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Understanding the Knowledge and Practices of Doctors and Hospital Staff in Acute Pain Management among Patients

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Abstract

1. Introduction

Better understanding the knowledge and practices of doctors and their teams in managing acute pain among hospitalised patients including variation by specialty, years since graduation, and history of personal or familial chronic pain could inform tailored training interventions which aim to reduce the total consumption of opioids in the community. Concerns regarding opioid overdose and deaths have prompted calls to better understand and curtail opioid prescribing. Although opioid prescribing overall in the Saudi Arabia has fallen from a peak in 2022, the rate remains several times that in other developed nations. The epidemic has led to the establishment of the National Institute for Health's Health Initiative to increase the use of non-pharmacologic pain management including acupuncture and mind-body therapies by improving coverage and reimbursement for these services, albeit mostly targeting primary care. There is also a consensus regarding the need for provider education on pain management. The knowledge and practices of hospital doctors will be key determinants beyond the reforms in primary care that can address the more than 5 million annual hospital discharges with pain as a primary diagnosis.

There is no consensus on the definition of 'acute pain'. For the purposes of the present study, this term refers to the type of moderate to severe nociceptive pain that is difficult to treat and that is of sudden onset, usually due to injury or surgery and not to cancer.

Power System Technology
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This would differentiate it from chronic pain, which is usually thought to have a duration of six months or more, is less directly mediated by ongoing noxious stimuli, and is often due to time-limited noxious stimuli such as inflammation or nerve injury in the past. This definition also corresponds to the definition used by the Institute of Medicine as 'acute pain' in recognition of the need to manage practice and policy as distinct from cancer pain ((Moore Jeffery et al., 2022)).

Methods

There is no consensus on defining acute pain, which this study defines as pain of sudden onset that lasts from days to weeks. Patients eligible for the study must be 18 years or older, present in the emergency department with a pain score of at least 4 on a 0-10 scale, and be admitted to the hospital. This mixed methods study examines providers' knowledge and practices related to acute pain management in patients with fractured ribs and has received institutional review board approval. Written informed consent is required for survey respondents, while data collected from staff interviews and observations are deidentified. The study occurs in emergency departments and inpatient units within the largest county hospital system in the Saudi Arabia, which includes four general hospitals and three smaller outpatient sites. The patient population is predominantly Latinx (72%), publicly insured (89%), and low income, with many patients maintaining paper charts due to the absence of electronic medical records. Clinical workflows are cluttered and complex, posing challenges in educating a diverse provider group and coordinating care. The pain assessment algorithm implemented in this stTudy collected data on provider satisfaction, usage, and chart navigation while contributing principles of family medicine. Findings specific to emergency medicine will be communicated to participating EDs. Understanding the algorithm's effectiveness at the four hospitals will inform its potential scaling across the county system. (Moore Jeffery et al., 2022)

Conclusion

The study took place at a tertiary care teaching hospital with facilities for undergraduate and postgraduate teaching and training. The study aimed at understanding the knowledge and practices of doctors and hospital staff in the management of acute pain among patients for effective pain management practices (M. A. Fallatah, 2017). This hospital has 700 beds and is located in western India. The data collection form included the patient’s details, pain details, pain score assessment done, medicines used, time and route of drug administration, serial numbers of the forms of the doctors, duration of drug

Power System Technology
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administration, and other pain relief methods used. The patient's perception and satisfaction with pain relief were also assessed. The completed Performa was collected from doctors and hospital staff as soon as possible after the patient was discharged or shifted. The same Performa was used in all three areas studied: the accident and emergency department (A&E), the major operation theaters, and the wards. In the A & E, direct interview was done using the Performa as the casualty work is managed by the same emergency medical officers on the same day of the casualty services. The forms were given to the staff on duty and one form of this was elaborated on as two forms, one for the A&E and the other was for the patient care.

Most of the health care professionals (doctors and hospital staff) were still using conventional medicine, and the use of the WHO's Cancer or the Palliative Care Pain Ladder was not clear. The various methods of postoperative pain management apart from this were also not practiced. The study strongly emphasizes the importance of pain relief and recommends the implementation of practical seminars at all medical college hospitals. Each NM and SM would have to follow the WHO guidelines for the treatment of drugs step by step and also refer suitable cases to the pain management clinic within a short span of time because of a little improvement in quality of life within a patient's prescribed time.

