HOSPITALIZED CHILDREN: CHARACTERISTICS OF PAIN MANAGEMENT BY NURSING STAFF

CRIANÇAS HOSPITALIZADAS: CARACTERÍSTICAS DO MANEJO DA DOR PELA EQUIPE DE ENFERMAGEM

LOS NIÑOS HOSPITALIZADOS: CARACTERÍSTICAS DE MANEJO DEL DOLOR POR PERSONAL DE ENFERMERÍA

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Abstract

Objective: to characterize pain management for children hospitalized by the nursing staff. Method: descriptive quantitative research performed in a teaching hospital, Londrina / Paraná / Brazil with 43 techniques / spotters / nursing attendants and six nurses from the inpatient unit and pediatric intensive care, using an automatic applicable instrument with objective matters "true or false" analyzed in numbers and percentages. The Research Ethics Committee has approved the research project, CAAE 2034.0.000.268-09. Results: about 94.0% of the professionals in the nursing staff felt that physiological and behavioral signs accompany the pain and used to assess it. Approximately 75.0% identified as unacceptable that the child feels pain during hospitalization. Almost 64.0% pointed out that morphine is not a last resort to treat chest pain (angina pectoris), although 67.3% considered it a powerful respiratory depressant. Conclusion: pain management is still a challenge for the assistance provided by the team of nursing the child, although there are instruments that allow an evaluation and effective intervention. Descriptors: Pain; Child; Hospitalization; Pediatric Nursing.

Resumen

Objetivo: caracterizar el manejo del dolor para los niños hospitalizados por el personal de enfermería. Método: investigación cuantitativa descriptiva realizada en un hospital de enseñanza en Londrina / Paraná / Brasil con 43 técnicas / auxiliares / atendentes de enfermería y seis enfermeras de la unidad de internación y de tratamiento intensivo pediátrico, utilizando un instrumento autoaplicable con preguntas objetivas "verdadero o falso" analizado en números y porcentajes. El proyecto de pesquisa foi aprobado pelo Comitê de Ética em Pesquisa, CAAE 2034.0.000.268-09. Resultados: aproximadamente 94,0% das profissionais de enfermagem consideraram que sinais fisiológicos e comportamentais acompanham a dor e podem ser utilizadas para avaliá-la. Cerca de 75,0% identificou ser inaceitável que a criança sinta dor durante a hospitalização. Quase 64,0% apontou que a morfina não é último recurso para tratar a dor, embora, 67,3% considerou-a um potente depressor respiratório. Conclusão: el manejo del dolor sigue siendo un reto para la asistencia proporcionada por el equipo de enfermería del niño, aunque existen instrumentos que permiten una evaluación y una intervención eficaz. Descriptores: Dolor; Niño; Hospitalización; Enfermería Pediátrica.

Resumo

Objetivo: caracterizar o manejo do dor da criança hospitalizada pela equipe de enfermagem. Método: pesquisa descritiva quantitativa realizada em um hospital escola, Londrina / PR / Brasil com 43 técnicas / auxiliares / atendentes de enfermagem e seis enfermeiras da unidade de internação e de tratamento intensivo pediátrico, utilizando-se um instrumento autoaplicável com questões objetivas "verdadeiro ou falso" analisadas em números e porcentagens. O projeto de pesquisa foi aprovado pelo Comitê de Ética em Pesquisa, CAAE 2034.0.000.268-09. Resultados: aproximadamente 94,0% das profissionais da equipe de enfermagem consideraram que sinais fisiológicos e comportamentais acompanham a dor e podem ser utilizadas para avaliá-la. Cerca de 75,0% identificou ser inaceitável que a criança sinta dor durante a hospitalização. Quase 64,0% apontou que a morfina não é última opção para tratar a dor, embora, 67,3% considerou-a um potente depressor respiratório. Conclusão: o manejo do dor ainda é um desafio para a assistência prestada pela equipe de enfermagem à criança, embora haja instrumentos que possibilitem uma avaliação e intervenção efetivas. Descriptores: Dor; Criança; Hospitalização; Enfermagem Pediátrica.
The International Association for the study of pain (IASP) conceptualizes the pain as “an unpleasant sensory and emotional experience and subjective, which can be associated with an actual or potential tissue damage or described in terms of such damage”.\(^1\) In the case of child hospitalized this sense emerges in a context permeated by exacerbated fears regarding bodily injury, insecurity and anxiety, change in routines, family separation and loss of control.\(^2\)

