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3 Spanish Version of the Knowledge and Attitudes Survey Regarding Pain  
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3 **SPANISH VERSION OF THE KNOWLEDGE AND ATTITUDES**

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5 **SURVEY REGARDING PAIN**

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7 **Abstract**

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10 There are a variety of valid tools to assess staff knowledge and attitudes regarding pain,  
11 among which is the Knowledge and Attitudes Survey Regarding Pain. Although this  
12 instrument has been widely and successfully used, a valid and adapted Spanish version  
13 is yet to be developed. The purpose of this study was to validate the Spanish version of  
14 the Knowledge and Attitudes Survey Regarding Pain. After translating and back-  
15 translating this tool, we conducted a cross-cultural adaptation and construct validation  
16 with 102 participants, including nursing professionals (in palliative care, oncology, and  
17 intensive care) from five health centers and final-year nursing students. All participants  
18 were recruited in the Principality of Asturias, Spain. We also evaluated the internal  
19 consistency and test-retest correlations. Cronbach's alpha was .781, and Pearson's  $r$  and  
20 the intraclass correlation coefficient between the test and retest scores were .881  
21 and .883, respectively. The mean questionnaire scores in the test and retest phases were  
22 65.8% and 67.6%, respectively. Palliative care nurses had the highest score, 70.8%,  
23 which differed significantly from the rest of the groups. The Spanish version of the  
24 Knowledge and Attitudes Survey Regarding Pain can effectively differentiate nursing  
25 staff in terms of their pain expertise. The results indicate that Spanish nurses have a gap  
26 in pharmacological knowledge that is comparable to that found in other countries, but  
27 their foundation in general pain concepts was solid.

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48 *Keywords:* Pain, Pain Management, Knowledge, Nursing.

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51 *Key Practice Points:*

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53 KASRP has not been validated in Spain, but a validated and adapted version will  
54 help nursing professionals to evaluate their knowledge and attitudes regarding pain.  
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## DEVELOPMENT AND VALIDATION OF SPANISH KASRP

Palliative care nurses had the highest score, and this differed significantly from the other groups.

Spanish nurses show a gap in pharmacological knowledge that is comparable to that found in other countries, but they have a solid foundation in general pain concepts.

**INTRODUCTION**

Inappropriate pain management is known to lead to increases in healthcare costs, and can have a negative impact on individuals' quality of life and even increase the risk of mortality (Dale et al., 2013; Robinson et al., 2008; Yamashita, Yamasaki, Matsuyama, & Amaya, 2017). Nowadays, pain management and relief are often considered the responsibilities of healthcare professionals who are in contact with suffering individuals (Dunwoody, Krenzischek, Pasero, Rathmell, & Polomano, 2008; Loeser, Butler, Chapman, Turk, & Bonica, 2003; Mosteiro Díaz & Graván Fernández, 2010). Nurses play a particularly crucial role in this regard, since they normally spend much of their time with patients and establish a more intimate contact.

However, multiple studies in different countries and hospital settings have shown that nurses tend to have relatively little knowledge of general pain concepts, pain evaluation, and correct treatment approaches (Al Qadire & Al Khalaileh, 2014; Eid, Manias, Bucknall, & Almazrooa, 2014; Erkes, Parker, Carr, & Mayo, 2001; Kubecka, Simon, & Boettcher, 1996; Latina et al., 2015; Martín et al., 2012; Salvadó-Hernández et al., 2009; Yildirim, Cicek, & Uyar, 2008). Other studies have shown the benefits of educational efforts in this field, particularly in the improvement of assessment and management of general pain (de Rond et al., 2000; Erkes et al., 2001; Keen et al., 2017; Machira, Kariuki, & Martindale, 2013; Schreiber et al., 2014; Zhang et al., 2008).

Ferrell and McCaffery developed the "Knowledge and Attitudes Survey Regarding Pain" (KASRP) in 1987 (Ferrell & McCaffery, 2014) to identify weaknesses in professionals' education regarding pain in order to improve their knowledge. In Europe, the Greek version of the KASRP was validated in 2002 (Tafas, Patiraki, McDonald, & Lemonidou, 2002), the Italian version in 2006 (Catania et al., 2006), and the Icelandic

version in 2011 (Gretarsdottir, Zoëga, Tomasson, & Gunnarsdottir, 2011). However, the KASRP has not been validated in Spain to date.

The KASRP comprises 39 items, 22 of which are “true-or-false” questions, 15 are multiple-choice questions, and 2 are clinical case studies comprising 2 questions each. This instrument has been used successfully and repeatedly over the years in various studies throughout the world, as it is freely available for use and is based on the recommendations on analgesia by the World Health Organization, American Pain Society, and National Comprehensive Cancer Network Pain Guidelines (American Pain Society, 2016; Swarm, Gafford, & Rabow, 2018; World Health Organization, 2012).

