Chapter 1: Foundations to Medical-Surgical Nursing Practice
Ignatavicius: Medical-Surgical Nursing, 9th Edition

MULTIPLE CHOICE

1. A new nurse is working with a preceptor on an inpatient medical-surgical unit. The preceptor advises the student that which is the priority when working as a professional nurse?
a. Attending to holistic client needs
b. Ensuring client safety
c. Not making medication errors
d. Providing client-focused care
ANS: B
All actions are appropriate for the professional nurse. However, ensuring client safety is the priority. Up to 98,000 deaths result each year from errors in hospital care, according to the 2000 Institute of Medicine report. Many more clients have suffered injuries and less serious outcomes. Every nurse has the responsibility to guard the clients safety.

DIF: Understanding/Comprehension REF: 2 KEY: Patient safety
MSC: Integrated Process: Nursing Process: Intervention
NOT: Client Needs Category: Safe and Effective Care Environment: Safety and Infection Control

2. A nurse is orienting a new client and family to the inpatient unit. What information does the nurse provide to help the client promote his or her own safety?
a. Encourage the client and family to be active partners.
b. Have the client monitor hand hygiene in caregivers.
c. Offer the family the opportunity to stay with the client.
d. Tell the client to always wear his or her armband.
ANS: A
Each action could be important for the client or family to perform. However, encouraging the client to be active in his or her health care as a partner is the most critical. The other actions are very limited in scope and do not provide the broad protection that being active and involved does.

DIF: Understanding/Comprehension REF: 3 KEY: Patient safety
MSC: Integrated Process: Teaching/Learning
NOT: Client Needs Category: Safe and Effective Care Environment: Safety and Infection Control

3. A nurse is caring for a postoperative client on the surgical unit. The clients blood pressure was 142/76 mm Hg 30 minutes ago, and now is 88/50 mm Hg. What action by the nurse is best?
a. Call the Rapid Response Team.
b. Document and continue to monitor.
c. Notify the primary care provider.
d. Repeat blood pressure measurement in 15 minutes.
ANS: A
The purpose of the Rapid Response Team (RRT) is to intervene when clients are deteriorating before they suffer either respiratory or cardiac arrest. Since the client has manifested a significant change, the nurse should call the RRT. Changes in blood pressure, mental status, heart rate, and pain are particularly significant. Documentation is vital, but the nurse must do more than document. The primary care provider should be notified, but this is not the priority over calling the RRT. The clients blood pressure should be reassessed frequently, but the priority is getting the rapid care to the client.

DIF: Applying/Application REF: 3
KEY: Rapid Response Team (RRT)| medical emergencies
MSC: Integrated Process: Communication and Documentation
NOT: Client Needs Category: Physiological Integrity: Physiological Adaptation

4. A nurse wishes to provide client-centered care in all interactions. Which action by the nurse best demonstrates this concept?
a. Assesses for cultural influences affecting health care
b. Ensures that all the clients basic needs are met
c. Tells the client and family about all upcoming tests
d. Thoroughly orients the client and family to the room
ANS: A
Competency in client-focused care is demonstrated when the nurse focuses on communication, culture, respect, compassion, client education, and empowerment. By

assessing the effect of the clients culture on health care, this nurse is practicing client-focused care. Providing for basic needs does not demonstrate this competence. Simply telling the client about all upcoming tests is not providing empowering education. Orienting the client and family to the room is an important safety measure, but not directly related to demonstrating client-centered care.

DIF: Understanding/Comprehension REF: 3
KEY: Patient-centered care| culture MSC: Integrated Process: Caring
NOT: Client Needs Category: Psychosocial Integrity

5. A client is going to be admitted for a scheduled surgical procedure. Which action does the nurse explain is the most important thing the client can do to protect against errors?
a. Bring a list of all medications and what they are for.
b. Keep the doctors phone number by the telephone.
c. Make sure all providers wash hands before entering the room.
d. Write down the name of each caregiver who comes in the room.
ANS: A
Medication errors are the most common type of health care mistake. The Joint Commissions Speak Up campaign encourages clients to help ensure their safety. One recommendation is for clients to know all their medications and why they take them. This will help prevent medication errors.

DIF: Applying/Application REF: 4
KEY: Speak Up campaign| patient safety MSC: Integrated Process: Teaching/Learning
NOT: Client Needs Category: Safe and Effective Care Environment: Safety and Infection Control

6. Which action by the nurse working with a client best demonstrates respect for autonomy?
a. Asks if the client has questions before signing a consent
b. Gives the client accurate information when questioned
c. Keeps the promises made to the client and family
d. Treats the client fairly compared to other clients
ANS: A
Autonomy is self-determination. The client should make decisions regarding care. When the nurse obtains a signature on the consent form, assessing if the client still has questions is

vital, because without full information the client cannot practice autonomy. Giving accurate information is practicing with veracity. Keeping promises is upholding fidelity. Treating the client fairly is providing social justice.

DIF: Applying/Application REF: 4
KEY: Autonomy| ethical principles MSC: Integrated Process: Caring
NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

7. A student nurse asks the faculty to explain best practices when communicating with a person from the lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) community. What answer by the faculty is most accurate?
a. Avoid embarrassing the client by asking questions.
b. Dont make assumptions about their health needs.
c. Most LGBTQ people do not want to share information.
d. No differences exist in communicating with this population.
ANS: B
Many members of the LGBTQ community have faced discrimination from health care providers and may be reluctant to seek health care. The nurse should never make assumptions about the needs of members of this population. Rather, respectful questions are appropriate. If approached with sensitivity, the client with any health care need is more likely to answer honestly.

DIF: Understanding/Comprehension REF: 4 KEY: LGBTQ| diversity
MSC: Integrated Process: Teaching/Learning
NOT: Client Needs Category: Psychosocial Integrity

8. A nurse is calling the on-call physician about a client who had a hysterectomy 2 days ago and has pain that is unrelieved by the prescribed narcotic pain medication. Which statement is part of the SBAR format for communication?
a. A: I would like you to order a different pain medication.
b. B: This client has allergies to morphine and codeine.
c. R: Dr. Smith doesnt like nonsteroidal anti-inflammatory meds.
d. S: This client had a vaginal hysterectomy 2 days ago.
ANS: B
SBAR is a recommended form of communication, and the acronym stands for Situation,

Background, Assessment, and Recommendation. Appropriate background information includes allergies to medications the on-call physician might order. Situation describes what is happening right now that must be communicated; the clients surgery 2 days ago would be considered background. Assessment would include an analysis of the clients problem; asking for a different pain medication is a recommendation. Recommendation is a statement of what is needed or what outcome is desired; this information about the surgeons preference might be better placed in background.

DIF: Applying/Application REF: 5
KEY: SBAR| communication
MSC: Integrated Process: Communication and Documentation
NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

9. A nurse working on a cardiac unit delegated taking vital signs to an experienced unlicensed assistive personnel (UAP). Four hours later, the nurse notes the clients blood pressure is much higher than previous readings, and the clients mental status has changed. What action by the nurse would most likely have prevented this negative outcome?
a. Determining if the UAP knew how to take blood pressure
b. Double-checking the UAP by taking another blood pressure
c. Providing more appropriate supervision of the UAP
d. Taking the blood pressure instead of delegating the task
ANS: C
Supervision is one of the five rights of delegation and includes directing, evaluating, and following up on delegated tasks. The nurse should either have asked the UAP about the vital signs or instructed the UAP to report them right away. An experienced UAP should know how to take vital signs and the nurse should not have to assess this at this point. Double-checking the work defeats the purpose of delegation. Vital signs are within the scope of practice for a UAP and are permissible to delegate. The only appropriate answer is that the nurse did not provide adequate instruction to the UAP.

