PAIN KNOWLEDGE EXAM WITH ANSWER RATIONAL
FINAL VERSION 11.21.11

Case study: Acute pain/short term rehab

Mr. Jones is an 85 year old widower who has prostate cancer with metastases to the bone. He has a history of cardiovascular disease, hypertension, gastrointestinal esophageal reflux disease, and mild dementia. He lives alone, has no close family members, and is withdrawn. He does not like to take medications and usually takes acetaminophen for pain. He was recently hospitalized following a fall at home. X-rays revealed three fractured ribs on his right side. He reports severe pain on his right side and describes it as sharp, especially with movement. Upon examination, he was found to be frail, alert with mild confusion, diminished appetite, and weighed 90 pounds.

1. Which of the following describes the type of pain Mr. Jones is experiencing?
   a) Visceral
   b) Neuropathic
   c) Nociceptive
   d) Chronic

Correct answer is' c'. All bone pain, which is somatic pain, arises from injury to musculoskeletal structures or superficial cutaneous tissue, is well localized, and is nociceptive in nature.

Resource: Polomano, R. (2010). Neurophysiology of pain. In B. St. Marie (Ed.), *Core curriculum for pain management nursing* (2nd ed.). Dubuque, IA: Kendall Hunt Publishing, pp. 63-90.

Competency 2

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In the hospital Mr. Jones was started on a 25 mcg. transdermal fentanyl patch every 72 hours with oxycodone 5mg, every four hours prn for breakthrough pain. A couple of weeks later he was transferred to a long term care facility for rehab services. Upon admission, he was found to have new behaviors of increased lethargy, increased confusion and non-cooperativeness with care. After being assessed to rule out any signs of infection or acute illness, he was evaluated by the interdisciplinary pain care team.

2. After evaluating Mr. Jones, the team agrees that his increased lethargy and confusion and non-cooperative behaviors are most likely due to:
   a) dehydration
   b) opioid-induced delirium
   c) metastatic cancer
   d) dementia

Correct answer is "b". The use of a 25 mcg transdermal fentanyl patch, a potent opioid, is not recommended in an opioid-naïve older adult and is most likely the cause of Mr. Jones's delirium as well as his transfer to a new environment which may be a contributing factor. Since elderly, cachectic, or older adults may have altered pharmacokinetics due to poor fat stores, muscle wasting, or altered renal clearance, opioid effects and analgesic needs should be closely evaluated prior to starting treatment.

Resource: Ghafoor, V., St. Marie, B. (2010). Overview of pharmacology. In B. St. Marie (Ed.), *Core curriculum for pain management nursing* (2nd ed.). Dubuque, IA: Kendall Hunt Publishing, pp. 235-306.

Competency 12

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3. After assessing Mr. Jones, which pain management recommendation would you make?
    a) Continue the transdermal fentanyl patch, add lorazepam to decrease anxiety and agitation, and involve him in more social activities.
    b) Discontinue the fentanyl patch; start a short-acting opioid every 4 hours prn to determine the 24hr, dose requirement, and reposition as needed for comfort.
    c) Discontinue the fentanyl patch and start an NSAID q 4 hrs. around the clock, and apply ice to the painful area.
    d) Continue the fentanyl patch and increase caffeine intake and activity to decrease lethargy

Correct answer is 'b'. The most reliable way to develop a controlled-release opioid regimen is to treat patients with an immediate-release opioid for 24-48 hours and titrate to optimal effect to learn the average daily dose requirement. Opioid effects and analgesic needs should be evaluated with immediate-release preparations before instituting a controlled-release opioid regimen in opioid-naïve patients.

Resource: Kelly, A. M. (2010). Gerontology pain management. In B. St. Marie (Ed.), *Core curriculum for pain management nursing* (2nd ed.). Dubuque, IA: Kendall Hunt Publishing, pp. 573-586.

Competency 8, 9, 10

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4. For which type of pain is a transdermal fentanyl patch appropriate?
    a) Acute pain
    b) Post-operative pain
    c) Moderate to severe intermittent pain
    d) Moderate to severe persistent pain

Correct answer is 'd'. A transdermal fentanyl patch is recommended for moderate to severe, persistent pain and not recommended for mild, intermittent, acute or post-operative pain. Due to the slow onset of action, with steady-state concentrations being reached within 12-24 hours, transdermal fentanyl is not suitable for the routine management of short-lasting, acute or intermittent pain states.

Resource: Ghafoor, V., St. Marie, B. (2010). Overview of pharmacology. In B. St. Marie (Ed.), *Core curriculum for pain management nursing* (2nd ed.). Dubuque, IA: Kendall Hunt Publishing, p. 287.

Competency 12

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5. Mr. Jones demonstrates the ability to use a pain rating scale that is easy for him to understand and tells you that his pain is "severe". His report is reflective of which scale?
    a) FLACC (faces, leg, activity, cry, consolability) scale
    b) NRS (numerical rating scale)
    c) VDS (verbal descriptor scale)
    d) Wong-Baker scale (faces scale)

Correct answer is 'c'. The verbal descriptor scale (VDS) contains verbal terms (e.g., mild, moderate, severe) which patients can use to express the intensity of their pain. The pain scale used should be appropriate to the patient's cognitive ability, easy for the older adult to understand and used consistently with that person.

Resource: Pasero C. & McCaffery, M. (2011). *Pain assessment and pharmacologic management*. St. Louis: Mosby, pp. 68-69, 84-85.

Competency 4
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6. Mr. Jones receives a short-acting opioid around the clock to manage his pain; however, he still reports moderate pain at times. With his metastatic bone disease and diminished appetite, which adjuvant drug would you recommend adding to his treatment regimen to provide optimal relief?
    a) An antidepressant
    b) A corticosteroid
    c) An NSAID
    d) An anticonvulsant

Correct answer is 'b'. Corticosteroids are considered multipurpose adjuvant drugs indicated for the treatment of metastatic bone pain because they inhibit prostaglandin synthesis, reduce edema surrounding neural tissues, have anti-inflammatory effects, improve appetite, decrease nausea, and enhance mood.

Resource: Pasero, C. & McCaffery M. (2011). *Pain assessment and pharmacologic management*. St Louis: Mosby, pp. 645-647.

Competency 15
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7. Mr. Jones admits he does not like to take medications and fears taking opioids. One of the biggest fears most often related to opioids is fear of:
    a) falls
    b) addiction
    c) nausea
    d) sedation

Correct answer is'b'. Fear of addiction among patients, physicians and nurses is consistently reported as a major concern and barrier to effective pain management.

