NURSING INTERVENTIONS FOR PATIENTS WITH ACUTE PAIN

INTERVENÇÕES DE ENFERMAGEM PARA PACIENTES COM DOR AGUDA

INTERVENCIONES DE ENFERMERÍA PARA PACIENTES CON DOLOR AGUDA

Júlia Torres Cavalheiro¹, Graciane Lafuente Ferreira², Michele Bulhosa de Souza³, Anali Martegani Ferreira⁴

ABSTRACT

Objective: to identify nursing interventions performed for patients with acute pain. **Method:** this is a qualitative, exploratory and descriptive study, carried out in a prompt care unit of a philanthropic hospital. The procedure of triangulation of techniques was adopted. The study was developed in three stages: documentary analysis; cross-mapping to Nursing Interventions Classification (NIC) 13 for pain and validation of Nursing interventions through a focus group. **Results:** 350 patient service bulletins attended at the emergency and emergency service were included. It was observed that, of the 350 service bulletins, 338 (96.6%) presented a diagnosis of Nursing "acute pain". It was verified that, in relation to the mapped Nursing interventions, the only identified Nursing intervention was "Medication Administration". This NIC activity was mapped. It was considered at the focus group session that the intervention mapped to the NIC was confirmed and, as a result, 12 new Nursing interventions were included. **Conclusion:** it was possible to identify and validate six Nursing interventions performed by the Nursing team and not registered in the nursing notes, and 12 new Nursing interventions. **Descriptors:** Nursing; Emergency Nursing; Acute pain; Nursing Process; Standardized Terminology in Nursing; Emergency Medical Services.

RESUMO:

Objetivo: identificar as intervenções de Enfermagem realizadas para pacientes com dor aguda. **Método:** trata-se de um estudo qualitativo, exploratório e descritivo, realizado em uma unidade de pronto atendimento de um hospital filantrópico. Adotou-se o procedimento de triangulação de técnicas. Desenvolveu-se o estudo em três etapas: análise documental; mapeamento cruzado à *Nursing Interventions Classification* (NIC)¹³ para a dor e validação das intervenções de Enfermagem por meio de um grupo focal. **Resultados:** incluíram-se 350 boletins de atendimento de pacientes atendidos no serviço de urgência e emergência. Observou-se que, dos 350 boletins de atendimento, 338 (96,6%) apresentaram diagnóstico de Enfermagem "dor aguda". Constatou-se que, em relação às intervenções de Enfermagem mapeadas, a única intervenção de Enfermagem identificada e registrada foi "Administração de medicamentos". Mapeou-se esta atividade da NIC. Considerou-se, na sessão do grupo focal, que houve a confirmação da intervenção mapeada à NIC e, a partir disso, houve a inclusão de 12 novas intervenções de Enfermagem. **Conclusão:** permitiu-se identificar e validar seis intervenções de Enfermagem realizadas pela equipe de Enfermagem e não registradas nas anotações de Enfermagem, e 12 novas intervenções de Enfermagem. **Descritores:** Enfermagem; Enfermagem em Emergência; Dor Aguda; Processo de Enfermagem; Terminologia Padronizada em Enfermagem; Serviços Médicos de Emergência.