In its original version, the construct validity was established by comparing the scores of nurses with various levels of expertise (i.e., students, newly graduated students, oncology nurses, and senior pain experts). Internal consistency (Cronbach’s  $\alpha > .70$ ) and test-retest reliability ( $r > .80$ ) were also established for both the knowledge and attitude domains. However, the original authors recommended an analysis of the full scale (where the percentage of correct answers is calculated) without consideration of these separate domains, as some questions mix both aspects (Ferrell & McCaffery, 2014). When the KASRP was originally developed, no pass mark was determined; however, in later studies, a passing score of 80% was set: if a nurse scored less than 80%, their ability to care for a patient experiencing pain was considered to be significantly compromised (McCaffery & Robinson, 2002). Moreover, the authors also allowed for modification of the questionnaire to better suit the needs of the particular service or institution.

The purpose of the study was to validate the Spanish version of the Knowledge and Attitudes survey Regarding Pain in order to faithfully illustrate its psychometric

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239 properties. We did not modify the questionnaire, in order to get a comprehensive  
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241 support tool to measure Spanish nursing pain Knowledge.  
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## 243 **METHOD**

### 244 **Design**

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246 It was a validation and transcultural adaptation of the KASRP.  
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### 248 **Procedure**

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250 We conducted a 2-step procedure for the development. The first step was a  
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252 content and linguistic validation from English to Spanish. The second step was a  
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254 construct and reliability validation using a test-retest procedure.  
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### 258 **Content and Linguistic Validation**

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260 A translation and back-translation of the original version of the questionnaire  
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262 according to an adaption of Brislin's model (Jones, Lee, Phillips, Zhang, & Jaceldo,  
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264 2001) was performed by six bilingual translators who had knowledge of healthcare to  
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266 ensure a correct interpretation of terms; no modifications to the items were made. In the  
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268 first step, the original document was sent to two translators. These translators each  
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270 produced Spanish versions, which were subsequently sent to two different translators  
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272 for back-translation (thus resulting in two new English-language questionnaires). All  
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274 four translators then met to consolidate both versions by clarifying terms and giving  
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276 meaning to items that might be unclear in Spanish. Once a common document was  
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278 obtained through consensus, two new bilingual translators conducted another round of  
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280 translation and back-translation. Finally, all six translators met to fine-tune the meaning  
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282 of the final items. Using this version, we conducted a pretest with 10 healthcare  
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284 professionals (5 doctors and 5 nurses) to evaluate and obtain semantic and cultural  
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286 equivalence.  
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## DEVELOPMENT AND VALIDATION OF SPANISH KASRP

To ensure that the target population fully understood the KASRP, we slightly modified item 16 because the medication it cited was not available in Spain (Vicodin®, the brand name for the combination of hydrocodone 5 mg and acetaminophen 300 mg). We contacted the Pharmacy Department of Hospital Universitario Central de Asturias to find an equivalent therapy in the Spanish market from a pharmacist's perspective. Following this consultation, we chose a combination of tramadol 37.5 mg and acetaminophen 325 mg, which in Spain is known by the trade name Zaldiar®, among others.

### **Construct Validity and Reliability**

We evaluated the test-retest reliability by distributing 140 copies of the final Spanish version of the KASRP (**Appendix A**) to three nursing professional groups (oncology, palliative care, and intensive care) from five institutions belonging to the healthcare network of the Principality of Asturias, as well as to final-year nursing students at the University of Oviedo. Construct validity was evaluated by discriminating validity, which shows differences between extreme groups. The survey was conducted between April and June 2017. The retest phase was conducted after an interval of 10–14 days to avoid memory bias. In addition to the KASRP, we collected data on age, gender, academic degree, years of nursing experience, and work shift type.

### **Permissions and ethics**

Regional Ethical Committee permission (No. 115/17) and written consents of all the institutions involved in the study were taken. The research team contacted all participating nurses, and informed consent was obtained from each participant after a full explanation of the study's purpose and nature was provided in a sealed envelope along with the questionnaire. To preserve their anonymity, they placed the survey back in the sealed envelope after completing it.

### Statistical Analysis

We calculated the KASRP score by assigning a score of 1 to correctly answered questions and a score of 0 to incorrectly answered or unanswered questions. We then calculated the total percentage of correct answers in the questionnaire, without consideration of these separate domains. After the normal distribution of each variable had been assessed by the Kolmogorov-Smirnov test, the Kruskal-Wallis H test was used to compare KASRP scores according to demographic data and participant groups due to violation of normality assumption. We conducted post-hoc analyses using the Tukey test. Statistically significant differences were indicated by  $p < .05$ .

The internal consistency and test-retest correlations were also assessed to evaluate the psychometric properties of the KASRP and facilitate comparison of our findings with those of the original and European versions of the tool. The data analysis was conducted using SPSS Statistics 22.

## RESULTS

A total of 102 questionnaires (72.8%) were completed at both the test and retest phases of the study. The sociodemographic characteristics of the respondents are shown in Table 1.

### Internal Consistency

Cronbach's alpha of the Spanish version of the KASRP was .781.