Resource: Pasero, C. & McCaffery, M. (2011). *Pain assessment and pharmacologic management*. St. Louis: Mosby, pp. 538-541.

Competency 1
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8. Which of the following statements about tolerance, physical dependence and addiction are correct?
    a) Tolerance and physical dependence are normal responses that occur with the regular administration of opioids and are part of the body's adjustment to the presence of the drug
    b) Addiction rarely results from the use of a drug when taken as prescribed for the sole purpose of pain relief.
    c) a only
    d) a and b

Correct answer is 'd'. Tolerance occurs with regular administration of an opioid and consists of a decrease in one or more effects of the opioid; physical dependence is a normal response that occurs with repeated administration of an opioid for more than 2 weeks and is manifested by the occurrence of withdrawal symptoms when the opioid is suddenly stopped or rapidly reduced or an antagonist is given – tolerance and physical dependence cannot be equated with addiction. Addiction is a chronic, neurologic and biologic disease influenced by genetic, psychosocial, and environmental factors and

characterized by behaviors which include impaired control of drug use, continued use despite harm, and craving. Less than 1% of patients who take opioids as prescribed for pain relief develop addiction.

Resource: Pasero, C. & McCaffery, M. (2011). *Pain assessment and pharmacologic management*. St. Louis: Mosby, pp. 33-35.

Competency 1, 13
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9. You explain to Mr. Jones that he will be placed on bowel regimen to prevent opioid-induced constipation. The standard recommended protocol for preventing constipation is:
    a) a stool softener
    b) a stool softener and bowel stimulant
    c) a stool softener and increase in fiber intake
    d) a stool softener and increased activity

Correct answer is 'b'. A combination of a stool softener and bowel stimulant is the standard recommendation for patients receiving daily opioid analgesics and is the proactive approach to opioid-induced constipation. Opioids affect bowel function primarily by inhibiting propulsive peristalsis through the small bowel and colon. Patients do not develop tolerance to the constipation side effects even with long-term use of opioids.

Resource: Pasero, C. & McCaffery, M. (2011). *Pain assessment and pharmacologic management*. St. Louis: Mosby, pp. 484-489.

Competency 12
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10. You explain to Mr. Jones the benefits of non-pharmacological methods for both pain relief and improving the ability to manage and respond to pain effectively. Which distraction methods would be the most valuable for Mr. Jones?
    a) Socialization and reading out loud
    b) Television viewing and use of humor
    c) Both a and b
    d) Unable to determine without discussing with Mr. Jones

Correct answer is 'd'. Studies indicate that distraction strategies are more effective if geared to the individual's needs, preferences, and abilities. While a variety of distraction methods can be considered, it is necessary to discuss which ones are preferred by the older adult. Distraction strategies are effective for both cognitively intact and cognitively impaired persons.

Resource: Elliott, J., Simpson, M. (2010) Persistent pain management. In B. St. Marie (Ed.), *Core curriculum for pain management nursing*, (2nd ed.). Dubuque, IA: Kendall Hunt Publishing, pp. 443-447.

Competency 16
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11. Which statement regarding the use of non-pharmacologic interventions for pain management in older adults is correct?
    a) Music is rated as the most effective, non-pharmacologic method
    b) Cognitive methods are preferred over physical methods by older adults.
    c) Non-pharmacologic methods preferred by older adults are based on prior experience with their use.

d) TENS (transcutaneous electrical nerve stimulation) is not effective in relieving post-operative pain in older adults.

Correct answer is 'c'. Older adults have past experiences and preferences regarding the type of nondrug approaches that work well for them and may be accustomed to using a specific method that is effective which should be considered as part of the treatment plan.

Resource: Elliott, J., Simpsom, M. (2010). Persistent pain management. In B. St. Marie (Ed.), *Core curriculum for pain management nursing*, (2nd ed.). Dubuque, IA: Kendall Hunt Publishing, pp. 443-447.

Competency 16
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Case Study: Chronic Pain/Diabetic Neuropathy
Betty is an 88year-old woman who was admitted to a nursing home after multiple falls at home and following several visits to the emergency room. She has a history of multiple hospitalizations for congestive heart failure, has diabetes, degenerative joint disease, severe osteoarthritis, renal insufficiency and hypertension. She has a supportive grandson who has seen a continued decline in Betty's physical ability and mental status over the past two years. During her last hospitalization, Betty realized that because of her declining medical and physical condition she could no longer care for herself at home, and upon the advice of her physician and grandson, was transferred to a nursing home.

At the nursing home, Betty tells you that her hips and knees have been very painful and the cause of some of her falls at home. She relates that on her last visit to the emergency room she was advised to take acetaminophen for the pain and was told that the pain was chronic and also due to "getting old". She said the doctor feared giving her stronger medication because of her age. She tells you that the pain in her knees and hips is 8 out of 10.

12. Which of these questions, when answered by Betty, would provide the most information about her prior functional ability?

    a) Are bathing, dressing, and grooming hard for you?
    b) Are you able to walk and climb stairs unassisted?
    c) What activities and social functions do you usually participate in?
    d) What can you no longer do because of the pain?

Correct answer is 'd'. The answer to this open-ended question will provide the most information about the older adult's usual activities of daily living including social activities

Resource: D'Arcy, Y. (2010). Pain assessment. In B. St Marie (Ed.), *Core curriculum for pain management nursing* (2nd ed.). Dubuque, IA: Kendall Hunt Publishing, p.218.

Competency 7
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13. A number of barriers to effective pain management in older adults have been identified in the literature. Which of the following is an identified barrier to pain management?
    a) Overprescribing of opioids by licensed professionals
    b) Lack of knowledge about pain management among healthcare professionals
    c) Lack of adequate methods to effectively treat pain

d) Inadequate pain assessment tools

Correct answer is'b'. Lack of knowledge about pain management among healthcare professionals is consistently reported as a major barrier to effective pain management and undertreatment of pain.

Resource: Curtiss, C. (2010). The pain management nurse as an educator. In B. St. Marie (Ed.), Core curriculum for pain management nursing (2nd ed.). Dubuque, IA: Kendall Hunt Publishing, p. 669.

Competency 1, 3

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14. At the nursing home, x-rays of Betty's knees and hips indicate severe degenerative changes. She is currently taking six oxycodone tablets a day (10 mg oxycondone/325 acetaminophen) for pain relief but still reports moderate pain, especially in her knees. What recommendation would you make in her pain management regimen?
    a) Change the oxycodone to a 12 mcg transdermal fentanyl patch q 72 hrs with short-acting opioid every 4 hours prn, and increase ambulation.
    b) Continue the oxycodone and make a referral to physical therapy to increase ambulation.
    c) Change the oxycodone to a long-acting opioid with a short-acting opioid every 4 hours prn, and initiate a physical therapy evaluation.
    d) Schedule the oxycodone every 6 hours around the clock, add an NSAID, and encourage daily exercise.