RESUMEN

Objetivo: identificar las intervenciones de Enfermería realizadas para pacientes con dolor agudo. **Método:** se trata de un estudio cualitativo, exploratorio y descriptivo, realizado en una unidad de pronta atención de un hospital filantrópico. Se adoptó el procedimiento de triangulación de técnicas. Se desarrolló el estudio en tres etapas: análisis documental; mapeo cruzado a la *Nursing Interventions Classification* (NIC)¹³ para el dolor y validación de las intervenciones de Enfermería a través de un grupo focal. **Resultados:** se incluyeron 350 boletines de atención de pacientes atendidos en el servicio de urgencia y emergencia. Se observó que, de los 350 boletines de atención, 338 (96,6%) presentaron diagnóstico de Enfermería "dolor agudo". Se constató que, en relación a las Intervenciones de Enfermería mapeadas, la única intervención de Enfermería identificada y registrada fue "Administración de medicamentos". Se ha mapeado esta actividad de la NIC. Se consideró en la sesión del grupo focal, que hubo la confirmación de la intervención asignada a la NIC y, a partir de eso, hubo la inclusión de 12 nuevas intervenciones de Enfermería. **Conclusión:** se permitió identificar y validar seis intervenciones de enfermería realizadas por el equipo de enfermería y no registradas en las anotaciones de Enfermería, y 12 nuevas intervenciones de Enfermería. **Descriptores:** Enfermería; Enfermería en Emergencia; Dolor Agudo; Proceso de Enfermería; Terminología Padronizada en Enfermería; Servicios Médicos de Emergencia.

¹Specialist, Federal University of Pampa / UNIPAMPA. Uruguaiana (RS), Brazil. Email: juliatcavalheiro@gmail.com ORCID ID: <https://orcid.org/0000-0003-0786-0575>; ²Nurse, Federal University of Pampa / UNIPAMPA. Uruguaiana (RS), Brazil. Email: gralafuente@hotmail.com ORCID ID: <https://orcid.org/0000-0002-8522-1667>; ³Master, Federal University of Pampa / UNIPAMPA. Uruguaiana (RS), Brazil. Email: michelebulhosa@gmail.com ORCID ID: <https://orcid.org/0000-0003-1818-9537>; ⁴PhD, Federal University of Rio Grande do Sul / UFRGS. Porto Alegre (RS), Brazil. Email: analimf@gmail.com ORCID ID: <https://orcid.org/0000-0002-9049-087X>

INTRODUCTION

Pain is presented as a subjective and multifactorial experience. It is known that each individual responds to painful stimuli according to personal experience and with influence and reflection of cultural, environmental, emotional, and sensory factors, among others.¹ It is observed that the prevalence is high mainly because it is associated, in most specific health problems or therapeutic procedures.²

In Brazil, there is no precise epidemiological data on the rates of pain occurring.³ However, it is the main cause of disability in work, when compared to other isolated health problems, including around 45 to 80% of the causes of hospital admissions.⁴

Urgency and emergency services are structured to provide assistance to patients in serious and life-threatening situations. They thus become sites with higher rates of pain patients.⁵ It is observed that acute pain presents as the main complaint reported by patients in emergency and emergency services, highlighting that, of approximately 90% 45% of the patients present the pain symptom related to some specific event.⁶

It is also observed that acute pain is the most prevalent in emergency room and emergency room visits.⁷ It can be seen that few visits to patients with chronic pain in these places are very few, since they seek care of urgency and emergency, most of the time, when a new acute process of the symptom occurs.⁸

It is described that acute pain occurs due to the triggering of several events involving the autonomic, peripheral and central nervous system.⁹ Several stimuli that can trigger the symptom are known: physical, chemical or thermal, and may be associated, commonly, to traumatism, infectious and / or inflammatory conditions.¹⁰

It is known that acute pain can cause an increase in blood pressure, heart rate and respiratory rate. It is also noticed that the considerable increase of cortisol (caused by the stress caused by the acute pain) can contribute to the appearance of other signs, such as sweating and anxiety.⁷

It is therefore considered a priority to evaluate and treat pain in health services, since pain presents as a symptom that can trigger psychic and physiological changes that can aggravate the health situation of patients.¹⁰

It is analyzed, however, that there are not many studies that address care and its impact

for patients attending urgency and emergency services.¹¹ It is noted that this situation hinders the process of raising awareness among professionals working in these services, making it difficult to plan actions and the organization of material and human resources.¹¹

It is also verified that pain control and relief become essential, especially when referring to patients who are life-threatening, since, besides presenting as a humanitarian and ethical issue, they contribute to the maintenance of the functions physiological characteristics of the patient, thus allowing the control of the side effects of pain persistence.¹² It is necessary for the control and relief of pain to identify and implement specific Nursing interventions.¹²

Therefore, the following question was asked: "Which Nursing interventions are performed in the emergency and emergency unit for patients with acute pain?"