With regard to this age group, the measures for the relief of pain tend to be ineffective, because the pass assessment and treatment by several obstacles, among which stands out the difficulty to identify, measure and control, due to the inability of the child to express it verbally.\(^3\)

This ineffectiveness reaffirmed in literature review\(^4\), when reporting that children have received under treatment of pain, and that this has perceived as a feeling of psychological order. The diagnosis of pain must include both characteristics as location, quality, intensity, frequency and duration, nature and etiology, as individual subjectivities that feel. This is because the ways of coping and interpretation of pain acquired and influenced by cultural beliefs and values originating in the society in which the individual inserts.

The influence and importance of culture in experience and interpretation of pain are confirmed by another study\(^5\), which emphasizes that one should consider the social dimension which involves pain, because there are different actors in the reality of the subject that the experience. In this way, one realizes that another limitation on the effective management of pain in childhood would be, beyond the difficulty of speech that exists between children, cultural diversity existing within hospitals, more precisely on the subject act directly in the care of these clients. It is said, “The previous experiences and cultural differences among the members of the health team also interfere in assessing the intensity of pain and can induce improper assessment symptom”.\(^6,0,04\)

Facing this reality has arisen the interest in understanding how health professionals involved in the care of children hospitalized in pediatric units recognize the children's pain. So, can contribute to minimize pain during hospitalization in pediatric units of lesser or greater complexity, taking into consideration the peculiarities of the different age groups. Thus, the present study aims to characterize pain management for children hospitalized by the nursing staff.

**METHODOLOGY**

Quantitative descriptive character study conducted with nursing professionals active in the Pediatric Unit (UP) and pediatric intensive care unit (UTIP) at the University Hospital of Londrina (HUL), the Universidade Estadual de Londrina (UEL), Paraná.

Both units serve only patients of the unified health system (SUS), under the age of 12 years. The UP has 34 beds divided into nine wards that meet clinical and Pediatric Surgery, in addition to specialties like orthopedics, hematology, neurosurgery, and ophthalmology, among others. This unit consists of a multidisciplinary team consisting of doctors, social worker, psychologist, engineer and medical residents, nursing and physiotherapy. The nursing staff is composed of technical/29 spotter/nursing attendants and six nurses. The nursing attendants were accepted when the hiring of category was legalized and only care how hygiene, comfort and food, without administering medication.

The UTIP offers five beds for the various specialties of surgical and clinical area. Also offers a multiprofessional team, being nursing staff consisting of 14 technical/nursing assistants and 2 nurses. On the team, there is no nursing attendant.

In 2007, the hospital implemented the “HU Project without pain” and began the training, through workshops, to all professionals involved in the assistance. It subsequently entered in prescribing pain nursing fifth vital sign. The workshops given to nursing teams UP and UTIP featured the particularities of child and newborn with appropriate pain assessment scales and duration of eight hours for nurses and four hours for technicians/assistants/nursing attendants. The HUL adopted the Neonatal Infant Pain scale NIPS-Scale for newborns and infants, which is composed of seven behavioral and physiological parameters, with scores ranging from zero or one, whose total score could range from zero to seven, increasing scale of pain. For children as young as three years old was adopted the scale of course, which depicts five faces of chives, of Maurício de Souza, with scores ranging from 0 to 4, indicating since absence of pain until the worst pain I’ve felt.

Data collection occurred in the period from November to December 2009 after approval of the institution and of the Committee of ethics in research in humans, opinion n° 135/09.
2034.0.000.268-09 CAAE. The data obtained using a single questionnaire auto applicable. Each professional in their work shifts, filed 24 issues of true type (V) or false (F) evaluate pain related, concepts about pain and pharmacological treatment and pharmacological pain. The instrument consists of 24 questions objective divided into two parts: 1. characterization of the study population: identification data, age, professional category, place of work and working time in pediatric area. For the techniques/spotter/nursing attendants added to question whether nursing graduation year, because believed that the formation could interfere in conceptions and knowledge about pain and II. The pain in children.

