Understanding the Essentials of Critical Care Nursing, 3e **(Perrin)**
Chapter 2 Care of the Critically Ill Patient

1) The nurse identifies a patient in the critical care unit as having "resiliency." What characteristic has the nurse identified in the patient?
1. Motivation to reduce anxiety through positive self-talk
2. Ability to bounce back quickly after an insult
3. Physical strength to endure extreme physical stressors
4. Ability to return to a state of equilibrium
Answer: 2
Explanation: 1. This is not a definition of resiliency.
2. The correct definition of "resiliency" is the ability to bounce back quickly after an insult. The degree of resiliency is placed along a continuum between being unable to mount a response to having strong reserves.
3. This is not a definition of resiliency.
4. This is not a definition of resiliency.
Cognitive Level: Analyzing
Client Need: Safe, Effective Care Environment
Client Need Sub: Management of Care
Nurs./Integ. Concepts: Nursing Process: Assessment
Learning Outcome: 2-1 Explain the characteristics of the critically ill patient described in the AACN Synergy Model.

2) While caring for a patient in the critical care unit, the nurse realizes that the patient's care needs must be a balance between the patient's long-term prognosis and the family's expectations of recovery. Which AACN Synergy Model characteristic does this situation describe?
1. Complexity
2. Predictability
3. Participation in care
4. Resource availability
Answer: 1
Explanation: 1. This situation describes the characteristic of complexity, which is the intricate entanglement of two or more systems (for example, a patient's illness with complex family dynamics).
2. Predictability is a characteristic that allows one to predict a certain course of events or course of illness.
3. Participation in care is the extent to which patient and/or family engage in care.
4. Resource availability is the extent of resources the patient, family, and community bring to the situation.
Cognitive Level: Analyzing
Client Need: Health Promotion and Maintenance
Nurs./Integ. Concepts: Nursing Process: Assessment
Learning Outcome: 2-1 Explain the characteristics of the critically ill patient described in the AACN Synergy Model.

3) The nurse realizes that which stressor is one of the primary concerns of critically ill patients and should be routinely included during assessments?
1. Inability to control elimination
2. Lack of family support
3. Hunger
4. Altered ability to communicate
Answer: 4
Explanation: 1. The inability to control elimination is not identified as a primary concern of critically ill patients.
2. Lack of family support is not identified as a primary concern of critically ill patients.
3. Hunger is not identified as a primary concern of critically ill patients.
4. Altered ability to communicate is identified as a primary concern of critically ill patients.
Cognitive Level: Applying
Client Need: Psychosocial Integrity
Nurs./Integ. Concepts: Nursing Process: Assessment
Learning Outcome: 2-2 Plan nursing responses to the concerns most commonly expressed by critically ill patients.

4) A patient has just completed a preoperative education session prior to undergoing coronary artery bypass surgery. Which patient statements indicate that teaching has been effective? Select all that apply.
Note: Credit will be given only if all correct choices and no incorrect choices are selected.
1. "I understand that I will have to blink my eyes to respond after the breathing tube is in my throat."
2. "I will be given frequent mouth care to help me when I am thirsty."
3. "I will be able to move about freely in bed and into the chair without help while connected to the electronic equipment for monitoring."
4. "I may need something to help me rest due to the unfamiliar lights and sounds of the ICU unit."
5. "I might not behave like my usual self after the surgery, but it will be because of the medications and my illness."
Answer: 1, 2, 4, 5
Explanation: 1. An alternate method of communication discussed in advance of tube placement will assist in better communication after the tube is inserted to aid the breathing process.
2. While intubated, oral hygiene is needed to prevent mucosal drying due to the inability of the patient to take oral fluids.
3. This statement indicates that additional teaching is required because the patient will not be able to move freely in bed and into a chair without assistance while being electronically monitored.
4. Due to environmental lights, sounds, and difference in sleeping environment, additional aids, such as drug management, may be needed to assist the patient to rest at night.
5. A patient concern in the critical care area is the inability to control self. This statement indicates the patient's understanding of the teaching.
Cognitive Level: Analyzing
Client Need: Safe, Effective Care Environment
Client Need Sub: Management of Care
Nurs./Integ. Concepts: Nursing Process: Evaluation
Learning Outcome: 2-2 Plan nursing responses to the concerns most commonly expressed by critically ill patients.