OBJECTIVE

- To identify the nursing interventions performed for patients with acute pain.

METHOD

This is a qualitative, exploratory and descriptive study, carried out in 2015, in a prompt care unit of a philanthropic hospital in the city of Uruguaiana, Rio Grande do Sul, Brazil. The procedure of triangulation of techniques was adopted. The study was developed in three stages: documentary analysis; cross-mapping to Nursing Interventions Classification (NIC)¹³ for pain and validation of Nursing interventions through a focus group.

For the first stage of the study, the documentary analysis was used, a data collection tool constructed by the researchers with the purpose of recording information contained in users' service bulletins (SB's). The service bulletins were selected from the following criteria: documents filled with legible information and with complete patient identification data.

The data collection instrument was applied containing the following variables: numerical code of identification of the user; number of records; date of birth; age; sex; time of service; health problem referred by the patient that determined the search for the list of health problems; nursing diagnoses (if the patient was described); defining characteristics of acute pain (if any) and interventions and care for pain recorded by nurses. The data for spreadsheets were

transcribed into the Microsoft Excel 2010 Program. The study analysis corpus was then formed.

Nursing Interventions Classification (NIC)¹³ was used for the second stage of the study, for each Nursing prescription or registration performed at the unit for patients with acute pain or definitive characteristics (signs and symptoms). symptoms) indicating the presence of this diagnosis. The interventions were selected according to the similarity suggested in the Nursing records.

The sample was composed by four nurses who developed assistance activities and/or teaching in the emergency and emergency unit. The following inclusion criteria were adopted: emergency and emergency nurses who had at least three years of experience in an emergency care unit. Nurses who were on vacation or health leave during the survey data collection period were excluded from the study.

The focus group was conducted from a moderator through a script with interventions pre-selected according to the NIC Classification and according to the research objective. A two-hour focal session was held in the afternoon, depending on the availability of participants. It is exposed that the meeting occurred in a room of the Nursing service in emergency and emergency of the co-participant institution.

It is evidenced that the focus group session was recorded and transcribed for further analysis. It is portrayed that one of the moderators investigated the opening of the focal group so that the participants of the group could present themselves, including the moderator and the observer.

The objectives of the study were presented, highlighting the theme - Nursing interventions for pain - identified in SB of

patients attended at the emergency and emergency unit and their correlation to the classification of NIC.¹²

Two printed copies of the Free and Informed Consent Term (FICT) were then handed out to each nurse and read. The FICT was signed by all the professionals who accepted to participate in the study, stating the procedures that would be performed and the contact of the researchers. For the maintenance of confidentiality of information, codes with the letter N (Nurse) and identification number 1, 2, 3 and 4 were used.

The group was provided with printed material with the complete list of Nursing interventions listed in the NIC Classification Book of Interventions.¹² The list of interventions was read out. After the group, the analysis and discussion of each one of the interventions was started until reaching a consensus of 100% agreement. It should be noted that participants had the possibility to include, change or exclude interventions. At the end of the meeting, the reading of the selected interventions and their confirmation by the group were carried out.

It is evidenced that the research was approved by the Research Ethics Committee of the Federal University of Pampa - Campus Uruguiana, under Protocol N. 996,155, dated 03/19/2015, in compliance with Resolution 466 of December 12, 2012, of the National Health Council (NHC).¹³

RESULTS

A total of 350 SB's of patients attended in the emergency and emergency services were used, and the mean age of the patients was 35.0 years, and of the 350 SBs, 338 (96.6%) had "acute pain" ND. The following table shows the demographic characteristics available in SB's.

Table 1. Demographic characteristics available in the Service Bulletins. Uruguiana / RS, Brazil, 2015.

