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Listening to Unheard Voices: Nurses' Communication Experiences with the NRS Pain Scale

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Abstract

This study examines nurses' experiences with the Numeric Rating Scale (NRS). These responses characterize the communication trials that nurses face with pain diagnosis, pain management, and overall patient care. Interviews with 20 nurses reveal three themes: subject dissatisfaction, feeling limited, and subjective satisfaction. An analysis of these themes reveals the need for renewed discussion about the way pain is communicated and the challenging expectations nurses must regularly confront. Implications for listening to important, but often quiet, even silent, voices in pain management and clinical practice are discussed.

Keywords: Nurses, pain scale, health communication, interviews, grounded theory

Introduction

In 2004, the National Coalition on Health Care (NCHC) declared that the U.S. health care system is under crisis “riddled with inefficiencies, excessive administrative expenses, inflated process, poor management and inappropriate care...” (NCHC, 2004). These concerns have escalated in the years since as health-care costs continue to rise annually. As the public debate about solutions continues, an additional problem is surfacing: a critical shortage of nurses. In fact, estimates suggest the U.S. nursing shortage will swell to “260,000 registered nurses by 2025. A shortage of this magnitude would be twice as large as any nursing shortage experienced in this country since the mid-1960s” (American Association of Colleges of Nursing [AACN], 2010). These shortages are also predicted to undermine quality medical care as nurses are stretched to their professional limits.

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Nurses are a vital part of health care, providing many services, including diagnosing and treating acute and chronic health problems; conducting prenatal, well-child, well-woman, and adult check-ups; managing and diagnosing minor trauma; and educating patients about health promotion and disease prevention (Canadian Nurses Association, 2002). Nurses' roles today not only include traditional bedside care, but also other duties, including team leaders, administrators, and supervisors. In fact, nurses are often on the front lines of the changes in their work roles, job responsibilities, and professional relationships. "These role additions come at a time when nurses are pressured to do more in less time, but without additional training, higher wages, or institutional support" (Apker, 2005, p. 245). These overwhelming pressures on nurses, ultimately, affect patient care, including the challenging area of managing patients' pain.

Now considered the fifth vital sign, pain must be assessed every four hours, whenever temperature, pulse, respiration, and blood pressure are measured (Terry, 2004). Some experts have observed, "The precise measurement of pain intensity represents one of the most frequent challenges that healthcare professionals have to face" (Larroy, 2002, p. 2). The mandate to communicate with patients about pain more frequently falls primarily on nurses' shoulders, adding to their already lengthy responsibilities (Terry, 2004).

Assessing pain by utilizing the Numeric Rating Scale (NRS) is particularly common. Despite mixed conclusions about the NRS' reliability and validity, it is acknowledged as a useful, subjective instrument. Manias, Bucknell, and Bottie (2004) argue that pain cannot be measured directly because of its subjective nature, but is determined by patients' manifested behaviors and self-reported pain. Thus, at its core, pain management is, in fact, a communication issue. As Campbell (2000) notes, the primary problem in treating pain "is that it eludes exact measurement," speaking directly to the need for effective communication between nurses and patients (p. 17A). Every patient perceives pain differently; one patient may rate the pain as a two while another patient with similar symptoms may rate the pain as a seven. As a collective group, nurses are competent, but some research shows that they consistently underestimate patients' pain levels (Sloman, Rosen, Ram, & Shir, 2005). The problem is a complex burden among the pain-scale instrument, perception, and communication between patients and nurses.

Although frustrations have been expressed regarding the NRS, research about nurses' valuable opinions and feelings toward this instrument is noticeably thin, especially considering the nurses' central role with pain assessment. This exploratory study examines nurses' experiences with the NRS and contributes to a renewed dialogue that is aimed at improving the diagnosis, treatment, and overall health-care quality by paying attention to the specific communication responses that nurses offer as they help patients accurately describe the perceptions of pain while simultaneously standing as gatekeepers between doctors and patients.