DIF: Applying/Application REF: 6
KEY: Supervision| delegation| unlicensed assistive personnel
MSC: Integrated Process: Communication and Documentation
NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

10. A newly graduated nurse in the hospital states that, since she is so new, she cannot participate in quality improvement (QI) projects. What response by the precepting nurse is best?
a. All staff nurses are required to participate in quality improvement here.
b. Even being new, you can implement activities designed to improve care.
c. Its easy to identify what indicators should be used to measure quality.
d. You should ask to be assigned to the research and quality committee.
ANS: B
The preceptor should try to reassure the nurse that implementing QI measures is not out of line for a newly licensed nurse. Simply stating that all nurses are required to participate does not help the nurse understand how that is possible and is dismissive. Identifying indicators of quality is not an easy, quick process and would not be the best place to suggest a new nurse to start. Asking to be assigned to the QI committee does not give the nurse information about how to implement QI in daily practice.

DIF: Applying/Application REF: 6
KEY: Quality improvement
MSC: Integrated Process: Communication and Documentation
NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

11. A nurse is talking with a client who is moving to a new state and needs to find a new doctor and hospital there. What advice by the nurse is best?
a. Ask the hospitals there about standard nurse-client ratios.
b. Choose the hospital that has the newest technology.
c. Find a hospital that is accredited by The Joint Commission.
d. Use a facility affiliated with a medical or nursing school.
ANS: C
Accreditation by The Joint Commission (TJC) or other accrediting body gives assurance that the facility has a focus on safety. Nurse-client ratios differ by unit type and change over time. New technology doesnt necessarily mean the hospital is safe. Affiliation with a health professions school has several advantages, but safety is most important.

DIF: Understanding/Comprehension REF: 2
KEY: The Joint Commission (TJC)| accreditation
MSC: Integrated Process: Communication and Documentation

NOT: Client Needs Category: Safe and Effective Care Environment: Safety and Infection Control

MULTIPLE RESPONSE

1. A nurse manager wishes to ensure that the nurses on the unit are practicing at their highest levels of competency. Which areas should the manager assess to determine if the nursing staff demonstrate competency according to the Institute of Medicine (IOM) report Health Professions Education: A Bridge to Quality? (Select all that apply.)
a. Collaborating with an interdisciplinary team
b. Implementing evidence-based care
c. Providing family-focused care
d. Routinely using informatics in practice
e. Using quality improvement in client care
ANS: A, B, D, E
The IOM report lists five broad core competencies that all health care providers should practice. These include collaborating with the interdisciplinary team, implementing evidence-based practice, providing client-focused care, using informatics in client care, and using quality improvement in client care.

DIF: Remembering/Knowledge REF: 3
KEY: Competencies| Institute of Medicine (IOM)
MSC: Integrated Process: Nursing Process: Assessment
NOT: Client Needs Category: Safe and Effective Care Environment: Safety and Infection Control

2. A nurse is interested in making interdisciplinary work a high priority. Which actions by the nurse best demonstrate this skill? (Select all that apply.)
a. Consults with other disciplines on client care
b. Coordinates discharge planning for home safety
c. Participates in comprehensive client rounding
d. Routinely asks other disciplines about client progress
e. Shows the nursing care plans to other disciplines
ANS: A, B, C, D
Collaborating with the interdisciplinary team involves planning, implementing, and

evaluating client care as a team with all other disciplines included. Simply showing other caregivers the nursing care plan is not actively involving them or collaborating with them.

DIF: Applying/Application REF: 4
KEY: Collaboration| interdisciplinary team
MSC: Integrated Process: Communication and Documentation
NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

3. The nurse utilizing evidence-based practice (EBP) considers which factors when planning care? (Select all that apply.)
a. Cost-saving measures
b. Nurses expertise
c. Client preferences
d. Research findings
e. Values of the client
ANS: B, C, D, E
EBP consists of utilizing current evidence, the clients values and preferences, and the nurses expertise when planning care. It does not include cost-saving measures.

DIF: Remembering/Knowledge REF: 6
KEY: Evidence-based practice (EBP)
MSC: Integrated Process: Nursing Process: Planning
NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

4. A nurse manager wants to improve hand-off communication among the staff. What actions by the manager would best help achieve this goal? (Select all that apply.)
a. Attend hand-off rounds to coach and mentor.
b. Conduct audits of staff using a new template.
c. Create a template of topics to include in report.
d. Encourage staff to ask questions during hand-off.
e. Give raises based on compliance with reporting.
ANS: A, B, C, D
A good tool for standardizing hand-off reports and other critical communication is the SHARE model. SHARE stands for standardize critical information, hardwire within your system, allow opportunities to ask questions, reinforce quality and measurement, and

educate and coach. Attending hand-off report gives the manager opportunities to educate and coach. Conducting audits is part of reinforcing quality. Creating a template is hardwiring within the system. Encouraging staff to ask questions and think critically about the information is allowing opportunities to ask questions. The manager may need to tie raises into compliance if the staff is resistive and other measures have failed, but this is not part of the SHARE model.

DIF: Applying/Application REF: 5
KEY: SHARE| hand-off communication
MSC: Integrated Process: Nursing Process: Intervention
NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

Chapter 2. Overview of Health Concepts for Medical-Surgical Nursing
MULTIPLE CHOICE

MULTIPLE CHOICE

1. A nurse identifies clinical practice problems on a cardiac unit. Which question is a background question?
a. How should a client experiencing chest pain be prioritized?
b. What is the experience of a cardiac catheterization like for middle-aged men?
c. How are a clients vital signs affected by anxiety?
d. What is the best treatment for a myocardial infarction?
ANS: C
A background question asks for a fact. The response of anxiety on vital signs is a background question. A foreground question asks a question of relationship and may be controversial (best treatment). Questions related to a clients experience and best treatment are foreground questions.

DIF: Understanding/Comprehension REF: 65
KEY: Foreground| background
MSC: Integrated Process: Nursing Process: Assessment
NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

2. A nurse researcher is evaluating clinical questions. Which is a quantitative question?
a. What are the effects of hourly rounding on client fall rates?
b. How do middle-aged men respond to premature balding?
c. What are the lived experiences of postoperative clients with pain?
d. What is the experience of having breast cancer like for young women?

ANS: A
Quantitative questions ask about the relationship between or among defined, measurable phenomena and include statistical analysis of information that is collected to answer a question. Qualitative questions focus on the meanings and interpretations of human phenomena or experiences of people, and usually analyze the content of what a person says during an interview or what a researcher observes.

DIF: Understanding/Comprehension REF: 65
KEY: Foreground| background
MSC: Integrated Process: Nursing Process: Evaluation
NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

3. A nurse is looking for the best interventions for postoperative pain control. When are the facilitys policies and procedures an appropriate source of evidence?
a. When policies are based on high-quality clinical practice guidelines
b. When evidence is derived from a valid and reliable quantitative research study
c. When procedures originated from opinions of the facilitys chief surgeon
d. When evidence is founded on recommendations from experienced nurses
ANS: A
Facility policies and procedures can be used as evidence of specific nursing practice in the clinical setting if the policies are based on high-quality evidence. Clinical practice guidelines are based on systematic reviews, which provide the highest level of evidence. Policies based on quantitative research, opinions, and experience should not be used because they are not founded on evidence of the highest quality.