Correct answer is'c'. Changing the oxycodone (short-acting opioid) to oxycontin (long-acting opioid) will provide better pain control for moderate to severe, persistent pain, decrease the amount of pills taken daily, prevent the possibility of acetaminophen toxicity, and be easily titrated to optimal relief. When converting someone from a short-acting opioid to a long-acting opioid, you need to calculate the 24 hour dose of the short-acting opioid (oxycodone 5mg x 4 doses = 20 mg in 24 hours) and then divide by 2 to obtain the 12 hour dose of the long-acting opoid (20 mg of oxycodone divided by 2 = 10 mg of oxycontin every 12 hours).

Resource: Kelly, A. M. (2010). Gerontology pain management. In B. St. Marie (Ed.), *Core curriculum for pain management nursing* (2nd ed.). Dubuque, IA: Kendall Hunt Publishing, p. 581.

Competency 8, 9

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15. Betty's grandson is concerned about the opioids she is taking daily and voices his fear about the possibility of respiratory depression. You reassure him and explain that the best way to assess and prevent opioid-induced respiratory depression is:
    a) blood gas analysis
    b) mechanical apnea monitoring
    c) monitoring of sedation level
    d) pulse oximetry and respiratory status

Correct answer is 'c'. Monitoring sedation level is the best method of determining respiratory status and preventing opioid-induced respiratory depression. Increased sedation precedes respiratory depression. If appropriate steps are taken to address persistent sedation, respiratory depression is unusual in patients receiving opioids.

Resource: Eksterwicz, N., Colwell, A., Vanderveer, B., Menez, J. (2010). Acute pain management. In B. St. Marie (Ed.), *Core curriculum for pain management* nursing (2nd ed.). Dubuque, IA: Kendall Hunt Publishing, pp. 364-365.

Competency 12
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16. Betty reports that she is feeling a burning, tingling sensation in both feet that is keeping her from sleeping at night and causing discomfort during the day. Betty is most likely experiencing neuropathic pain as a complication of her diabetes. Neuropathic pain is usually caused by:
    a) the normal processing of sensory input by the peripheral and central nervous system
    b) the progressive decrease in the discharge of the dorsal horn neurons
    c) the repeated injury to motor neurons
    d) the repeated noxious stimuli resulting in spinal cord hyperexcitability and hypersensitivity

<u>Correct answer is 'd'.</u> Neuropathic pain is the result of repeated, prolonged, noxious stimuli causing hyperexcitability and hypersensitivity leading to chronic neuropathic pain states; it is pain sustained by abnormal processing of sensory input by the peripheral or central nervous system, most often as a result of injury.

<u>Resource:</u> Pasero, C. & McCaffery, M. (2011). *Pain assessment and pharmacologic management*. St. Louis: Mosby, p. 95-98.

Competency 2
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17. Which medication not recommended for older adults, would you question if ordered for Betty?
    a) Amitriptyline (Elavil)
    b) Desipramine (Norpramine)
    c) Gabapentin (Neurontin)
    d) Duloxetine (Cymbalta)

<u>Correct answer is 'a'.</u> Amitriptyline is not recommended for older adults due to its high incidence of anticholinergic and sedative adverse effects and long half-life; it is the least well-tolerated of all the tricyclic antidepressants in older adults.

<u>Resource:</u> Kelly, A. M. (2010). Gerontology pain management. In B. St Marie (Ed.), *Core curriculum for pain management nursing* (2nd ed.). Dubuque, IA: Kendall Hunt Publishing, p. 581.

Competency 11
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18. Which of these adjuvant drugs would be the most appropriate to treat Betty's neuropathic pain?
    a) Desipramine (Norpramine) 25 mg.at hs
    b) Gabapentin (Neurontin) 100 mg tid
    c) Duloxetine (Cymbalta) 60 mg bid
    d) Nortriptyline (Pamelor) 25 mg in am

<u>Correct answer is 'b'.</u> Gabapentin 100 mg tid is the correct dose to start treating the neuropathic pain and titrate to effect; Gabapentin has no known drug-drug- interactions and is reported to be safe for older adults. Desipramine, duloxetine, and nortriptyline should be started at the lowest possible dose and nortriptyline is safer when given at bedtime.

<u>Resource</u>: Pasero, C. & McCaffery, M. (2011). *Pain assessment and pharmacologic management*. St. Louis: Mosby, pp. 664-665.

Competency 15
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19. Which information in Betty's history would be the most significant when considering the pharmacologic management of pain?
    a) A decline in renal function
    b) Degenerative joint disease
    c) Impairment or decline in mental status
    d) Decreased mobility

Correct answer is 'a'. A decline in renal function is most important because elimination of drugs is impeded by the age-related reduction in renal mass and blood flow, making older adults at higher risk for drug accumulation and toxicity, especially with drugs that have a long half-life.

Resource: Pasero, C. & McCaffery, M. (2011). *Pain assessment and pharmacologic* m*anagement*. St. Louis: Mosby, pp. 363-365.

Competency 7, 12
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20. When establishing priorities for an effective pain management plan, which considerations would be the most important?
    a) The older adult's functional ability
    b) The older adult's cognitive status
    c) The older adult's goals
    d) The older adult's support system

Correct answer is 'c'. An effective plan of care involves the older adult whose perspective is key in establishing appropriate goals of care and ensuring effective pain management according to the older adult's needs and wishes.

Resource: Curtiss, C. (2010). The pain management nurse as an educator. In B. St. Marie (Ed.), *Core curriculum for pain management nursing* (2nd ed.). Dubuque, IA: Kendall Hunt Publishing, p.666.

Competency 8, 9
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21. Which organization set standards for all healthcare facilities (clinics, hospitals, and long-term care facilities) in 2000, which ensure patients' rights to effective assessment and management of pain?
    a) The American Pain Society (APS)
    b) The American Society for Pain Management Nursing (ASPMN)
    c) Centers for Medicare and Medicaid Services (CMS)
    d) The Joint Commission (TJC)

Correct answer is 'd'. The Joint Commission introduced standards in 2000 that hold healthcare organizations accountable for the assessment and management of pain in all patients upon admission through discharge.

Resource: Brown, M., Bennett, P. (2010). Social, political, and ethical forces influencing nursing practice. In B. St Marie (Ed.), *Core curriculum for pain management nursing* (2nd ed.). Dubuque, IA: Kendall Hunt Publishing, p. 187.