Characteristics	n	%
Adults	216	81.4
Sex (Female)	201	57.4
Children (1 - 11 years)	63	18.6
Sex (Female)	39	61.9
Elderly (> 60 years)	59	17.4
Sex (Female)	34	57.6
Total	896	30.3

Variables expressed in median and percentile. Categorical variables expressed in n (%).

It should be noted that the demographic characteristics for the characterization of the sample available in the SB's records were age, sex and previous health problems, since there are not too many demographic data in the SB's records.

ND defining characteristics related to the change in vital signs "acute pain" , such as "changes in heart rate", "changes in respiratory rate" and "changes in blood pressure" were identified. Patients who presented a diagnosis or history of previous diseases, such as Diabetes Mellitus, systemic

arterial hypertension and heart problems, were not included in the study, in order to avoid confusing the physiological changes related to the pathologies with the alterations caused by the pain.

It should be noted that the defining characteristics identified for adult and elderly patients were: "verbal report of pain"; "Changes in heart rate"; "Changes in respiratory rate"; "Changes in blood pressure" and "observed evidence of pain (invasive procedures and/or trauma)".

It is mentioned, in relation to the children, that the defining characteristics observed in the SB records were: "changes in expressive behavior"; "Verbal report of pain"; "Changes in heart rate"; "Changes in respiratory rate" and "changes in expressive behavior".

In relation to the mapped Nursing interventions, it was found that the only identified and recorded Nursing intervention was "medication administration", which was observed in the entire sample. It was mapped

to the NIC activity: ¹³ "to ensure that the patient receives accurate analgesia care".

However, during the focus group session, other interventions were mentioned by the nurses, as already performed at the unit. It is specified that the nurses emphasize the concern with the evaluation of pain in this environment. It is emphasized that they indicated that performing non-drug interventions is an important strategy for the adjuvant treatment of patients with pain.

The intervention mapped to NIC was confirmed at the focus group session.¹³ New nursing interventions were included. 41 Nursing interventions described in the classification of NIC¹³ that had not been identified in the Nursing records of the unit were presented. It is reported that, of these, the group identified that, in addition to the mapped intervention, it performed six (6) other interventions in the nursing practice, which were not being registered. These interventions are shown in figure 1.

Choose and implement a variety of measures (ie. pharmacological, non-pharmacological, interpersonal);
To investigate the current use of pharmacological methods of pain relief by the patient;
Ensure that the patient receives accurate analgesia care;
To investigate with the patient the factors that alleviate/worsen the pain;
Notify the physician if the measures do not work or if the current complaint consists of a significant change in the patient's previous experience.

Figure 1. Nursing interventions performed in clinical practice by nurses, from 2014 to 2015. Uruguiana (RS). Brazil, 2018.

Besides these interventions, a further 12 were identified as possible to be implemented in the Nursing practice in the unit. Figure 1

shows the Nursing interventions validated by the nurses.

Evaluate pain as fifth vital sign;
Observe the occurrence of nonverbal indicators of discomfort, especially in patients unable to communicate effectively;
Use a properly developed evaluation method that allows monitoring of changes in pain and helps to identify actual and potential precipitating factors (eg, flow chart, record);
Determine the frequency needed to make a patient comfort assessment and implement a pain monitoring plan;
Analyze the patient's willingness to participate, their ability to do so, their referrals, important people's support for methods and contraindications when choosing some pain relief strategy;
Encourage the patient to monitor their own pain and intervene adequately;
Encourage the patient to use medicine suitable for pain;
Use pain control measures prior to worsening, ensure pre-treatment analgesia and / or non-pharmacological strategies prior to painful procedures;
Provide accurate information to promote family awareness of how to respond to the pain experience, as well as perceive this response;
Perform a complete assessment of pain, including location, characteristics, onset / duration, frequency, quality, intensity and severity, in addition to precipitating factors;
Reduce or eliminate factors that precipitate or increase the pain experience (eg, fear, fatigue, monotony, and lack of information);
Consider the type and source of pain and select a strategy for their relief.

Figure 2. Nursing interventions validated by nurses, from 2014 to 2015. Uruguiana (RS). Brazil, 2015.