DIF: Understanding/Comprehension REF: 67
KEY: Policies| clinical practice guidelines
MSC: Integrated Process: Nursing Process: Planning
NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

4. A medical-surgical nurse asks the nurse researcher, What is the difference between qualitative and quantitative questions? How should the nurse researcher respond?
a. Quantitative questions analyze the content of what a person says or does.
b. Qualitative questions utilize a strict statistical analysis of information.
c. Quantitative questions identify relationships between measurable concepts.
d. Qualitative questions ask about associations among defined phenomena.
ANS: C
Quantitative questions ask about the relationship between or among defined, measurable phenomena and include statistical analysis of information that is collected to answer a question. Qualitative questions focus on the meanings and interpretations of human phenomena or experiences of people and usually analyze the content of what a person says during an interview or what a researcher observes.

DIF: Understanding/Comprehension REF: 65
KEY: Qualitative research| quantitative research
MSC: Integrated Process: Teaching/Learning
NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

5. A nurse is searching for evidence related to a qualitative PICOT question. Which type of evidence should the nurse search first?

a. Meta-analyses with credible synthesized findings
b. Systematic reviews
c. Multi-site randomized clinical trials
d. Meta-syntheses
ANS: D
If searching for answers to qualitative questions, the nurse should first look for meta-syntheses. Top-level evidence for quantitative questions includes meta-analyses, systematic reviews, and multi-site randomized clinical trials.

DIF: Remembering/Knowledge REF: 67 KEY: Level of evidence
MSC: Integrated Process: Nursing Process: Assessment
NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

6. A nurse assesses this PICOT question: In the adult hospitalized client, does a COX-2 inhibitor decrease the risk of gastrointestinal bleeding compared with other NSAIDs? What is the outcome component in this question?
a. Adult hospitalized client
b. Cyclooxygenase-2 (COX-2) inhibitor
c. Decreased risk of gastrointestinal bleeding
d. Other nonsteroidal anti-inflammatory drugs (NSAIDs)
ANS: C
The outcome component of the clinical question specifies the measureable and desired outcomes of the practice innovation. In this question, the decreased risk of gastrointestinal bleeding is the outcome. The population is adult hospitalized clients, the comparison component is NSAIDs, and innovative practice is COX-2 inhibitors.

DIF: Remembering/Knowledge REF: 66 KEY: PICOT question
MSC: Integrated Process: Nursing Process: Assessment
NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

7. A health care facility is implementing a new evidence-based nursing protocol. Which action is necessary to ensure successful implementation?
a. Develop evaluation processes to validate the protocol.
b. Ask for recommendations from senior nursing administration.
c. Assess cost-effectiveness of the evidence-based protocol.
d. Attain support from nurses who are implementing the protocol.
ANS: D
Complete buy-in from the people who will be involved in implementing the new protocol is essential to the success of implementation.

DIF: Remembering/Knowledge REF: 68 KEY: PICOT question
MSC: Integrated Process: Nursing Process: Planning
NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

8. A research nurse meets with the nurse manager to discuss plans for the development of evidence-based practice (EBP) guidelines using the Reavy and Tavernier model. Which statement should the nurse include in the discussion?
a. Our efforts should focus on forming a team to develop an EBP initiative.
b. I will assist staff nurses with literature reviews and the synthesis of evidence.
c. You should identify barriers to evidence-based implementation.

d. I will develop a PICOT question and share it with the staff nurses.
ANS: B
The Reavy and Tavernier model views the staff nurse as the clinical expert and believes that the expertise of a nurse researcher should facilitate the EBP process by supporting nursing staff in identifying areas for improvement, assisting staff with literature reviews and synthesis of evidence, and helping with the implementation and evaluation of EBP projects. Team forming is a component of the Iowa model. Identification of strengths and barriers to EBP implementation is a component of the ARCC model. Staff nurses should identify their own PICOT questions from burning clinical questions.

DIF: Applying/Application REF: 69
KEY: Reavy and Tavernier model
MSC: Integrated Process: Nursing Process: Planning
NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

9. A nurse who wants to incorporate evidence-based practices into client care on a medical unit is meeting resistance. Which barrier does the nurse identify as preventing nurses from engaging in evidence-based practices?
a. Difficulty accessing research materials
b. Lack of value for client preferences
c. Trouble understanding client needs
d. Inadequate nurse-client ratios
ANS: A
Major barriers that prevent nurses from engaging in evidence-based practice include lack of time, lack of value for research in practice, lack of understanding of organization or structure of electronic databases, difficulty accessing research materials, lack of computer skills, and difficulty understanding research articles.

DIF: Remembering/Knowledge REF: 66
KEY: Barriers| nurse engagement MSC: Integrated Process: Teaching/Learning
NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

10. A nurse wants to explore why clients who receive patient-controlled analgesia (PCA) after abdominal surgery ambulate sooner than clients who receive nurse-administered pain medications. Which action should the nurse take first?
a. Contact the medical centers clinical pharmacist.
b. Search the medical library for the best evidence.
c. Recommend PCA for all clients.
d. Appraise data obtained through client chart audits.
ANS: B
After asking the burning question, the nurse should find the very best evidence to try to answer it. The clinical pharmacist may be knowledgeable, but this is not the best evidence available. Information from client chart audits may demonstrate better outcomes with PCA, but this again is not the best evidence. The nurse should wait and recommend clinical practice changes until best evidence is found, appraised, and synthesized.

DIF: Applying/Application REF: 67
KEY: Steps of evidence-based practice
MSC: Integrated Process: Nursing Process: Analysis
NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

11. A nurse manager educates staff nurses in the use of clinical practice guidelines. Which statement should the nurse include in this teaching?
a. Clinical practice guidelines are implemented by The Joint Commission.
b. Practice guidelines are based on hospital management staffs expertise.
c. Clinical practice guidelines are official recommendations based on evidence.
d. Practice guidelines allow for greater reimbursement from insurance companies.
ANS: C
Clinical practice guidelines are based on evidence and provide an official recommendation for the diagnosis and/or management of health problems. These are usually developed from high-quality evidence. Although The Joint Commission publishes guidelines, clinical practice guidelines are not implemented by The Joint Commission. The hospitals management staff may be involved in the development and implementation of clinical practice guidelines, but these guidelines should not be based solely on management expertise. Clinical guidelines provide for better client outcomes. These guidelines are not focused on reimbursement.

DIF: Understanding/Comprehension REF: 67
KEY: Steps of evidence-based practice; level of evidence
MSC: Integrated Process: Communication and Documentation
NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

12. A cardiac nurse wants to know about the best practices to prevent pneumonia after open-heart surgery. In what order do the steps of the evidence-based practice (EBP) process take place?
1. Asking burning clinical questions
2. Making recommendations for practice improvement
3. Implementing accepted recommendations
4. Finding the very best evidence to try to answer those questions
5. Evaluating outcomes
6. Critically appraising and synthesizing the relevant evidence
a. 5, 1, 4, 6, 3, 2
b. 1, 5, 4, 3, 2, 6
c. 1, 4, 6, 2, 3, 5
d. 5, 2, 1, 4, 6, 3
ANS: C
The process of EBP is systematic and includes the following steps: (1) asking burning clinical questions; (2) finding the very best evidence to try to answer those questions; (3) critically appraising and synthesizing the relevant evidence; (4) making recommendations for practice improvement; (5) implementing accepted recommendations; and (6) evaluating outcomes.

