January 2020

The “Knowledge and Attitudes Survey Regarding Pain” tool can be used to assess nurses and other professionals in your setting and as a pre and post test evaluation measure for educational programs. The tool was developed in 1987 and has been used extensively from 1987 - present. The tool has been revised over the years to reflect changes in pain management practice.

Regarding issues of reliability and validity: This tool has been developed over several years. Content validity has been established by review of pain experts. The content of the tool is derived from current standards of pain management such as the American Pain Society, the World Health Organization, and the National Comprehensive Cancer Network Pain Guidelines. Construct validity has been established by comparing scores of nurses at various levels of expertise such as students, new graduates, oncology nurses, graduate students, and senior pain experts. The tool was identified as discriminating between levels of expertise. Test-retest reliability was established ($r>.80$) by repeat testing in a continuing education class of staff nurses ($N=60$). Internal consistency reliability was established (alpha $r>.70$) with items reflecting both knowledge and attitude domains.

Regarding analysis of data: We have found that it is most helpful to avoid distinguishing items as measuring either knowledge or attitudes. Many items such as one measuring the incidence of addiction really measures both knowledge of addiction and attitude about addiction. Therefore, we have found the most benefit to be gained from analyzing the data in terms of the percentage of complete scores as well as in analyzing individual items. For example, we have found it very helpful to isolate those items with the least number of correct responses and those items with the best scores to guide your educational needs.

Enclosed for your use is a copy of our instrument and an answer key. You may use and duplicate the tool for any purpose you desire in whole or in part. References to some of our studies which have included this tool or similar versions are included below. We have received hundreds of requests for the tool and additional use of the tool can be found in other published literature. We also acknowledge the assistance of several of our pain colleagues including Judy Paice, Chris Pasero, and Nessa Coyle in the revisions over the years. If using or publishing the tool results please cite the reference as **“Knowledge and Attitudes Survey Regarding Pain” developed by Betty Ferrell, RN, PhD, FAAN, (www.cityofhope.org/NRE/resources), revised 2014.**

We hope that our tool will be a useful aid in your efforts to improve pain management in your setting.

Sincerely,

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Department of Population Sciences
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Knowledge and Attitudes Survey Regarding Pain

True/False – Circle the correct answer.

T **F** 1. Vital signs are always reliable indicators of the intensity of a patient's pain.

T **F** 2. Because their nervous system is underdeveloped, children under two years of age have decreased pain sensitivity and limited memory of painful experiences.

T **F** 3. Patients who can be distracted from pain usually do not have severe pain.

T **F** 4. Patients may sleep in spite of severe pain.

T **F** 5. Aspirin and other nonsteroidal anti-inflammatory agents are NOT effective analgesics for painful bone metastases.

T **F** 6. Respiratory depression rarely occurs in patients who have been receiving stable doses of opioids over a period of months.

T **F** 7. Combining analgesics that work by different mechanisms (e.g., combining an NSAID with an opioid) may result in better pain control with fewer side effects than using a single analgesic agent.

T **F** 8. The usual duration of analgesia of 1-2 mg morphine IV is 4-5 hours.

T **F** 9. Opioids should not be used in patients with a history of substance abuse.

T **F** 10. Elderly patients cannot tolerate opioids for pain relief.

T **F** 11. Patients should be encouraged to endure as much pain as possible before using an opioid.

T **F** 12. Children less than 11 years old cannot reliably report pain so clinicians should rely solely on the parent's assessment of the child's pain intensity.

T **F** 13. Patients' spiritual beliefs may lead them to think pain and suffering are necessary.

T **F** 14. After an initial dose of opioid analgesic is given, subsequent doses should be adjusted in accordance with the individual patient's response.

T **F** 15. Giving patients sterile water by injection (placebo) is a useful test to determine if the pain is real.

T **F** 16. Vicodin (hydrocodone 5 mg + acetaminophen 300 mg) PO is approximately equal to 5-10 mg of morphine PO.

T **F** 17. If the source of the patient's pain is unknown, opioids should not be used during the pain evaluation period, as this could mask the ability to correctly diagnose the cause of pain.

T **F** 18. Anticonvulsant drugs such as gabapentin (Neurontin) produce optimal pain relief after a single dose.

T **F** 19. Benzodiazepines are not effective pain relievers and are rarely recommended as part of an analgesic regiment.

T **F** 20. Narcotic/opioid addiction is defined as a chronic neurobiologic disease, characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving.

T **F** 21. The term 'equianalgesia' means approximately equal analgesia and is used when referring to the doses of various analgesics that provide approximately the same amount of pain relief.

T **F** 22. Sedation assessment is recommended during opioid pain management because excessive sedation precedes opioid-induced respiratory depression.

Multiple Choice – Place a check by the correct answer.

23. The recommended route of administration of opioid analgesics for patients with persistent cancer-related pain is
    ____ a. intravenous
    _____ b. intramuscular
    _____ c. subcutaneous
    _____ d. oral
    _____ e. rectal

24. The recommended route administration of opioid analgesics for patients with brief, severe pain of sudden onset such as trauma or postoperative pain is
    _____ a. intravenous
    _____ b. intramuscular
    _____ c. subcutaneous
    _____ d. oral
    _____ e. rectal

25. Which of the following analgesic medications is considered the drug of choice for the treatment of prolonged moderate to severe pain for cancer patients?
    _____ a. codeine
    _____ b. morphine
    _____ c. meperidine
    _____ d. tramadol

26. A 30 mg dose of oral morphine is approximately equivalent to:
    _____ a. Morphine 5 mg IV
    _____ b. Morphine 10 mg IV
    _____ c. Morphine 30 mg IV
    _____ d. Morphine 60 mg IV