DISCUSSION

It was evidenced a high index of patients with complaints of pain who sought care in the emergency and emergency unit. It is emphasized that this result corroborates previous studies according to which approximately 90% of the patients treated in

emergency and emergency units are due to the presence of acute pain or the process of exacerbation of chronic and / or recurrent pain.¹¹

It was observed that there was a predominance of females in all age groups analyzed in this study. However, it has been

observed that studies indicate that there is a predominance of males when related to morbidity and mortality compared to females.¹⁰ It is emphasized that this factor may be associated with the fact that men seek less urgency services and emergence than women when they present the pain symptom.⁹

It is also added that the hormonal oscillations present, mainly in women, can help to exemplify the differences between the sexes, since these are cause of multiple pathologies that present the pain as main symptom.¹⁴

It is also observed that female children are more prevalent when compared to males.¹⁵ It is reported that such differences in the perception of pain among children are physiological, with hormonal changes being the main causes of differences of this perception.¹⁶

It is emphasized, therefore, that the physical development of female children happens more rapidly.¹⁵ It is observed that the hormonal discharge, for bone growth occurs, for example, occurs gradually for male children, unlike what occurs with female children.¹⁷

It is observed that, in the case of the defining characteristic "changes in vital signs", for adult and elderly patients, they are important indicators of the presence of pain, especially when the patient presents some cognitive deficit or decrease of the level of consciousness.¹⁶

It is noteworthy that, although the "verbal report and/or self-report" is considered gold standard for the identification of pain, characteristics related to changes in vital signs are observed and become, also, imperative for the identification of the diagnosis of Nursing pain sharp.¹⁷

Thus, in this study, it was possible to identify that about 80% of the adult and elderly patients presented vital signs changes. It is noted that these changes occurred due to physiological processes that occur as soon as the painful information is received by the central nervous system. It is reported that each person's behavioral response to pain is a physiological response that occurs after the person's perception.¹¹

It is shown, in summary, that pain results from the interpretation of the physical-chemical aspect of the nociceptors with emotional factors such as, for example, humor.¹⁸ It is thus possible to emphasize that emotional and physiological factors favor autonomic responses. Key changes in vital

signs, diaphoresis and pupillary dilation are among the main findings.¹⁷ It is noteworthy that these were not identified in this study.

Another important characteristic identified was the "observed evidence of pain" associated with invasive procedures and/or trauma.¹⁸ In this study, it was observed that in relation to invasive procedures, 100% of patient records indicate that they were submitted to some invasive procedure that determined the presence of pain, which makes this defining characteristic an important indicator of the presence of pain in these patients.

In the case of children, it can be seen that the psychological and contextual aspects expressed in a pain situation are the main factors of their difficulty in understanding the origin of the pain and its intensity.¹⁹ It is noteworthy that for children, the experience of pain is influenced by external and internal factors.²⁰ It is generally found that the more tense, anxious and fearful the child is, the more intense the painful sensation becomes. This can be explained by the child's lack of clear understanding of health and disease issues.²⁰

In this way, the observation in the change in the children's behavior gave rise to the identification of another defining characteristic: the "verbal report of pain or self-report". It is reported, in this case, that the behavioral indicators could be identified by the caregivers of the child, facilitating the verbal report. It is considered that, according to the results obtained in this study, "self-report of pain" was the main defining characteristic identified. The "changes in expressive behavior" in adjuvant signs to confirm the diagnosis of Nursing "acute pain" in older children.¹⁹

It is understood, starting from this premise, that physiological indicators are aspects that may also help in the identification of pain in children, such as salivary cortisol, change in heart rate and respiratory rate (change in oxygen saturation).¹⁹ It is explained, however, that these are considered as complementary measures for the identification of pain in children.¹⁶ Thus, it is observed that the physiological indicators are extremely sensitive to changes in any situations in which the child is exposed, example, the change in the environment.¹⁸

It was verified, in relation to the mapped Nursing interventions, that the only Nursing intervention identified and registered in the SBs was "medication administration". It is noted that the fact that only care related to drug administration has been identified may

point to an overvaluation of drug therapy and that attention is directly focused on medical prescription.