DIF: Remembering/Knowledge REF: 65
KEY: Steps of evidence-based practice
MSC: Integrated Process: Nursing Process: Planning
NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

MULTIPLE RESPONSE

1. A nurse is developing a clinical question in a PICOT format. What components are included in the question? (Select all that apply.)
a. Patient

b. Comparison
c. Outcome
d. Implementation
e. Time
ANS: B, C, E
The major components of a PICOT question are population, intervention, comparison, and outcome, with an added time component when appropriate.

DIF: Remembering/Knowledge REF: 65 KEY: PICOT question
MSC: Integrated Process: Nursing Process: Assessment
NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

2. A nurse plans evidence-based care for a client on a medical-surgical unit. Which elements should the nurse assess when developing this plan of care? (Select all that apply.)
a. Client values
b. Nurses experiences
c. Organizational budget
d. Staffing ratios
e. Best available evidence
ANS: A, B, E
Evidence-based practice incorporates best current evidence with the expertise of the clinician and the clients values.

DIF: Understanding/Comprehension REF: 64
KEY: Steps of evidence-based practice
MSC: Integrated Process: Nursing Process: Assessment
NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

Chapter 3: Common Health Problems of Older Adults
Ignatavicius: Medical-Surgical Nursing,

MULTIPLE CHOICE

1. A nursing faculty member working with students explains that the fastest growing subset of the older population is which group?
a. Elite old
b. Middle old
c. Old old
d. Young old
ANS: C
The old old is the fastest growing subset of the older population. This is the group comprising those 85 to 99 years of age. The young old are between 65 and 74 years of age; the middle old are between 75 and 84 years of age; and the elite old are over 100 years of age.

DIF: Remembering/Knowledge REF: 9
KEY: Adulthood| aging| old old MSC: Integrated Process: Teaching/Learning
NOT: Client Needs Category: Health Promotion and Maintenance

2. A nurse working with older adults in the community plans programming to improve morale and emotional health in this population. What activity would best meet this goal?
a. Exercise program to improve physical function
b. Financial planning seminar series for older adults
c. Social events such as dances and group dinners
d. Workshop on prevention from becoming an abuse victim
ANS: A
All activities would be beneficial for the older population in the community. However, failure in performing ones own activities of daily living and participating in society has direct effects on morale and life satisfaction. Those who lose the ability to function independently often feel worthless and empty. An exercise program designed to maintain and/or improve physical functioning would best address this need.

DIF: Applying/Application REF: 12
KEY: Independence| autonomy| older adult
MSC: Integrated Process: Nursing Process: Planning
NOT: Client Needs Category: Psychosocial Integrity

3. A nurse caring for an older client on a medical-surgical unit notices the client reports frequent constipation and only wants to eat softer foods such as rice, bread, and puddings. What assessment should the nurse perform first?
a. Auscultate bowel sounds.
b. Check skin turgor.
c. Perform an oral assessment.
d. Weigh the client.
ANS: C
Poorly fitting dentures and other dental problems are often manifested by a preference for soft foods and constipation from the lack of fiber. The nurse should perform an oral assessment to determine if these problems exist. The other assessments are important, but will not yield information specific to the clients food preferences as they relate to constipation.

DIF: Applying/Application REF: 10
KEY: Nutrition| dentures| older adult
MSC: Integrated Process: Nursing Process: Assessment
NOT: Client Needs Category: Physiological Integrity: Basic Care and Comfort

4. A nurse caring for an older adult has provided education on high-fiber foods. Which menu selection by the client demonstrates a need for further review?
a. Barley soup
b. Black beans
c. White rice
d. Whole wheat bread
ANS: C
Older adults need 25 to 50 grams of fiber a day. White rice is low in fiber. Foods high in fiber include barley, beans, and whole wheat products.

DIF: Applying/Application REF: 11
KEY: Nutrition| fiber| older adult
MSC: Integrated Process: Nursing Process: Evaluation
NOT: Client Needs Category: Physiological Integrity: Physiological Adaptation

5. A nurse is working with an older client admitted with mild dehydration. What teaching does the nurse provide to best address this issue?
a. Cut some sodium out of your diet.
b. Dehydration can cause incontinence.
c. Have something to drink every 1 to 2 hours.
d. Take your diuretic in the morning.
ANS: C
Older adults often lose their sense of thirst. Since they should drink 1 to 2 liters of water a day, the best remedy is to have the older adult drink something each hour or two, whether or not he or she is thirsty. Cutting some sodium from the diet will not address this issue. Although dehydration can cause incontinence from the irritation of concentrated urine, this information will not help prevent the problem of dehydration. Instructing the client to take a diuretic in the morning rather than in the evening also will not directly address this issue.

DIF: Applying/Application REF: 11
KEY: Dehydration| older adult| hydration MSC: Integrated Process: Teaching/Learning
NOT: Client Needs Category: Physiological Integrity: Physiological Adaptation

6. A home health care nurse is planning an exercise program with an older client who lives at home independently but whose mobility issues prevent much activity outside the home. Which exercise regimen would be most beneficial to this adult?
a. Building strength and flexibility
b. Improving exercise endurance
c. Increasing aerobic capacity
d. Providing personal training
ANS: A
This older adult is mostly homebound. Exercise regimens for homebound clients include things to increase functional ability for activities of daily living. Strength and flexibility will help the client to be able to maintain independence longer. The other plans are good but will not specifically maintain the clients functional abilities.

DIF: Applying/Application REF: 12
KEY: Exercise| functional ability| older adult
MSC: Integrated Process: Nursing Process: Planning
NOT: Client Needs Category: Physiological Integrity: Reduction of Risk Potential

7. An older adult recently retired and reports being depressed and lonely. What information should the nurse assess as a priority?
a. History of previous depression
b. Previous stressful events
c. Role of work in the adults life
d. Usual leisure time activities
ANS: C
Often older adults lose support systems when their roles change. For instance, when people retire, they may lose their entire social network, leading them to feeling depressed

and lonely. The nurse should first assess the role that work played in the clients life. The other factors can be assessed as well, but this circumstance is commonly seen in the older population.

DIF: Applying/Application REF: 12
KEY: Depression| older adult
MSC: Integrated Process: Nursing Process: Assessment
NOT: Client Needs Category: Psychosocial Integrity

8. A nurse is assessing coping in older women in a support group for recent widows. Which statement by a participant best indicates potential for successful coping?
a. I have had the same best friend for decades.
b. I think I am coping very well on my own.
c. My kids come to see me every weekend.
d. Oh, I have lots of friends at the senior center.
ANS: A
Friendship and support enhance coping. The quality of the relationship is what is most important, however. People who have close, intimate, stable relationships with others in whom they confide are more likely to cope with crisis.

DIF: Remembering/Knowledge REF: 12
KEY: Coping| relationships| older adult
MSC: Integrated Process: Nursing Process: Assessment
NOT: Client Needs Category: Psychosocial Integrity

9. A home health care nurse has conducted a home safety assessment for an older adult. There are five concrete steps leading out from the front door. Which intervention would be most helpful in keeping the older adult safe on the steps?
a. Have the client use a walker or cane on the steps.
b. Install contrasting color strips at the edge of each step.
c. Instruct the client to use the garage door instead.
d. Tell the client to use a two-footed gait on the steps.
ANS: B
As a person ages, he or she may experience a decreased sense of touch. The older adult may not be aware of where his or her foot is on the step. Installing contrasting color strips at the end of each step will help increase awareness. If the client does not need an assistive device, he or she should not use one just on stairs. Using an alternative door may be necessary but does not address making the front steps safer. A two-footed gait may not help if the client is unaware of where the foot is on the step.

