mainly due to professional beliefs and attitudes[11].

The consequences of unrelieved pain cannot be underestimated. It is known that there are long-term impairments in perception, sensitivity, response to stress, behavior, learning and development, being a predictive factor for chronic pain in adult life, affecting the child and family, who can express dissatisfaction and resistance to care. For the institution, pain can prolong hospitalization, increase care costs and readmissions[1,13,14]. Therefore, it is important to recognize the barriers to translating the use of pain management steps into clinical practice.

Countries such as the United States[15], Ethiopia[3], China[6] and Qatar[16] have recently dedicated to research about barriers to pain management. A literature review on knowledge, barriers and facilitators to pain management demonstrated that there is no study conducted in Brazil on the phenomenon[1], with Brazilian investigations being necessary, mainly due to the cultural aspect being one of the factors that influence perceptions. Thus, the following concern emerged: what are the perceptions of the nursing team regarding barriers to pain management in hospitalized children?

This study aimed to understand the perceptions of the nursing team about the barriers in pain management when caring for hospitalized children. Understanding professional perceptions regarding barriers can guide future strategies

to change the context, with action against each individual and collective barrier, aiming to make pain important, understood, visible and better managed.

METHOD

Study design

Descriptive-exploratory study with a qualitative approach. The writing followed the recommendations of the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines)[17].

Study location

The study was conducted at the University Hospital of the *Universidade de São Paulo* (HU-USP), between June and September 2022, in the pediatric division, in the following units: Pediatric Emergency Room (PER); Pediatric Inpatient Unit (PIU); and Pediatric and Neonatal Intensive Care Units (ICU). These units work with children aged from newborn to 15 years of age. In this institution, there is no established pain management protocol, just a systematization of assessment using different instruments attached to an institutional form. The form includes the NIPS, FLACC, Wong-Baker FACES Pain Rating Scale, EVN and COMFORT-b scales, with guidance for assessment every four hours, and a space for assessing pain in painful procedures.

Eligibility criteria

Fifteen professionals participated, eight nurses and seven nursing technicians. Nurses and nursing technicians who worked in the pediatric division sectors were included, regardless of the shift (morning, afternoon, and night), and who were present in the practical field at the time of the researchers' immersion. Nursing residents and the head of the sector were excluded.

Data collection

Sampling was conducted by convenience. Participants were personally recruited during their working hours, depending on the researcher's presence at the location, and were invited to participate in the investigation.

Data were collected through individual and semi-structured interviews, conducted by two researchers: a final-year female nursing student, previously trained by the main researcher; and a male nursing resident in child and adolescent health, with previous experience in conducting qualitative interviews. The approach with two researchers allowed to explore the phenomenon in its complexity, with deepening of the discourses in complementary approaches[18]. It is worth noting that the resident was immersed in the nursing team, which facilitated the approach professionals for recruitment, but his participation in conducting the interviews occurred neutrally.

The data collection was conducted using a participant characterization instrument, filled out prior to recording, with sociodemographic variables, and in an interview, conducted with the following open questions: Could you tell me about the pain management (assessment, intervention, and reassessment) in hospitalized children? Do you encounter barriers in carrying out the mentioned steps? What do you believe should be done to change this context of pain management and the barriers mentioned? The questions were formulated jointly by the study researchers. No pilot test was carried out. However, as the interviews were conducted, the researchers discussed their progress, reflecting on gaps and possible ways of improvement.

The researcher requested authorization to the nurse in charge of the sector regarding the employee's leaving for data collection. With authorization, participant was taken to a reserved space, provided by the institution, with the presence of two researchers and the participant, conducted on different work shifts and days of the week, depending on the availability of researchers and participants. Fifteen professionals were approached, and all agreed to participate.

The interviews were audio-recorded using an electronic device. There were three hours and 48 minutes of interviews, which were fully transcribed by one of the study researchers. Repeated interviews were not conducted, and transcripts were not sent to participants. No field notes were taken.

To complete the empirical data collection, the technique of theoretical data saturation in qualitative research was employed, which allows participants to be included until the objectives were achieved and no new themes were established or until there were no new questions[19], being discussed and agreed upon by consensus among researchers.