### Test-retest Correlation

We calculated Pearson's correlation between the test and retest phase scores, which yielded a value of  $r = .884$  ( $p < 0.001$ ). We also calculated the intraclass correlation coefficient to ensure greater accuracy of the reliability, which yielded a value of .883 (95% confidence interval = 0.812–0.928).

### Descriptive statistics and construct validity



## DEVELOPMENT AND VALIDATION OF SPANISH KASRP

The overall mean percentage of correct answers was 65.8% ( $SD = 9.7$ ) for the test phase and 67.6% ( $SD = 10.1$ ) for the retest phase. The comparison of the different participant groups revealed that the palliative care group scored higher (70.8%,  $SD = 9.2$ ) than did the oncology (67.3%,  $SD = 7$ ), intensive care (64.7%,  $SD = 9.2$ ), and student (62.4%,  $SD = 10.8$ ) groups. The Kruskal-Wallis H-test revealed significant group differences ( $p < .034$ ) and post hoc testing revealed that the palliative care group and students group differed significantly ( $p < .031$ ), as shown in **Figure 1 and Table 2**. We did not find significant differences in KASRP scores by gender, academic degree, age, or work shift as shown in **Table 3**. When examining the responses to each item, we observed that 13 items had scores below 50% and 15 items had scores above 80%, as shown in **Table 4**.

### DISCUSSION

The results of the Spanish KASRP version were similar to those of the original version. In fact, the internal consistency was greater than that of the original English survey (Cronbach's alpha  $> .70$ ) (Ferrell & McCaffery, 2014), positioning it among the Greek, Italian, and Icelandic versions (.88, .69, and .75, respectively) (Catania et al., 2006; Gretarsdottir et al., 2011; Tafas et al., 2002). The test-retest correlation was also greater than that of the original version ( $r > .80$ ), which again positions the Spanish version among the Greek and Italian versions (.69 and .97, respectively). Although we have no data available with regard to the intraclass correlation coefficient, the values obtained in this study reflect excellent reliability.

We also observed that group differences were similar to the validated Italian version of the survey (Catania et al., 2006), and allow for clear discrimination between levels of pain-related expertise (Catania et al., 2006; Gretarsdottir et al., 2011). This supports the overall purpose of the KASRP. Unfortunately, we could not compare the

intensive care group with these previous studies as the previous authors used other professional groups. The higher score of the palliative care group compared to the other groups (particularly the student group, with which the difference was significant) seems logical, given their greater proximity to end-of-life situations and focus on providing relief in difficult situations. The other groups might also lack education and experience at a professional technical level, and in the case of students, in emotional management.

We found higher KASRP scores than those of previous surveys conducted in other countries, such as Italy, Greece, Taiwan, Saudi Arabia, or China (Eid et al., 2014; Kiekkas et al., 2015; Lai et al., 2003; Latina et al., 2015; Samarkandi, 2018; Zhang et al., 2008), and the scores in our study were essentially the same as those found in samples from the United States and Iceland (Gretarsdottir, Zoëga, Tomasson, Sveinsdottir, & Gunnarsdottir, 2017; Kubecka et al., 1996). However, our scores were lower than those found in more recent studies conducted in the United States (Al-Shaer, Hill, & Anderson, 2011; Keen et al., 2017). Furthermore, none of the participants reached the minimum standard of correct answers of 80%, which indicated a general lack of education in pain.

The oncology group in this study showed a higher KASRP score than that of the same group in studies conducted in other countries such as Turkey, Saudi Arabia, or Italy (Alqahtani & Jones, 2015; Bernardi, Catania, & Tridello, 2007; Yildirim et al., 2008), which is the same as found in Iran (Shahriary et al., 2015) and lower than in Norway (Utne, Småstuen, & Nyblin, 2018). The student group in comparison to students from Jordan obtained a higher score (Al-Khawaldeh, Al-Hussami, & Darawad, 2013), although our group had a similar score to that of students in the United States (Plaisance & Logan, 2006). As for the intensive care group, our results were lower than those obtained in other studies conducted in the United States, where a similar

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534 population of such nursing professionals had a mean score of 72.9% (Erkes et al.,  
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536 2001), although a modified version of the survey was used.

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539 As for the relationship between the KASRP and the assessed sociodemographic  
540 variables, the results of this study were consistent with those conducted in Italy, Greece,  
541 and the United States, where there was no relationship found between KASRP scores  
542 and age, academic degree, or professional experience (Erkes et al., 2001; Kiekkas et al.,  
543 2015; Latina et al., 2015). However, studies carried out in Turkey, Holland, Taiwan,  
544 and Iceland, and other studies conducted in the United States, showed a statistically  
545 significant correlation between professional experience/academic degree and KASRP  
546 scores (Al-Shaer et al., 2011; Brunier, Carson, & Harrison, 1995; de Rond et al., 2000;  
547 Gretarsdottir et al., 2017; Lai et al., 2003; Yildirim et al., 2008). These discrepancies  
548 render the results inconclusive; thus, further studies are necessary to objectively address  
549 this question.  
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Items for which the correct answer rate did not reach 50% mainly related to pharmacological concepts, which is consistent with a previous finding (Bernardi et al., 2007). In Spain, medications are prescribed by doctors, which is probably why nurses obtained lower scores. Furthermore, this indicates a need for further education about these concepts for nurses. The item that related to assessing a smiling patient's pain also had a lower score, both in terms of pain interpretation and therapeutic choice, which was in agreement with other studies showing how nursing staff tend to underestimate it (Bernardi et al., 2007; Lai et al., 2003; Salvadó-Hernández et al., 2009; Yildirim et al., 2008). This could be related to a phenomenon of desensitization (Holl & Carmack, 2015; Manias, Bucknall, & Botti, 2005) or to a traditional view of pain as having only diagnostic value. Accordingly, a more specific study on this subject might be necessary.