DIF: Applying/Application REF: 13
KEY: Safety| falls| older adult
MSC: Integrated Process: Nursing Process: Implementation
NOT: Client Needs Category: Safe and Effective Care Environment: Safety and Infection Control

10. An older adult is brought to the emergency department because of sudden onset of confusion. After the client is stabilized and comfortable, what assessment by the nurse is most important?
a. Assess for orthostatic hypotension.

b. Determine if there are new medications.
c. Evaluate the client for gait abnormalities.
d. Perform a delirium screening test.
ANS: B
Medication side effects and adverse effects are common in the older population. Something as simple as a new antibiotic can cause confusion and memory loss. The nurse should determine if the client is taking any new medications. Assessments for orthostatic hypotension, gait abnormalities, and delirium may be important once more is known about the clients condition.

DIF: Applying/Application REF: 13
KEY: Medications| medication safety| older adult
MSC: Integrated Process: Nursing Process: Assessment
NOT: Client Needs Category: Physiological Integrity: Pharmacological and Parenteral Therapies

11. An older adult client takes medication three times a day and becomes confused about which medication should be taken at which time. The client refuses to use a pill sorter with slots for different times, saying Those are for old people. What action by the nurse would be most helpful?
a. Arrange medications by time in a drawer.
b. Encourage the client to use easy-open tops.
c. Put color-coded stickers on the bottle caps.
d. Write a list of when to take each medication.
ANS: C
Color-coded stickers are a fast, easy-to-remember system. One color is for morning meds, one for evening meds, and the third color is for nighttime meds. Arranging medications by time in a drawer might be helpful if the person doesnt accidentally put them back in the wrong spot. Easy-open tops are not related. Writing a list might be helpful, but not if it gets misplaced. With stickers on the medication bottles themselves, the reminder is always with the medication.

DIF: Applying/Application REF: 14
KEY: Medications| medication safety| older adult
MSC: Integrated Process: Nursing Process: Implementation
NOT: Client Needs Category: Safe and Effective Care Environment: Safety and Infection Control

12. An older adult client is in the hospital. The client is ambulatory and independent. What intervention by the nurse would be most helpful in preventing falls in this client?
a. Keep the light on in the bathroom at night.
b. Order a bedside commode for the client.
c. Put the client on a toileting schedule.
d. Use siderails to keep the client in bed.
ANS: A
Although this older adult is independent and ambulatory, being hospitalized can create confusion. Getting up in a dark, unfamiliar environment can contribute to falls. Keeping the light on in the bathroom will help reduce the likelihood of falling. The client does not need a commode or a toileting schedule. Siderails used to keep the client in bed are considered restraints and should not be used in that fashion.

DIF: Applying/Application REF: 21
KEY: Falls| safety| older adult
MSC: Integrated Process: Nursing Process: Implementation
NOT: Client Needs Category: Safe and Effective Care Environment: Safety and Infection Control

13. An older client had hip replacement surgery and the surgeon prescribed morphine sulfate for pain. The client is allergic to morphine and reports pain and muscle spasms. When the nurse calls the surgeon, which medication should he or she suggest in place of the morphine?
a. Cyclobenzaprine (Flexeril)
b. Hydromorphone hydrochloride (Dilaudid)
c. Ketorolac (Toradol)
d. Meperidine (Demerol)
ANS: B
Cyclobenzaprine (used for muscle spasms), ketorolac, and meperidine (both used for pain) are all on the Beers list of potentially inappropriate medications for use in older adults and should not be suggested. The nurse should suggest hydromorphone hydrochloride.

DIF: Remembering/Knowledge REF: 16
KEY: Medications| Beers list| older adult
MSC: Integrated Process: Communication and Documentation
NOT: Client Needs Category: Physiological Integrity: Pharmacological and Parenteral Therapies

14. A nurse admits an older client from a home environment where she lives with her adult son and daughter-in-law. The client has urine burns on her skin, no dentures, and several pressure ulcers. What action by the nurse is most appropriate?
a. Ask the family how these problems occurred.
b. Call the police department and file a report.
c. Notify Adult Protective Services.
d. Report the findings as per agency policy.
ANS: D
These findings are suspicious for abuse. Health care providers are mandatory reporters for suspected abuse. The nurse should notify social work, case management, or whomever is designated in policies. That person can then assess the situation further. If the police need to be notified, that is the person who will notify them. Adult Protective Services is notified in the community setting.

DIF: Applying/Application REF: 19 KEY: Abuse| older adult
MSC: Integrated Process: Communication and Documentation
NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

15. A nurse caring for an older client in the hospital is concerned the client is not competent to give consent for upcoming surgery. What action by the nurse is best?
a. Call Adult Protective Services.
b. Discuss concerns with the health care team.
c. Do not allow the client to sign the consent.
d. Have the clients family sign the consent.
ANS: B

In this situation, each facility will have a policy designed for assessing competence. The nurse should bring these concerns to an interdisciplinary care team meeting. There may be physiologic reasons for the client to be temporarily too confused or incompetent to give consent. If an acute condition is ruled out, the staff should follow the legal procedure and policies in their facility and state for determining competence. The key is to bring the concerns forward. Calling Adult Protective Services is not appropriate at this time. Signing the consent should wait until competence is determined unless it is an emergency, in which case the next of kin can sign if there are grave doubts as to the clients ability to provide consent.

DIF: Applying/Application REF: 16
KEY: Competence| autonomy| older adult
MSC: Integrated Process: Communication and Documentation
NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

MULTIPLE RESPONSE

1. A nursing student working in an Adult Care for Elders unit learns that frailty in the older population includes which components? (Select all that apply.)
a. Dementia
b. Exhaustion
c. Slowed physical activity
d. Weakness
e. Weight gain
ANS: B, C, D
Frailty is a syndrome consisting of unintentional weight loss, slowed physical activity and exhaustion, and weakness. Weight gain and dementia are not part of this cluster of manifestations.

DIF: Remembering/Knowledge REF: 9
KEY: Frailty| frail elderly| older adult
MSC: Integrated Process: Nursing Process: Assessment
NOT: Client Needs Category: Health Promotion and Maintenance

2. A home health care nurse assesses an older client for the intake of nutrients needed in larger amounts than in younger adults. Which foods found in an older adults kitchen might indicate an adequate intake of these nutrients? (Select all that apply.)
a. 1% milk
b. Carrots
c. Lean ground beef
d. Oranges
e. Vitamin D supplements
ANS: A, B, D, E
Older adults need increased amounts of calcium; vitamins A, C, and D; and fiber. Milk has calcium; carrots have vitamin A; the vitamin D supplement has vitamin D; and oranges have vitamin C. Lean ground beef is healthier than more fatty cuts, but does not contain these needed nutrients.

DIF: Applying/Application REF: 10
KEY: Nutrition| nutritional requirements| older adults

MSC: Integrated Process: Nursing Process: Assessment
NOT: Client Needs Category: Physiological Integrity: Basic Care and Comfort

3. A nurse working with older adults assesses them for common potential adverse medication effects. For what does the nurse assess? (Select all that apply.)
a. Constipation
b. Dehydration
c. Mania
d. Urinary incontinence
e. Weakness
ANS: A, B, E
Common adverse medication effects include constipation/impaction, dehydration, and weakness. Mania and incontinence are not among the common adverse effects, although urinary retention is.