With the 56 employees, almost all 49 (87.5%) filled out the questionnaire. In the period of collecting six professionals were on leave and refused to participate in research.

The data analyzed in numbers and percentages, later grouped into two categories: 1-professionals-nurses and 2-techniques/spotter/nursing attendants. It should be noted that the category 2 was grouped by submit approximate values. Also grouped the UP and UTIP as children’s unit, however, at times the results were presented separately to note differences in answers about pain in children, taking into account the complexity of the performance of the units.

RESULTS

Among the 13 (23.2%) employees of UTIP, 11 (78.6%) exercised the function of Nursing Assistant and 3 (21.4%) of nursing technician. In UP, 21 (72.4%) were nursing assistants, 4 (13.8%) and 4 nursing techniques (13.8%) nursing attendants. Approximately 15 (38.5%) of techniques/spotter/nursing attendants attended or were graduated in nursing, being 5 (33.3%) of the UTIP and 10 (66.7%) of the UP. The nursing attendants had no top-level training.

The average age was 45 years to the techniques/spotter/nursing attendants and 42 years for nurses in both units. In relation to working time in pediatric area average was 17 years, being the largest of techniques/spotter/nursing attendants (18 years) and the lowest among nurses (11 years).

With regard to the responses of the nursing staff on the evaluation of pain, it observed in table one that none of the nurses and 7.0% of the techniques/spotter/nursing attendants considered true that the child doesn’t know how to say about his own pain.

The practice of offering distraction to your child as a way to find out if this feel pain was regarded as true to check if she really feels pain or not by 74.4% and 33.3% of the techniques/spotter/nursing attendants and nurses, respectively.

For the nurses, the experience and intuition of the health professional not considered unique Tools to assess the truthfulness of pain in children, while 9.3% of the techniques/spotter/nursing attendants stated as true.

With regard to the child lie with pain to receive a secondary gain, as special treatment or benefits, approximately 42.0% of the techniques/spotter/nursing attendants and 33.3% of the nurses considered true. However, analyzing the data for inpatient unit (UP and UTIP) none of the UTIP nurses considered the true issue, 50.0% of nurses against UP.

All of the nurses and 93.0% of the techniques/spotter/nursing attendants considered true that the child with pain presents physiological and behavioral measurable signals.

Table 1. Responses from employees of the nursing staff of the children's units on the evaluation of pain in children, 2009, Londrina (PR), Brazil.

<table>
<thead>
<tr>
<th>Assessment of pain in children</th>
<th>Techniques/spotter/nursing attendants</th>
<th>Nurses</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(V) n %</td>
<td>(F) n %</td>
<td>(V) n %</td>
</tr>
<tr>
<td>1. The child does not know to inform about your pain.</td>
<td>3 7.0 40 93</td>
<td>- 6 100.0 3 6.1 46 93.9</td>
<td></td>
</tr>
<tr>
<td>2. Distract the child is a way to find out whether or not the pain.</td>
<td>32 74.4 11 25.6 2 33.3 4 66.7 34 69.4 15 30.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Professional experience and intuition are sufficient to identify whether or not there is pain.</td>
<td>4 9.3 39 90.7</td>
<td>- 6 100.0 4 8.2 45 91.8</td>
<td></td>
</tr>
<tr>
<td>4. Awards or special treatment decrease or eliminate the pain.</td>
<td>18 41.9 25 58.1</td>
<td>2 33.3 4 66.7 20 40.8 29 59.2</td>
<td></td>
</tr>
<tr>
<td>5. Physiological and behavioral Signs accompany the pain and used to verify their existence and intensity.</td>
<td>40 93.0 3 7.0</td>
<td>6 100.0 - 46 93.9 3 6.1</td>
<td></td>
</tr>
</tbody>
</table>

In Table 2 presented the replies of professionals from nursing staff regarding the concepts about pain in children. More than 75.0% considered that the child doesn't lie about his own pain and almost all claimed to be true that the threshold of pain is similar, but that there is variability in tolerance.
There is also that there was divergence in the responses of the nurses compared to the techniques/spotter/attendants with relation to the pain be similar among children during physical stimuli, 33.3% and 79.1%, respectively, claimed to be true.