The intervention mapped to NIC was confirmed in the focus group session.¹³ New nursing interventions that had not been registered were included. It is emphasized that the records of nursing care provided to patients, besides guaranteeing quality care, are a way of proving the quality of the care performed by the Nursing team.¹⁶

It should be noted, therefore, that Cofen Resolution N. 429/2012 subsidizes Nursing records in the medical records or documents of Nursing to favor the continuity of care, since it provides important information that will help in the continuity of the effective care plan, as well as in the evaluation of its results.²⁰

It is known that incomplete records or their absence, or their inadequate performance, indicates the need to qualify the stages of the Nursing process. It is recognized that this strategy will contribute to overcoming fragmented care processes, avoiding damages to patients and the Nursing team, as well as collaborate to qualify the assistance.

In this sense, it is verified that the records represent and identify the care provided to the patient in order to guarantee the safety and quality of the care offered.²⁰ It is noticed that some factors, for example, the great demand of patients and the deficiency (work overload and stress), are the main impediments to the implementation of nursing interventions and / or non-drug interventions, which make the patient's treatment for pain strictly medicated.²¹

It has been assumed that understanding the causes of pain and treating them adequately becomes an indispensable condition for maintaining the quality of life and safety of patients. Thus, it is essential to evaluate pain in the same way as other vital signs, allowing the implementation of interventions appropriate to the needs of each person.¹⁷ It is stressed that the implementation of accurate interventions is aimed at meeting the rights of users in the which is related to the evaluation and continuity of pain treatment, thus contributing to the qualified and effective care of Nursing care.²⁰

It is identified that the accomplishment of complete records subsidizes and proves the care taken. In this sense, the lack of Nursing records may indicate a fragility of the service, contributing to the risk of failure to continue the implementation of accurate interventions.¹⁹

It is also worth noting that documenting the presence of this symptom, through the identification of the "acute pain" ND and of the interventions provided, is a way of guaranteeing continuity of treatment and may help to reduce costs for hospital institutions, a since this symptom may contribute to clinical complications that increase hospital financial costs.²¹

CONCLUSION

Six nursing interventions performed by the Nursing team and not registered in the Nursing notes were identified and validated, in addition to 12 new Nursing interventions.

It is inferred that drug administration is one of the main interventions performed for pain in the urgency and emergency unit under study. It was also evidenced that some Nursing interventions are performed by the nurses, however, these are not recorded in the service bulletins. It is understood that this situation reinforces the need to qualify Nursing records and implement all stages of the Nursing process.

It is confirmed that non-drug interventions are strong allies of the treatment of the patient with pain, becoming imperative for their recovery process. It is necessary, however, the implementation of these activities in the daily work of Nursing in order to contribute to the relief of pain.

In this perspective, the identification of the interventions, according to the classification of NIC (2010), is presented as a strategy to subsidize care for the patient with a diagnosis of "Acute pain". It contributes, therefore, to the control of pain, once it becomes clear the need to join pharmacological and non-pharmacological interventions in order to provide comfort and safety to patients.

Thus, the results of this study contribute to improving the organization of Nursing work, facilitating the choice of care for patients with acute pain and increasing the forms of treatment, as the patients treated in an emergency and emergency unit restrict their treatments to analgesia. It is also ensured that the hospital institution will be providing humanized care that guarantees patients' rights and the adequate and effective treatment of pain.

It is pointed out that the Nursing interventions validated by the nurses point out the concern with the quality of care to be provided to this clientele, reflecting the demands of care of patients in emergency and emergency unit. Thus, it is necessary to carry

out new studies, considering that the issue of pain in emergency and emergency units is not widely covered in the literature.

