

Bridging the Gap: A Survey of Emergency Staff Perspectives on Paediatric Pain Management in an Academic Hospital

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Keywords

Pain Management; Pain Scales; Paediatric Analgesia; Painful Procedures

Abstract

Background

Paediatric pain is a common reason for emergency department (ED) presentation, yet pain assessment and management remain inconsistent despite the availability of evidence-based interventions. Limited data exist on clinicians' perspectives regarding barriers to optimal paediatric pain care.

Methods

We conducted a monocentric cross-sectional survey among physicians and nurses working in a tertiary-care ED. The questionnaire assessed paediatric pain assessment practices, pharmacological and non-pharmacological management, procedural analgesia, clinician confidence, and perceived barriers. Quantitative data were analysed descriptively and by subgroup comparison.

Results

Of 225 eligible staff members, 108 responded (48% response rate), and 87 completed questionnaires were included (38.7% inclusion rate). While 91% of respondents reported routinely assessing pain at presentation, only 18% consistently reassessed pain after interventions or procedures. Familiarity with paediatric-specific pain scales was limited, with only 10% and 7% reporting use of the Wong-Baker FACES and FLACC scales, respectively. Only 16% of participants reported high confidence in paediatric analgesic administration, whereas lack of formal training was identified as the most important barrier (47%). Procedural pain management showed substantial variability; 52% of respondents reported no analgesia or anxiolysis during bladder catheterization, and 46% reported none during cast application. Non-pharmacological interventions, particularly distraction techniques, were widely used and perceived as effective. Most participants emphasized the need for improved training and standardized protocols.

Conclusion

Significant gaps persist in paediatric pain reassessment, clinician confidence, and procedural pain management in the ED. Standardized protocols, targeted education, and multimodal approaches may improve guideline-concordant and child-centred paediatric pain care.

Introduction

Pain is one of the leading reasons for presentation to the emergency department (ED), particularly in paediatric populations, where children account for a substantial proportion of visits (1,2). Painful conditions and procedures are common in the paediatric ED and may contribute to significant distress, anxiety, and negative long-term healthcare experiences if inadequately managed (3-5). Despite growing awareness and the availability of evidence-based interventions, paediatric pain management in the ED remains sub-optimal. Studies consistently report inadequate pain assessment and undertreatment, with children frequently receiving less analgesia than adults with comparable conditions (6,7). Increasing ED crowding, time pressure, and workflow demands further complicate timely and effective pain care (8). Although

multimodal approaches combining pharmacological and non-pharmacological strategies have shown beneficial effects on procedural pain and anxiety, implementation in routine emergency care remains inconsistent (9,10). Current literature has primarily focused on patient outcomes and intervention efficacy, while less attention has been paid to the experiences and perspectives of ED healthcare professionals responsible for paediatric pain management. Greater insight into clinicians' practices, perceived barriers, and challenges is needed to support guideline-concordant and child-centred pain care in the emergency setting. This survey therefore aims to explore how ED physicians and nurses assess and manage paediatric pain and to identify factors influencing optimal pain care in daily clinical practice.

TABLE 1: Demographic Characteristics of Participants.

		Count (N)	Count (%)
Profession	Emergency Nurse	39	44.8%
	Emergency Physician	21	24.1%
	Paediatric Nurse	1	1.1%
	Paediatrician	21	24.1%
	Surgeon	3	3.4%
	Other	2	2.3%
Years of Clinical Experience	0-5	43	49.4%
	6-10	14	16.1%
	11-15	7	8.0%
	16-20	6	6.9%
	>20	17	19.5%
Paediatric Patient Volume	0	1	1.1%
	1-5	42	48.3%
	6-15	21	24.1%
	16-30	8	9.2%
	>30	15	17.2%
Formal Training	No	75	86.2%
	Not Sure	3	3.4%
	Yes	9	10.3%

Materials and Methods

Study Design and Setting

A monocentric, cross-sectional survey was conducted at UZ Leuven, a tertiary care emergency department. The study aimed to explore healthcare professionals' (doctors and nurses) experiences and perceptions regarding paediatric pain management, including barriers, facilitators, and current practices.