All the pain considered identifiable amongst professionals (77.6%), with the higher the greater the tissue injury pain sensation, noted differences between the occupational categories, for 48.8% of the techniques/spotter/nursing attendants and 83.3% of the nurses independently conceptualized as false.

Little more than 75.0% of the techniques/spotter/attendants considered that it is not acceptable for the child to feel pain during hospitalization. As regards the assertion that if the child sedated won’t feel pain, 55.8% and 83.3% of the nurses considered false. When we look at the answers for workplace, 58.6% of the techniques/spotter/nursing attendants and 79.1% of the nurses independently conceptualized the issue as real against 14.3% of the UTIP.

Table 2. Responses of the nursing staff of the children's units pertaining to concepts about pain in children, 2009, Londrina (PR), Brazil.

<table>
<thead>
<tr>
<th>Concepts about pain in children</th>
<th>Techniques/spotter/attendants</th>
<th>Nurses</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. It is common the child lie about the existence of pain.</td>
<td>11 25.6</td>
<td>32 74.4</td>
<td>01 16.7</td>
</tr>
<tr>
<td>2. Although the pain threshold is similar, the pain tolerance is varied.</td>
<td>41 95.3</td>
<td>02 4.7</td>
<td>05 83.3</td>
</tr>
<tr>
<td>3. The pain is similar among children during physical stimuli (e.g., venipuncture)</td>
<td>34 79.1</td>
<td>09 20.9</td>
<td>02 33.3</td>
</tr>
<tr>
<td>4. All the pain has an identifiable physical cause.</td>
<td>34 79.1</td>
<td>09 20.9</td>
<td>04 66.7</td>
</tr>
<tr>
<td>5. The higher the degree of tissue injury the greater the intensity of the pain.</td>
<td>22 51.2</td>
<td>21 48.8</td>
<td>01 16.7</td>
</tr>
<tr>
<td>6. It is unacceptable to the child feel pain during hospitalization.</td>
<td>12 27.9</td>
<td>31 72.1</td>
<td>0- -</td>
</tr>
<tr>
<td>7. Child sedated feels no pain.</td>
<td>19 44.2</td>
<td>24 55.8</td>
<td>01 16.7</td>
</tr>
</tbody>
</table>

With regard to the pharmacological treatment of children's pain, can check in table 3 that all nurses and 58.1% of the techniques/spotter/nursing attendants stated be false that morphine is the last option for pain relief. However, 16.7% of nurses and 74.4% of the techniques/spotter/nursing attendants pointed the morphine as a potentiator of respiratory depression. However, analyzing the responses separately, 86.2% of the techniques/spotter/UTIP nursing attendants pointed out this issue as real against 50.0% technical/spotter/nursing attendants.

To 67.4% of the techniques/spotter/nursing attendants and 33.3% of the nurses to morphine cause psychic dependence. While the occupational categories, 65.1% and 100.0%, respectively, noted that the non-steroidal anti-inflammatory analgesics cause dependence. The ineffectiveness of analgesia in children with chronic diseases considered as false to 76.7% of the techniques/spotter/nursing attendants and 100.0% of the nurses.

For both the techniques/spotter/nursing attendants (69.8%) and nurses (83.3%) is best to use painkillers when the prescription has fixed times.
As for non-pharmacological treatment of children’s pain, noted in table 4 that approximately 96.0% of professionals considered false that children should guide to feel pain to increase tolerance. However, 58.1% of the techniques/spotter/nursing attendants claimed to be false which when your child endure the pain should not be treating her as he investigates the cause. Only 44.2% of the techniques/spotter/nursing attendants considered that one should not tolerate the pain and analgesic use spacing, avoiding excess. On the contrary, all the nurses considered false.