5) When providing care to critically ill patients, whether they are responsive or unresponsive, what should the nurse do?
1. Clearly explain what care is to be done before starting the activity.
2. Perform the activity and then let the patient rest without explaining the care.
3. Make sure the patient always responds and is cooperative before giving care.
4. Explain to the family that the patient will not understand or remember any of the discomfort associated with care.
Answer: 1
Explanation: 1. By explaining to both the responsive and unresponsive patient, the nurse provides orientation, reassurance, respect, and assessment of the patient's mental status. Seeking permission and apologizing if discomfort is involved will also minimize the stress of the critically ill patient by allowing the patient to hear what is about to occur. Even the unresponsive patient has been known to explain procedures, conversations, and feelings once he or she has awakened.
2. If the patient is not informed, autonomy and the right to choose have been violated; in addition, the stress of the unknown may be perceived incorrectly by the patient as an assault.
3. Some unresponsive patients will never respond; therefore, the care would not be performed as needed. Cooperation is also not possible in some cases whereby the patient has altered thinking. Although the nurse desires these, the care should not be stopped just because they cannot be obtained. Explaining should still be done, and the care should proceed as needed.
4. The nurse cannot always reassure the family that the patient will not remember.
Cognitive Level: Applying
Client Need: Psychosocial Integrity
Nurs./Integ. Concepts: Nursing Process: Implementation
Learning Outcome: 2-3 Describe nursing actions to meet some of the basic physiologic needs of critically ill patients.

6) Which communication strategy should the critical care nurse use when communicating with a ventilated patient?
1. Use professional terminology and provide the patient with detailed information.
2. Use simple language and explain in other terms if the patient does not seem to understand.
3. Provide minimal information so the patient is not overwhelmed.
4. Discuss issues primarily with the family because the patient is unlikely to understand the information.
Answer: 2
Explanation: 1. Individuals who are not familiar with health care often do not understand professional language. Confusion and a lack of understanding often result if the information is presented only with professional terminology.
2. Simple layman's language of information is better understood, and repeating or rephrasing gives the patient a better understanding when in a stressful situation.
3. Minimal disclosure of information will increase the stress of the patient by increasing confusion and concerns from the lack of understanding about the illness or treatment process. Complete disclosure is the right of the patient and the obligation of health care professionals.
4. Disclosing information or communicating only with the patient's family denies the patient the right of choice and the respect or dignity expected. Legally and ethically, except under very specific restrictions, the patient has a right to know, and it is the health care professional's responsibility to explain clearly for informed consent to occur.
Cognitive Level: Applying
Client Need: Psychosocial Integrity
Nurs./Integ. Concepts: Nursing Process: Implementation
Learning Outcome: 2-3 Describe nursing actions to meet some of the basic physiologic needs of critically ill patients.

7) During an assessment, a ventilated patient begins to frown and wiggle about in bed. Which assessment strategy would be most helpful for the nurse to validate these observations?
1. Glasgow Scale
2. Maslow's hierarchy levels
3. Critical-Care Pain Observation Tool (CPOT)
4. Vital signs trends
Answer: 3
Explanation: 1. The Glasgow Coma Scale will identify the level of consciousness present to evaluate the sedation level that is used with patients who are intubated. But this scale does not identify the source of the problem that has increased the patient's facial changes or movement.
2. Maslow's hierarchy of needs prioritizes needs based on essential to higher-level functions in the body; it would not help identify the source of the changes noted in the patient.
3. The CPOT pain scale will identify if pain is present and the degree of effectiveness of drug management in a patient who cannot speak due to intubation.
4. Vital signs might tell the nurse that a change has occurred, but they do not indicate the source of the discomfort or problem.
Cognitive Level: Applying
Client Need: Physiological Integrity
Client Need Sub: Reduction of Risk Potential
Nurs./Integ. Concepts: Nursing Process: Assessment
Learning Outcome: 2-3 Describe nursing actions to meet some of the basic physiologic needs of critically ill patients.