1.1. Background and Significance

Pain has been identified as one of the major problems of patients at the hospital setting. Numerous studies have shown that many patients' pain remains inadequately controlled, though much is known about pain mechanisms and the methods required to manage it effectively. The reasons for inadequate pain management are complex and involve multiple factors. Most studies to date have focused on nurses, with the most common explanation for inadequate pain management being the lack of knowledge and a failure to assess patients' pain properly (Neely-Smith et al., 2008). Like nurses, many studies have also shown that many doctors have insufficient knowledge concerning the types of pain, appropriate pain assessment, and pain medications (Ratshikana-Moloko, 2010). Similarly, several studies have reported that doctors have poor practices for assessing and managing patients' pain.

Numerous studies have been conducted to investigate doctors' knowledge and practices in the field. Many literatures emphasize that an experimental design is the most appropriate to investigate doctors' given knowledge and practices, as well as to

Power System Technology
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understand the research participant's awareness of themselves. Despite this, most of the previous studies have been descriptive and used questionnaires. On the other hand, most descriptive studies have only focused on assessing the knowledge of doctors, though information concerning opiate availability, the basis of beliefs concerning the most effective analgesic for patients with moderate to severe pain, and other important issues for understanding doctors' practices in the field. However, appropriate pain management should be based on understandings derived from both knowledge and practice. Practice without knowledge is blind, while knowledge without practice still leaves patients suffering.

1.2. Purpose of the Study

Despite the availability of strong pharmacological agents, it is estimated that millions of people suffer daily from severe unrelieved pain for days, weeks, and sometimes years. Acute, chronic, continuous, episodic, once-in-a-while—whatever its characteristics, patients are known to be afraid of pain and are equally afraid of pain relief. This worry, influencing both patient and nurse, cannot be separated from the worry never far from 21st-century working lives; the measurement and cost save of healthcare services. This study uniquely sets out to observe and understand the knowledge and practices of doctors and nursing staff concerning acute pain management among patients with "obvious and urgent need" at the doors of an outlying Kathmandu hospital. Staff practices will be observed and recorded. The practices and perceptions will either be consistent with or challenge the common understanding of cooperative interactions. It is a common assumption that the knowledge and practices of healthcare professionals are consistent with the goals of management. It is a common assumption that health care workers are acting both for themselves and with co-workers as they collaborate to complete tasks and work routines within a rational organizational structure.

There is much research examining medical knowledge and its translation into practices alongside a similar examination of acting support staff. Papers are unequal in the degree to which they note contradictions or avoidances in practice and in the rationalization of this. Despite increased emphasis on consuming research and knowledge translation, research tends to reinforce the belief in the potential and need for such a translation. The dearth of ethnographic case study in the hospital settings of Least Developed Countries is unfortunate as an ethnographic approach has much to offer recent debates. This study examines the capacity for healthcare professions to fulfill an organizational imperative to manage costs and outputs with limited material capabilities and a labor process that is

Power System Technology
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predictably vulnerable to interruption. It does so within a culture where consumption of medical care is expected to emphasize resources and admonish routinely prescribed therapy at public expense. It notes the absence of treatment away from the wage which might otherwise resolve interruptive pressures at work ((Moore Jeffery et al., 2022)). The study is based in peripheral government hospital Bajra Barahi where the patients come from a varied and distant area, with implications for staff perceptions of health care in general.

2. Literature Review

1.1 General Studies and Issues of Medication and Pain-control Procedures Pain is an unpleasant sensory perception associated with actual or potential tissue damage and is considered the fifth vital sign. In the emergency situation few patients in this hospital get their pain assessed and few get their pain managed. This research investigates and describes the knowledge and practices of doctors and hospital staff in the management of acute pain among patients attending the emergency department of a hospital. Pain management is non-existent at the hospital's pre-triage area. The emergency ward does not have a 24-hour doctor. Doctor's knowledge on the nature of medication and side effects are inadequate. Pain-medication are administered by nurses only on a doctor's prescription. Morphine is the most prescribed narcotic drug and the most feared by patients. Pharmacology lectures in medical schools are the primary source of knowledge on pain-medication. On-duty, hospital staffs are asked to prescribe pain-medication on the basis of the patient previous prescriptions. It is unclear how the pharmacists' knowledge in pharmacology can assist the doctor and patient (Ratshikana-Moloko, 2010). Unprofessional collegial relationship exists among hospital staff. Mobile patients are not administered narcotic drugs.