The use of placebo associated with referred pain relief for the child indicating that there are simulation of pain considered a real situation to 83.7% of the techniques/spotter/nursing attendants and 50.0% of the nurses. Analyzing separately, has that 75.0% of nurses noted the issue of UP to true, against none of the UTIP. The assertion that the use of techniques of distraction for pain relief is only effective when there is emotional tension considered true by 67.4% of the techniques/spotter/nursing attendants and by 16.7% nurses.

Regarding the need to cure the disease and not the pain of the child was marked as false by 81.4% of the techniques/spotter/nursing attendants and 100.0% of the nurses.

Table 3. Responses of the nursing staff of the children’s units on the pharmacological treatment of pain in children, 2009, Londrina (PR), Brazil.

<table>
<thead>
<tr>
<th>Pharmacological treatment of pain in children</th>
<th>Techniques/spotter/ attendants</th>
<th>Nurses</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(V)</td>
<td>(F)</td>
<td>(V)</td>
</tr>
<tr>
<td>1. Morphine should use only as a last resort.</td>
<td>18</td>
<td>41.9</td>
<td>25</td>
</tr>
<tr>
<td>2. Morphine presents a high risk of respiratory depression.</td>
<td>22</td>
<td>74.4</td>
<td>11</td>
</tr>
<tr>
<td>3. Psychological Addiction is rare with the use of morphine.</td>
<td>14</td>
<td>32.6</td>
<td>29</td>
</tr>
<tr>
<td>4. Anti-inflammatory Painkillers may viti ate the person easily.</td>
<td>15</td>
<td>34.9</td>
<td>28</td>
</tr>
<tr>
<td>5. Pain relievers don’t solve the pain in chronic diseases.</td>
<td>10</td>
<td>23.3</td>
<td>33</td>
</tr>
<tr>
<td>6. for children with potential risk of pain is appropriate to maintain the prescription of painkillers “if necessary” than fixed times.</td>
<td>30</td>
<td>69.8</td>
<td>13</td>
</tr>
</tbody>
</table>

Table 4. Responses of the nursing staff of the children’s units on the pharmacological treatment of pain in children, 2009, Londrina (PR), Brazil.

<table>
<thead>
<tr>
<th>Pharmacological treatment of pain in children</th>
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<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(V)</td>
<td>(F)</td>
<td>(V)</td>
</tr>
<tr>
<td>1. Guide the longer children experience pain, the greater the tolerance.</td>
<td>02</td>
<td>4.7</td>
<td>41</td>
</tr>
<tr>
<td>2. Pain bearable not treated before investigating the cause.</td>
<td>18</td>
<td>41.9</td>
<td>25</td>
</tr>
<tr>
<td>3. Stand the pain and space use of painkillers is a way to avoid excess medication.</td>
<td>24</td>
<td>55.8</td>
<td>19</td>
</tr>
<tr>
<td>4. Refer to pain relief after a placebo means there is simulation of pain.</td>
<td>36</td>
<td>83.7</td>
<td>07</td>
</tr>
<tr>
<td>5. The distraction and relaxation techniques can assist in pain relief only in cases of emotional tension.</td>
<td>29</td>
<td>67.4</td>
<td>14</td>
</tr>
<tr>
<td>6. Do I need to cure the disease and not the pain?</td>
<td>08</td>
<td>18.6</td>
<td>35</td>
</tr>
</tbody>
</table>

DISCUSSION

It turns out in this study that the nursing staff considered the ability of the child to inform about your pain. This result conforms with the literature, since children have the ability to evaluate and demonstrate their suffering through verbal or non-verbal expressions, actions that vary according to the degree of development and age range in which they find themselves.3

The possibility to assess the pain in childhood is confirmed by the existence of specific ranges, as pointed out in a systematic review conducted in 2010 World2, which brings "exclusive scales for newborns", "scales common to newborns and older kids" (Neonatal Facial Coding; Behavioral System; Faces, Legs, Activity, Cry and Consolability; Visual Analogue Scale; Children's and Infant's post-operative Pain Scale; Riley Infant Pain Scale; and composed: Comfort; Multidimensional Pain Assessment Scale; Neonatal Assessment of Pain Intensity), besides "scales validated for older children and used in newborns", among which there are those who need validation for this age group such as Children’s Hospital of Eastern Ontario.
Pain Scale; Attia modified and McGrath Affective Facial Scale.