Literature Review

Notwithstanding its universality, pain is a slippery concept to understand (Montes-Sandoval, 1999). Researchers have sought to comprehend and define the feeling of pain since the time of Aristotle (Criste, 2002). More recently, pain has been defined as an "unpleasant sensory and emotional experience associated with actual or potential tissue damage and described in terms of such damage" (Ong & Seymour, 2004, p. 15). The physiological effects of pain can negatively alter nearly every body system. Pain can affect sympathetic nervous-system stimulation; pain can also cause decreased lung volume, hyperglycemia, immune dysfunction,

altered coagulation, psychological distress, gastrointestinal ileus, and urinary retention (Criste, 2002; Hospice and Palliative Nurses Association [HPNA], 2004).

The subjective nature of pain makes it difficult to conceptualize another person's pain. Specific pain experiences are not simple, one-time occurrences, but components of past pain experience, that are influenced by socio-cultural factors and legitimized through language (Montes-Sandoval, 1999). Because pain symptoms are often described in a vague, ambiguous, or arbitrary manner, confusion can become a significant concern, thus clear communication channels are essential (Montes-Sandoval, 1999). Unrelieved pain can cause sleep disturbances, hopelessness, a loss of control, and impaired social interactions. The physiological stress and decreased mobility caused by pain may even hasten death (HPNA, 2004).

Pain Scales

Wood (2004) argued that nurses have “a moral, ethical, humanitarian and professional responsibility to provide an adequate standard of pain assessment” (p. 42). To meet this obligation, different assessment instruments have been developed and are used in a variety of nursing environments (Holdgate, Asha, Craig, & Thompson, 2003).

The two most frequently used instruments are the NRS and the visual analogue scale (VAS; Mawdsley, Moran, and Conniff, 2002). Although the VAS is considered to be the “gold standard” for pain assessment (Aubrun, Paqueron, Langeren, Coriat, & Riou, 2003; Ong & Seymore, 2004), an extensive study by Aubrun et al. (2003) found that nurses preferred the NRS, citing it as more rapid and easier to use. When comparing the two most commonly used tools, the VAS and NRS, Holdgate et al. (2003) found that both scales perform equally well for assessing changes in pain; the researchers also concluded that, by measuring the two scales together, the agreement may be overestimated. The inconsistent findings for pain assessment point to the conclusion that different tools may address various pain components (Coll, Ameen, & Mead, 2004). Another challenge comes from the fact there is no universally accepted pain-assessment tool, and clinicians and researchers lack a common language to discuss and compare the outcomes of pain assessment and management (National Cancer Institute, 2006). It is no wonder that Manias et al. (2004) reported that, despite the variety of pain-assessment methods available, 43.7% of the time no assessment activities were used by nurses as they conducted pain-related activities; simple questioning occurred 45.3% of the time.

Nurses

According to the U.S. Department of Labor (2010), registered nurses made up the largest portion of all health-care occupations, holding over 2.5 million positions in 2009, a much larger number compared to physicians, including specialists, for the same time period. Reflecting these reports, Ballard (2003) argued that the main commodity provided in most health-care settings is not health care, but nursing care.

The nurses' role in overall health care cannot be underestimated. In addition to patient treatment, nurses develop and implement nursing care plans, maintain medical records, advise patients about health maintenance and disease prevention, educate patients and their families, and administer diagnostic tests as well as analyzing the results (U.S. Department of Labor, 2010).

Nurses provide the majority of inpatient care (Rothschild et al., 2006), and patients clearly recognize that nurses are key players in that care. In a compelling story aired by the BBC (2002), it was reported that a review of 34 studies revealed that not only were nurses viewed as “front-line” health-care workers, usually the first point of contact and the personnel who made initial assessments, but also patients were generally more satisfied with nursing care than with the care provided by general practitioners. A similar review of 16 studies came to the same conclusions; nurses spent more time with patients, provided more information, and received higher patient-satisfaction ratings than physicians (Lourant, 2005). Moreover, researchers studying medical mistakes found that, in 69% of cases involving errors, nurses recognized and corrected the problem before it reached the patient (Rothschild et al., 2006). In short, nurses’ communication ability and the information that they are able to glean from patient interactions ought to be of greater concern to practitioners, communication scholars, and researchers.