Participants

Eligible participants included all physicians and nurses actively working in the emergency department during the study period. Participation was voluntary, and responses were anonymized to ensure confidentiality.

Survey Instrument

A structured questionnaire was developed based on existing literature and previous surveys on paediatric pain management (1,2,10). The survey included sections on demographics, professional background, assessment and management of paediatric pain, use of procedural sedation and analgesia, non-pharmacologic interventions, perceived barriers (to analgesia administration and to overall pain and anxiety management), and suggestions for improvement. The survey addressed general pain management practices across all types of paediatric pain presentations (including

procedural pain), rather than analysing subcategories separately. Questions comprised multiple-choice items, Likert-scale ratings, and open-ended responses to capture qualitative insights. The questionnaire was developed based on prior research and guidelines in paediatric pain management; an interdisciplinary panel of ED clinicians reviewed items for face validity and clarity, and minor revisions were made based on feedback to ensure content validity.

Data Collection

The survey was administered online using LimeSurvey. Invitations were sent via institutional email to all eligible staff. To maximize response rates, three reminder emails were issued at one-week intervals following the initial invitation. Data collection was open from March to mid-April 2026. We excluded surveys that were largely incomplete from the final analysis. Some respondents did not answer every question; these missing responses were not imputed, and denominators for percentages reflect the number of respondents for each specific item.

Statistical Analysis

Quantitative responses were analysed using descriptive statistics (frequencies, percentages, means, and standard deviations). Group comparisons (e.g. between physicians and nurses) were performed using appropriate statistical tests (chi-square tests for

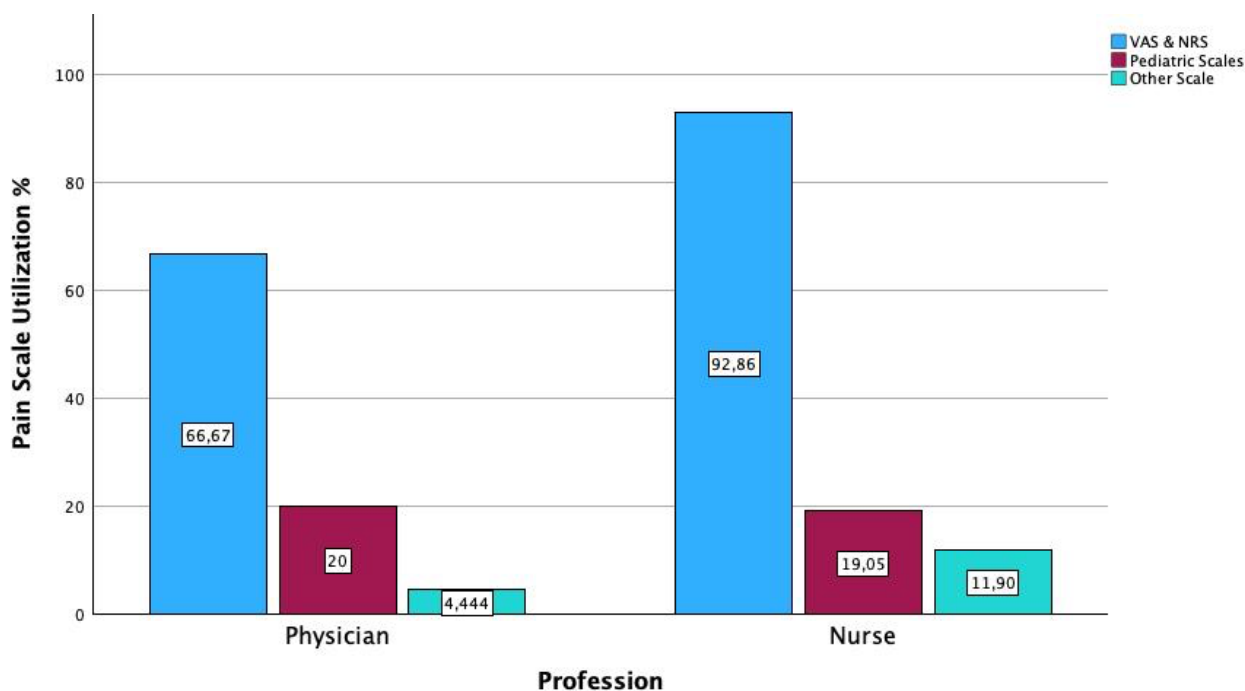


FIGURE 1: Frequency of Pain Scale Utilization By Professional Category.