To confirm the existence or not of pain in children, the professionals of this study stated that the distraction is an effective strategy. However, the literature points out that this is a form of non-pharmacological treatment and not a pain assessment method that includes, among other factors, the standard identification, location, intensity, nature and the success of treatment employed.8,9

Another factor that draws attention is the significant portion of the nursing staff consider to real pain reduction in children using the award. This statement is troubling because it can influence negatively the management of pain and, consequently, damage an effective intervention for the relief of the same. It is important to evaluate the response of the child in different situations and consider that if caregivers or family members only offer child care at a time when this presents pain, she can use this strategy to get such affection, not meaning that she’s not actually going through a painful experience.9 literature has pointed out that the assessment of pain often is performed according to the beliefs, expectations and personal values, professional and not objectively, based on scientific evidence. In this logic, when the nurse or even one of their own family go through painful experiences, raising awareness with the pain on the other tends to be larger, providing greater link and effectively of the treatment of pain.5

Although the results suggest that there is still erroneous knowledge and beliefs about pain in children, all the nurses and more than 90.0% of the techniques/spotter/nursing attendants considered to have professional experience is not sufficient to assess whether the child is in pain or not, and physiological and behavioral changes during the pain. These are indeed important signs, however there are caveats, since the physiological and/or change of vital signs is more acute than pain related to chronic pain, due to somatoform autonomic responses caused by the painful stimulus.9

It turns out that, with regard to concepts about children’s pain, nursing staff still relates the veracity of pain to identifiable physical causes, invalidating the mentioned by infant. This refers to one of the myths that remains among the health professionals: that the child lies about the existence of pain. This would be correct if the pain is not a sensory experience as emotional, features that bring the need to give credit to what is pointed to by the subject, whether verbal or non-verbal.1

As for the threshold of pain, you might want to highlight that this is “the least experience of pain that a person can recognize”10: 397 and pain tolerance is “the highest level of pain that the person is prepared to tolerate”.10: 398 this recognition of pain varies by genre, culture, drug action and age, being smaller at birth.10 This confirms the results in which most professionals pointed to true variability of tolerance, but otherwise, most of the techniques/spotter/attendants and the minority of the nurses considered real the pain be similar among children during physical stimuli.

It should noted that pain is a subjective experience and multidimensional that can be experienced in different ways compared to similar situations, or even in the absence of any apparent injury9,11, therefore is not determined solely by the degree of tissue injury. Such rationale contradicts the answers between the occupational categories in which less than half of the techniques/spotter/nursing attendants and almost the entirety of the nurses considered false that the higher the degree of the injury the greater the intensity of the pain. On the other hand, less than 21.0% of the techniques/spotter/nursing attendants and 34.0% of the nurses claimed to be false that all the pain has an identifiable physical cause.

12,13 studies claim that previous experiences, beliefs, lack of understanding of what pain is and attitudes of nursing staff, coupled with the poor organization of health services may influence the action of pain relief. Certainly beliefs as to what is acceptable for a large number of children feel pain during hospitalization and when is sedated this sensation disappears, are often held up by the lack of updating of the practice, which interferes directly in the control of the pain of those customers.