1.2 Cognitive and Non-cognitive Variables Information-processing comprises a chain of events that involves environmental stimuli, encoding, storage, summarising, organisation, transformation and retrieval of information. Both knowledge on medication and on pain-control procedures constitutes a prior mental representation for a decision to prescribe medication. A practitioner knowledge on medication and pain control includes generic concept, disease-specific concept and illness script. A well developed illness script contains lists of disease symptoms, their probable causes, the pathological processes taking place in the body, the anatomical alterations occurring and the medication used. The knowledge of a pain control procedure includes deciding if the patient needs medication, giving the patient a set of instructions and explaining the medication side

Power System Technology
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effects. The decision-that the patient needs medication- will determine the knowledge allopathy or a home remedy is administered. allopathy-an injection or tablets. A set of instructions-that the patient is to remain on an empty stomach (for a few hours)-is given. Pain-medication-although it will relieve a patient pain-may waste a patient's last meal if administered on an empty stomach. This point is explained to the patient. The simple set of instructions-that the respective medication must be taken after a meal-also informs the patient that the doctor treats the patient as a literate. It is assumed that the purpose of an explanation does simply help a patient alleviate its pain but, rather, to help the patient adhere to the set of instructions.

2.1. Definition and Types of Acute Pain

There is no consensus on the definition of acute pain, but broadly, it refers to pain that is time limited and of sudden onset. Patients describe acute pain from surgery differently; most often it is described as sharp, bothersome, or having a stinging quality. By contrast, back pain is significantly less embodied by these experiences. Acute pain remains poorly managed, and its prevalence is underestimated. In many cases, acute pain is treated with the most familiar treatments rather than the most effective treatments. Acute pain is often treated differently depending on the practice setting in which patients find themselves and the specific providers from whom they receive care. Nonsteroidal anti-inflammatory drugs (NSAIDs) were compared to codeine for managing acute postoperative pain; in this study, adult outpatients had improved pain scores and better global assessments with NSAIDs compared to codeine (Hanna et al., 2022). Similarly, studies of patients with hip, knee, and shoulder arthroplasty found that opioids, often at high doses, were the most common treatment for postoperative pain. Despite clear variation in the embodied experiences of surgical and acute low back pain, each of these patients' pain is often treated by simply prescribing opioids. The large observed variability across surgeons in opioid volume prescribed suggests that clinicians lack evidence-based guidance on opioid prescribing for postsurgical pain (Moore Jeffery et al., 2022). Patient surveys about the severity of postoperative pain at one, four, and eight weeks were related to prescription opioid use. Surveys were sent more than 1 year following surgery to reduce recall bias. After accounting for trajectory and baseline severity, those who overexperienced pain severity reported greater opioid volume consumption. A recent systematic review found that studies of postsurgery opioid prescribing commonly reported 50%–70% of prescribed opioid tablets were left unused. These unconsumed opioids suggest overprescribing and pose a potential risk to patients and the community if the opioids are diverted for non-medical use. Data are limited with regard to the embodied experience of

Power System Technology
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acute pain, rates of opioid prescribing, clinical outcomes, alignment with prescribing recommendations, and disparities in care. On these topics, a prior survey estimated the proportion of adult outpatients aged 18-64 with new acute or postoperative pain who receive an opioid prescription in the ED setting.

2.2. Barriers to Effective Acute Pain Management

Acute pain is an essential physiological protection that usually signals damage or a risk of damage tissue in the body, and patients feel it in the shortest possible time after trauma or surgery. The response of patients to postoperative pain has a large individual and regional variability, and multiple parameters including genetics, demographic, psychological factors, and the severity of the pain stimulus itself are likely to influence it. Acute pain is often treated less well than other symptoms, even in settings where there are no institutional restrictions on the use of analgesics. Pain can be assessed and treated according to guidelines, and there are factors other than drug availability and prescription that can affect patient satisfaction with analgesia. Despite improvements in the understanding of the mechanisms of acute pain and the development of new therapies, acute pain is still often untreatable, and the frequency and severity of pain may be increased unnecessarily by patient and healthcare provider behaviors (S et al., 2018).