Theoretical framework

The data were analyzed in light of the theoretical framework of Symbolic Interactionism (SI)[20], with the understanding of the meanings that the phenomenon has and its construction, which occurs in the interactions between the parties involved, from the social point of view of everyday reality. The individual is the agent of the action. The action occurs according to the meaning that the phenomenon (objects, actions, ideas, and activities) has for the individual, which is formulated in the interaction with the self (individual

with oneself), the mind (thoughts) and society (social organizations constituted by individuals), generating human action (outcome) (Figure 1).

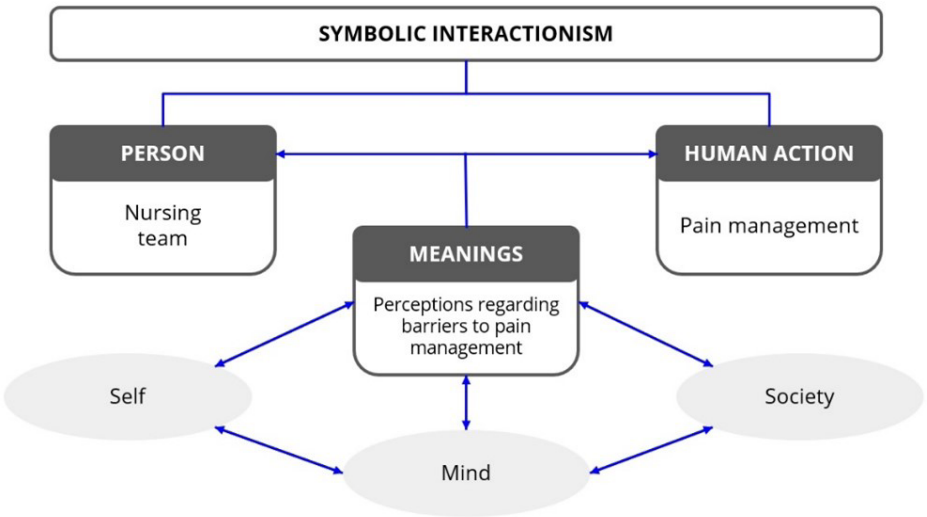
Data analysis

The data were analyzed using Bardin's thematic content analysis technique, with the following steps: 1) Pre-analysis, with repeated reading of the interviews (floating reading), conducted between five and ten times, approximating the content and its possible assumption; 2) Exploration of the material, with the extraction of possible themes and units of meaning extracted from the data; and 3)Data processing, where themes and units of meaning were grouped into categories and subcategories[21]. The analysis was conducted in pairs, independently, with deliberations on themes and resolution of discrepancies through the construction of consensus among all researchers involved, producing the categories and subcategories (Figure 2).

Ethical aspects

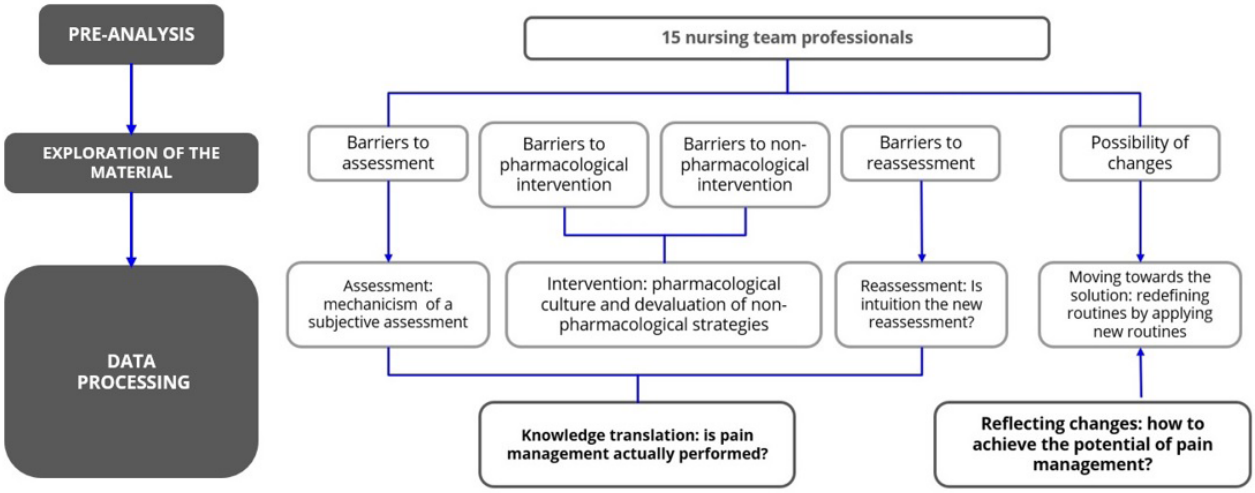
The study had ethical approval by the Research Ethics Committee of the School of Nursing of the *Universidade de*