Nurses have been studied in a variety of ways, including how they communicate to manage role tension (Apker, Propp, & Ford, 2005), their coping behaviors in stressful situations (Sheldon, Barrett, & Ellington, 2006; Wanzer, Booth-Butterfield, & Booth-Butterfield, 2005), their pain assessments compared to patients’ pain assessments (Sloman et al., 2005), and their response to patients’ pain descriptions. In a literature review of nurse-patient interactions, Shattell (2004) reported that most of the research done on nurse patient-interactions focused on nurses’ communication. Despite the importance of Shattell’s focus on nurse-patient interaction, patient perceptions about the interactions, and patient care-seeking communication, two of these concerns are patient focused. Notably absent in this, and other research, is nurses’ perceptions about their interactions with patients. While there is a large body of research available on nurses and pain assessment (e.g., McDonald, LaPorta, & Meadows-Oliver, 2007, there is little to be found on nurses’ communication regarding pain assessment, despite the fact that it is primarily their responsibility to assess patient pain (“A Nursing Approach,” 2005). Coyne et al. (1999) observed, “The general public assumes, and patients hope, that nurses and physicians . . . possess a comprehensive knowledge of pain management that is readily translated into clinical practice” (p. 154). While Coyne and her colleagues concluded that nurses should be educated about pain assessment and treatment, the research stops short of uncovering or evaluating nurses’ experiences with pain assessment.

While there are entire books devoted to understanding patient perspectives and experiences (Charon, 2006; Harter, Japp, & Beck, 2005), there is little research examining nurses’ communicative reflections about a central part of their duties: managing patients’ pain. This obvious gap in the literature leaves unanswered questions about what nurses would reveal regarding their critical role in assessing patients’ pain. Accordingly, the following research question is posed:

RQ: How do nurses communicate about and reconcile their experiences with patients while using the NRS Pain Scale as required by health-care organizations?

Method

The researchers began by contacting the public relations (PR) director at a small, regional hospital in the southwestern United States to discuss the possibility of interviewing nurses for the study. Upon his recommendation, the researchers were connected with the hospital’s nursing manager for a brief conversation about the study’s purposes/goals. Her positive response led the researchers to secure appropriate documentation from the university’s institutional review board,

which was presented to each participant and to the hospital PR director. The hospital agreed to post a flyer at the nurses' station, and from that point, the researchers were able to secure initial participants. Despite hospital approval, participants were primarily chosen by using a snowball sampling method where each respondent assists the researchers with finding the next subject until there are a sufficient number of people to answer the research question (Offredy, 2000). Because of shift work and nurses' family and personal responsibilities, it was difficult to secure participants due to the focused and time-sensitive nature of the interviews; additionally, some nurses did not want to be bothered by participating in the study.

As with previous investigations using the snowball method, steps were taken to reduce sample bias. Such procedures included (a) choosing subjects from varying fields of the nursing profession (e.g., Nurses had worked in a regular hospital, emergency room, home health, and hospice.) and (b) finding a range of experience levels. Participants were 20 nurses (16 females, 4 males; all Caucasian) from a broad spectrum of fields, including the emergency room, surgical procedures, regular hospital, and home health and hospice care. Their collective experience fell between one and 30 years, with an average of at least 9 years as a full-time nurse. Each participant was familiar with different pain-management scales, the NRS in particular, due to popularity and the health facility's preference.

Each participant was interviewed using a semi-structured question format. Interviews were conducted over the phone and in person, depending on the participant's schedule and individual comfort level (e.g., Most people were more comfortable on the phone.). Each interview began by asking participants to explain their pain-assessment protocol and procedures when working with a patient to establish how the nurses orient a patient toward the NRS. In most cases, participants gave a prompt such as "With 10 being the worst pain you could experience and 1 being almost no pain, how would you rate your pain right now?" Depending on the treatment's duration, participants reported similar variations of patient follow up by asking "How is your pain now, and what number would you give it based on the pain scale we used earlier?"

Next, participants described their protocol for when they felt a patient's reported pain level and their perception of the patient's pain status were incongruent. Other questions were specifically aimed at eliciting nurses' feelings about the NRS and whether they would prefer this tool to another one, such as the VAS. They also explained their perceptions about how satisfied they believed other nurses are with the pain scale. Such questioning included the challenge of helping patients translate their pain into a number as well as how satisfied the patients seemed to be. The participants were encouraged to share a brief example that characterized their experiences and satisfaction level.