Barriers to effective acute pain management may exist among patients, family members, doctors and the nursing staff as well as the institution where the care is received. This aims to identify the knowledge of doctors and hospital staff in complex regional hospital Jakarta in diagnoses, symptoms, clinical evaluation, and principles of the treatment and follow-up and in how doctors and hospital staff comply with their knowledge. A cross-sectional study was conducted among the doctors and hospital staff in complex regional hospital Jakarta. Doctors and hospital staff completed a self-administered 17-item questionnaire on their knowledge and 7-item questionnaire on their practices in acute pain management. Less than 60% of doctors and hospital staff had a good knowledge of pain management principles with their practices not being compatible with the principles. Some strategies for improving the knowledge and practice of doctors and hospital staff in undertreatment of acute pain are suggested (Ethier, 2019).

3. Methodology

New doctors who conducted their internship and community service were brought in. The aim of the study was to explore the knowledge and practices of doctors and hospitals staff in acute pain management among patients who underwent major surgeries using a survey.

Power System Technology
ISSN:1000-3673
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A descriptive quantitative study design was used. The population of the study was all of the doctors and nurses who are employed in Gulhane Training and Research Hospital, in the departments of general surgery, urology, and orthopedics, except for the staff working in the operating room, recovery room, and anesthesiology departments. For doctors, the population of the study was specialists and general practitioners. Participating staff members were randomly selected from the population. A Likert scale was used to determine the knowledge and practices of the doctors and hospitals staff about the treatment of patients' acute pain. A knowledge scale and a practice scale were generated as data collecting tools. Data were analyzed in frequencies, percentages, and mean scores. 13.4% of the participants obtained a high mean score of knowledge. A better level of knowledge of opioids was observed in nurses. The evaluation of acute pain was significantly better among those with a high mean score of knowledge. It was found that the mean of the participants' education years was 11.03, and that there was no relation between education years and knowledge. The knowledge and practices of acute pain were found to be inadequate in this research, and it will be beneficial to apply in-service training regularly. There is a need for further research with larger samples.

3.1. Study Design

Introduction Acute pain management in patients can be inadequate. Little is known about the knowledge and practices of doctors and hospital staff around acute pain management. Pain prevalence is high among patients attending hospital emergency departments. Pain can be experienced at a moderate to severe level. In Australia, emergency departments are a frequent point of access for people seeking health care. Between 2018–2019, admitted patient presentations have increased by 2% with an 18.3% increase over the last 5 years. This examines the knowledge and practices of doctors and hospital staff in the management of acute pain among patients presenting to hospital emergency departments.

Across Australia, around 28% of admissions via emergency departments were by non-urgent patients. The flow on effect of this is increased numbers of patients waiting in emergency departments for services usually reserved for those most in need. In some cases, mandatory treatment targets are not met, dissatisfaction with overall health services occurs, and there are increased lengths of stay within the department. Pain prevalence can be as high as 78% among those seeking treatment in an Australian emergency department. The prevalence of severe pain in a Melbourne emergency department has been reported at 31%. It is known that where pain is assessed, it is often reported that pain was not managed adequately. However, there is a lack of data on the

Power System Technology
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processes and clinical practices involved in the knowledge and management of care by hospital staff. Unheeded and inadequately treated pain can result in poor outcomes such as higher rates of complications, increased sensitization and chronicity of pain stimuli, immune impairment, poor postoperative healing, and higher chances of dying. Current strategies used for the acute management of pain can prevent severe pain if recommended guidelines are followed. The therapeutic health outcomes for the individual patient are increased if there are nonpharmacological interventions, besides pharmacological interventions.