categorical variables and t-tests for continuous variables). SPSS version 30.0 was used for the statistical analysis. Qualitative responses from open-ended questions were collected to capture additional insights but were included in the final manuscript. All analyses were conducted in accordance with institutional guidelines for research ethics. The study was approved by the Institutional OBC (MP031293) and completion of the survey was considered to constitute informed consent.

Results

Participant characteristics

Of 225 eligible staff, 108 initiated the survey (48% response rate), and 87 completed questionnaires were included in the analysis (38.7% of eligible staff). Nurses accounted for 46% of respondents and physicians for 52% (Table 1). Among physicians, specialties included Paediatrics (n = 21), Emergency Medicine (n = 21), and Surgery (n = 3). Fifty percent of participants had fewer than 5 years of clinical experience, and 20% had more than 20 years of experience. Approximately 70% of respondents reported seeing fewer than 15 paediatric patients per week. Among general ED providers, 76% of emergency physicians and 58% of emergency nurses reported treating fewer than five paediatric patients weekly. Specific training in paediatric pain management was reported by 10.3% of respondents (n = 9), including 7 paediatric specialists.

Pain Assessment Practices

Pain assessment at initial presentation was reported as “always” by 45% of participants and as “often” by 46%. Consistent reassessment of pain after painful

procedures or therapeutic interventions was reported by 18% (95% CI: 11.6%–27.8%) of participants. The 10-point Visual Analogue Scale (VAS) or similar numeric rating scales were familiar to nearly all respondents, indicating that most staff rely on general pain scales even for children. In contrast, familiarity with paediatric-specific pain scales was limited—only 10% and 7% of participants reported using the Wong–Baker FACES and FLACC scales, respectively, for young children. Use of paediatric-specific pain scales did not differ significantly between physicians and non-physicians (20% vs 19%; $\chi^2(3, 87) = 1.95$, $p = 0.58$) or by paediatric experience (22.7% vs 18.5%; $\chi^2(3, 87) = 1.67$, $p = 0.66$) (Figure 1). Reported barriers to paediatric pain assessment included difficulty assessing pain in non-verbal or young children (62.5%; 95% CI [52.3%, 72.7%]), parental presence complicating assessment (51%), lack of patient cooperation (40%), insufficient formal training in paediatric pain assessment (35.6%), and time pressure in the ED environment (35%).

Pain management practices

Pharmacological

Only 16% (95% CI [8.3%, 23.7%]) of respondents reported being “very confident” or completely comfortable with paediatric analgesic administration. Moderate confidence was reported by 35% of participants, while 12.5% reported uncertainty or discomfort with paediatric analgesic use. No significant association was identified between years of clinical experience and self-rated confidence in paediatric analgesia ($\chi^2(16, 87) = 13.0$, $p = 0.66$) (Figure 2). Within the trauma team subgroup two of the three participants reported uncertainty regarding paediatric pain medication use.

TABLE 2: Frequency and Distribution of Analgesic Choices Across Mild, Moderate, and Severe Pain Intensity Levels.

	None	Paracetamol	NSAIDs	Tramadol	Fentanyl	Morphine	Ketamine	Other
Mild Pain (n=87)	9 (10.3%)	81 (93.1%)	21 (24.1%)	0	0	0	0	0
Moderate Pain (n=87)	1 (1.1%)	76 (87.4%)	54 (62.1%)	11 (12.6%)	0	0	0	0
Severe Pain (n=86)	1 (1.1%)	46 (53.5%)	36 (41.9%)	24 (27.9%)	46 (53.5%)	12 (14%)	11 (12.6%)	2 (2.3%)
Percentages exceed 100% as respondents could select multiple options								