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593 Moreover, participants demonstrated adequate knowledge of general concepts, with  
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595 many of these items having a correct answer rate above 80%.  
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### 597 **Limitations**

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599 The results of this study must be interpreted within the context of the sample.  
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601 That is, the findings cannot be extrapolated to other populations due to the specificity of  
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603 the sample. Nevertheless, the Spanish version of the KASRP is a valid tool for focusing  
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605 educational efforts on specific areas, and will contribute to improving pain  
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607 management.  
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### 610 **CONCLUSION**

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612 The Spanish version of the KASRP is a valid and reliable tool for  
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614 comprehensively measuring nursing staff's knowledge and attitudes regarding pain.  
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616 This instrument can effectively discriminate between levels of expertise. This tool will  
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618 help in providing a clear picture of where the educational gaps are and might  
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620 simultaneously facilitate the channeling of activities to where they are most needed. Our  
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622 findings highlight the need for providing more education on pain management during  
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624 basic and continuing education for nurses.  
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## DEVELOPMENT AND VALIDATION OF SPANISH KASRP

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### **Conflict of interest**

The authors declare no conflicts of interest.

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827 DEVELOPMENT AND VALIDATION OF SPANISH KASRP

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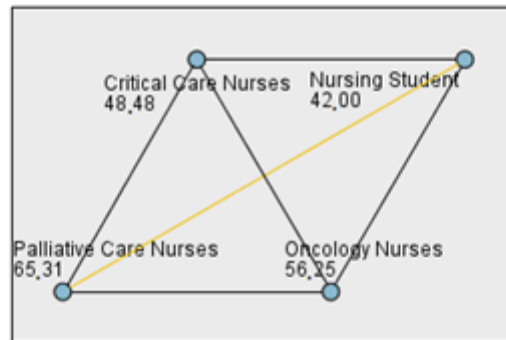
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### Pairwise Comparisons of Nursing Group



Each node shows the sample average rank of Nursing Group.

**Figure 1.** Post hoc analyses of differences of the Knowledge and Attitudes Survey

Regarding Pain scores between nursing groups.

**Table 1****Sociodemographic Characteristics**

	<i>Students</i> ( <i>n</i> = 31) 30.4%	<i>Intensive Care</i> ( <i>n</i> = 30) 29.4%	<i>Oncology</i> ( <i>n</i> = 20) 19.6%	<i>Palliative Care</i> ( <i>n</i> = 21) 20.6%
Age, <i>M</i> ( <i>SD</i> )	25.8 (6.4)	40.4 (6.6)	38.1 (8.0)	46.2 (11.4)
Gender	3 males 28 females	4 males 26 females	3 males 17 females	1 male 20 females
Academic degree	--	25 Bachelor 5 Master	15 Bachelor 5 Master	15 Bachelor 6 Master
Years of professional experience, <i>M</i> ( <i>SD</i> )	--	17.2 (6.5)	12.8 (7.4)	22.1 (10.9)
Work shifts	--	30 rotating	11 rotating 9 fixed shift	12 rotating 9 fixed shift

**Table 2****Post Hoc Analyses of differences of the Knowledge and Attitudes Survey****Regarding Pain scores (n=102)**

<b>Sample 1–Sample 2</b>	<b>Test</b>	<b>Std.</b>	<b>Std.</b>	<b>Test</b>	<b>sig.</b>	<b>Adj. sig.</b>
	<b>statistic</b>	<b>error</b>	<b>statistic</b>			
Nursing Student–Critical Care Nurses	-6.483	7.551	-0.859		.391	1.000
Nursing Student– Oncology Nurses	-14.250	8.456	-1.685		.092	.0552
Nursing Student– Palliative Care Nurses	-23.310	8.333	-2.797		.005	.031
Critical Care Nurses– Oncology Nurses	-7.767	8.511	-0.912		.362	1.000
Critical Care Nurses– Palliative Care Nurses	-16.826	8.389	-2.006		.045	.269
Oncology Nurses– Palliative Care Nurses	-9.060	9.212	-0.983		.325	1.000

*Note.* Each row tests the null hypothesis that the sample 1 and sample 2 distributions are the same. Asymptotic significance (2-sided tests) is displayed. The significance level is .05

