

CAREGIVERS' ATTITUDES AND BELIEFS ABOUT ADMINISTERING PAIN MEDICATION

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10/30/16

General Statement

- Caregivers' attitudes and beliefs about pain medication administration often create barriers for pain management
 - Myths, fears, outdated information and cultural, or religious beliefs and expectations foster a biased attitude about pain in general (McPherson, Hadjistavropoulos, Devereaux, & Lobchuk, 2014).
 - Lack of credible and specific health promotion material about pain medication administration create knowledge gaps (Andreasen, Lund, Aadahl, & Sørensen, 2015).
 - Allows possible faulty or incorrect beliefs about pain medication administration to continue without update or correction (Andreasen et al., 2015).

Beliefs and Attitudes

- Reflection
 - Personal beliefs
 - Beliefs about others in pain
 - Professional Beliefs

Pain Scales

Wong-Baker FACES Pain Rating Scale



No Hurt



Hurts Little
Bit



Hurts Little
More



Hurts Even
More



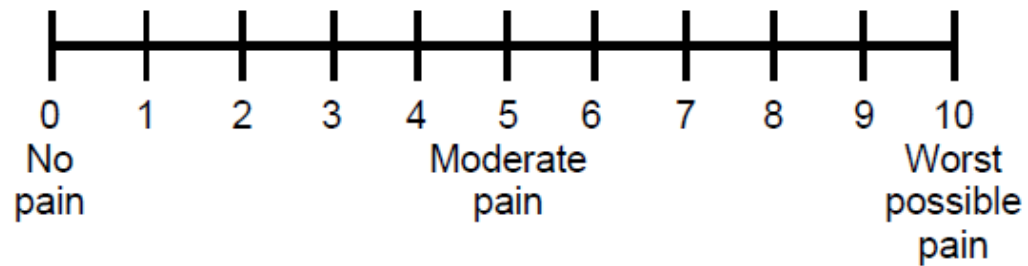
Hurts
Whole Lot



Hurts Worst

Pain Scales

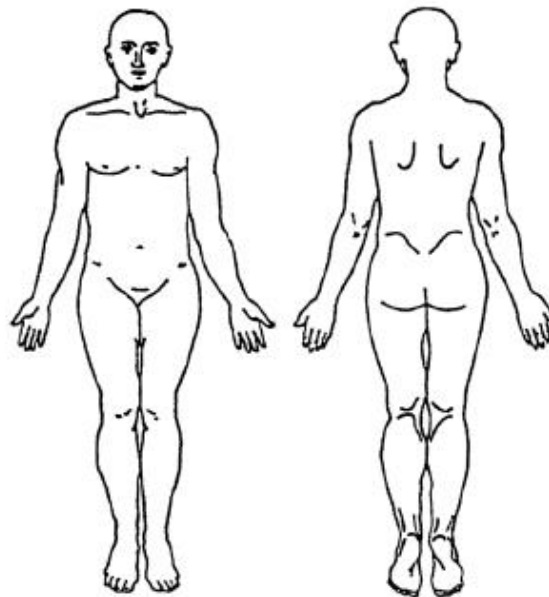
0–10 Numeric Pain Rating Scale



Pain Scales

Where is Your Pain?

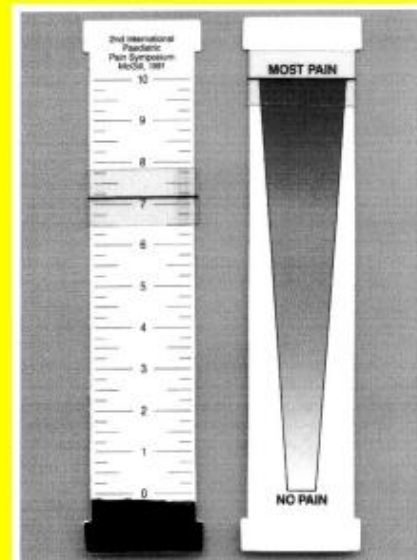
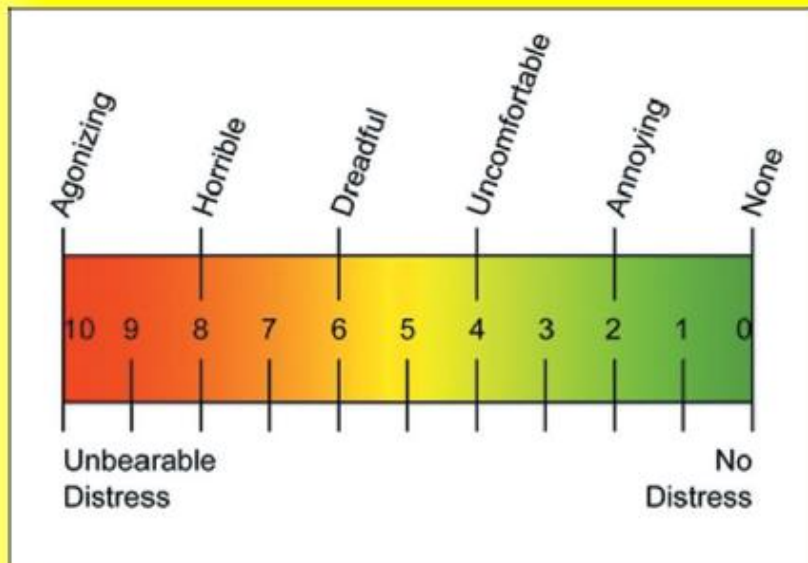
Please mark, on the drawings below, the areas where you feel pain. Write "E" if external or "I" if internal near the areas which you mark. Write "EI" if both external and internal.