The frequency and distribution of analgesic choices across mild, moderate, and severe pain intensity levels is shown in Table 2. For mild pain, 93% of participants selected acetaminophen (paracetamol) as first-line treatment, and 24% reported use of non-steroidal anti-inflammatory drugs (NSAIDs). For moderate pain, paracetamol was used by 87% of participants, and 62% reported its use in combination with NSAIDs. Opioid use for moderate pain included tramadol in 12.6% (11/87) of respondents. No respondents reported use of morphine, fentanyl, or ketamine for moderate pain. For severe pain, 53.5% of participants reported use of intravenous fentanyl. Morphine was reported by 14% and ketamine by 13%. Tramadol was reported by 28%. NSAID use was reported by 42%. It is important to note that not all respondents answered every question, and analyses for each item use the number of responses to that item as the denominator (n=86 for severe pain). Emergency physicians reported higher use of fentanyl and ketamine compared with paediatricians ($p < 0.01$). The most frequently reported barrier specific to analgesic administration was lack of formal education or training in paediatric pain pharmacotherapy (47%, Table 3), 29.9% of participants reported no barriers to giving analgesics. No significant difference was observed between respondents with and without paediatric experience ($p = 0.098$). A significant difference was observed between nurses and physicians ($p = 0.008$). Reported barriers also included uncertainty about dosing or guidelines (31%) and fear of adverse effects in children (30%). Parental reluctance and limited drug availability were reported less frequently.

Non-Pharmacological

The use of non-pharmacological strategies to alleviate paediatric pain and anxiety was widespread (Table 4). Distraction techniques (such as toys, games, or storytelling) were the most commonly employed non-drug intervention, reported by the vast majority of participants (mentioned by 83 respondents, ~95%). Other frequently used non-pharmacological measures included offering pacifiers or oral sucrose for infants (64% of respondents), encouraging breastfeeding or oral feeding for comfort (54%), and using comfort positioning (holding or swaddling children in secure, comforting positions; 52%). In contrast, specialized support from paediatric psychologists or play therapists was rarely available, with only 3 participants reporting access to such services during paediatric procedures. In terms of perceived efficacy, nearly half of participants (45%) believed these non-pharmacological methods definitely reduce children's anxiety during painful procedures, while an additional 49% observed at least some partial anxiety reduction when using them.

Pain Management by Procedure

The survey assessed analgesic use across common emergency department (ED) procedures (Table 5). For venipuncture/IV cannulation, 76% of respondents reported use of topical local anaesthetics, while 28% reported no analgesic or anxiolytic measures. 56% of respondents reported use of systemic analgesia (most commonly opioids), and 67% reported use of

TABLE 3: Identified barriers to the administration of pain medication across professional disciplines.

	None	Lack Of Training	Fear of Side Effects	Parental Resistance	Drug Shortage	Insecurity About Guidelines	Other
Total	26 (29.9%)	41 (47.1%)	26 (29.9%)	10 (11.5%)	3 (3.4%)	27 (31%)	4 (4.6%)
Paediatrician	6 (28.6%)	11 (52.4%)	8 (38.1%)	2 (9.5%)	1 (4.8%)	3 (14.3%)	0 (0%)
Emergency Physician	7 (33.3%)	7 (33.3%)	7 (33.3%)	2 (9.5%)	0 (0%)	7 (33.3%)	2 (9.5%)
Surgeon*	0 (0%)	3 (100%)	1 (33.3%)	0 (0%)	0 (0%)	2 (66.7%)	0 (0%)
Emergency Nurse	11 (28.2%)	19 (48.7%)	10 (25.6%)	5 (12.8%)	2 (5.1%)	15 (38.5%)	2 (5.1%)
* Surgeon group only consists of three participants. Percentages exceed 100% as respondents could select multiple options.							