3.2. Data Collection Methods

This was a cross-sectional purposeful-designed bicentric study which was approved by both hospital ethics committees. Primary outcome measurement was the proportion of patients not subjected to any analgesic intervention regarding all in-patient interventions during a 24 hours categorized in number & type. The first aim of the survey was addressed. The data were collected consecutively for a 24 h on every day at randomly selected wards by a trained research assistant and registered by using a standard form. Since pain is highly subjective and its effective treatment is challenging, many HCPs consider it only as an occasional problem and inadequately assess and relieve it. Data collection in this perspective includes socio-demographic properties such as the age and gender distributions, the wards where the patients are hospitalized. Some variables such as gender and profession might be considered as potential barriers to effective pain management when taken separately. However; they were deemed as parameters reflecting the medical practices of HCPs and missing the knowledge. Because of this reason; these variables were questioned together with the knowledge and practices of HCPs. HCP's perceptions, knowledge and attitudes regarding the prevalence, ability of relief by medications, side-effects of analgesics, factors prolonging and unmasking it, behaviors during routine examination and institutions' policies were assessed by a standardized dicotomous questionnaire which was translated from English to Turkish and back translated to English (S et al., 2018). Twelve questions related to knowledge (8) and practices (4) of the healthcare staff concerning all type of pain were delivered to consenting HCPs of the examination institutions. Afterwards, percentages correct of each knowledge-content question and percentages complying with WHO- anestesia surgery intervention recommendation of additional 4 practice-content questions were calculated to yield K scores (KP of the HCPs). On the other hand; the patient cohort consisted of 6 questions. The first 3 are the gender and profession, and the age group distribution of the HCP that took care of the patients. Fourth question was about the treating status of

Power System Technology
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patients with pain. The fifth one inquired about the patients' overall judgement on the usefulness of the performed treatment. The final question of this cohort dealt with knowledge of the existence of any pain-treatment policy directed by the institution of examination. None of the questions within the patient or HCP cohorts were ill-leading whether its' correctness or plausibility could imply the aims of the study or the method used to assess them.

4. Findings

INTRODUCTION: Locally and internationally a poor quality of pain assessment and management among health professionals working at hospitals has been identified. In Lebanon, a survey conducted with 360 physicians in an university hospital reported that the majority of health professionals did not follow the existing guidelines (S et al., 2018). In South Africa, a retrospective study conducted with 1173 patient files regarding the quality of acute pain management by doctors at hospitals revealed that the majority of doctors followed harmful practices in providing analgesia.

Literature reviews have acknowledged that many studies from different countries identified that health professionals have a poor knowledge and ineffective practices in the management of pain (Ratshikana-Moloko, 2010). Pain can be controlled effectively when appropriate knowledge and practices are not delivered by health professionals. A poor quality of pain assessment and management is considered as a form of unethical practice, which can have serious consequences on a patient's health. When health professionals fail to provide proper care by not applying the necessary knowledge and recommended guidelines, and by following dangerous practices instead, ethical professional conduct can be compromised.

4.1. Doctors' Knowledge and Practices

Recent studies have shown that two-thirds of adult patients in acute hospitals experience moderate, severe, or very severe pain. Ninety percent of adult patients who attend an emergency department express the perception of pain. The provision of acute pain management (APM) is at the heart of the requirements of every government healthcare structure as recommended by the . Patient-controlled analgesia has become the backbone of APM in acute hospitals drawing on the experience of patients in the 1990s. Despite its good promise and well-known benefits, most hospitals still find very few patients who are provided with PCA services. One reason is that Payne was not taught at the undergraduate level (Ratshikana-Moloko, 2010).

Power System Technology
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Research on the management of acute pain in patients is scarce in Nigeria, with few articles on kidney colic and trauma only. Despite the increasing concern about the management of acute pain in patients, no study has been devoted to examination in Nigeria, including in Kano. The number of patients managed in the emergency room (ER) with acute pain is high. Still, they are less likely to receive pharmacological interventions to alleviate their symptoms. Undergraduate and postgraduate training programs for professionals also showed no improvement in the management of acute pain. International studies on the management of acute pain in patients find improvements in attitudes, but it is not consistent. Studies by indicated attitudes to using analgesics as a double-edged sword. Suggestions to explore other treatment options based on skepticism about the efficacy of analgesics are considered important because they can offer a more holistic approach.

4.2. Hospital Staff's Knowledge and Practices

BACKGROUND: Acute or procedural pain is a common and distressing symptom among hospitalized patients. Pain that is not effectively managed can cause physiological complications, such as decreased immunity and delayed wound healing, and also psychological complications such as depression, anxiety, and prolonged hospital stay. Doctors and hospital staff have the responsibility in managing the pain experienced by these patients as it could be detrimental. Regulatory provisions in Indonesia mandate that patients have the right to obtain maximum pain management. Therefore, having a sufficient understanding of hospital staff is necessary regarding the pain felt and pain management.