DIF: Remembering/Knowledge REF: 14
KEY: Medications| adverse effects
MSC: Integrated Process: Nursing Process: Assessment
NOT: Client Needs Category: Physiological Integrity: Pharmacological and Parenteral Therapies

4. A nurse manager institutes the Fulmer Spices Framework as part of the routine assessment of older adults in the hospital. The nursing staff assesses for which factors? (Select all that apply.)
a. Confusion
b. Evidence of abuse
c. Incontinence
d. Problems with behavior
e. Sleep disorders
ANS: A, C, E
SPICES stands for sleep disorders, problems with eating or feeding, incontinence, confusion, and evidence of falls.

DIF: Remembering/Knowledge REF: 20
KEY: SPICES| older adult
MSC: Integrated Process: Nursing Process: Assessment
NOT: Client Needs Category: Physiological Integrity: Reduction of Risk Potential

5. A visiting nurse is in the home of an older adult and notes a 7-pound weight loss since last months visit. What actions should the nurse perform first? (Select all that apply.)
a. Assess the clients ability to drive or transportation alternatives.
b. Determine if the client has dentures that fit appropriately.
c. Encourage the client to continue the current exercise plan.
d. Have the client complete a 3-day diet recall diary.
e. Teach the client about proper nutrition in the older population.
ANS: A, B, D
Assessment is the first step of the nursing process and should be completed prior to intervening. Asking about transportation, dentures, and normal food patterns would be part of an appropriate assessment for the client. There is no information in the question about the older adult needing to lose weight, so encouraging him or her to continue the current

exercise regimen is premature and may not be appropriate. Teaching about proper nutrition is a good idea, but teaching needs to be tailored to the clients needs, which the nurse does not yet know.

DIF: Applying/Application REF: 10
KEY: Nutrition| older adult
MSC: Integrated Process: Nursing Process: Assessment
NOT: Client Needs Category: Physiological Integrity: Physiological Adaptation

6. A hospitalized older adult has been assessed at high risk for skin breakdown. Which actions does the registered nurse (RN) delegate to the unlicensed assistive personnel (UAP)? (Select all that apply.)
a. Assess skin redness when turning.
b. Document Braden Scale results.
c. Keep the clients skin dry.
d. Obtain a pressure-relieving mattress.
e. Turn the client every 2 hours.
ANS: C, D, E
The nurses aide or UAP can assist in keeping the clients skin dry, order a special mattress on direction of the RN, and turn the client on a schedule. Assessing the skin is a nursing responsibility, although the aide should be directed to report any redness noticed. Documenting the Braden Scale results is the RNs responsibility as the RN is the one who performs that assessment.

DIF: Applying/Application REF: 22
KEY: Skin breakdown| older adult| delegation| unlicensed assistive personnel
MSC: Integrated Process: Communication and Documentation
NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

7. A nurse admits an older client to the hospital who lives at home with family. The nurse assesses that the client is malnourished. What actions by the nurse are best? (Select all that apply.)
a. Contact Adult Protective Services or hospital social work.
b. Notify the provider that the client needs a tube feeding.
c. Perform and document results of a Braden Scale assessment.
d. Request a dietary consultation from the health care provider.
e. Suggest a high-protein oral supplement between meals.
ANS: C, D, E
Malnutrition in the older population is multifactorial and has several potential adverse outcomes. Appropriate actions by the nurse include assessing the clients risk for skin breakdown with the Braden Scale, requesting a consultation with a dietitian, and suggesting a high-protein meal supplement. There is no evidence that the client is being abused or needs a feeding tube at this time.

DIF: Applying/Application REF: 20
KEY: Nutrition| malnutrition| older adult| Braden Scale
MSC: Integrated Process: Nursing Process: Implementation
NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

Chapter 4: Assessment and Care of Patients with Pain
Ignatavicius: Medical-Surgical Nursing,

MULTIPLE CHOICE

1. A student asks the nurse what is the best way to assess a clients pain. Which response by the nurse is best?
a. Numeric pain scale
b. Behavioral assessment
c. Objective observation
d. Clients self-report
ANS: D
Many ways to measure pain are in use, including numeric pain scales, behavioral assessments, and other objective observations. However, the most accurate way to assess pain is to get a self-report from the client.

DIF: Remembering/Knowledge REF: 25
KEY: Pain| pain assessment
MSC: Integrated Process: Nursing Process: Assessment
NOT: Client Needs Category: Health Promotion and Maintenance

2. A new nurse reports to the precepting nurse that a client requested pain medication, and when the nurse brought it, the client was sound asleep. The nurse states the client cannot possibly sleep with the severe pain the client described. What response by the experienced nurse is best?
a. Being able to sleep doesnt mean pain doesnt exist.
b. Have you ever experienced any type of pain?
c. The client should be assessed for drug addiction.
d. Youre right; I would put the medication back.
ANS: A
A clients description is the most accurate assessment of pain. The nurse should believe the client and provide pain relief. Physiologic changes due to pain vary from client to client, and assessments of them should not supersede the clients descriptions, especially if the pain is chronic in nature. Asking if the new nurse has had pain is judgmental and flippant, and does not provide useful information. This amount of information does not warrant an assessment for drug addiction. Putting the medication back and ignoring the clients report of pain serves no useful purpose.

DIF: Understanding/Comprehension REF: 28
KEY: Pain| pain assessment
MSC: Integrated Process: Communication and Documentation
NOT: Client Needs Category: Health Promotion and Maintenance

3. The nurse in the surgery clinic is discussing an upcoming surgical procedure with a client. What information provided by the nurse is most appropriate for the clients long-term outcome?
a. At least you know that the pain after surgery will diminish quickly.
b. Discuss acceptable pain control after your operation with the surgeon.
c. Opioids often cause nausea but you wont have to take them for long.
d. The nursing staff will give you pain medication when you ask them for it.

ANS: B
The best outcome after a surgical procedure is timely and satisfactory pain control, which diminishes the likelihood of chronic pain afterward. The nurse suggests that the client advocate for himself and discuss acceptable pain control with the surgeon. Stating that pain after surgery is usually short lived does not provide the client with options to have personalized pain control. To prevent or reduce nausea and other side effects from opioids, a multimodal pain approach is desired. For acute pain after surgery, giving pain medications around the clock instead of waiting until the client requests it is a better approach.

DIF: Applying/Application REF: 26 KEY: Pain| acute pain
MSC: Integrated Process: Teaching/Learning
NOT: Client Needs Category: Health Promotion and Maintenance

4. A nurse is assessing pain on a confused older client who has difficulty with verbal expression. What pain assessment tool would the nurse choose for this assessment?
a. Numeric rating scale
b. Verbal Descriptor Scale
c. FACES Pain Scale-Revised
d. Wong-Baker FACES Pain Scale
ANS: C
All are valid pain rating scales; however, some research has shown that the FACES Pain Scale-Revised is preferred by both cognitively intact and cognitively impaired adults.

DIF: Applying/Application REF: 30
KEY: Pain assessment| FACES
MSC: Integrated Process: Nursing Process: Assessment
NOT: Client Needs Category: Health Promotion and Maintenance

5. The nurse is assessing a clients pain and has elicited information on the location, quality, intensity, effect on functioning, aggravating and relieving factors, and onset and duration. What question by the nurse would be best to ask the client for completing a comprehensive pain assessment?
a. Are you worried about addiction to pain pills?
b. Do you attach any spiritual meaning to pain?
c. How high would you say your pain tolerance is?
d. What pain rating would be acceptable to you?
ANS: D
A comprehensive pain assessment includes the items listed in the question plus the clients opinion on a functional goal, such as what pain rating would be acceptable to him or her. Asking about addiction is not warranted in an initial pain assessment. Asking about spiritual meanings for pain may give the nurse important information, but getting the basics first is more important. Asking about pain tolerance may give the client the idea that pain tolerance is being judged.

