Do you know what they “know”?

Addressing Myths & Misconceptions About Pain

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Disclosure

- Brenda Nordstrom MSN, RN-BC, CHPN
  - No Conflict of Interest

Objectives

- Analyze the gap between evidence and current practice of pain management education
- Examine common myths, misconceptions, and attitudes regarding pain
- Discuss elements of a successful pain management education program
The Cost of Pain

- Approximately 100 million people experience chronic pain
- The financial cost of pain, including lost productivity, is greater than $600 billion
- Leads to decreased productivity and potential job loss
- Exacerbates depression, fear, anxiety, and anger
- Reduces ability to carry out social roles
- Increases physiological stress
  - Diminishes immunocompetency, decreases mobility, increases risk of pneumonia and thromboembolism among other physical effects
- Diminishes quality of life

(IOM, 2011)

Gap Between Evidence & Current Practice

Personal Experience

- As a CHPN and a Hospice QA Manager, noted ineffective pain management occurred too frequently
- As a Nursing Clinical Instructor working in LTC setting, noted facility nurses disagreed that non-verbal patients were expressing pain
- Personal pain experience, physician and office nurse unaware of need to treat nerve pain different from nociceptive pain
  - Opioids severely restricted, yet no alternatives given
  - PCP not aware of adjuvant meds - especially for nerve pain

The Joint Commission

- Reports pain is more prevalent in America than cancer, diabetes & heart disease combined
- Created a Pain Management Standard in 2001
- In 2010, a follow up study reported that “approximately 80% of patients surveyed still experienced moderate, severe or extreme pain after surgery despite all of the interventions used to manage their pain.” (Dahlof, 2013)

HCAHPS

- 2015 report – national average of 71% for patient satisfaction with pain management falls below the 76% target. (CMS, 2017)
Gap Between Evidence & Current Practice

IOM 2011 Report – Relieving Pain in America
- There are “gaps in knowledge and competencies related to pain assessment and management, cultural attitudes about pain, negative and ill-informed attitudes about people with pain, and stereotyping and biases that contribute to disparities in pain care” (p.9)
- Recognizes that nurses are essentially responsible for pain management (p. 203)
- There is a need to “sensitize and educate nursing students” about misconceptions and personal biases that affect their clinical behavior (p. 203)

Gap Between Evidence & Current Practice

Pain Education – Pre-Licensure
- AACN (2008) – BSN nurses should be implementing “evidence-based nursing interventions as appropriate for managing the acute and chronic care of patients”
  - Multiple studies report this is not occurring
  - Nursing students world-wide receive insufficient pain education
  - Insufficient pain management education during nursing school is cyclical
  - Nursing students have misconceptions about pain
  - Nursing students have misconceptions & personal biases that affect clinical behavior (Chan & Chow, 2014)

The Problem:
- There is a knowledge and skill set deficit regarding pain management among nursing students who, upon graduation, become nurses who then bring the deficit with them when they provide patient care.
- Experienced nurses continue to be educated on how to manage pain yet evidence indicates that current education does not illicit change in behavior.
Evidence of Need to Address Myths, Misconceptions, & Attitudes


**Strongest biases toward**
1. Unconscious & mechanically ventilated
2. Patients with addiction
3. Patients who attempted suicide

**Misconceptions related to**
1. Respiratory depression
2. Placebos
3. Pain behaviors
4. Inability to assess cognitively impaired

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Evidence of Need to Address Myths, Misconceptions, & Attitudes


**Knowledge & Attitude deficits identified**
Average total score = 68.8% (K&A-RSP scores range 35.4% - 73.8%)
1. Pain behaviors – especially ability to sleep
2. Dependence vs. Addiction
3. Adjuvant medications
4. Willingness to give increased IV opioid dose when appropriate
5. Equianalgesics

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Evidence of Need to Address Myths, Misconceptions, & Attitudes


**Four themes identified**
1. Understanding the patient
2. Importance of pain education
3. Nurse’s self-awareness
4. Interpretation of personal values

“Nurses who learned how their personal values affect their pain management decisions described new insights into their own approach to pain management.”
Knowledge and Attitudes Survey Regarding Pain (Ferrell & McCaffery, 2014)

1. Visible signs always accompany pain & can verify pain existence & severity.
   False: Even with severe pain, adaptation occurs, leading to periods of minimal or no signs of pain. Lack of pain expression does not necessarily mean lack of pain.