This study examined that the myths regarding the use of morphine are still present in the healthcare practice. The respect of this drug, the literature points out that this is an opioid, class maid when only painkillers relieve pain. The side effects of this category of drugs are dose-related, which has no ceiling dose and should then be adapted to the characteristics of the client. The most common reactions caused by morphine are “[…] constipation, urinary retention and respiratory depression […]” 6,15

Despite scientific evidence pointing in the other direction, the children’s pain-related beliefs still remain, among them can be
mentioned: the kids don’t feel so much pain as adults or don’t always tell the truth about the pain; pain is important to build character (the strongest tolerate better the pain); they get used to pain or painful procedures; narcotics are more dangerous for children than for adults; cause respiratory depression and hooked; is difficult and takes a lot of time treat chest pain (angina pectoris). 4, 5, 14-7

As for the belief of the opioids cause addiction, documented that its incidence occurs in small frequency when these are used for the treatment of pain. In addition, there may be confusion between the terms physical and psychic dependence of medicine. Psychological dependence is the intense desire to repeat a desired effect of a drug, and that this be perpetuated, since the physical dependence is an Adaptive State manifested by a set of organic reactions when an opioid is suspended administered an antagonist, this event usually occurs weeks after administration of the first dose. 9

The myths that are still present, the use of sub-therapeutic doses of painkillers and sedatives, the prescription of these on demand system (only if necessary) and not in the schedule, and the ignorance of professionals can contribute to an inadequate pain treatment. 10This instigates a reflection on technical responses/spotter/nursing attendants that encompass dependence by anti-inflammatory medication time, tolerance, truthfulness and pain treatment, since although in small percentages, the choice of alternative “true”.

The use of painkillers aims to relieve pain, gain stability, decreasing physiological anxiety and minimize the negative physiological consequences, and has greater success when performed by associating with sedatives. 6

Results like this suggest risk of occurrence of inadequate management of pain arousing concern with the quality of assistance, since the literature States that children are less medicated for pain than adults in similar situations and often with sub-therapeutic doses, and no pain treatment is a form of neglect of care. 7

It has been reported the best results in the treatment of pain with the Association of pharmacological and non-pharmacological methods, constant reassessment and prescription medicines at fixed times whenever possible, avoiding the use of “if necessary”. 4, 12 this comes to meet the satisfactory results, in that most nurses and techniques/spotter/nursing attendants pointed out how real the question who values

the delivery of medicines at fixed times and “if necessary”.

For pain relief be effective, it must associate pharmacological and non-pharmacological resources, offering service chronicity cases by a multidisciplinary team. 9 yet, little more than 23.0% of the techniques/spotter/nursing attendants considered true that chronic pain is not resolved with medication.

Another important method for adequate pain control is the active participation of the child, so she should be encouraged to use techniques that reduce their pain and anxiety, without physically restrict. No less important is the presence and participation of their relatives in pain management, because in their presence, the child feels more secure, reducing feelings of abandonment, fear of the unknown and anxiety. 3, 9

As explained earlier, the pharmacological treatment of pain is an ally of the pharmacological treatment and walk together, preferably in this study still approximately 68.0% of the techniques/spotter/nursing attendants and approximately 17.0% of nurses felt that the distraction and relaxation only help pain in cases of emotional tension.

Despite all the scientific knowledge produced about pain in children is still the promotion of an adequate management of infant pain and, consequently, more humane treatment are limited. Therefore, is a long-term work, the awareness of health professionals with regard to numerous variables of painful experience?

CONCLUSION

It can observed that almost all of the professionals believes that the child is able to recognize the pain, but when you don’t recognize, you can identify it by means of physiological and behavioral signs. The majority considered the morphine, as an appropriate treatment for children’s pain, although a small portion of professionals have considered be true that morphine should be the last option of analgesia for causing dependence psychic and respiratory depression.

Pain management represents a challenge in assistance provided by nursing staff and, despite all the theoretical available and initiatives for increasing updated professional scientific knowledge, still remain the beliefs regarding the use of opioids, truthfulness of pain of the child and the little efficaciousness of the pharmacological treatment of pain. That same cascade of misunderstandings, the
evaluation of the pain still be misdiagnosed even pain scales are available in pediatric units. On the other hand, other study should conducted to deepen the theme and offer subsidies to encourage an accurate assessment and minimize possible under treatment of pain.

Therefore, it is necessary to resume investment in human resources through continuing education, implement multidisciplinary teams combined with a change of institutional philosophy regulated by the professional practice. Also if should consider the inclusion of teaching of pain in its various facets of trainers courses new professionals.

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