The interview transcripts generated 22 single-spaced pages of data. Creswell (2013) recommended establishing reliability for the data analysis by seeking agreement among the designated coders. For our study, three coders analyzed the data independently; then, they convened to assess intercoder agreement. Although qualitative research does not generally utilize statistical tests to determine intercoder reliability, a general understanding about three themes emerged among the coders. These dominant themes were identified, and differences were reconciled using a specific method of grounded theory called constant comparison in order to ensure thorough and systematic discovery (Glaser & Strauss, 1967). According to Creswell (2013), grounded theory provides a procedure for developing information categories, interconnecting those categories, building a story that connects the categories, and ending with a discursive set of theoretical propositions. Grounded theory is utilized when there is inadequate

theory to explain a given communication phenomenon. In these cases, the researcher allows the theory to emerge organically from the text. When using grounded theory, there are three phases of coding: open, axial, and selective. During the open-coding process, the researcher examines the text, looking for broad information categories that are supported by the text. The researcher analyzes these categories until he or she reaches a point of theoretical saturation, meaning that there is a reasonable expectation that continuing the open-coding process would not yield any additional categories. Open coding reduces the text to a set of overall themes that represent the text's key characteristics (Strauss & Corbin, 1998). Creswell (2013) advises researchers to utilize at least two verification procedures when validating the findings. This study used a negative case analysis to determine if there were any discordant themes. Finding none, the other verification procedure was peer review, where we sought feedback from a colleague who advised us to use our first two interviews as a pilot test for conducting the interviews and analyzing the data.

In the axial-coding process, the researcher attempts to put the categories together much like a puzzle, determining how the different categories generated with the open-coding process relate to each other (Strauss & Corbin, 1998). Within this coding process, information is organized into a theoretical model where a theory is built or generated. From there, the researcher generates hypotheses that connect the categories in the coding process, which is known as the final process, selective coding. Within selective coding, a diagram called a conditional matrix is created to help the researcher visualize the consequences and conditions related to the phenomenon being studied (Creswell, 2013).

Results¹

This analysis identified three important themes related to the way nurses communicate about and utilize the NRS Pain Scale in their various clinical capacities. Each response underscores the cognitive/affective ebb and flow that nurses experience when using the existing tools, such as the NRS, noting the simultaneous dialectical tensions that nurses feel between satisfaction and dissatisfaction with the instruments. Specifically, the themes were subjective dissatisfaction, feeling limited, and subjective satisfaction. In the next sections, these themes are examined as they relate to the research question guiding this study.

Subjective Dissatisfaction

In spite of the widespread use of the NRS, nurses expressed dissatisfaction with the instrument which was often reported as a conflicted dialectical story of satisfaction-dissatisfaction. Participant #17 stated, "I think . . . it's an imperfect system, and I think nurses are a lot of time, well pretty much nurses, all nurses myself included, don't rely very heavily at all on the pain scale." This apparent distrust of the NRS stemmed from a mix of subjectivity and patient empowerment that the scale provides, creating a discrepancy between nurses' perceptions of patient pain and patients' self-rating. At the same time, nurses run the risk of not following

¹ The authors recognize that there are grammatical issues and sentence fragments in the participants' responses but felt that it was important to let the data speak accurately about the nurses' thoughts and feelings. Some issues, such as "like," "and," etc., were often signs of the participants thinking about their answers while making sense of their experiences. We have chosen to omit the typical [sic.] with every quotation to keep the quotations cleaner and easier to read.

policy in medical settings where the pain scale is required. Researchers speculated that, due to the discrepancy between the organizational mandates and the nurses' personal beliefs and practices, some nurses might perceive a potential for disciplinary action if their true feelings were revealed regarding the pain scale's shortcomings. Such disregard for standard protocols could leave nurses directly exposed to job sanctions, even termination.