Competency 19
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CASE STUDY 3: Persistent pain in an older adult with cognitive impairment and limited or nonexistent verbal abilities

Mr. Smith is a 76-year-old male with moderate dementia who has resided in your facility for 2 years. His ability to understand others is limited, but generally, he responds to short questions, recognizes his wife, and follows brief directions. He has a long history of arthritis in his hips for which he receives corticosteroid injections every 3 months.

22. You want to monitor Mr. Smith's pain in between steroid injections. What would be your first step?

   a. Attempt to obtain a self-report of pain from Mr. Smith.
   b. Observe Mr. Smith for behaviors that might indicate pain.
   c. Ask family members about Mr. Smith's history of pain.
   d. Attempt an analgesic trial and observe changes in Mr. Smith's behavior.

Correct answer is 'a'. It is important to attempt a self-report whenever possible, because Mr. Smith still has some verbal ability. People with dementia vary in their ability to report pain, and some may be able to report one pain and not another. A self-report can be combined with a behavioral assessment scale, especially if self-report is inconsistent or unreliable.

Resource: American Geriatrics Society (2009). Pharmacological management of persistent pain in older persons. *Journal of the American Geriatrics Society, 57*(8), pg. 1333.

Kelly, A. M. (2010). *Gerontology pain management.* In B. St. Marie (Ed.), *Core curriculum for pain management nursing* (2nd ed.), pg. 578.

Pasero, C, & McCaffery, M. (2011). *Pain Assessment and Pharmacologic Management*. St. Louis: Mosby, pg.123

Competency 5
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23. Which of the following statements about assessment of pain in older adults with dementia is false?

   a. People with dementia need extra time to process information in a pain rating scale.
   b. A large percentage of people with moderate dementia are able to use at least one pain rating scale.
   c. Pain ratings by people with dementia are lower, because cognitive impairment reduces the ability to feel painful stimuli.
   d. Facial grimacing is one of the most common behaviors indicating pain.

Correct answer is 'c'. It is a myth that people with cognitive impairment do not experience as much pain as those who are cognitively intact. Several research studies examining mechanisms and differences in pain transmission and perception in older adults with dementia document that the pain transmission process is unaltered, although cognitive processing and interpretation of the pain stimulus may be impaired, resulting in different presentations or responses to painful stimuli. Many people with dementia are able to use a pain rating scale, but need time to process the information. Facial grimacing is one of the most common pain behaviors for both cognitively intact and cognitively impaired people.

Resource: Pasero, C., & McCaffery, M. (2011). *Pain assessment and pharmacologic management.* St. Louis: Mosby, pp. 123-124.

Competency 5
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After trying several times to use a pain tool with Mr. Smith, you have determined that he is unable to use it. You continue to ask Mr. Smith if he has pain at each assessment but also look for behaviors that might indicate pain.

24. All of the following behaviors are likely indicators that Mr. Smith is experiencing pain EXCEPT:

    a. Change in sleep pattern and resisting care.
    b. Taking and hoarding items belonging to others and increased exit-seeking in his wheelchair.
    c. Rigid, tense body posture, grimacing during movement.
    d. Appetite change and combativeness.

Correct answer is 'b'. It is good practice to always ask an older adult with dementia whether he/she has pain and assess their response. When the individual's response is either lacking or inconsistent, it is important to assess for behaviors that might indicate pain. For people with dementia, the scope of potential pain indicators is much broader than the common pain behaviors, such as grimacing, moaning, bracing, rubbing, and guarding. Atypical behavioral presentation of pain can include agitation, restlessness, irritability, combativeness, resisting care, changes in appetite or sleep, or usual activities. Six major categories of behavior that indicate pain have been outlined by the American Geriatrics Society. They are facial expression, verbalizations/vocalizations, body movements, changes in interpersonal interactions, changes in activity, patterns or routines, and changes in mental status.

Resource: Pasero, C, & McCaffery, M. (2011). *Pain assessment and pharmacologic management*. St. Louis, Mosby, pp. 124-125.

American Geriatrics Society (2002). The management of persistent pain in older adults. *Journal of the American Geriatrics Society, 50*(6), pp. S204-S224.

Competency 5, 6
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After his corticosteroid injection, Mr. Smith's pain behaviors decrease for a few weeks, but as time goes on, he becomes aggressive, resists care, holds his arms rigidly to his chest, and stays in bed throughout the day. Based on his known arthritis and increasing behaviors you think he may have unrelieved pain. His responses to your attempts at a self-report continue to be inconsistent and unclear.

25. Before starting an analgesic medication, what additional information do you need to consider in order to rule out other causes of his behaviors?

    a. Whether there is a procedure or acute illness that is likely to cause pain. (For example, physical therapy or a urinary infection)
    b. Whether or not behaviors resolve after increasing his participation in known meaningful activities, such as interacting with the facility therapy dog.
    c. Whether or not behaviors continue after attention to basic needs and comfort measures are provided
    d. Whether ADLs are performed in a manner that could exacerbate pain

Correct answer is 'b'. A hierarchical approach to identifying the presence of pain in nonverbal older adults has been recommended. This approach includes assessing for acute illness, getting a report from family members, evaluating potentially painful procedures or activities, and determining whether

behaviors continue after assessment for acute illness, and after basic needs are met and comfort measures provided. In addition the manner in which assistance with ADLs is provided (for example, moving painful joints during dressing) can be a common source of pain and should be evaluated to find ways to minimize pain. Meaningful activities can enhance quality of life and may serve as a distraction from pain, but are not an alternative to adequate analgesia.

Resource: Pasero, C., & McCaffery, M. (2011). *Pain assessment and pharmacologic management*. St. Louis: Mosby, p. 126.

Herr, K, Coyne, P, Key, T, et al. (2006). Pain assessment in the nonverbal patient: Position statement with clinical practice recommendations. *Pain Management Nursing, 7*(2), 44-52.

Talerico, KA, Miller, LL, Swafford, K, Rader, J, Sloane, PD, & Hiatt, SO. (2006). Psychosocial approaches to prevent and minimize pain in people with dementia during morning care. *Alzheimer's Care Quarterly, 7*(3), 1-12.

Competency 5
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26. A pain behavior score obtained from an observational pain tool is not equivalent to a pain intensity score.

    a. True
    b. False

Correct answer is 'a'. A pain intensity score (e.g., severe pain, or a '9' on a 0-10 scale) can only be determined by a person's self-report. When self-report is possible and is consistent, treatment decisions can be made based on this single measure. However, a pain behavior score is only one piece of the broader assessment picture, and treatment decisions should be made based on the assessment hierarchy.
This approach includes getting a report from family members, evaluating potentially painful procedures or activities, and determining whether behaviors continue after basic needs are met and comfort measures provided. In addition the manner in which assistance with ADLs is provided (for example, moving painful joints during dressing) can be a common source of pain and should be evaluated to find ways to minimize pain.