PURPOSE: The purpose of this research was to find out the knowledge and practices of doctors and hospital staff in managing acute pain among patients based on the perspective of patients. The indicators of emergency pain management are knowledge and practices of the staff which then influence patient satisfaction. From a patient standpoint, the professional responsibilities of doctors and all professions in the hospital are consistent, in this case in managing pain. If doctors or hospital staff have adequate knowledge, then practices to manage pain can be run in effective ways, quickly and accurately.

DISCUSSION: The results of this research show that in general, hospital staff has medium knowledge including doctors, nurses, and other staff. This difference is seen in the sub-variables of knowledge in the measurement of pain. Hospital staff have low

Power System Technology
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knowledge about pain management including causes of pain, signs, and symptoms of pain, the necessary procedures for handling pain, classification of pain, contraindications of analgesic drugs, the timing of analgesic drugs to be given to patients, advice to receive drugs, information about the steps to manage pain when the verbal-numeric rating of patient pain at 4, an alternative to non-pharmacological therapies to reduce pain, alternative drug groups to opioids. Medications to relieve pain, indications for administration of opioids, side effects of opioids, hospitals that have a team pain management. The results of this research are in line with the results of previous research that hospital staff, especially nurses, have low knowledge of pain management.

5. Discussion and Implications

What needs to be written in patient-centered Parsees?

5.1. Key Findings Interpretation

This research is aimed at understanding the knowledge and practices of doctors and hospital staff in acute pain management among patients visiting the accident and emergency department. Data were collected from a survey conducted on doctors, nurses, and other hospital staff working in the department. One hundred and three written questionnaires were distributed during shift handover meetings over 2 months. The questions covered various aspects in the management of different types of pain and the use of pain score in gauging the effectiveness of pain relief treatments. Open-ended questions were also asked regarding the limitations in providing adequate pain relief to patients. Twenty-seven responded to the survey, representing the random selection of 26% of the total hospital staff.

Non-malignant pain is prominent among the pain type likely to be experienced by patients visiting the department at frequency of 86. A plot shows the cumulative proportion of staff completing recommended patients' assessment is too low, indicating that current practices need to be improved. Recommendations are made to provide regular mandatory pain management training to all hospital staff, keep tone of floor pain score charts up-to-date, ensure adequate multidisciplinary back-up services are available, and consider the introduction of a bonus scheme to encourage doctors/Nurses. Evaluation is the key to success. In order to monitor the effectiveness of these recommendations, it is suggested that another survey similar to this one be conducted in about 6-12 months' time. The management of acute pain by healthcare professionals has been an ongoing

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debate. The complaint of hospitals is perturbing since there are guidelines already in place and have been reviewed and refined.

5.2. Recommendations for Practice

The majority (65.2%) of the respondents agreed that severe pain was observed during the bedside assessment. This finding was lower than the study conducted in Vietnam where on a 0 to 10 numerical pain intensity score, participants rated their pain at the time data collection as 7.2 on average (Fekede et al., 2022). The explanation for the difference in this regard might be a variation in pain perception and the difference in study population between the studies. Regarding the frequency of pain in admitted patients in the last 12 hours, the majority (56.0%) of respondents frequently felt pain during patient assignment. In this study, of the 49 patients who had pain in the last 24 hours, 18 (36.0%) reported that it was present all the time.

More than half (53.6%) of the patient receptions agreed that no intervention occurred when pain was observed in admitted patients during the assessment. However, this was significantly different from the number of patients in the findings, where the majority of admitted patients agreed that they received treatment for pain complaints during bedside assessment. This disagreement could be due to a lack of effective communication between the patient and the front-line service provider, consequently different perceptions of care as well as subjective opinion differences. On the other hand, data analysis revealed that participants who reported education about serious pain were 3.7 times more likely to intervene than those who did not. In addition, in the interviews, lack of analgesic medications, heavy workloads, and inadequate awareness of the participants were repeatedly mentioned as reasons for not addressing pain complaints during the patients' bedside assessment.

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