Figure 1 – Symbolic Interactionism. São Paulo, São Paulo, Brazil, 2023



Source: Authors, 2023.

Figure 2 – Coding tree diagram. São Paulo, São Paulo, Brazil, 2023



Source: Authors, 2023.

São Paulo (CAAE: 56500822,3,0000,5392) and HU-USP (CAAE: 56500822,3,3001,0076). The ethical principles of Resolution No. 466/12 of the National Health Council (*Conselho Nacional de Saúde* – CNS)[22] were complied. At the time of invitation to participate in the study, the researcher conducted a joint reading of Informed Consent Form, and upon acceptance, it was signed in two copies (one for the participant and one for the researcher), followed with the beginning of the interview. It was decided to analyze the nursing team, rather than individual professionals, identified by the letter N, followed by a number according to the order of entry into the study, such as N1, N2, N3…

RESULTS

Fifteen professionals from the nursing team participated: eight nurses and seven nursing technicians. They worked in the PIU (3 nurses and 2 technicians), PER (2 nurses and 4 technicians) and Pediatric and Neonatal ICU (3 nurses and 1 technician). All professionals were female, aged between 34 and 62 years old, and have worked in pediatric nursing for between 9 and 28 years, and in the aforementioned sector, between 1 and 28 years. From the analysis, two following categories emerged: 1) Knowledge translation: is pain management actually performed? and 2) Reflecting changes: how to achieve the potential of pain management?), with interconnected subcategories, described below.

1) Knowledge translation: is pain management actually performed?

In the subcategory "Assessment: the mechanicism of a subjective assessment" (Chart 1), professionals demonstrated theoretical mastery regarding pain assessment, with only two relating the FACES scale to components of the FLACC scale and using the FACES scale for sedated patients. It was observed that knowledge translation to clinical practice is a challenge. Professionals reported a rigidity in the routine, with assessments recommended every four hours, leading to automatic care. There are difficulties in applying the scale, especially in patients with neuropathies or intubated patients, with the recognition that pain in this profile is undervalued. They mentioned the subjectivity of the instruments as a barrier, but with ambivalent speeches as they considered it an ally to assessment. The professional was skeptical of the scores, disregarding pain, especially if the child continues to perform activities of daily living. Additionally, there is no documentation of pain scores beyond the recommended times.

There is greater attention to orthopedic and surgical patients, due to frequent pain, and attention to those for whom the nurse or medical team indicated for assessment. In painful procedures, professionals mention making an assessment through intuition, only in procedures that they believed would lead to pain (e.g., burn dressings), or did not assess due to the high number of procedures to be performed, such as in ICUs. Furthermore, they cited a heavy workload, with the reduced number of employees predicting a low assessment of pain due to time spent for scale application.

Regarding the subcategory "Intervention: the pharmacological culture and devaluation of non-pharmacological strategies" (Chart 1), professionals indicated an overvaluation of the use of medications for pain relief, due to the ease and quick action. However, this depends on the prescription and medical decision, which implied: use of medications with low analgesic content for the pain score; prescription of medications with higher analgesic content to surgical and orthopedic children at expense of other specialties; absence of medication prescription for painful procedures; absence of a physician in the units, especially at night; and restriction of drug use in some groups, such as newborns, with the belief that they do not experience pain. They reported that communication between the team and the physician has by barriers, by the belief of an invasion of space, which makes it difficult for nurses to indicate that a patient is in pain. Four professionals did not indicate barriers to medications.