Resource: Pasero, C., & McCaffery, M. (2011). P*ain assessment and pharmacologic management*. St. Louis: Mosby, p. 127.

Competency 5, 6
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You want to use an observational pain assessment tool to monitor Mr. Smith's pain.

27. All of the following observational pain assessment tools are recommended for assessment of persistent pain in older nursing home residents EXCEPT:

    a. CNPI (Checklist of Nonverbal Pain Indicators)
    b. FLACC (face, legs, activity, crying and consolability)
    c. PAIN-AD (Pain Assessment in Advanced Dementia)
    d. PACSLAC (Pain Assessment Checklist for Seniors with Limited Ability to Communicate)

Correct answer is 'b. Many tools for assessment of pain in nonverbal older adults have been developed in recent years and are in various stages of development. However, important differences

exist in scope and application, and there is no universally accepted tool for this population with good reliability, validity and clinical utility. Three tools for the assessment of pain in nonverbal older adults for use in nursing homes are currently recommended because there is at least minimum evidence supporting their use : 1) the CNPI; 2) the PAINAD; and 2) the PACLSAC. The CNPI is a brief clinically useful observational list of 6 common pain behaviors. The PAINAD also focuses on the more common pain behaviors and contains 5 categories of behavior. The PACSLAC, on the other hand, provides a listing of 60 behaviors (many atypical) that may be exhibited in this population as an expression of pain or discomfort. It is important to understand that the particular behaviors exhibited are unique to each individual. The same tool(s) should be used with individual older adults once it has been selected in order to provide consistent assessment information. These 3 tools continue to be tested and new tools continue to be developed. Clinicians are encouraged to keep abreast of changes in recommendations and to understand that there should be evidence to support the use of the pain assessment tool(s) they choose. A detailed critique of existing pain tools, is available at http://prc.coh.org/PAIN-NOA.HTM The FLACC is designed for children, ages 2-7, and some of the behaviors in the FLACC are not typically seen in older adults.

Resource: D'Arcy, Y. (2010). Pain assessment. In B. St Marie (Ed.), *Core curriculum for pain management nursing* (2nd ed.). Dubuque, IA: Kendall Hunt Publishing, p. 229.

Pasero, C, & McCaffery, M. (2011). *Pain assessment and pharmacologic management*, St. Louis, Mosby. pp. 128-135.

Herr, K, Bursch, H, Ersek, M, Miller, LL, & Swafford, K. (2010). Use of pain –behavioral assessment tools in the nursing home: Expert consensus recommendations for practice. *Journal of Gerontological Nursing, 36*(3), 18-29.

Competency 5, 6

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28. In addition to consistently asking the person with dementia whether he/she has pain, which of the following statements about pain assessment in this population is accurate?

    a. Family members' report on intensity of pain should be obtained.
    b. Observational assessments for pain should be conducted both at rest and during movement or activity.
    c. Greater number of pain behaviors indicates greater pain intensity.
    d. Pain intensity should be determined and recorded in the same way as with cognitively intact people.

Correct answer is 'b'. Pain behaviors may be present either at rest or during movement and activity, and observational assessment should occur during both rest and movement. Some studies have illustrated that observation for pain-related behaviors at rest can be misleading and can lead to incorrect judgment about the presence of pain, therefore it is necessary to observe during both rest and movement. Although family members can often give reliable information about whether or not pain is present in the older person with dementia, their reports of how severe or intense they think the pain is for the person are often inaccurate and should not be obtained. Finally, a pain behavior score is not equivalent to a pain intensity score.

Resource: Kelly, A. M. (2010). Gerontology pain management. In B. St. Marie (Ed.), *Core curriculum for pain management nursing* (2nd ed.) (p. 578). Dubuque, IA: Kendall Hunt Publishing.

Pasero C., & McCaffery, M. (2011). *Pain Assessment and Pharmacologic Management*. St. Louis: Mosby, p. 127.

Competency 5, 6
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You determine that the analgesic medication that Mr. Smith is currently receiving, 500mg of acetaminophen QID, is not adequate because his behaviors increase over time after his steroid injection.

29. What would your next step be in changing his analgesic medication?

a. Stop the scheduled acetaminophen and start hydrocodone 5/325, 1 tablet QID for 2 days and then reassess
b. Stop the acetaminophen and start ibuprofen 400 mg TID for 2 days and then reassess
c. Increase his acetaminophen to 1000mg and schedule it Q6H around-the-clock for 2 days and then reassess
d. None of the above

Correct answer is 'a'. Starting a weak opioid, such as hydocodone at the 5/325 dose would be an appropriate initial opioid to try in this case. Assessing for effectiveness and sedation side effects for the first 48 hours would be important. Owing to its relative safety, acetaminophen is recommended as first-line therapy for persistent pain, but it is now recommended at no more than 3000mg/day. Because older adults are at higher risk of adverse events from NSAIDs, they should be used with caution in older adults and reserved for short-term use.

Resource: American Geriatrics Society (2009). Pharmacological management of persistent pain in older persons. *Journal of the American Geriatrics Society, 57*(8), pg. 1334.

Competency 9, 10, 11
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30. Which of the following factors in Mr. Smith would lead you to avoid increasing his dose of acetaminophen?

a. Hepatic insufficiency
b. History of alcohol abuse
c. Medications such as warfarin and methotrexate
d. all of the above

Correct answer is 'd'. Because acetaminophen is metabolized in the liver, the dose of acetaminophen should be reduced to 50-75% in people with either hepatic insufficiency, a history of alcohol abuse, or taking high risk medications such as warfarin and methotrexate.

Resource: American Geriatrics Society (2009). Pharmacological management of persistent pain in older persons. *Journal of the American Geriatrics Society, 57*, pg. 1335.

Competency 10
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31. Because of the above-noted factors, you and Mr. Smith's primary care provider decide to try using a low-dose opioid with Mr. Smith rather than increasing his acetaminophen. Opioids are associated with a number of side effects. Which of the following statements is NOT true about side effects associated with starting Mr. Smith on a low-dose opioid?

a. Increased sedation is more likely if Mr. Smith is taking other CNS depressants, such as benzodiazepines, antipsychotics, sleeping pills, and anti-depressants.

b. A small increase in risk for falling is most likely to occur during transfers and is most likely due to increased sedation, which should decrease in a few days as Mr. Smith adjusts to the medication.
c. Respiratory depression is a serious side effect and should be monitored as long as the person is taking opioids.
d. Constipation is the one side effect of opioids for which tolerance does not develop.