The limitations of the study are related to the sample size, noting that the study was performed only in an emergency and emergency unit, a factor that may restrict the generalization of the results obtained. It is also evidenced that the fragility of Nursing records contributed to the exclusion of SBs that did not present, in a clear way, the description of the presence of defining characteristics of ND "Acute pain", a factor that may have contributed to a sample number lower than expected.

REFERENCES

1. Castol CC, Pereira AK da, Bastos BR. Implementação da avaliação da dor como o quinto sinal vital. *Revenferm UFPEonline* [Internet]. 2018 Nov [cited 2018 Dec 12]; 12(11):3009-14. Doi: <https://doi.org/10.5205/1981-8963-v9i4a10477p7186-7192-2015>
2. Queiróz DTG, Carvalho MA, Carvalho GDA, Santos SR, Moreira AS, Silveira MFA. Pain - 5th Vital sign: nurses' knowledge. *J Nurs UFPE on line* [Internet]. 2015 Apr [cited 2018 July 8];9(4):7186-92. Doi: [10.5205/reuol.7275-62744-1-SM.0904201501](https://doi.org/10.5205/reuol.7275-62744-1-SM.0904201501)
3. Souza RCS, Garcia DM, Sanches MB, Gallo AMA, Martins CPB, Siqueira ILCP. Conhecimento da equipe de enfermagem sobre avaliação comportamental de dor em paciente crítico. *Rev Gaucha Enfermon line* [Internet]. 2013 Sept [cited 2016 May 16]; 34(3):55-63. Doi: <https://dx.doi.org/10.1590/S1983-14472013000300007>
4. Oliveira AL, Palma Sobrinho N, Cunha BAS. Chronic cancer pain management by the nursing team. *Rev Dor on line* [Internet]. 2016 July/Sept [cited 2017 jan 10]; 17(3):219-22. Doi:<https://dx.doi.org/10.5935/1806-0013.20160075>
5. Saça CS, Carmo FA, Arbuleia JPS, Souza, Regiane CX, Alves S, Rosa B. Pain as 5th vital sign: role of the nursing staff in a private hospital with management of Basic Health Unit. *J. Health Sci. Inst. online*[Internet]. 2010 Feb [cited 2018 July 12];28(1):35-41. Available from: https://www.unip.br/presencial/comunicacao/publicacoes/ics/edicoes/2010/01_janmar/V2_8_n1_2010_p35-41.pdf
6. Kipel AGB, Franco SC, Muller LA. Nursing practices for pain management in hospitals of a city of Santa Catarina. *Rev Dor on line* [Internet]. 2015 July/Sept [cited 2017 May 21];16(3):198-203. Doi: <http://dx.doi.org/10.5935/1806-0013.20150040>
7. Lourenço SMC, Cruz ICF. Chronic pain in adults customers in critical review - systematic literature care. *J Spec Nurs Care* [Internet]. 2014 Nov [cited 2018 Feb 15];7(2):[about 5 p]. Available from: <http://www.jsncare.uff.br/index.php/jsncare/article/view/2710/646>
8. Oliveira Junior NJ, Oliveira SBS, Migowski ER, Riegel F. Nurses' role in the nonpharmacological pain treatment in cancer patients. *Rev Dor on line* [Internet]. 2017 July/Sept [cited 2018 Jan 21]; 18(3):261-5. Doi:<https://dx.doi.org/10.5935/1806-0013.20170112>.
9. Araujo LC, Romero B. Dor: avaliação da dor como quinto sinal vital. Uma reflexãoteórica. *Rev Dor on line* [Internet]. 2015 Oct/Dec [cited 2017 May 21];16(4):291-6. Doi: <https://dx.doi.org/10.5935/1806-0013.20150060>
10. Mocerí JT, Drevdahl DJ. Nurses' knowledge and attitudes toward pain in the emergency department. *J Emerg Nurs* [Internet] 2014 Jul [cited 2015 June 12];40(1):6-12. Doi: <https://doi.org/10.1016/j.jen.2012.04.014>.
11. Santos CE, Krelling MCGD, Karino ME, Yagi MCN, Vendrameto MM. Analysis of pain evaluation in nursing records of victims of trauma Braz. *J Surg Clin Res* [Internet]. 2017 Sept/Nov [cited 2017 nov 26];20(3):31-35. Available from: https://www.mastereditora.com.br/periodico/20171104_142005.pdf
12. Oliveira Junior NJ, Oliveira SBS, Migowski ER, Riegel F. Nurses' role in the nonpharmacological pain treatment in cancer patients. *Rev Dor on line* [Internet] .2017 July/Sept [cited 2016 Jan 12]; 18(3):261-5. Doi: <https://dx.doi.org/10.5935/1806-0013.20170112>
13. Bulechek GM, Dochterman J, Butcher H. NIC: Classificação das Intervenções de Enfermagem. Elsevier; 2010
14. Vuille M, Foerster M, Foucault E, Hugli O. Pain assessment by emergency nurses attriage in the emergency department: A qualitative study. *J Clin Nurs* [Internet] 2018 Dec [cited 2018 July 01]; 27 (3-4): 669-676. Doi: <https://doi.org/10.1111/jocn.13992>
15. Pierik JGJ, IJzerman MJ, Gaakeer MI, Vollenbroek-Hutten MMR, Doggen CJM. Painful Discrimination in the Emergency Department: RiskFactors for UnderassessmentofPatients' Pain by Nurses. *J EmergNurs* [Internet] 2017