**Table 3. Relationships between KASRP and the demographic variables**

<b>Variable</b>	<b>Options</b>	<b>Mean</b>	<b><i>p</i></b>
Gender	Men	27.73	.693
	Female	26.88	
Age Group	18-30 years old	26.03	.054
	31-50 years old	27.00	
	>51 years old	30.50	
Academic Degree	Bachelor	27.36	.278
	Master	28.00	
Work Shifts	Fixed Shift	28.66	.123
	Rotating	27.04	
Years of Professional Experience	1-5 years	27.80	.742
	6-10 years	27.58	
	11-15 years	27.37	
	16-20 years	27.20	
	21-25 years	25.17	
	26-30 years	28.43	
Professional Group	>30 years	30.00	.034
	Student	25.58	
	Intensive Care	26.53	
	Oncology	27.60	
	Palliative Care	29.05	



**Table 4****Frequency distribution**

Item No.	Question (Correct answer)	Correct responses	
		n	%
<b>True or false questions</b>			
1	Vital signs are always reliable indicators of the intensity of a patient's pain. (False)	82	80.4
2	Because their nervous system is underdeveloped, children under two years of age have decreased pain sensitivity and limited memory of painful experiences. (False)	65	63.7
3	Patients who can be distracted from pain usually do not have severe pain. (False)	59	57.8
4	Patients may sleep in spite of severe pain. (True)	26	25.5
5	Aspirin and other nonsteroidal anti-inflammatory agents are NOT effective analgesics for painful bone metastases. (False)	47	46.1
6	Respiratory depression rarely occurs in patients who have been receiving stable doses of opioids over a period of months. (True)	50	49
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. (True)	90	88.2
8	The usual duration of analgesia of 1–2 mg morphine IV is 4–5 hours. (False)	21	20.6

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62	9	Opioids should not be used in patients with a history of substance	70	68.6
63		abuse. (False)		
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65				
66	10	Elderly patients cannot tolerate opioids for pain relief. (False)	97	95.1
67				
68				
69	11	Patients should be encouraged to endure as much pain as possible	101	99
70		before using an opioid. (False)		
71				
72				
73	12	Children less than 11 years old cannot reliably report pain so	102	100
74		clinicians should rely solely on the assessment of the parent's		
75		child's pain intensity. (False)		
76				
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79	13	Patients' spiritual beliefs may lead them to think pain and	100	98
80		suffering are necessary. (True)		
81				
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84	14	After an initial dose of opioid analgesic is given, subsequent doses	99	97.1
85		should be adjusted in accordance with the individual patient's		
86		response. (True)		
87				
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89				
90	15	Giving patients sterile water by injection (placebo) is a useful test	68	66.7
91		to determine if the pain is real. (False)		
92				
93				
94	16	Zaldiar® (Tramadol 37.5 mg + acetaminophen 325 mg) PO is	38	37.3
95		approximately equal to 5–10 mg of morphine PO. (True)		
96				
97				
98				
99	17	If the source of the patient's pain is unknown, opioids should not	41	40.2
100		be used during the pain evaluation period, as this could mask the		
101		ability to correctly diagnose the cause of pain. (False)		
102				
103				
104				
105	18	Anticonvulsant drugs such as gabapentin (Neurontin) produce	72	70.6
106		optimal pain relief after a single dose. (False)		
107				
108				
109	19	Benzodiazepines are not effective pain relievers and are rarely	56	54.9
110		recommended as part of an analgesic regiment. (True)		
111				
112				
113	20	Narcotic/opioid addiction is defined as a chronic neurobiologic	87	85.3
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121 disease, characterized by behaviors that include one or more of  
122  
123 the following: impaired control over drug use, compulsive use,  
124  
125 continued use despite harm, and craving. (True)  
126  
127  
128 21 The term “equianalgesia” means approximately equal analgesia 98 96.1  
129  
130 and is used when referring to the doses of various analgesics that  
131  
132 provide approximately the same amount of pain relief. (True)  
133  
134 22 Sedation assessment is recommended during opioid pain 92 90.2  
135  
136 management because excessive sedation precedes opioid-induced  
137  
138 respiratory depression. (True)  
139