Correct answer is 'c'. Respiratory depression, though serious, would not be an ongoing priority because tolerance develops quickly. Further, respiratory depression usually results from rapid dosing increases and not from low-dose medications, even in opioid-naïve individuals. However, increased sedation may be a risk, especially if Mr. Smith takes other CNS depressants. There is little research suggesting that opioid use increases the risk of falling, but it may in certain individuals, such as those with a history of falls or gait abnormalities. Constipation is a common side effect of opioid medications and should be treated proactively at the start of opioid treatment.

Resources: American Geriatrics Society (2002). The management of persistent pain in older adults. *Journal of the American Geriatrics Society, 50*(6), pp. S204-S224.

American Geriatrics Society (2009). Pharmacological management of persistent pain in older persons. *Journal of the American Geriatrics Society, 57*(8), p. 1339.

Competency 13
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32. Of the following statements about using opioids to treat pain in cognitively impaired older adults, which one is accurate?

    a. Using opioids in cognitively impaired older adults should be avoided because of increased risk of sedation and falls.
    b. Opioids should be given to cognitively impaired older adults starting with low doses, followed by frequent reassessment of optimum pain relief and side effects.
    c. Because cognitively impaired older adults are less sensitive to pain, they should not require strong opioids to relieve pain.
    d. Opioids should be avoided due to risk of constipation/impaction.

Correct answer is 'b'. As with cognitively intact older adults, the "start low, go slow" guideline is appropriate for cognitively impaired individuals as well. An opioid analgesic trial can be used if pain is assumed to be present based on 1) pathology or procedures likely to stimulate pain, 2) continuation of pain behaviors after attention to known causes of pain, basic needs, and comfort measures, and 3) surrogate (family members, caregivers) report of previous pain or behaviors indicative of pain. Side effects, such as sedation and constipation should be monitored, but are not reasons to avoid opioids.

Resource: Kelly, A. M. (2010). Gerontology pain management. In B. St. Marie (Ed.), *Core curriculum for pain management nursing* (2nd ed.). Dubuque, IA: Kendall Hunt Publishing, p. 581.

Pasero, C, & McCaffery, M. (2011). *Pain assessment and pharmacologic management.* St. Louis: Mosby, pp8. 123-126.

Competency 10, 13
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33. As you initiate these changes in Mr. Smith's medications, you want to ensure that the interdisciplinary team members know their role in Mr. Smith's pain management. Which of the following statements about the role of the interdisciplinary team is NOT true?

   a. All nurses working with Mr. Smith should understand about medication changes in the care plan and monitor for effectiveness and side effects.
   b. Physical therapists and occupational therapists should evaluate Mr. Smith and develop interventions to optimize both upper and lower extremity functioning.
   c. The Activities Director should plan for activities that can help to maintain functioning and distract Mr. Smith from his pain.
   d. Because Mr. Smith will not be able to remember the PT's instruction, a physical therapy referral is not indicated.

Correct answer is 'd'. An interdisciplinary approach is vital to a successful pain management program. The nurse's role in pain management is to act as the coordinator of the plan, involving all the key people in a collaborative manner to optimize the treatment plan. A physical therapy referral is appropriate and can help with positioning and maintaining lower extremity functioning.

Resource: Gordon, D. B. (2010). Quality Evaluation and Improvement. In B. St. Marie (Ed.), *Core curriculum for pain management nursing* (2nd ed.). Dubuque, IA: Kendall Hunt Publishing, p. 653.

Competency: 17
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34. You want to augment analgesic medication with non-pharmacological treatments. Which of the following non-pharmacological treatments would NOT be appropriate for Mr. Smith?

   a. Physical activity
   b. Massage
   c. Cognitive behavioral interventions such as biofeedback
   d. Positioning techniques

Correct answer is 'c'. Due to Mr. Smith's cognitive impairment, he would not be able to understand and participate in cognitive behavioral interventions. Physical activity, massage and positioning techniques all are appropriate non-pharmacological interventions for people with dementia.

Resource: American Geriatrics Society (2002). The management of persistent pain in older adults. *Journal of the American Geriatrics Society, 50*(6), pp. S218-S220.

Competency: 8, 16
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After 4 days, the interdisciplinary team members are in agreement that the medication change has been helpful to Mr. Smith's pain. This conclusion is further supported by a reduction in pain-related behaviors documented during regular observational assessments. However, Mr. Smith has experienced an increase in confusion since the new opioid medication was started. His wife and the team are expressing concern and suggesting that he be taken off the opioid.

35. After ruling out other causes, you conclude that the changes in mental status are related to opioid use. What will your next steps be?

   a. Taper the opioid slowly and discontinue. Restart the ATC acetaminophen.

b. Educate the team and family about the likelihood that opioid-related confusion resolves within a couple of weeks at most.
c. Administer naloxone to reverse the opiate's effects and reduce the daily opiate dose by 25%
d. Reduce the daily opioid dose by 25% and reassess in 2-3 days.

Correct answer is 'd'. In this case, it is concluded that the analgesia received from the opiate is satisfactory, but with apparent side effects. When this is the situation, it is best to reduce the dose by 25% and reassess in 2-3 days. Until these steps are taken and reassessment can occur, it would be premature to discontinue what appears to be a successful medication. Further, naloxone should not be administered, even if changes in cognition are significant, as doing so can precipitate severe pain that is very difficult to control.

Resource: Pasero, C., & McCaffery, M. (2011). *Pain assessment and pharmacologic management.* St. Louis: Mosby, pp.487& 520.

Competency: 9, 13
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CASE STUDY 4: Post-herpetic Neuralgia

For the first time, you're caring for Mrs. Lee, a cognitively intact 79-year-old woman recently treated for the acute phase of herpes zoster (shingles). However, she is continuing to experience ongoing pain. She describes a burning sensation with a shooting component around her chest. The pain is present 80% of the day but varies in intensity on a numerical rating scale from 3-7/10. It does keep her awake on occasion. Pain related medications include ibuprofen, 600mg q6h, and Tylenol #3, one tablet q4h.

36. Her type of pain would be classified as ______ and occurs because of ____.
   a. nociceptive; abnormal processing of sensory input by the peripheral or central nervous system damage
   b. neuropathic; normal physiological response to tissue damage
   c. neuropathic; abnormal processing of sensory input by the peripheral or central nervous system damage
   d. nociceptive; normal physiological response to tissue damage

Correct answer is 'c'. This is a case of post-herpetic neuralgia, which occurs in approximately 20% of people who experience an acute case of shingles. Neuropathic pain, such as in this case study, is caused by a primary lesion or dysfunction in the either the central or peripheral nervous system, or both.