Mar [cited 2018 Sept 20];43(3):228-238. Doi: <https://doi.org/10.1016/j.jen.2016.10.007>

16. Sollami A¹, Marino L, Fontechiari S, Fornari M, Tirelli P, Zenunaj E. Strategies for pain management: a review. *Acta Biomed* [Internet]. 2015 July [cited 2016 June 10];86(2):150-7. Available from: <https://pdfs.semanticscholar.org/0acc/842b4b77b0385077fce43314d729381915b3.pdf>

17. Conselho Federal de Enfermagem. Resolução do COFEN nº 358 de 15 de outubro de 2009. Dispõe sobre a Sistematização da Assistência de Enfermagem e a implementação do Processo de Enfermagem em ambientes públicos ou privados. Conselho Federal de Enfermagem [Internet]. 2009 [cited 2014 Sept 28]. Available from: http://www.cofen.gov.br/resoluco-cofen3582009_4384.html

18. Rodrigues ISA, Oliveira LMM de, Fernandes FECV, Teles MEV. Prevalence of acute pain in patients attending the emergency room. *Rev Dor on line* [Internet]. 2017 Oct/Dec [cited 2018 Jan 10]; 18(4): 327-31. Doi: <http://dx.doi.org/10.5935/1806-0013.20170124>

19. Barros SR, Albuquerque AP. Nursing approaches for pain diagnosis and classification of outcomes. *Rev Dor on line* [Internet]. 2014Abr/June [cited 2016 July 15];15(2):107-11. Doi: <http://dx.doi.org/10.5935/1806-0013.20140021>

20. Bertoncello KCG, Cavalcanti CDK, Ilha P. Diagnósticos reais e proposta de intervenções de enfermagem para os pacientes vítimas de múltiplos traumas. *Rev Eletr Enf* [Internet]. 2013 Oct/Dec[cited 2016 May 18]; 15(4):905-14. Doi: <http://dx.doi.org/10.5216/ree.v15i4.19497>

21. Schug SA, Palmer GM, Scott DA, Halliwell R, Trinca J. Acute pain management: scientific evidence, fourth edition, 2015. *Med J Aust* [Internet]. 2016 May [cited 2017 Oct 18];204(8):315-7. PubMed; PMCID: 27125806.

Submission: 2018/09/04

Accepted: 2019/01/21

Publishing: 2019/03/01

Corresponding Address

Júlia Torres Cavalheiro
Rua General Daltro Filho, 858 / Ap. 303
Bairro Hidráulica
CEP: 97574-512— Santana do Livramento (RS),
Brazil