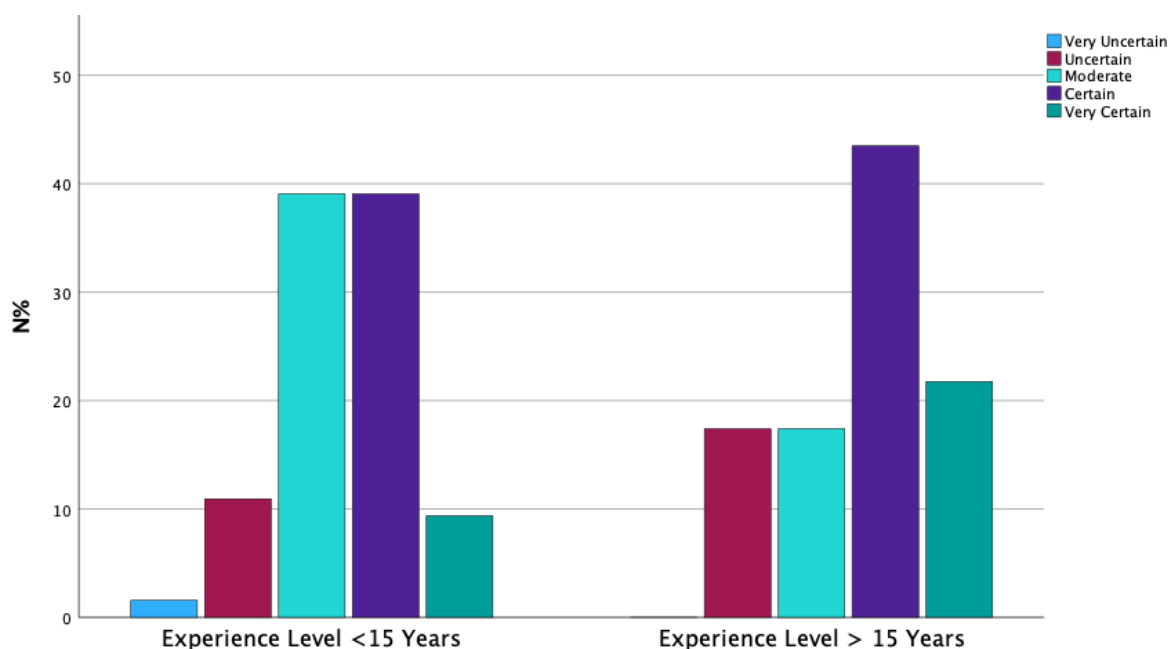


FIGURE 2: Association Between Professional Experience and Self-Rated Certainty in Paediatric Pain Management.

procedural sedation for fracture reduction. For bladder catheterization, 52% of respondents reported no analgesic or anxiolytic use. And 46% reported no analgesic or anxiolytic use for orthopaedic cast application. For lumbar puncture, 52% of respondents reported using a topical anesthetic, while 23% reported performing the procedure without any analgesic or anxiolytic measures. When asked to identify the most significant barriers to providing effective overall paediatric pain and anxiety management in the ED (including non-pharmacological aspect), participants reported a multifaceted set of challenges (Table 6). The most frequently cited barrier was insufficient specialized training in paediatric pain management, endorsed by approximately 21% of respondents. Time constraints in a busy ED were the second most common barrier (17.5%), and the absence of standardized protocols was the next major obstacle (~15%) reported. Notable barriers included inadequate staffing (14.8%) and the inherent difficulty of assessing pain in young children (12.7%). Very few respondents (~3%) felt that lack of medication availability was a significant barrier.

Importance of Pain management and Improvement

There was unanimous agreement among participants on the importance of effective pain management for children: 35% rated it “important” and 65% “very important,” with 100% of respondents affirming that paediatric pain control is a priority in emergency care. Looking forward, the survey asked participants to identify key requirements for improving paediatric pain management in their ED. The top priorities were overwhelmingly enhanced training and education (selected by 75.9% of respondents) and the development or updating of standardized paediatric pain

management protocols (71.3%). Many also emphasized the need for a more child-friendly environment in the ED (47%) to reduce anxiety and pain, as well as improved age-appropriate pain assessment tools (28.7%). In contrast, relatively few saw “better access to pharmacological agents” as a pressing need (only ~14% selected this), implying that the drug formulary was generally considered adequate.

Discussion

Despite substantial advances in paediatric pain management, inadequate analgesia remains a persistent challenge in emergency care. This study demonstrates that although emergency department clinicians consistently recognize pain management as a clinical priority, this awareness does not reliably translate into a standardized protocol-driven practice. As a result, children continue to experience preventable and undertreated pain during emergency encounters (11).