Resource: Pasero, C. & McCaffery, M. (2011). *Pain assessment and pharmacologic management*. St. Louis: Mosby, p. 7

Competency 2
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37. What would be your first priority in addressing her pain?
   a. Call or fax her prescriber to request adjustments in her current treatment plan
   b. Identify the patient's goals for pain relief, determine her level of knowledge about the disease, and establish a plan for her involvement in documenting her pain experience
   c. Initiate two non-pharmacological interventions to offer pain relief: cold (ice) compresses to the painful area followed by a gentle massage with peppermint oil

d. Contact family members to gather additional information about her pain history and disease process

Correct answer is ‘b’. Having an identified goal provides a necessary target for the treatment of pain for each individual. The nurse’s role includes educating the older person about the pain and encouraging active participation in her/his care. Selection of a valid and reliable pain assessment tool that she finds particularly useful will be a top priority. The non-pharmacological interventions mentioned here would be appropriate in this case, but they would not be a priority until her goals are determined.

Resource: Kelly, A. M. (2010). Gerontology pain management. In B. St. Marie (Ed.), *Core curriculum for pain management nursing* (2nd ed.). Dubuque, IA: Kendall Hunt Publishing, p. 583.

Competency 4, 8, 16
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38. It is important to consistently use a tool that measures the intensity of an older adult’s pain. Because you want to use the tool that Mrs. Lee prefers, you introduce her to recommended reliable and valid tools. Which ones will you review with her?

    a. The verbal descriptor scale, the PAINAD, and the numeric rating scale
    b. The FACES pain scale (revised version), the numeric rating scale, and the PACSLAC
    c. The verbal descriptor scale, the FACES pain scale (revised version), and the numeric rating scale
    d. The PACSLAC, the PAINAD, and the numeric rating scale

Correct answer is ‘c’. The PAINAD and PACSLAC are pain tools for cognitively IMPAIRED older adults and require observation of behaviors. The verbal descriptor scale, he FACES pain scale (revised version), and the numeric rating scale are recommended for use in the cognitively intact older adult population due to their reliability, validity and simplicity of use. If you are unfamiliar with any of these scales, see the Cognitively Intact Pain Assessment section of the geriatricpain.org website.

Resource: American Geriatrics Society (2002). The management of persistent pain in older persons. *Journal of the American Geriatrics Society*, *50*(6), pp. 208-210.

Competency: 4, 8
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39. Your assessment reveals that her current medications are not effectively managing her pain. Knowing the potential consequences of untreated or poorly treated pain specific to older persons, what additional issues will you want to assess and address?
    a. cognitive changes and nutritional intake
    b. decreased interest in social activities and relationships
    c. mood, including risk of depression and/or anxiety
    d. All of the above

Correct answer is ‘d’. All of the listed issues may arise as a consequence of untreated pain. In addition to these, nurses will need to keep in mind that there are additional potential consequences. These include sleep disturbance, alteration in immune function, change in functional abilities, and an overall increase in health care utilization.

Resource: American Geriatrics Society (2002). The management of persistent pain in older persons. *Journal of the American Geriatrics Society, 50*(6), p. 205.

Competency: 9, 3
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40. Her current pain treatment regimen is ineffective. She is taking ibuprofen, 600mg q6h, along with a proton-pump inhibitor (e.g. omeprazole/Prilosec), and acetaminophen with codeine (Tylenol #3), one tablet q4h. In preparation for contacting her prescriber, you review her medical history and medications. You note the following: Which of these is/are important in considering recommendations about her NSAID use?

    a. Chronic constipation
    b. Decreased appetite
    c. The fact that she's been on the ibuprofen regularly for 6 weeks
    d. Reports of sleep disturbance

Correct answer is 'c'. Prolonged NSAID use is a considerable concern for older persons, who are four times more likely to experience a peptic ulcer, and five times more likely to die from a GI bleed associated with NSAID use. Prior history of a peptic ulcer or the use of any anti-ulcer therapy for any reason puts the older adult at a high to very high risk for a serious GI event. Also, the beginning of therapy (first 3 months) holds the highest risk of serious complications, such as a GI bleed.

Resources: Pasero, C. & McCaffery, M. (2011). *Pain assessment and pharmacologic management*. St. Louis: Mosby, p. 191.

Kelly, A. M. (2010). Gerontology pain management. In B. St. Marie (Ed.), *Core curriculum for pain management nursing* (2nd ed.). Dubuque, IA: Kendall Hunt Publishing, p. 580.

Competency 9, 10, 14
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41. In general, particular caution must be exercised when considering NSAID therapy for individuals with which of the following?

    a. High fall risk and confusion
    b. Gastropathy and cardiovascular disease
    c. Hepatic insufficiency and low blood pressure
    d. Low creatinine clearance

Correct answer is 'b'. Patients with a history of gastropathy are considered at high or very high risk for an adverse GI event with NSAID use. NSAIDs also carry a cardiovascular side effect risk, which can be compounded when there is pre-existing CV disease. Additionally, with CV disease, individuals are most often taking low-dose aspirin, again increasing the risk of adverse GI events when taken with NSAIDs as well as increasing bleeding time. There is some concern that ibuprofen may interfere with aspirin's antiplatelet effect, adding another consideration for both the management of pain and heart disease. Finally, when individuals are taking anticoagulants, there is an increased risk in GI mucosal break and subsequent hemorrhage. INR should be monitored closely if acetaminophen or NSAIDs are taken at the same time as warfarin.

The lowest effective NSAID dose, for the shortest period of time, is the best principle to follow when NSAID therapy is indicated. If acetaminophen has been tried and is insufficient to meet analgesic needs, an opioid trial or other centrally-acting analgesic should be considered, as the American Geriatrics Society suggests that opioids may be safer than NSAIDs in some patients.

Resources: Pasero, C. & McCaffery, M. (2011). *Pain assessment and pharmacologic management.* St. Louis: Mosby, p. 193.

American Geriatrics Society (2009). Pharmacological management of persistent pain in older persons. *Journal of the American Geriatrics Society*, 57, pp. 1335, 1337.

Kelly, A. M. (2010). Gerontology pain management. In B. St. Marie (Ed.), *Core curriculum for pain management nursing* (2nd ed.). Dubuque, IA: Kendall Hunt Publishing, p. 580.