140 **Multiple choice questions**

- 141  
142 23 The recommended route of administration of opioid analgesics for 58 56.9  
143  
144 patients with persistent cancer-related pain is. (Oral)  
145  
146 24 The recommended route administration of opioid analgesics for 77 75.5  
147  
148 patients with brief, severe pain of sudden onset such as trauma or  
149  
150 postoperative pain is. (Intravenous)  
151  
152  
153 25 Which of the following analgesic medications is considered the 54 52.9  
154  
155 drug of choice for the treatment of prolonged moderate to severe  
156  
157 pain for cancer patients? (Morphine)  
158  
159 26 A 30 mg dose of oral morphine is approximately equivalent to. 67 65.7  
160  
161 (Morphine 10mg IV)  
162  
163 27 Analgesics for post-operative pain should initially be given. 98 96.1  
164  
165 (Around the clock on a fixed schedule)  
166  
167  
168 28 A patient with persistent cancer pain has been receiving daily 34 33.3  
169  
170 opioid analgesics for 2 months. Yesterday the patient was  
171  
172 receiving morphine 200 mg/hour intravenously. Today he has  
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	been receiving 250 mg/hour intravenously. The likelihood of the patient developing clinically significant respiratory depression in the absence of new comorbidity is. (Less than 1%)		
29	The most likely reason a patient with pain would request increased doses of pain medication is. (The patient is increased pain)	98	96.1
30	Which of the following is useful for treatment of cancer pain? (All of the above)	76	74.5
31	The most accurate judge of the intensity of the patient's pain is. (The patient)	101	99
32	Which of the following describes the best approach for cultural considerations in caring for patients in pain. (Patients should be individually assessed)	94	92.2
33	How likely is it that patients who develop pain already have an alcohol and/or drug abuse problem? (5-15%)	39	38.2
34	The time to peak effect for morphine given IV is. (15 min.)	82	80.4
35	The time to peak effect for morphine given orally is. (1-2 hours)	64	62.7
36	Following abrupt discontinuation of an opioid, physical dependence is manifested by the following. (Sweating, yawning, diarrhea and agitation...)	32	31
37	Which statement is true regarding opioid induced respiratory depression. (Obstructive sleep apnea is an important risk factor)	50	49

227 **Case studies**

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38A	Case study: Andrew is 25 years old and this is his first day following abdominal surgery. As you enter his room, he smiles at	30	29.4
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DEVELOPMENT AND VALIDATION OF SPANISH KASRP

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.

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. (8)

38B Your assessment, above, is made 2 hours after he received 19 18.6 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. (Morphine 3 mg IV now)

39A Robert is 25 years old and this is his first day following 70 68.6 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. 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: (8)

39B Your assessment, above, is made two hours after he received 47 46.1

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298 morphine 2 mg IV. Half hourly pain ratings following the  
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300 injection ranged from 6 to 8 and he had no clinically significant  
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302 respiratory depression, sedation, or other untoward side effects.  
303  
304 He has identified 2/10 as an acceptable level of pain relief. His  
305  
306 physician's order for analgesia is "morphine IV 1-3 mg q1h PRN  
307  
308 pain relief." Check the action you will take at this time.  
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311 (Morphine 3 mg IV now)  
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4 **Appendix A. Spanish version of the Knowledge and Attitudes Survey Regarding Pain**  
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7 **Verdadero/Falso – Marque la respuesta correcta.**  
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- 9 **V F 1.** Los signos vitales son siempre indicadores fiables de la intensidad del dolor del paciente.  
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11 **V F 2.** Debido a que su sistema nervioso está poco desarrollado, los niños menores de 2 años  
12 tienen reducida la sensibilidad al dolor y una memoria limitada de experiencias dolorosas.  
13 **V F 3.** Los pacientes que pueden ser distraídos del dolor, normalmente no tienen dolor intenso.  
14 **V F 4.** Los pacientes pueden dormir a pesar de tener dolor intenso.  
15 **V F 5.** El Ácido Acetil Salicílico (AAS) y otros Antiinflamatorios No Esteroideos (AINEs) **NO**  
16 son analgésicos efectivos en las metástasis óseas dolorosas.  
17 **V F 6.** La depresión respiratoria raramente se da en pacientes que han estado recibiendo dosis  
18 fijas de opiáceos durante meses.  
19 **V F 7.** Combinar analgésicos que funcionan por diferentes mecanismos (ej. combinar un AINE  
20 con un opiáceo) puede dar como resultado un mejor control del dolor con menos efectos  
21 secundarios que usando un único agente analgésico.  
22 **V F 8.** La duración habitual de la analgesia con Morfina 1-2mg IV es de 4-5horas.  
23 **V F 9.** Los opiáceos no deberían ser administrados en pacientes con un historial de abuso de  
24 drogas.  
25 **V F 10.** Los pacientes en edad avanzada no toleran los opiáceos como tratamiento para el dolor.  
26 **V F 11.** Se debe animar a los pacientes a soportar el máximo dolor posible antes de usar  
27 opiáceos.  
28 **V F 12.** Los niños menores de 11 años no pueden referir su dolor de forma fiable, así que los  
29 médicos deberían apoyarse únicamente en la valoración de los padres acerca del dolor del  
30 niño.  
31 **V F 13.** Las creencias religiosas de los pacientes pueden llevarles a pensar que el dolor y el  
32 sufrimiento son necesarios.  
33 **V F 14.** Después de administrar una dosis inicial de analgésico opiáceo, las dosis siguientes  
34 deberían ajustarse de acuerdo con la respuesta individual del paciente.  
35 **V F 15.** Administrar a los pacientes placebos es una prueba útil para determinar si el dolor es  
36 real.  
37 **V F 16.** El ZALDIAR® (Tramadol 37.5mg + Paracetamol 325mg) VO es aproximadamente  
38 igual a 5-10mg de Morfina VO.  
39 **V F 17.** Si la causa del dolor del paciente es desconocida, no se deberían usar opiáceos durante  
40 el periodo de evaluación del dolor, ya que podrían enmascarar el correcto diagnóstico de la  
41 causa del mismo.  
42 **V F 18.** Drogas anticonvulsivantes como la Gabapentina (Neurontin®) producen un alivio  
43 óptimo del dolor tras una única dosis.  
44 **V F 19.** Las benzodiazepinas no son efectivas en el tratamiento del dolor y raramente se  
45 recomiendan como parte de un régimen analgésico.  
46 **V F 20.** La adicción a narcóticos/opiáceos se define como una enfermedad neurobiológica  
47 crónica, caracterizada por comportamientos que incluyen uno o más de los siguientes:  
48 reducción de la capacidad de control sobre el consumo de drogas, consumo compulsivo,  
49 consumo continuado a pesar de que produzca daños y “mono”.  
50 **V F 21.** El término Equianalgesia significa aproximadamente “igual analgesia” y se usa al hablar  
51 de las dosis de diferentes analgésicos que tienen aproximadamente la cantidad equivalente  
52 de efecto analgésico.  
53 **V F 22.** Se recomienda evaluar el estado de sedación del paciente mientras el dolor se controle  
54 con opiáceos, ya que una sedación excesiva precede a la depresión respiratoria inducida por  
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opiáceos.