2. Sleep equals pain relief.
   False: People may sleep as a means to cope with unrelied pain.

3. Everyone who takes an opioid will become addicted.
   False: Depends on their personal risk of addiction.
   • Screen for risk factors: a family history of addiction, a personal history of alcohol and drug abuse, or certain psychiatric disorders.
   • Use of recreational drugs increases likelihood of prescription pain medication addiction.

Addiction is often confused with tolerance & physical dependence!
Myths & Misconceptions

4. It’s unsafe to give opioids to children or the elderly.
   False: Opioids are safe as long as they are adjusted to past history of opioid use. Children will also need dose adjusted to their size & weight.

5. Opioids are frequently associated with respiratory depression.
   False: Respiratory depression can occur. However, in long term stable dosing, this will not occur.
   • With short term or acute pain, titrate up based on history of opioid use
   • Sedation will ALWAYS precede respiratory depression

6. If a person doesn’t ask for pain medication, then they don’t have pain.
   False: Some cultures consider asking for pain medication a sign of weakness, however, if asked, they will admit they need pain relief. Some patients don’t want to be viewed as a “pest” or “complainer” and won’t volunteer information. Others fear being seen as a drug seeker.

7. If a person asks for a specific pain medication, or an increase in the dose of pain medication, they are “drug seeking”.

So now what??
Creating your pain management education module
Pain Management Education

- Address myths, misconceptions, & attitudes before the mechanics of pain management
  - Utilize clinical vignettes

  **Patient A:** Andrew is 75 years old and this is his first day following abdominal surgery. As you enter his room, he remains in bed and remains talking and smiling with his visitor. Your assessment reveals the following information. BP = 120/80, RR = 18, O2 = 95, on a scale of 0-10 (0 = no pain, 10 = worst pain imaginable) he rates his pain at 8.

  A. On the patient's ward you must mark his pain on the scale below. Circle the number that represents your assessment of the patient's pain.

     | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
     |---|---|---|---|---|---|---|---|---|---|----|
     |   |   |   |   |   |   |   |   |   |   |    |

    Pain: __________________

  B. Your patient, alone, has not taken any medications. Your previous experience of other patients with similar pain suggests your patient’s pain is greater than 5. The nurse orders 1 mg of morphine IV q4h. The nurse asks you to give the patient 2 mg of morphine IV. You administer 2 mg of morphine IV and record the patient’s pain at 2.

    i. Administration of the IV medication
    ii. Administration of the 2 mg IV dose
    iv. Administration of the 2 mg IV dose
    v. Administration of the 2 mg IV dose

  (Ferrell & McCaffery, 2014)

- Myths, Misconceptions, Attitudes, Bias, Values, Judgements
  - Be sure to define the vocabulary
  - May elicit negative emotions
  - May become defensive

- Psycho-social assessment is just as important as the physical assessment
  - City of Hope – Psychosocial Pain Assessment Form
  - Shirley Otis-Green, MSW, LCSW (sotis-green@coh.org)
  - Role Play or actually conduct an assessment of a chronic pain patient

- Assess pain history
  - Respect past difficulties, traumas, abuse
  - Identify past strengths and coping skills
Pain Management Education

- Importance of word choices during interview

Discomfort  Soreness  Agony

Aches  Suffering  Hurt

PAIN

- Physical Pain Assessment
  - Type of pain affects choice of intervention
  - Utilizing intensity scale vs. assessment of functionality & QOL

Wong-Baker MASC® Pain Rating Scale

- Nurse driven interventions
  - Distraction, massage, relaxation, music, art, humor, guided imagery, acupressure, mindfulness, acceptance, diet . . . .
  - Allow time to practice
Do you know what they “know”?

- Take time to assess your audience
  - Don’t assume you know what they need to know
  
  “Determining nurses’ knowledge and attitude regarding pain is essential in the process of improving pain management and pain education.”
  
- Mentoring and consistent reinforcement is more effective than yearly staff development / education
  
- Be engaging!!
  - Change isn’t driven by knowledge – it’s driven by emotion

Resources