Professionals reported theoretical knowledge regarding non-pharmacological interventions for pain relief, citing physical, mechanical, environmental interventions, comfort, distraction, and integrative and complementary practices (ICPs). Three reported no barriers to the use of these interventions, but others indicated: personal preference for pharmacological interventions; dependence on the knowledge, belief and individual attitude of the professional, often with low usage since disbelief in their effectiveness; use of interventions only in mild pain due to the lack of protocols guiding the practice; fear of use and its influence on the clinical condition, citing 25% glucose; difficulty in accessibility to interventions; time requirement for its application; and nurses who did not recognize their autonomy in applying these interventions. They mentioned that length of experience could be a negative predictor of use, considering the statement that "*I've always done it this way, why should I change now?* (N15)". They reported that, when they use it, they do not document. One of the professionals indicated lack of motivation due to colleagues' prejudice regarding interventions, exemplifying Reiki energy therapy.

Professionals acknowledged the importance of reassessment for pain management. However, only one professional said performed it using validated scales, while fourteen

expressed the use of intuition as a tool, when remembering the need to reassessment. They reported that the reassessment is not performed systematically with a standard or time protocol after the application of any intervention and that the institution does not request this reassessment, respecting the predetermined schedules in the instrument, regardless of the pain and the possibility of using the nursing notes. The use of intuition was based on children complaint (if they did not complain, they do not have pain) and on the intervention (if they have already been medicated, they will no longer have pain), as seen in the subcategory "Reassessment: Is intuition the new reassessment?" (Chart 1).

Chart 1 – Professionals' discourses regarding the category "Knowledge translation: is pain management actually performed?". São Paulo, São Paulo, Brazil, 2023

THEORETICAL CATEGORY: "Knowledge translation: is pain management actually performed?"
Subcategory: "Assessment: the mechanicism of a subjective assessment"
What I see is that the assessment is based on our experience rather than using scales. We look at the patient, we see that he is not in pain, we don't even apply the scale, we already mark it as zero there (instrument).(N1) *When the child is undergoing a procedure, is going to be intubated, and is half awake, you notice that the child is moving in pain, it must be horrible. Venous punctures also, but we do not assess this pain.* [...] *we don't score it, we don't document it at all. And the child screams, cries... no type of procedure records the pain the child is experiencing... we don't do that.*(N3) *A child who, in theory, would not have a diagnosis, such as a fracture and surgery, would have no reason to be in pain*. (N2) *The assessment is mechanical, in the sense that it only assesses whether the patient complains*. (N2) *We have barriers such as professional scale, accumulation of tasks, routine, high demand, high occupancy rate. There is overload*. (N5) *In the emergency room, I've never seen anyone thinking about pain*. (N6) *Pain assessment is based on experience, as we didn't have scales before*. (N12)
Subcategory: "Intervention: the pharmacological culture and devaluation of non-pharmacological strategies"
We need the physician's assessment to medicate. Even if we prove that the child is in pain, even if we say that we applied the scale, there is always the barrier of depending on clinical assessment, and they have difficulty medicating. (N1) *There is a culture that newborns do not feel pain.* [...] *when you say that the child is in pain, pediatricians listen to you more than neonatologists*. (N9) *The application of non-pharmacological interventions depends on each professional, once again subjectivity*. (N1) *I am trained in ICPs*, but I feel afraid and coerced, because there is prejudice, especially on the medical side. It's as if he were practicing charlatanism. I know that* (ICPs*) *will help, but I'm scared of someone seeing it, anyone, and creating a situation, even if the mother authorizes it.* [...] *I'm afraid of being punished: "Who told you to do that? You're not hired for this."*(N6) *Like I told you, I comfort, hold, give affection, massage, but always following medical guidance.* (N15)
Subcategory: "Reassessment: Is intuition the new reassessment?"
The reassessment is intuitive, we deduce that, if he/she stopped crying, the pain improved. We don't go back to check, but there will be the next record (every 4 hours) *that the pain has gone away*. (N1) *We know that once the patient is in pain, that I have performed an intervention, I have to reassess. We have that in the instrument, but it is not a routine, there is no protocol, it is neglected*. (N1) *I don't use scales, we see if the child has calmed down. If they calm down, it's because there's no pain*. (N15)

Source: Authors, 2023.
*ICPs – integrative and complementary practices.