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**Test de respuesta múltiple - Marque la opción correcta.**

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**23.** La vía recomendada para la administración de analgésicos opiáceos en pacientes con dolor de tipo oncológico crónico, es:

- a). Intravenosa.
- b). Intramuscular.
- c). Subcutánea.
- d). Oral.
- e). Rectal.

**24.** La vía recomendada para la administración de analgésicos opiáceos en pacientes con dolor breve e intenso, de aparición súbita, como en el caso de un traumatismo o de dolor post quirúrgico, es:

- a). Intravenosa.
- b). Intramuscular.
- c). Subcutánea.
- d). Oral.
- e). Rectal.

**25.** ¿Cuál de los siguientes analgésicos se considera de primera elección en el tratamiento del dolor crónico de tipo moderado a intenso en pacientes oncológicos?:

- a). Codeína.
- b). Morfina.
- c). Meperidina.
- d). Tramadol.

**26.** Una dosis de 30mg de Morfina vía oral es aproximadamente equivalente a:

- a). 5mg de Morfina IV.
- b). 10mg de Morfina IV.
- c). 30mg de Morfina IV.
- d). 60mg de Morfina IV.

**27.** La analgesia para el dolor postoperatorio debería administrarse inicialmente:

- a). Siguiendo una pauta horaria fija/prescrita.
- b). Sólo cuando el paciente la pida.
- c). Sólo cuando la enfermera considere que el paciente tiene un disconfort moderado o mayor.

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**28.** Un paciente con dolor de tipo oncológico crónico ha estado tomando analgésicos opiáceos a diario durante 2 meses. Ayer el paciente estaba recibiendo Morfina 200mg/h IV. Hoy ha estado recibiendo 250mg/h. La probabilidad de que el paciente desarrolle una depresión respiratoria significativa en ausencia de una nueva comorbilidad es:

- a). < 1%
- b). del 1 al 10%
- c). del 11 al 20%
- d). del 21 al 40%
- e). > 41%



119  
120 **29.** La razón más probable por la cual un paciente con dolor pediría aumentar la dosis de  
121 analgesia es:  
122

- 123 a). El paciente está sintiendo un dolor mayor.  
124 b). El paciente está sintiendo mayor ansiedad o depresión.  
125 c). El paciente está pidiendo más atención por parte de los trabajadores.  
126 d). Las demandas del paciente están relacionadas con una adicción.  
127

128 **30.** ¿Cuál de los siguientes fármacos es útil para el tratamiento del dolor oncológico?:  
129

- 130 a). Ibuprofeno  
131 b). Hidromorfona  
132 c). Gabapentina  
133 d). Todos los anteriores.

134 **31.** La persona que mejor puede juzgar la intensidad del dolor del paciente, es:

- 135 a). El médico que le trata.  
136 b). La enfermera de atención primaria del paciente.  
137 c). El paciente.  
138 d). El farmacéutico.  
139 e). El cónyuge o la familia del paciente.

140 **32.** ¿Cuál de los siguientes describe el mejor abordaje de las consideraciones culturales en el  
141 cuidado de pacientes con dolor?:  
142

- 143 a). Ya no existen las influencias culturales en España debido a la diversidad de la población.  
144 b). Las influencias culturales se pueden determinar por el origen étnico del individuo (pe: los  
145 asiáticos son estoicos, los italianos son expresivos, etc).  
146 c). Los pacientes deberían ser valorados individualmente para determinar sus influencias  
147 culturales.  
148 d). Las influencias culturales de un individuo pueden determinarse por su estatus socioeconómico  
149 (ej. los obreros declaran más dolor que los trabajadores cualificados).  
150

151 **33.** ¿Cuál es la probabilidad de que los pacientes que desarrollan dolor tengan algún problema  
152 previo de abuso de alcohol y/o drogas?:  
153

- 154 a). < 1%  
155 b). 5 – 15%  
156 c). 25 – 50%  
157 d). 75 – 100%

158 **34.** El efecto pico de la Morfina administrada IV se produce tras

- 159 a). 15min.  
160 b). 45min.  
161 c). 1hora.  
162 d). 2horas.