DIF: Applying/Application REF: 29 KEY: Pain assessment
MSC: Integrated Process: Nursing Process: Assessment
NOT: Client Needs Category: Physiological Integrity: Reduction of Risk Potential

6. A nurse is assessing pain in an older adult. What action by the nurse is best?
a. Ask only yes-or-no questions so the client doesnt get too tired.

b. Give the client a picture of the pain scale and come back later.
c. Question the client about new pain only, not normal pain from aging.
d. Sit down, ask one question at a time, and allow the client to answer.
ANS: D
Some older clients do not report pain because they think it is a normal part of aging or because they do not want to be a bother. Sitting down conveys time, interest, and availability. Ask only one question at a time and allow the client enough time to answer it. Yes-or-no questions are an example of poor communication technique. Giving the client a pain scale, then leaving, might give the impression that the nurse does not have time for the client. Plus the client may not know how to use it. There is no normal pain from aging.

DIF: Applying/Application REF: 32
KEY: Pain assessment| older adult
MSC: Integrated Process: Communication and Documentation
NOT: Client Needs Category: Psychosocial Integrity

7. The nurse receives a hand-off report. One client is described as a drug seeker who is obsessed with even tiny changes in physical condition and is on the light constantly asking for more pain medication. When assessing this clients pain, what statement or question by the nurse is most appropriate?
a. Help me understand how pain is affecting you right now.
b. I wish I could do more; is there anything I can get for you?
c. You cannot have more pain medication for 3 hours.
d. Why do you think the medication is not helping your pain?
ANS: A
This is an example of therapeutic communication. A client who is preoccupied with physical symptoms and is demanding may have some psychosocial impact from the pain that is not being addressed. The nurse is providing the client the chance to explain the emotional effects of pain in addition to the physical ones. Saying the nurse wishes he or she could do more is very empathetic, but this response does not attempt to learn more about the pain. Simply telling the client when the next medication is due also does not help the nurse understand the clients situation. Why questions are probing and often make clients defensive, plus the client may not have an answer for this question.

DIF: Applying/Application REF: 33
KEY: Pain| pain assessment
MSC: Integrated Process: Communication and Documentation
NOT: Client Needs Category: Psychosocial Integrity

8. A nurse on the medical-surgical unit has received a hand-off report. Which client should the nurse see first?
a. Client being discharged later on a complicated analgesia regimen
b. Client with new-onset abdominal pain, rated as an 8 on a 0-to-10 scale
c. Postoperative client who received oral opioid analgesia 45 minutes ago
d. Client who has returned from physical therapy and is resting in the recliner
ANS: B
Acute pain often serves as a physiologic warning signal that something is wrong. The client with new-onset abdominal pain needs to be seen first. The postoperative client needs 45 minutes to an hour for the oral medication to become effective and should be seen shortly to assess for effectiveness. The client going home requires teaching, which should be done

after the first two clients have been seen and cared for, as this teaching will take some time. The client resting comfortably can be checked on quickly before spending time teaching the client who is going home.

DIF: Analyzing/Analysis REF: 25
KEY: Acute pain| pain assessment
MSC: Integrated Process: Nursing Process: Assessment
NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

9. A nurse uses the Checklist of Nonverbal Pain Indicators to assess pain in a nonverbal client with advanced dementia. The client scores a zero. What action by the nurse is best?
a. Assess physiologic indicators and vital signs.
b. Do not give pain medication as no pain is indicated.
c. Document the findings and continue to monitor.
d. Try a small dose of analgesic medication for pain.
ANS: A
Assessing pain in a nonverbal client is difficult despite the use of a scale specifically designed for this population. The nurse should next look at physiologic indicators of pain and vital signs for clues to the presence of pain. Even a low score on this index does not mean the client does not have pain; he or she may be holding very still to prevent more pain. Documenting pain is important but not the most important action in this case. The nurse can try a small dose of analgesia, but without having indices to monitor, it will be difficult to assess for effectiveness. However, if the client has a condition that could reasonably cause pain (i.e., recent surgery), the nurse does need to treat the client for pain.

DIF: Applying/Application REF: 34
KEY: Pain assessment| Checklist of Nonverbal Pain Indicators
MSC: Integrated Process: Nursing Process: Assessment
NOT: Client Needs Category: Physiological Integrity: Physiological Adaptation

10. A student nurse asks why several clients are getting more than one type of pain medication instead of very high doses of one medication. What response by the registered nurse is best?
a. A multimodal approach is the preferred method of control.
b. Doctors are much more liberal with pain medications now.
c. Pain is so complex it takes different approaches to control it.
d. Clients are consumers and they demand lots of pain medicine.
ANS: C
Pain is a complex phenomenon and often responds best to a regimen that uses different types of analgesia. This is called a multimodal approach. Using this terminology, however, may not be clear to the student if the terminology is not understood. Doctors may be more liberal with pain medications, but that is not the best reason for this approach. Saying that clients are consumers who demand medications sounds as if the nurse is discounting their pain experiences.

DIF: Understanding/Comprehension REF: 34
KEY: Pain| pharmacologic pain management| multimodal pain management
MSC: Integrated Process: Teaching/Learning
NOT: Client Needs Category: Physiological Adaptation: Pharmacological and Parenteral Therapies

11. A client who had surgery has extreme postoperative pain that is worsened when trying to participate in physical therapy. What intervention for pain management does the nurse include in the clients care plan?
a. As-needed pain medication after therapy
b. Client-controlled analgesia with a basal rate
c. Pain medications prior to therapy only
d. Round-the-clock analgesia with PRN analgesics
ANS: D
Severe pain related to surgery or tissue trauma is best managed with round-the-clock dosing. Breakthrough pain associated with specific procedures is managed with additional medication. An as-needed regimen will not control postoperative pain. A client-controlled analgesia pump might be a good idea but needs basal (continuous) and bolus (intermittent) settings to accomplish adequate pain control. Pain control needs to be continuous, not just administered prior to therapy.

DIF: Applying/Application REF: 34
KEY: Pharmacologic pain management| pain
MSC: Integrated Process: Nursing Process: Implementation
NOT: Client Needs Category: Physiological Integrity: Pharmacological and Parenteral Therapies

12. A nurse on the postoperative inpatient unit receives a hand-off report on four clients using patient-controlled analgesia (PCA) pumps. Which client should the nurse see first?
a. Client who appears to be sleeping soundly
b. Client with no bolus request in 6 hours
c. Client who is pressing the button every 10 minutes
d. Client with a respiratory rate of 8 breaths/min
ANS: D
Continuous delivery of opioid analgesia can lead to respiratory depression and extreme sedation. A respiratory rate of 8 breaths/min is below normal, so the nurse should first check this client. The client sleeping soundly could either be overly sedated or just comfortable and should be checked next. Pressing the button every 10 minutes indicates the client has a high level of pain, but the device has a lockout determining how often a bolus can be delivered. Therefore, the client cannot overdose. The nurse should next assess that clients pain. The client who has not needed a bolus of pain medicine in several hours has well-controlled pain.