2) Reflecting changes: how to achieve the potential of pain management?

The ICU professionals indicated that the severity of the patients, sedation use and the high number of painful procedures affected pain management, while those from the PER indicated that children's lives are prioritized, considering pain a low priority. When asked to assess pain management in their sector, 11 professionals reported it as inadequate and superficial, focusing only on those expected to be in pain, and described it as weak, poor, and needing improvement. Only two PER professionals indicated it as good management.

When indicating barriers, professionals associated them as a result of interaction with the work routine. Thus, they were asked what could be done to change this context, as seen in the subcategory "Moving towards the solution: redefining routines by applying new routines" (Chart 2). When reflecting on this context, professionals listed change strategies such as: educating the multiprofessional team with constant updates; educational actions; reformulating institutional documents, with linearity in all sectors; greater institutional oversight with frequent audits; greater supervision of nurses regarding their team, oversight that these possibilities should be integrated into the sector's routine without becoming a new demand or disrupting the workflow. All professionals listed the formulation of an institutional protocol to guide the steps of pain management, but it is worth reflecting on whether the implementation of a flowchart will always be used or may fall into disuse due to a routine, such as the assessment instrument, already institutionalized.

After completing the data analysis, the researchers made a video with the main results, uploading it to the YouTube®, and produced a promotional leaflet distributed to all units providing childcare in the participating institution, aiming to provide feedback to the team so they can reflect on their practices.

Chart 2 – Professionals' discourses regarding the category "Reflecting changes: how to achieve the potential of pain management?". São Paulo, São Paulo, Brazil, 2023

THEORETICAL CATEGORY: Reflecting changes: how to achieve the potential of pain management?
Subcategory: Moving towards the solution: redefining routines by applying new routines
I believe the instrument needs to be readapted. (N6) *It is necessary to implement training. On how the steps will be done, when to do them. The dissemination of this information.* (N7) *I think we need to implement a protocol and training. That's missing, there should be encouragement for that.* (N3) *I think that, in the emergency room, things must be practical, there is no point in inventing protocols that do not streamline and hinder our service. In practice, it will be left aside. It should be something practical, like a checklist. After a while, we can adapt better and do it by memory by knowing the steps.* (N14)

Source: Authors, 2023.

DISCUSSION

In this study, barriers that permeate the pain management of hospitalized children are observed, making the experience of pediatric hospitalization marked by professionals' limitations regarding pain control. The SI framework allowed this understanding, by interpreting the influences of practical experiences on pain management, with the perceptions of barriers, both reported and intrinsic to the discourse.

Despite the standardization of pain assessment with different instruments for each age group, its systematization is still illusory, with the professional's subjectivity prevailing over the validation and sensitivity of the scales[1,14]. In a study conducted in the United States with 110 children with pain during a 24-hour period of hospitalization, 48.2% rated their pain as intense, but only 15% had documentation of this score[23]. This aspect demonstrates the subjectivity, distrust and low documentation of pain scores, as seen in this study. Another Australian study portrays the lack of pre-established times for pain assessment as a barrier[5]. However, in the co-participating institution of this study, there is such standardization, but numerous other barriers related to the nursing team influence the assessment.

The professionals in this study recognize that they make little use of pain assessment instruments, which corroborates a cross-sectional study conducted in Finland with 294 nurses

from a neonatal ICU, in which 23% reported that they used the instruments "almost daily", despite institutional standards[24]. In addition, there are also professionals who have never had contact with the scales, as reported by 82.6% of the 224 nurses in another study from Turkey[25]. Another point is that the professionals who assess often do not document, as seen in a Spanish cross-sectional study conducted with 737 professionals from the nursing team, with 54.2% reporting an absence of documentation[14].