A central finding of this study is the discontinuity between initial pain recognition, intervention, and structured reassessment. While pain is frequently identified at presentation, systematic follow-up after analgesic administration is inconsistently performed, reflecting an “evaluation gap” described in prior literature (12). Similar deficiencies have been reported across paediatric emergency and trauma settings, where clinical pathways fail to ensure completion of the assessment–treatment–reassessment cycle (13). A key contributor to this gap appears to be the inconsistent integration of validated paediatric pain assessment tools into routine practice. The study by Ali et al is a good example of a structured way to implement post-analgesia pain assessment in a clinical trial which is transferable to standard clinical practice

TABLE 4: Table 4: Distribution and Frequency of Reported Non-Pharmacological Interventions for Pain Management By Profession.

Intervention	Response	Emergency Nurse		Emergency Physician		Paediatric Nurse		Paediatrician		Trauma Surgeon	
		N	N%	N	N%	N	N%	N	N%	N	N%
Distraction	No	3	7.7%	0	0.0%	0	0.0%	0	0.0%	1	33.3%
	Yes	36	92.3%	21	100.0%	1	100.0%	21	100.0%	2	66.7%
Swaddling	No	26	66.7%	14	66.7%	0	0.0%	2	9.5%	2	66.7%
	Yes	13	33.3%	7	33.3%	1	100.0%	19	90.5%	1	33.3%
Breastfeeding	No	21	53.8%	15	71.4%	0	0.0%	0	0.0%	3	100.0%
	Yes	18	46.2%	6	28.6%	1	100.0%	21	100.0%	0	0.0%
Pacifier	No	15	38.5%	11	52.4%	0	0.0%	1	4.8%	3	100.0%
	Yes	24	61.5%	10	47.6%	1	100.0%	20	95.2%	0	0.0%
Heat/Cold Therapy	No	31	79.5%	18	85.7%	0	0.0%	16	76.2%	3	100.0%
	Yes	8	20.5%	3	14.3%	1	100.0%	5	23.8%	0	0.0%
Comfort Positioning	No	20	51.3%	14	66.7%	1	100.0%	6	28.6%	1	33.3%
	Yes	19	48.7%	7	33.3%	0	0.0%	15	71.4%	2	66.7%
Paediatric psychologists or play therapists	No	38	97.4%	21	100.0%	0	0.0%	20	95.2%	3	100.0%
	Yes	1	2.6%	0	0.0%	1	100.0%	1	4.8%	0	0.0%
None	No	38	97.4%	21	100.0%	1	100.0%	21	100.0%	2	66.7%
	Yes	1	2.6%	0	0.0%	0	0.0%	0	0.0%	1	33.3%
Other	No	32	82.1%	21	100.0%	1	100.0%	19	90.5%	3	100.0%
	Yes	7	17.9%	0	0.0%	0	0.0%	2	9.5%	0	0.0%
Percentages exceed 100% as respondents could select multiple options.											

(14). Although international guidelines, including those from the European Society for Emergency Medicine, emphasize the use of age-appropriate, validated instruments, their inconsistent application likely reduces both the accuracy of pain evaluation and the reliability of reassessment over time (15). However, the evaluation gap is not only an individual caregiver problem, it reflects broader system-level constraints. In high-acuity emergency environments, competing clinical priorities, overcrowding, and workflow pressures often result in reassessment being deprioritized relative to diagnostic or life-saving interventions (11,16). Evidence from resource-limited settings similarly demonstrates that structural bottlenecks and the absence of standardized pain pathways impede consistent monitoring of analgesic response (17). Collectively, these findings suggest that the principal barrier is not recognition of pain, but the failure to embed reassessment into routine emergency workflows as a mandatory clinical step.