The nurses' responses reflected an ongoing problem with patients' discrepancies because the patients both underrated and overrated their pain. Nurses expressed frustration when a patient rated his or her pain low when he or she was in obvious pain. Because of the low rating, the nurses felt that they couldn't do anything about it because of the organization's medical protocol. Moreover, a low pain score was indicative that pain is present, but not necessarily to a degree where pain meds were needed. Participant #14 put it this way:

I can't say every time, but it is a very high percentage, maybe nine out of 10 times a patient will report a numeric, a pain level that I as a nurse can't, you know, that I wouldn't match. I wouldn't say hey that's really a pain level 10, you know. I think it's lower than that or its opposite, like you will have some tough cowboy kind of a guy, and they will say "Oh one or two" and they're just dying; their blood pressure is up; their heart rate is up; and you want to treat them, but really I can't. If they report a one or two below a three I can't treat them.

Nurses also expressed frustration when they perceived that patients rated pain higher than nurses thought it should be. Most nurses who expressed this frustration described these patients as "drug seekers" or as patients who were seeking faster or more attention. For example, participant #19 recalled:

We had a guy that had been in the ER over 12 times in the last month . . . he's a drug seeker, and he is there for pain meds. He asks for Benadryl right when it is due, Phenergan right when it's due, Dolson right when it's due, Dollata right when it's due, and it's a little frustrating when he's saying his pain is a 10 and, and they are not finding a thing wrong with the guy, you know.

Whether patients were rating their pain too low or too high, the respondents felt that the NRS was often a detriment to patient care, despite its centrality and overall purpose.

Feeling Limited

As an extension of the first theme, nurses who shared their experiences noted that they felt the NRS scale limited their ability to help patients in the manner and to the extent that they would like. As a whole, the participants felt slightly less satisfaction with their jobs and the quality of care that they were able to provide. For example, participant #4 stated, "I've run into, don't empathize with the patient and go strictly by objective criteria instead of subjective interpretation, and it is unfortunate when I see that because the patient has been left in an uncomfortable state." Here, participant #4 was referencing the standard hospital protocol that must be followed to find the sweet spot for keeping patients comfortable while preventing any start toward addiction.

Because nurses view themselves in a role of helping patients, their frustrations with the contradictions inherent with the NRS greatly limit their ability to treat pain. As participant #14 noted, despite being able to state a number, patients "don't adequately understand the scale, or they misuse it." These feelings ultimately led some nurses to rely more on their instincts while steering them away from the scale after the initial categorization that occurs during the admission

process. Unfortunately, these limitations continue to compound the pressures that nurses must manage in order to do their job effectively for themselves, their patients, and their medical employer (e.g., hospital or hospice).

Subjective Satisfaction

Not all of the responses regarding the NRS and subsequent communication about it were negative. The participants also described their experiences with the NRS as a satisfying, subjective experience. In short, nurses valued the subjective nature of the scale that allows patients to consider their individual pain separate from other people because pain is an individual experience that is based on factors such as patient anxiety and pain threshold. For example, participant #3 expressed:

I think it's a very effective tool because pain is a symptom you know; it's something the patient has to tell you. A lot of things that you do in assessment is what the patient has to tell you, and pain is one thing the patient has to tell you. A lot of people are okay with tolerating a higher level of pain, and they don't want medication, and so that's why the pain scale is good.

Participant #6 stated, "I like that it can be individualized for each patient. You know, pain is a different experience for every different person. And so, a patient is able to give it the number that they feel is appropriate personally for them."

In addition to the feelings of personalization, nurses reported that they believed patients liked the NRS. Participant #11 stated, "I think that probably 75% of patients like it because they can give us an answer." However, the answer was often a guess because patients, especially people with little NRS experience, were trying to use a ranking system that they use nowhere else in their lives. The nurses who participated in the study believed that the NRS' subjective nature provides a means for patients to not only express their pain, but can also facilitate a conversation between nurses and patients, thereby initiating a climate of trust, if both parties can get in sync communicatively. Such a climate not only facilitates more communication, but also a higher-quality interaction, leading to more effective and efficient pain treatment.