In this sample, professionals overvalue pharmacological interventions, but list barriers to their use, which corroborate the barriers portrayed by nurses in a study from the United States, such as inadequate or insufficient prescription, insufficient time for medication before painful procedures and low priority for pain relief by prescribers[16]. It is worth reflecting that these barriers are beyond control of nurses, and future qualitative studies involving prescribers are necessary. Previous investigations indicate that the main reason for low pain relief prescriptions is the professional's fear of side effects, such as respiratory depression and dependence on medication. In a Chinese cross-sectional research with 211 nurses and 45 pediatricians, it was noted that 57.3% of nurses and 66.7% of physicians were hesitant to provide medications with high analgesic content[26].

Medication is the gold standard for pain relief[7], but its combination with non-pharmacological interventions enhances analgesic effects. In this study, the team emphasizes the low medication prescription, listing numerous non-pharmacological interventions, but does not recognize their autonomy and the possibility of use, despite being simple, viable, low-cost, effective, with high-quality evidence and strong recommendations[6]. These barriers may be associated with professional beliefs and attitudes. In the Chinese study with 211 nurses and 45 pediatricians, 12.6% of nurses and 11.1% of physicians believed that non-pharmacological interventions were ineffective and, consequently, did not use them[26].In a literature review, it was observed that nurses believed that these interventions only had an effect on mild pain[1]. Another aspect, as seen in this study, is the negative attitude of professionals regarding interventions. This stigmatization of the popular imagination towards interventions, such as ICPs, is a reflection of the remnants of the biomedical model and the overvaluation of the clinician, underestimating interventions that do not come from hard and palpable technologies, such as medications[27], overvalued in this research. There is a need for non-pharmacological interventions to move from their role of devaluation to the professional appreciation, due to their proven effects and the possibility of empowering the nursing team in pain relief interventions[6].

These barriers are also observed regarding painful procedures. A Brazilian study, with 90 newborns followed for three days of hospitalization, showed a total of 2,732 painful procedures, but only 19.7% non-pharmacological interventions and 7.9% pharmacological interventions were performed[28]. This aspect may be related to the discourse on the difficulty of pain management in neonatology, as seen in this study. Results of an integrative review showed that nursing professionals believed that repeating painful procedures increased the child's tolerance to pain[1].

Regarding reassessment, intuition was listed as the main strategy, however, the importance of using standardized scales is emphasized again, even if the instrument requests assessment for every four hours, as nursing record is a place capable of documenting this aspect. The absence of reassessment limits the professional from knowing whether the intervention was effective or whether there is a need for new conduct. In a study conducted in Ghana, reassessment is well established, with 91.7% of 180 nurses reporting performing and documenting it[29].

The social interactions of the nursing team with the child in pain, their family and institutional routines are marked by barriers that lead to pain devaluation[20]. In the literature, low knowledge predominates as the main professional barrier[15,30], being listed as a negative predictor of pain management[31]. There is no doubt that professional knowledge is essential to guarantee the integrity of the steps[1], however, beyond that, professional attitude will be a predominant predictor[3]. From the SI perspective, the individual acts in accordance with the definitions elaborated from each situation[20], thus, their beliefs and attitudes will influence the knowledge translation[1,4], as seen in this study. It is worth reflecting on whether nurses consider their low priority for pain management to be a problem, as seen in a study with nurses in the United States, in which the low priority given by them to pain relief was classified as the least significant barrier[16]. Furthermore, the institution (society)[20] must also recognize these barriers as a problem, since the team is immersed in direct interaction with it.

Lack of resources, incentives, institutional policies, and professional overload are also listed in the literature as institutional barriers. The barrier regarding the child consists of their exclusion from professional communication, with a lack of interest in reporting the pain or disqualification[32]. These barriers corroborate other investigations that list that nurses believe that children do not feel pain like adults, that their reports are not reliable, and they naturalize that hospitalization will lead to pain[1,5,13].