8) Which parameter indicates that a patient in the intensive care unit being mechanically ventilated is ready for an interruption in sedation? Select all that apply.
Note: Credit will be given only if all correct choices and no incorrect choices are selected.
1. MAP of 75 and heart rate of 76
2. Awakens with verbal stimuli
3. Frowns when turned but otherwise shows no muscular tension
4. Activates the ventilator alarms, but the alarms stopped spontaneously
5. Receives neuromuscular blocking agents to ensure adequate ventilation
Answer: 1, 2, 3, 4
Explanation: 1. Hemodynamic stability is one criterion that indicates daily weaning of sedatives should be automatically attempted.
2. Awakening with verbal stimuli indicates that daily weaning of sedatives should be attempted.
3. Control of pain is an indication that daily weaning of sedatives should be attempted.
4. Patient-ventilator synchrony is an indication that daily weaning of sedatives should be attempted.
5. Receiving neuromuscular blocking agents indicates that daily weaning of sedatives should *not* be attempted.
Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub: Pharmacological and Parenteral Therapies
Nurs./Integ. Concepts: Nursing Process: Assessment
Learning Outcome: 2-3 Describe nursing actions to meet some of the basic physiologic needs of critically ill patients.

9) A patient scores positive on the Confusion Assessment Method of the Intensive Care Unit (CAM-ICU). Which nursing diagnosis would have the highest priority based on this positive score?
1. Injury, Risk for
2. Family Processes, Altered
3. Social Interaction, Impaired
4. Memory Impaired
Answer: 1
Explanation: 1. Injury falls into the safety/security level, which is the highest priority according to Maslow's hierarchy of needs.
2. This nursing diagnosis would not be a priority for the patient in the intensive care unit.
3. This nursing diagnosis would not be a priority for the patient in the intensive care unit.
4. This nursing diagnosis would not be a priority for the patient in the intensive care unit.
Cognitive Level: Analyzing
Client Need: Safe, Effective Care Environment
Client Need Sub: Management of Care
Nurs./Integ. Concepts: Nursing Process: Diagnosis
Learning Outcome: 2-3 Describe nursing actions to meet some of the basic physiologic needs of critically ill patients.

10) Which nursing action would be appropriate when the nurse initiates an infusion of morphine sulfate for a post-operative patient who is experiencing pain?
1. Anticipate that the patient will begin to experience the effect of the morphine 15 minutes after the start of the infusion.
2. Provide additional intermittent boluses of morphine sulfate if the patient experiences breakthrough pain.
3. Complete the Critical-Care Pain Observation Tool scale 5 minutes after increasing the infusion rate each time.
4. Begin the infusion at the lowest ordered dose, and increase the rate every 30 minutes if the patient continues to have pain.
Answer: 2
Explanation: 1. The desired effects should become apparent 5 minutes after intravenous administration.
2. A critically ill patient will often receive an IV bolus of an analgesic followed by an ongoing infusion of the pain medication with intermittent boluses and increases in infusion until the drug attains steady state and the patient experiences pain relief.
3. Assessing the patient 5 minutes after increasing the infusion rate each time might be too soon to assess for pain control.
4. When IV infusion rates are repeatedly increased versus the administration of intermittent boluses as a means of responding to acute pain, the risk for excessive analgesia dosing exists.
Cognitive Level: Applying
Client Need: Physiological Integrity
Client Need Sub: Pharmacological and Parenteral Therapies
Nurs./Integ. Concepts: Nursing Process: Implementation
Learning Outcome: 2-3 Describe nursing actions to meet some of the basic physiologic needs of critically ill patients.

11) Which strategies should the nurse include in the plan of care when trying to minimize sleep disruptions for a patient in an ICU?
Select all that apply.
Note: Credit will be given only if all correct choices and no incorrect choices are selected.
1. Instituting a short course of therapy for sleeping agents
2. Accurate scoring and vigilance in sedation and sedation scoring
3. Managing the environment to reduce lighting and sound
4. Minimizing staff interruptions during sleep periods
5. Scheduling treatments only during the day or at least 4 hours apart at night
Answer: 1, 2, 3, 4
Explanation: 1. This is a strategy to minimize interruptions of sleep and to maximize the rest benefits that will shorten the duration of care based on research findings.
2. This is a strategy to minimize interruptions of sleep and to maximize the rest benefits that will shorten the duration of care based on research findings.
3. This is a strategy to minimize interruptions of sleep and to maximize the rest benefits that will shorten the duration of care based on research findings.
4. This is a strategy to minimize interruptions of sleep and to maximize the rest benefits that will shorten the duration of care based on research findings.
5. Planning the care for only the day hours or at least 4 hours is not practical to improve the outcomes of the patient, because some medications, therapies, and assessments need to be made around the clock for the greatest benefits to occur. The minimum time for resting that is suggested is to not interrupt less than 2 to 3 hours of sleep in order to minimize sleep fragmentation and improve restful sleep.
Cognitive Level: Applying
Client Need: Psychosocial Integrity
Nurs./Integ. Concepts: Nursing Process: Planning
Learning Outcome: 2-3 Describe nursing actions to meet some of the basic physiologic needs of critically ill patients.