Beyond structural constraints, clinician-related factors also contribute to variability in reassessment practices. Prior work has shown that paediatric pain assessment is sometimes influenced by subjective judgment and uncertainty regarding the reliability of children's pain expression (11). Such variability may lead to inconsistent thresholds for reassessment and analgesic escalation. The findings of this study

support the need for institutionalised, protocol-driven pain management systems to reduce variability in care. Current practice patterns suggest reliance on individual clinician decision-making rather than embedded clinical pathways (11). Evidence from implementation studies demonstrates that structured protocols significantly improve both process and outcome measures. Nurse-initiated analgesia pathways, for example, have been associated with faster time to treatment and improved pain reassessment rates (18). Similarly, structured nurse-driven protocols have been shown to improve caregiver satisfaction and analgesic consistency (19). Current guidelines advocate algorithm-based approaches that integrate early analgesic initiation and mandatory reassessment (15). In this context, intranasal fentanyl is increasingly recommended as a first-line option for moderate-to-severe pain due to its rapid onset and favourable safety profile (20,21). Limited use of tramadol aligns with ongoing safety concerns. Importantly, effective protocols extend beyond pharmacological escalation and include multimodal strategies combining pharmacological and non-pharmacological interventions.

A concerning finding was the inconsistent management of procedural pain, particularly during routine interventions such as bladder catheterisation, where analgesia or anxiolysis was frequently absent. This aligns with prior evidence demonstrating systematic

TABLE 5: Reported Frequency of Pharmacological and Non-Pharmacological Interventions Across Different Clinical Procedures.

Procedure	None	Non- Pharmacological	Pharmacological / Systemic	Topical	Sedation	Other
IV Access	24 (27.6%)	50 (57.5%)	6 (6.9%)	66 (75.9%)	10 (11.5%)	1 (1.1%)
Bladder catheterization	45 (51.7%)	38 (43.7%)	7 (8%)	8 (9.2%)	2 (2.3%)	3 (3.4%)
Lumbar puncture	20 (23%)	34 (39.1%)	19 (21.8%)	45 (51.7%)	21 (24.1%)	3 (3.4%)
Fracture reduction	1 (1.1%)	13 (14.9%)	49 (56.3%)	3 (3.4%)	58 (66.7%)	5 (5.7%)
Suturing	2 (2.3%)	29 (33.3%)	29 (33.3%)	58 (56.7%)	15 (17.2%)	3 (3.4%)
Wound care	27 (31%)	40 (46%)	34 (39.1%)	15 (17.2%)	11 (12.6%)	3 (3.4%)
Casting (plaster)	40 (46%)	25 (28.7%)	27 (31%)	2 (2.3%)	9 (10.3%)	5 (5.7%)
Percentages exceed 100% as respondents could select multiple options.						

under-treatment of so-called “minor” procedures, despite clear evidence of significant distress and potential long-term psychological impact (12). Such findings reflect the continued normalisation of procedural pain in emergency settings, particularly when procedures are perceived as routine or low-risk (11). However, current international guidelines strongly oppose this practice, recommending routine prevention of procedural pain through multimodal strategies, including topical, inhalational, and dissociative approaches (15). Evidence further supports the use of nitrous oxide-based regimens as effective, workflow-compatible interventions that reduce procedural pain and anxiety while maintaining operational efficiency (22).

The observed analgesic prescribing pattern demonstrates a partial deviation from the WHO Paediatric Pain Ladder framework, particularly in moderate-to-severe pain management (23). A marked preference for fentanyl over morphine was identified, consistent with current evidence supporting fentanyl as a first-line opioid in acute paediatric care due to its rapid onset and reduced adverse effect profile (21,24). Conversely, limited use of tramadol aligns with ongoing safety concerns regarding unpredictable

metabolism in paediatric populations. These findings suggest partial adaptation of contemporary pharmacological evidence; however, inconsistency remains in structured escalation pathways and procedural analgesia application. Interestingly, nearly one-third of participants reported no significant barriers to administering analgesics to children. This subgroup may represent a particularly experienced or well-supported portion of staff, suggesting that adequate training and resources can enable clinicians to overcome common barriers.