DIF: Applying/Application REF: 35
KEY: Patient-controlled analgesia (PCA) pump| pharmacologic pain management
MSC: Integrated Process: Nursing Process: Assessment
NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

13. A registered nurse (RN) and nursing student are caring for a client who is receiving pain medication via patient-controlled analgesia (PCA). What action by the student requires the RN to intervene?
a. Assesses the clients pain level per agency policy
b. Monitors the clients respiratory rate and sedation
c. Presses the button when the client cannot reach it
d. Reinforces client teaching about using the PCA pump
ANS: C

The client is the only person who should press the PCA button. If the client cannot reach it, the student should either reposition the client or the button, and should not press the button for the client. The RN should intervene at this point. The other actions are appropriate.

DIF: Applying/Application REF: 35
KEY: Patient-controlled analgesia (PCA)| pharmacologic pain management
MSC: Integrated Process: Communication and Documentation
NOT: Client Needs Category: Safe and Effective Care Environment: Safety and Infection Control

14. A client is put on twice-daily acetaminophen (Tylenol) for osteoarthritis. What finding in the clients health history would lead the nurse to consult with the provider over the choice of medication?
a. 25pack-year smoking history
b. Drinking 3 to 5 beers a day
c. Previous peptic ulcer
d. Taking warfarin (Coumadin)
ANS: B
The major serious side effect of acetaminophen is hepatotoxicity and liver damage. Drinking 3 to 5 beers each day may indicate underlying liver disease, which should be investigated prior to taking chronic acetaminophen. The nurse should relay this information to the provider. Smoking is not related to acetaminophen side effects. Acetaminophen does not cause bleeding, so a previous peptic ulcer or taking warfarin would not be a problem.

DIF: Applying/Application REF: 35
KEY: Acetaminophen| pharmacologic pain management
MSC: Integrated Process: Communication and Documentation
NOT: Client Needs Category: Physiological Integrity: Pharmacological and Parenteral Therapies

15. A nurse is preparing to give a client ketorolac (Toradol) intravenously for pain. Which assessment findings would lead the nurse to consult with the provider?
a. Bilateral lung crackles
b. Hypoactive bowel sounds
c. Self-reported pain of 3/10
d. Urine output of 20 mL/2 hr
ANS: D
Drugs in this category can affect renal function. Clients should be adequately hydrated and demonstrate good renal function prior to administering ketorolac. A urine output of 20 mL/2 hr is well below normal, and the nurse should consult with the provider about the choice of drug. Crackles and hypoactive bowel sounds are not related. A pain report of 3 does not warrant a call to the physician. The medication may be part of a round-the-clock regimen to prevent and control pain and would still need to be given. If the medication is PRN, the nurse can ask the client if he or she still wants it.

DIF: Applying/Application REF: 37
KEY: Pharmacologic pain management| opioid analgesics| prostaglandins
MSC: Integrated Process: Communication and Documentation
NOT: Client Needs Category: Physiological Integrity: Pharmacological and Parenteral Therapies

16. A hospitalized client uses a transdermal fentanyl (Duragesic) patch for chronic pain. What action by the nurse is most important for client safety?
a. Assess and record the clients pain every 4 hours.
b. Ensure the client is eating a high-fiber diet.
c. Monitor the clients bowel function every shift.
d. Remove the old patch when applying the new one.
ANS: D
The old fentanyl patch should be removed when applying a new patch so that accidental overdose does not occur. The other actions are appropriate, but not as important for safety.

DIF: Applying/Application REF: 38
KEY: Pharmacologic pain management| opioid analgesics| transdermal patch
MSC: Integrated Process: Nursing Process: Implementation
NOT: Client Needs Category: Physiological Integrity: Pharmacological and Parenteral Therapies

17. A hospitalized client has a history of depression for which sertraline (Zoloft) is prescribed. The client also has a morphine allergy and a history of alcoholism. After surgery, several opioid analgesics are prescribed. Which one would the nurse choose?
a. Hydrocodone and acetaminophen (Lorcet)
b. Hydromorphone (Dilaudid)
c. Meperidine (Demerol)
d. Tramadol (Ultram)
ANS: B
Hydromorphone is a good alternative to morphine for moderate to severe pain. The nurse should not choose Lorcet because it contains acetaminophen (Tylenol) and the client has a history of alcoholism. Tramadol should not be used due to the potential for interactions with the clients sertraline. Meperidine is rarely used and is often restricted.

DIF: Analyzing/Analysis REF: 40
KEY: Pharmacologic pain management| opioid analgesics
MSC: Integrated Process: Nursing Process: Analysis
NOT: Client Needs Category: Physiological Integrity: Pharmacological and Parenteral Therapies

18. A client has received an opioid analgesic for pain. The nurse assesses that the client has a Pasero Scale score of 3 and a respiratory rate of 7 shallow breaths/min. The clients oxygen saturation is 87%. What action should the nurse perform first?
a. Apply oxygen at 4 L/min.
b. Attempt to arouse the client.
c. Give naloxone (Narcan).
d. Notify the Rapid Response Team.
ANS: B
The Pasero Opioid-Induced Sedation Scale is used to assess for unwanted opioid-associated sedation. A Pasero Scale score of 3 is unacceptable but is managed by trying to arouse the client in order to take deep breaths and staying with the client until he or she is more alert. Administering oxygen will not help if the clients respiratory rate is 7 breaths/min. Giving naloxone and calling for a Rapid Response Team would be appropriate for a higher Pasero Scale score.

DIF: Applying/Application REF: 44
KEY: Pasero Opioid-Induced Sedation Scale| pharmacologic pain management| opioid analgesics MSC: Integrated Process: Nursing Process: Implementation
NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

19. An older adult has diabetic neuropathy and often reports unbearable foot pain. About which medication would the nurse plan to educate the client?
a. Desipramine (Norpramin)
b. Duloxetine (Cymbalta)
c. Morphine sulfate
d. Nortriptyline (Pamelor)
ANS: B
Antidepressants and anticonvulsants often are used for neuropathic pain relief. Morphine would not be used for this client. However, older adults do not tolerate tricyclic antidepressants very well, which eliminates desipramine and nortriptyline. Duloxetine would be the best choice for this older client.

DIF: Applying/Application REF: 45
KEY: Neuropathic pain| pharmacologic pain management
MSC: Integrated Process: Nursing Process: Analysis
NOT: Client Needs Category: Physiological Integrity: Pharmacological and Parenteral Therapies

20. An emergency department (ED) manager wishes to start offering clients nonpharmacologic pain control methodologies as an adjunct to medication. Which strategy would be most successful with this client population?
a. Listening to music on a headset
b. Participating in biofeedback
c. Playing video games
d. Using guided imagery
ANS: A
Listening to music on a headset would be the most successful cognitive-behavioral pain control method for several reasons. First, in the ED, the nurse does not have time to teach clients complex modalities such as guided imagery or biofeedback. Second, clients who are anxious and in pain may not have good concentration, limiting the usefulness of video games. Playing music on a headset only requires the client to wear the headset and can be beneficial without strong concentration. A wide selection of music will make this appealing to more people.

DIF: Understanding/Comprehension REF: 47
KEY: Distraction| nonpharmacologic pain management
MSC: Integrated Process: Nursing Process: Implementation
NOT: Client Needs Category: Physiological Integrity: Basic Care and Comfort

21. An older client who lives alone is being discharged on opioid analgesics. What action by the nurse is most important?
a. Discuss the need for home health care.
b. Give the client follow-up information.
c. Provide written discharge instructions.
d. Request a home safety assessment.