Competency 10, 11, 14
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42. What will you recommend when you contact her prescriber?

   a. Propose a plan to discontinue both the ibuprofen and the acetaminophen with codeine (Tylenol #3) and switch to a different NSAID along with a long-acting opioid.
   b. Request an increase in the ibuprofen to 800mg q6hr in addition to increasing the acetaminophen with codeine (Tylenol #3) to 2 tabs Q4hr. Also, request a prn opioid for breakthrough pain.
   c. Propose a plan to discontinue the ibuprofen, taper the acetaminophen with codeine (Tylenol #3) and evaluate for initiation of either an anticonvulsant or an antidepressant with analgesic properties (such as a tricyclic antidepressant or a SNRI) along with a scheduled short-acting opioid.
   d. Discontinue NSAID use altogether and increase the strength of opioid to oxycodone, ensuring that it is administered around the clock.

Correct answer is 'c'. Post-herpetic neuralgia can be very painful, often requiring both an opioid and adjuvant medication. It is also important to remember that NSAIDs are generally not effective for neuropathic pain. Based on the older person's profile, second generation anticonvulsants (e.g., gabapentin, pregabalin) should be considered first-line drugs for the treatment of neuropathic pain. If depression occurs at the same time as the neuropathic pain, an antidepressant with analgesic properties (e.g., tricyclic antidepressant: nortriptyline, serotonin–norepinephrine reuptake inhibitors: duloxetine, venlafaxine) would be the preferred choice. Regarding the acetaminophen-codeine, remember that the codeine component is extremely constipating and, for some individuals, codeine is ineffective because of the inability to metabolize codeine to morphine, a necessary conversion step for the drug to be active. Finally, you would want to propose a plan to taper the Tylenol #3 rather than discontinue abruptly and risk unnecessary pain or withdrawal symptoms. This final step is not necessary if the selection of an alternative medication is a short acting opioid.

Resource: Pasero, C. & McCaffery, M. (2011). *Pain assessment and pharmacologic management*. St. Louis: Mosby, pp. 330 & 657.

Competencies 2, 9, 10, 15
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43. As you discuss the pharmaceutical options with her prescriber, what general age-related changes do you need to be aware of that would influence the treatment plan?

   a. Decreases in gastric pH and motility can result in 1) increases in GI irritation, bleeding, and ulceration with NSAID use and 2) increased risk of constipation related to opioid use
   b. Decreases in glomerular filtration rates result in decreased renal excretion, potentially requiring either a lower dose or longer dosing intervals.
   c. Age-related decreases in hepatic function can result in a prolonged drug half-life, causing an accumulation of drugs and metabolites, leading to an increased risk of toxicity
   d. All of the above

Correct answer is 'd'. Nurses need to be aware of age-related changes that prolong the effect of medications and the risk of toxicity. With this awareness, nurses need to be vigilant in monitoring for toxic effects of all medications. Starting at lower doses and increasing the intervals between administering doses is a good general guideline.

Resource: American Geriatrics Society (2009). Pharmacological management of persistent pain in older persons. *Journal of the American Geriatrics Society, 57*(8), 1331-1346 (see Table 2).

Competency 7
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44. Which of the following medications used to treat pain is best avoided in older persons?

a. Gabapentin (Neurontin)
b. Morphine
c. Amitriptyline (Elavil)
d. Hydromorphone (Dilaudid)

Correct answer is 'c'. Amitriptyline should be avoided in older persons . Amitriptyline, a tricyclic antidepressant, is frequently used as an adjuvant analgesic, but is best avoided in older persons because of the high risk of anticholinergic side effects (e.g., change in cognition, dry mouth, loss of coordination, vision changes, and tachycardia). Gabapentin, morphine and hydromorphone, on the other hand, can be effective, safe analgesics for older persons. However, it is important to keep in mind that toxic metabolites of morphine can limit its usefulness in older adults with renal insufficiency or if high-doses are require

Resources: American Geriatrics Society (2009). Pharmacological management of persistent pain in older persons. Journal of the American Geriatrics Society, 57(8), pp. 1331-1346 (see Table 2)

Pasero, C. & McCaffery, M. (2011). *Pain assessment and pharmacologic management*. St. Louis: Mosby**,** p. 353.

Kelly, A. M. (2010). Gerontology pain management. In B. St. Marie (Ed.), *Core curriculum for pain management nursing* (2nd ed.) (pp. 573-586). American Society for Pain Management Nursing, p. 581.

Competency: 11
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45. Medication changes have been made, and you are caring for Mrs. Lee a week later. As you assess her pain at the beginning of your shift, she reports significant improvement in pain relief. She has needed her breakthrough pain medication three times in the week prior, but says she's feeling reluctant to ask for it, even though it has been helpful. When you explore further, which of the following would concern you??

a) "I had to wait so long for someone to bring me the medicine, I just quit asking"
b) "It's so much better than it was, I think I can handle it"
c) "I keep thinking I might become addicted."
d) All of the above

Correct answer is 'd'. Many barriers to effective pain management exist. The perceptions, experiences, and beliefs of each individual older person have significant bearing on the overall pain plan.

Resource:

Resources: Kelly, A. M. (2010). Gerontology pain management. In B. St. Marie (Ed.), *Core curriculum for pain management nursing* (2nd ed.). Dubuque, IA: Kendall Hunt Publishing, p. 574.

Competency: 1, 4, 18
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46. What is/are some action(s) you would want to take to address a reluctance to report pain and request medication when needed?

a. Request that her prn opioid be made routine so that she no longer has to ask for the medication
b. Reflect on whether you may inadvertently communicate that you're too busy or do not believe reports of pain
c. Educate the older person about the critical importance of reporting their pain experience
d. b and c

Correct answer is 'd'. Self-reflection is essential to improve nursing practice and sensitivity to an older person's reports. Through self-reflection, you have the opportunity to address unrecognized misconceptions or beliefs that affect your ability to provide excellent pain management. Equally important is educating older people about how critical it is that they be actively involved in the treatment plan One of the key ways for them to do this is through consistently reporting their experience of pain and response to interventions via the consistent use of one valid and reliable pain assessment tool. Additionally, because many older adults have concerns about addiction, it is important to help the person understand the inevitable development of tolerance to opioid medications. Finally, in a collaborative manner, you would also want to educate the appropriate staff members about the problem in order to assure that the issue is resolved

Resource: Grimes, T. (2010). The pain management nurse as change agent. In B. St. Marie (Ed.), *Core curriculum for pain management nursing* (2nd ed.). Dubuque, IA: Kendall Hunt Publishing, pp. 639-640.

Competency: 1, 4, 8, 18
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