Non-pharmacological interventions were widely integrated into routine care, reflecting increasing alignment with multimodal pain management principles. Distraction techniques were frequently used and associated with perceived reductions in anxiety, consistent with evidence supporting behavioural interventions in procedural pain management (24). Emerging evidence suggests that digital distraction technologies, including virtual reality, may offer superior analgesic and anxiolytic effects compared with traditional distraction methods (25,26). Additionally, established infant comfort measures such as sucrose, breastfeeding, and pacifier use were consistently applied, consistent with international recommendations (23). Comfort positioning was also frequently used and is supported by evidence demonstrating reduced physiological stress responses compared with restraint-based approaches (27). However, access to specialised psychosocial support was limited. This is notable given evidence linking such services to reduced procedural distress, decreased sedation requirements, and improved caregiver satisfaction (28). Their limited availability suggests reliance on frontline staff to deliver behavioural support, potentially contributing to variability in non-pharmacological care.

A key strength of this study is its multidisciplinary design, incorporating perspectives from both nursing and medical staff across multiple specialties, thereby providing a comprehensive view of paediatric pain management practices in the emergency department. The study also identifies actionable gaps across the assessment–intervention–reassessment cycle, offering

TABLE 6: Proportional Distribution of Reported Barriers to Adequate Pain and Anxiety Management in Emergency Departments.

	Count (N)	(Count %)
No Limitations	9	3.9%
Time Pressure	40	17.5%
Difficult Pain Score Assessment	29	12.7%
Medication Shortage	7	3.1%
Staffing Shortage	34	14.8%
Clinical Culture	26	11.4%
Lack Of Training	48	21.0%
Lack Of Protocol	34	14.8%
Other	2	0.9%
Percentages exceed 100% as respondents could select multiple options.		

clinically relevant targets for quality improvement. However, several limitations should be acknowledged. First, the sample included a high proportion of early-career clinicians, particularly among nursing staff, which may have influenced reported confidence and protocol familiarity. Second, the single-centre design at a tertiary academic hospital limits generalisability, particularly given the unique workflow in which paediatric emergency care is managed separately from general emergency medicine. Third, the extremely small sample for certain subgroups (e.g. surgeons, $n=3$) limits statistical power and the reliability of any comparisons involving those groups. Fourth, reliance on self-reported data introduces the possibility of social desirability bias. Finally, the cross-sectional design prevents assessment of temporal changes in practice or the impact of future interventions.

Conclusion

This study demonstrates a clear and clinically significant disparity between the recognition of paediatric pain and the consistent execution of a complete assessment–treatment–reassessment cycle in the emergency department. Although initial pain screening appears to be well embedded in practice, a substantial evaluation gap, reflected in the low rate of post-intervention reassessment (18.4%), represents a critical breakdown in the continuity of care. This gap indicates that pain management is frequently initiated but not systematically evaluated for effectiveness, limiting the ability to ensure adequate analgesic response. The underlying barriers appear to be predominantly structural and educational rather than purely logistical. These include ongoing uncertainty regarding pharmacological choices, concerns about potential adverse effects, and limited familiarity with validated paediatric pain assessment tools such as the FLACC and Wong-Baker FACES scales. Together, these factors contribute to inconsistent application of standardized pain assessment and monitoring practices, undermining evidence-based care delivery. In addition, the perception of parental involvement as a limiting factor by more than half of respondents (51%) highlights a persistent tension in clinical practice and underscores the need to strengthen the implementation of family-centred care principles. Rather than being viewed as an obstacle, caregiver involvement should be systematically integrated as a supportive component of paediatric pain assessment and reassurance, particularly in younger or non-verbal children. Addressing these challenges requires a shift away from ad hoc clinical decision-making toward a standardized, protocol-driven, and nurse-empowered model of care. Evidence from structured initiatives such as the PROSA program and the Kids Pain Collaborative demonstrates that implementation of standardized triage algorithms and nurse-initiated analgesia pathways can significantly improve timeliness of treatment and ensure mandatory reassessment, thereby closing critical gaps in the care continuum.

Ultimately, closing the evaluation gap is essential not only for improving acute pain relief but also for mitigating the long-term psychological consequences associated with poorly managed early healthcare experiences, including heightened procedural anxiety and needle phobia. Sustained improvement will depend on targeted education of clinical staff, reinforcement of validated assessment tool usage, and the formal integration of multimodal, age-appropriate pain management strategies into routine emergency department workflows.

Statement

The authors have no conflicts of interest to declare with regard to the topic discussed in this manuscript.

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