27. Analgesics for post-operative pain should initially be given
    _____ a. around the clock on a fixed schedule
    _____ b. only when the patient asks for the medication
    _____ c. only when the nurse determines that the patient has moderate or greater discomfort

28. A patient with persistent cancer pain has been receiving daily opioid analgesics for 2 months. Yesterday the patient was receiving morphine 200 mg/hour intravenously. Today he has been receiving 250 mg/hour intravenously. The likelihood of the patient developing clinically significant respiratory depression in the absence of new comorbidity is
    _____ a. less than 1%
    _____ b. 1-10%
    _____ c. 11-20%
    _____ d. 21-40%
    _____ e. > 41%

29. The most likely reason a patient with pain would request increased doses of pain medication is
    _____ a. The patient is experiencing increased pain.
    _____ b. The patient is experiencing increased anxiety or depression.
    _____ c. The patient is requesting more staff attention.
    _____ d. The patient's requests are related to addiction.

30. Which of the following is useful for treatment of cancer pain?
    _____ a. Ibuprofen (Motrin)
    _____ b. Hydromorphone (Dilaudid)
    _____ c. Gabapentin (Neurontin)
    _____ d. All of the above

31. The most accurate judge of the intensity of the patient's pain is
    _____ a. the treating physician
    _____ b. the patient's primary nurse
    _____ c. the patient
    _____ d. the pharmacist
    _____ e. the patient's spouse or family

32. Which of the following describes the best approach for cultural considerations in caring for patients in pain:
_____ a. There are no longer cultural influences in the U.S. due to the diversity of the population.
_____ b. Cultural influences can be determined by an individual's ethnicity (e.g., Asians are stoic, Italians are expressive, etc).
_____ c. Patients should be individually assessed to determine cultural influences.
_____ d. Cultural influences can be determined by an individual's socioeconomic status (e.g., blue collar workers report more pain than white collar workers).

33. How likely is it that patients who develop pain already have an alcohol and/or drug abuse problem?

< 1% 5 – 15% 25 - 50% 75 - 100%

34. The time to peak effect for morphine given IV is
_____a. 15 min.
_____b. 45 min.
_____c. 1 hour
_____d. 2 hours

35. The time to peak effect for morphine given orally is
_____a. 5 min.
_____b. 30 min.
_____c. 1 – 2 hours
_____d. 3 hours

36. Following abrupt discontinuation of an opioid, physical dependence is manifested by the following:
_____ a. sweating, yawning, diarrhea and agitation with patients when the opioid is abruptly discontinued.
_____ b. Impaired control over drug use, compulsive use, and craving.
_____ c. The need for higher doses to achieve the same effect.
_____ d. a and b

37. Which statement is true regarding opioid induced respiratory depression:
_____ a. More common several nights after surgery due to accumulation of opioid.
_____ b. Obstructive sleep apnea is an important risk factor.
_____ c. Occurs more frequently in those already on higher doses of opioids before surgery.
_____ d. Can be easily assessed using intermittent pulse oximetry.

Case Studies

Two patient case studies are presented. For each patient you are asked to make decisions about pain and medication.

Directions: Please select one answer for each question.

38. Patient A: Andrew is 25 years old and this is his first day following abdominal surgery. As you enter his room, he smiles at you and continues talking and joking with his visitor. Your assessment reveals the following information: BP = 120/80; HR = 80; R = 18; on a scale of 0 to 10 (0 = no pain/discomfort, 10 = worst pain/discomfort) he rates his pain as 8.

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

0 1 2 3 4 5 6 7 8 9 10

No pain/discomfort Worst Pain/discomfort

B. Your assessment, above, is made two hours after he received morphine 2 mg IV. Half hourly pain ratings following the injection ranged from 6 to 8 and he had no clinically significant respiratory depression, sedation, or other untoward side effects. He has identified 2/10 as an acceptable level of pain relief. His physician's order for analgesia is "morphine IV 1-3 mg q1h PRN pain relief." Check the action you will take at this time.

_____ 1. Administer no morphine at this time.
_____ 2. Administer morphine 1 mg IV now.
_____ 3. Administer morphine 2 mg IV now.
_____ 4. Administer morphine 3 mg IV now.

39. Patient B: Robert is 25 years old and this is his first day following abdominal surgery. As you enter his room, he is lying quietly in bed and grimaces as he turns in bed. Your assessment reveals the following information: BP = 120/80; HR = 80; R = 18; on a scale of 0 to 10 (0 = no pain/discomfort, 10 = worst pain/discomfort) he rates his pain as 8.

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

0 1 2 3 4 5 6 7 8 9 10

No pain/discomfort Worst Pain/discomfort

B. Your assessment, above, is made two hours after he received morphine 2 mg IV. Half hourly pain ratings following the injection ranged from 6 to 8 and he had no clinically significant respiratory depression, sedation, or other untoward side effects. He has identified 2/10 as an acceptable level of pain relief. His physician's order for analgesia is "morphine IV 1-3 mg q1h PRN pain relief." Check the action you will take at this time:

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Answer Key

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0 1 2 3 4 5 6 7 **8** 9 10

No pain/discomfort Worst Pain/discomfort

B. Your assessment, above, is made two hours after he received morphine 2 mg IV. Half hourly pain ratings following the injection ranged from 6 to 8 and he had no clinically significant respiratory depression, sedation, or other untoward side effects. He has identified 2/10 as an acceptable level of pain relief. His physician's order for analgesia is "morphine IV 1-3 mg q1h PRN pain relief." Check the action you will take at this time.

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

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