163 **35.** El efecto pico de la Morfina administrada VO se produce tras:  
164

- 165 a). 5min.  
166 b). 30min.  
167 c). 1-2horas.  
168 d). 3horas.

169 **36.** Tras la interrupción súbita de un opiáceo, la dependencia física se manifiesta con los  
170 siguientes:

- 171 a). Sudoración, bostezos, diarrea y agitación.  
172 b). Afectación sobre el control del consumo de drogas, consumo compulsivo, y ansiedad.  
173 c). La necesidad de dosis mayores para conseguir el mismo efecto.  
174 d). a y b.  
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180 **37. Qué afirmación es correcta con respecto a la depresión respiratoria inducida por opiáceos:**

- 181 a). Es más común después de varias noches post-cirugía debido a la acumulación de opiáceos.  
182 b). La apnea obstructiva del sueño es un factor de riesgo importante.  
183 c). Se da más frecuentemente en aquellos que estaban con dosis altas de opiáceos antes de la  
184 cirugía.  
185 d). Puede valorarse fácilmente usando una pulsioximetría de forma intermitente.  
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187 **Casos Prácticos-Marque la opción correcta.**

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188 Se presentan dos casos prácticos con pacientes. Se te pide que tomes decisiones sobre dolor y  
189 medicación para cada paciente.

190 Paciente A: Andrés tiene 25 años y éste es el primer día tras una cirugía abdominal. Cuando entras  
191 en su habitación, te sonríe y continúa hablando y bromeando con su visitante. Tu valoración revela  
192 la siguiente información: PA = 120/80; FC = 80; FR = 18; en una escala de 0 a 10 puntúa **SU** dolor  
193 en un 8 (0 = ningún dolor/discomfort, 10 = el peor dolor/discomfort).  
194

- 195  
196 A. En la historia del paciente debes marcar su dolor en la escala de abajo.  
197 Marca el número que representa **TU** valoración del dolor de Andrés.

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200 0 1 2 3 4 5 6 7 8 9 10  
201 Ningún Peor  
202 dolor/discomfort dolor/discomfort  
203

- 204 B. Tu valoración, arriba, se hizo dos horas después de que recibiera 2mg de Morfina  
205 IV. Tras la inyección, las puntuaciones del dolor hechas cada media hora oscilaban  
206 entre 6 y 8, y él no tenía ningún signo clínico significativo de depresión  
207 respiratoria,  
208 sedación, u otro efecto secundario adverso. Él ha identificado 2/10 como un nivel  
209 aceptable de efecto analgésico. Su prescripción médica de analgesia es: Morfina IV  
210 de 1 a 3 mg cada hora, como analgesia “si precisa” (a demanda del paciente).  
211

212 Compruebe qué medidas tomará esta vez.

- 213  
214  
215 1. No administrar Morfina esta vez.  
216 2. Administrar Morfina 1mg IV  
217 ahora.  
218 3. Administrar Morfina 2mg IV  
219 ahora.  
220 4. Administrar Morfina 3mg IV  
221 ahora.  
222

223  
224 Paciente B: Roberto tiene 25 años y éste es el primer día tras una cirugía abdominal. Cuando entras  
225 en su habitación, él está tumbado en la cama en silencio y hace muecas de dolor cuando se gira en  
226 la cama. Tu valoración revela la siguiente información: PA = 120/80; FC = 80; FR = 18; en una  
227 escala de 0 a 10 puntúa **SU** dolor en un 8 (0 = ningún dolor/discomfort, 10 = el peor  
228 dolor/discomfort).  
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- 230  
231 A. En la historia del paciente debes marcar su dolor en la escala de abajo.  
232 Marca el número que representa **TU** valoración del dolor de Roberto.  
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0 1 2 3 4 5 6 7 8 9 10  
Ningún Peor  
dolor/disconfort dolor/disconfort dolor/disconfort

B. Tu valoración, arriba, se hizo dos horas después de que recibiera 2mg de Morfina IV. Tras la inyección, las puntuaciones del dolor hechas cada media hora oscilaban entre 6 y 8, y él no tenía ningún signo clínico significativo de depresión respiratoria, sedación, u otro efecto secundario adverso. Él ha identificado 2/10 como un nivel aceptable de efecto analgésico. Su prescripción médica de analgesia es: Morfina IV de 1 a 3 mg cada hora, como analgesia “si precisa” (a demanda del paciente).

Compruebe qué medidas tomará esta vez.

1. No administrar Morfina esta vez.
2. Administrar Morfina 1mg IV ahora.
3. Administrar Morfina 2mg IV ahora.
4. Administrar Morfina 3mg IV ahora.