Discussion

This study attempted to understand the way(s) that nurses communicate about the NRS Pain Scale while attempting to understand the instrument's utility as a routine part of patient care. The research question explored the communicative means that nurses use to make sense of their experiences with the NRS Pain Scale as a regular, required part of their jobs. The responses showed a troubling pattern. A scale that allows a patient to talk with a nurse is valuable because it opens an important line of communication and can create a climate of caring and trust, a type of medical partnership. However, most of the nurses in this sample were caught in a dialectical tension with their perceptions. On the one hand, they felt that patients struggle with the translation from physiological/psychological sensations to a specific number. The result was a desire to discontinue using the scale. On the other hand, the nurses were restrained by hospital policies and were required to do exactly the opposite. The themes pointed to a need for medical professionals to re-examine their policies. Such procedures should provide nurses with the flexibility to adjust the medication strength based on their interactions with the patient and pain management, in general, rather than relying on the numbers alone.

In the myriad of responsibilities that nurses must juggle, institutional pressure to follow rules may account for the positive communication and nurses' high estimate (e.g., 75%) of patient satisfaction with the NRS scale. This observation is consistent with a number of studies in the literature which talk about the constricted and increasingly demanding environment surrounding nurses (Apker et al., 2005; Rothschild et al., 2006; Shattell, 2004). Nurses must follow rules and provide front-line care for patients, unlike the doctors whose time with patients is much more limited. The findings show that nurses are trapped between a world of not wanting to create or perpetuate patient addiction to painkillers and not wanting patients to suffer needlessly because they fail to use the NRS the way it is intended. Additionally, the scale itself is hopelessly flawed for a number of cases because it requires patients to rate pain that they have no basis for comparing due to experiential novelty (e.g., a woman in labor for the first time).

Conclusion

Although exploratory in nature, this study is useful in many ways. It reveals that there is a level of frustration felt by nurses in regard to pain assessment, generally, and the NRS, more specifically. While nurses view their role as one of helping the patient, they expressed feelings that, in some ways, the NRS constrains them for this important role. The most interesting finding is that the essence of their complaints is the communication problem created by the scale, showcasing the need for clear, precise communication with patients as well as the void that is created when these avenues are partially blocked. Nurses are caught in a hopeless situation where they have to use a highly fallible instrument, forcing them into situations where they must break the rules and trust their own judgment, a professional ethics quandary (Manias et al., 2004). Nurses report that they feel helpless because the consequences for mismanaging pain can lead to addiction for patients as well as potentially strained relationships with doctors and administrators if mistakes are made and if second-guessing occurs. Moreover, the frustration that patients report when trying to give their pain a number, using metaphors such as "it feels like someone hit me with a bat," may seem concrete to them while leaving nurses in a precarious position. The nurses are then forced into premature judgment and frustration as they aid patients in understanding how to translate their pain sensations and to match them with the appropriate number.

There are several limitations that should be noted. The sample was limited to nurses from one small region of the country, and they only represent one of many cultural backgrounds working in health care. Language barriers, cultural beliefs and similarities may have changed the outcome if this study had captured such data. The sample size, 20, could also be viewed as limiting, despite the study's qualitative nature. Additionally, participants gave shorter-than-anticipated answers because researchers promised to be brief, perhaps too brief. Taking the time to catalog more in-depth stories from nurses' experiences may provide richer insight about the themes discovered as part of this study. Due to the nature of their erratic shift work, the nurses agreed to phone interviews. That technique was most convenient for them so that nurses could focus on their responsibilities.

A certain amount of speculation seems to be in order about the reservations that some nurses felt with how this data would be used and how they might be tied to the results, despite careful steps to maintain participant privacy. Such concerns may have exacerbated the overly brief responses, and the fears of being "too negative" about an instrument and system that they cannot change may be attributed to making the best of a challenging situation. These barriers

lead to some uneven depth with the responses, but they also speak to the time pressures and increasing responsibility which nurses do, in fact, face on a regular basis.

Clearly, it is time to listen to these important, unheard voices, allowing them to set the agenda for change, not only about the instrument, but also about the quality of communication between nurses and patients. While this study serves as an initial foray into looking closer at the pain-management problem from the inside out, the results are worthy of consideration because all parties involved with the healing process win when a regular, healthy dialogue about pain diagnosis and management can be fostered.

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