Reprinted from *Pain*, Vol 1, Melzack R, The McGill Pain Questionnaire: major properties and scoring methods, 277-299, Copyright 1975, with permission from the *International Association for the Study of Pain*.

Pain Scales

Color Analog Scale (CAS)



- Score recorded in centimeters (0 – 10)

Pain Scales

Oucher Scale

- Used in children 4 – 12 years
- Patients point to face that represents pain
- Score 0 – 10



Pain Scales

FLACC

Categories	Scoring		
	0	1	2
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant frown, clenched jaw, quivering chin
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid, or jerking
Cry	No cry (awake or asleep)	Moans or whimpers, occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractable	Difficult to console or comfort

- Each category is scored 0 – 2, scores are added
- Total score range: 0 – 10

Questions

- What are the attitudes and beliefs of non-nursing caregivers younger than 65 that become barriers to pain treatment and prevention for patients 65 and over?
- How do non-nursing caregivers describe their attitudes and beliefs about pain medication administration that prompt them to take actions that are contrary to the doctor's order?
- Why do non-nursing caregivers hesitate to administer pain medication as ordered when certain verbal and nonverbal patient responses are present or absent?
- What are caregivers' general attitudes toward attending pain medication administration training?

Theory

- Theoretical frameworks
 - Maslow's Hierarchy of Needs -to define relationships between concepts, cultural expectations, and myths and stereotypes concerning caregiver motivation and pain medication administration
 - Biopsychosocial model for pain- to develop questions for the interview process concerning caregiver attitudes and beliefs about the biological, psychological and social aspects of pain

Barriers to Assessment

- Pain is a part of growing old
- Some patients are unable to report pain
- Pain is a psychological response
- Doctors and nurses are the experts about pain
- Stoicism
- Pain perception is the same
- Pain cannot be controlled for some populations

Categories

- Fatalism
 - Fatalism is a belief that our destiny is fixed by fate and that there is nothing that one can do to alleviate the pain and suffering that are part of the disease or aging process (Waller, 2011).
 - Fatalistic beliefs about pain management often prompt feelings of resentment and hopelessness or apathy because of the belief that nothing can be done to alleviate the pain (Waller, 2011).
- Hesitancy to administer
 - Beliefs are complex
 - Pain medication may be scarce, too expensive or that stronger medications may not be available (Bedard, G., Hawley, P., Zhang, L., Slaven, M., Gagnon, P., Bisland, S., . . . Chow, E. 2013).
- Interest in pain medication training
 - Guides resource allocation and level of perceived training needed.

Questions

- **Fatalism**
 1. How do you manage your patient's cultural needs concerning pain medication administration?
 2. Tell me about the aspects of your patient's cultural indifference that may lead to a reduction or acceptance of PRN pain medication?
 3. What fears do you have concerning the intensity of your patient's pain symptoms?
- **Hesitancy to Administer**
 4. Describe any concerns that you may have that too much or too little pain medication may slow the healing process?
 5. When does the side effects of pain medication become a concern for your patient?
 6. Explain how the side effects of pain medication could add to the confusion about the timing and dosage of pain medication?
 7. When faced with administering patient pain medication more frequently, what are your concerns about pain management as the disease advances?
 8. What are your thoughts about patients in pain becoming addicted to pain medication?
 9. What are your beliefs about regularly scheduled pain medication?
- **Interest in pain medication administration training**
 10. What kind of pain medication administration training would you like to see available for caregivers?

Conclusion

- Caregiver's attitudes and beliefs about pain medication administration vary greatly
- Caregivers may rely on myths, stereotypes and outdated information

Questions

- Thank you!

References

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