In this study, the reasons that lead to human behavior of pain devaluation were considered and how it is

interconnected with oneself and others. Based on the SI[20], the nursing team (subject) is influenced by their professional construction, their knowledge, attitudes and beliefs (self and mind) which, when interacting with the child in pain in an institution (society) and their management (phenomenon), builds its perceptions (symbols), here related to subjectivity, devaluation, intuition and the desire for resignifications. To this end, these aspects must be considered in a process of change, marked by the transition of the subject from a passive recipient to a perception of an active individual that influences the entire pain management process.

In this context, professionals desire the construction of an institutional protocol similar to other studies[33,34]. However, it is worth reflecting on this aspect, considering that a protocol is a guide that should be followed by all professionals in the institution. Even though it allows linear assistance, where everyone acts in the same way, it is not free from being used routinely. This reflection arose from the ambivalence throughout the statements, considering that professionals say that routines, such as the systematization of assessment, lead to automaticity of care, however, in the end, they aim for a new standardization. The criticism exposed here is not about the formulation of protocols, but rather their implementation without acting on the interactions that generate the symbols (barriers), as seen in Figure 1.

Undoubtedly, the implementation of a protocol leads to positive results in care, as seen in a pre- and post-intervention study conducted in a pediatric ICU in the United States, with 51 trained professionals in a pain management protocol. In three months, an improvement in assessment was observed by 98.6%; in six months, this rate was reduced to 97.1%[34]. The rate remained high, but the 1.5% drop in a period of three months may reflect the lack of consistency. The period is still short, but we reiterate the hypothesis that, if this same assessment were performed after 1 year, the decrease could be greater, and professionals would be acting without using the recommended systematization. In a study conducted with 253 healthcare professionals working in five hospitals in Qatar, 97.3% were aware of the presence of an institutional protocol, but only 66.9% felt confident in its implementation[17], corroborating the reflection here that a combination of strategies is necessary.

Institutions must aim to disseminate evidence-based practice, with knowledge translation. This comprises two phases: 1) Preparation phase, with the identification of the problem in clinical practice, considering that this study operates in this phase by recognizing the main limitations for pain management; and 2) Implementation and change phase, with planning, development and action[12,35]. A Canadian research that used this action model provided better results in pain relief[12].

For implementation, the following can be used as strategies for behavioral change: encouraging interprofessional collaborative practice[1,15]; training of effective leaders who can disseminate the importance of pain management to their staff[4]; educational strategies beyond passive education, using interactive education that is continuously and far-reaching[5]; audits of medical records with institutional charges regarding documentation of actions; and formulation of a pain team within the institution[30,35]. For this, a customized design must be carried out to achieve the desired objective, in this case, the change of interpretative processes that influence human actions[20], must consider the context of action and the possibility of use. It is worth noting that the feedback that researchers made from this research to the institution can be a positive predictor for reflecting on their actions, however there is a need for future investments.

This study has limitations, such as the results reflecting a single organizational structure, although barriers may be experienced in other Brazilian states, the approach occurred only with the nursing team – despite their active role in pain management, ideally it would be an interdisciplinary approach – and the study did not explore facilitators for pain management. For future studies, a qualitative approach with a multidisciplinary team is suggested, along with a quantitative approach for statistical analysis of barriers. It is hoped that this research can contribute to the formulation of strategies that allow these barriers to be effectively addressed in clinical practice and worked towards their resignification, thus ensuring effective pain management for children.

FINAL CONSIDERATIONS

This study provided an analysis of the barriers faced by the nursing team in pain management at a Brazilian hospital. It was observed that professionals demonstrated theoretical knowledge regarding the stages of pain management and its importance, however there are difficulties in translating it into clinical practice, which is permeated by numerous barriers, associated with professional attitudes, such as devaluation of scales, overvaluation of pharmacological interventions, low recognition of non-pharmacological interventions, predominance of intuition, and routine when faced with reassessment. Participants in this study reported a desire for protocol implementation, which, if not well worked on amid ongoing education and other strategies, can become a new routine, being ambivalent. In the light of interactionism, to move towards the resignification of barriers to pain relief,

there is a need to integrate actions that focus on professionals' meanings regarding the phenomenon and its context, so that pain is recognized, understood, and managed.

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