12) The nurse confirms medication orders and the schedule to administer a sedative to a patient with delirium. Which dosing schedule maximizes the effectiveness of the drugs?
1. Only in the early morning
2. Only at bedtime (HS)
3. Around the clock with higher dosages in the evening
4. Only on an as-needed (PRN) basis
Answer: 3
Explanation: 1. This schedule would not control the condition equally throughout the 24-hour period.
2. This schedule would not control the condition equally throughout the 24-hour period.
3. Timing medication given around the clock with a greater dosage in the evening will match the symptom of sundowning, when the symptoms appear the greatest later in the day.
4. This schedule would not control the condition equally throughout the 24-hour period.
Cognitive Level: Applying
Client Need: Physiological Integrity
Client Need Sub: Pharmacological and Parenteral Therapies
Nurs./Integ. Concepts: Nursing Process: Planning
Learning Outcome: 2-3 Describe nursing actions to meet some of the basic physiologic needs of critically ill patients.

13) The charge nurse reviews information about patients received during morning report. Which patient is at risk for nutritional imbalances? Select all that apply.
Note: Credit will be given only if all correct choices and no incorrect choices are selected.
1. Client recovering from a myocardial infarction
2. Client receiving hemodialysis treatments 3 times a week
3. Client with slightly elevated liver enzymes
4. Client who is intubated for respiratory failure
5. Client recovering from extensive burns
Answer: 1, 2, 4, 5
Explanation: 1. This patient is at risk for nutritional imbalances.
2. This patient is at risk for nutritional imbalances.
3. Although the liver does filter and alter the breakdown of drugs, nutrition is rarely modified just for slightly elevated liver enzymes. Severe liver damage or failure will result in restrictions of alcohol and fatty foods, and an increase of protein may be needed.
4. This patient is at risk for nutritional imbalances.
5. This patient is at risk for nutritional imbalances.
Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub: Reduction of Risk Potential
Nurs./Integ. Concepts: Nursing Process: Assessment
Learning Outcome: 2-3 Describe nursing actions to meet some of the basic physiologic needs of critically ill patients.

14) Members of the multidisciplinary care team review a patient's nutritional status and analyze assessment values. Which value would need additional investigation?
1. A serum albumin of more than 3.5 g/dL or 35 g/L
2. A weight increase of 1.5 kg in a day
3. A serum hemoglobin of 11.7 g/dL or 117 mmol/L
4. A prealbumin level of 35 mg/dL
Answer: 2
Explanation: 1. This value would not need additional investigation.
2. A weight change of 1.5 kg (approximately 3.3 lb) reflects approximately 1.5 L of fluid. Additional assessment needs to be done to evaluate the cause and risks.
3. This value is at the lower end of normal levels for an adult patient and would not need additional investigation.
4. This value would not need additional investigation.
Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub: Reduction of Risk Potential
Nurs./Integ. Concepts: Nursing Process: Evaluation
Learning Outcome: 2-3 Describe nursing actions to meet some of the basic physiologic needs of critically ill patients.

15) The nurse inserts a nasogastric tube and plans to confirm placement of the tube prior to starting enteral feedings. Which is the most accurate method for confirming tube placement?
1. Obtaining a radiological x-ray of the abdomen
2. Checking gastric aspirate for a pH of less than 7
3. Instilling 30 mL of air while listening with a stethoscope when placed over the fundus of the stomach
4. Determining the presence of carbon dioxide
Answer: 1
Explanation: 1. The appropriate method for identifying placement of the feeding tube in the stomach is visualizing the tube in the stomach on an abdominal x-ray.
2. This is not the appropriate method for identifying placement of the feeding tube in the stomach.
3. This is not the appropriate method for identifying placement of the feeding tube in the stomach.
4. This is not the appropriate method for identifying placement of the feeding tube in the stomach.
Cognitive Level: Applying
Client Need: Physiological Integrity
Client Need Sub: Reduction of Risk Potential
Nurs./Integ. Concepts: Nursing Process: Planning
Learning Outcome: 2-3 Describe nursing actions to meet some of the basic physiologic needs of critically ill patients.

16) Which nursing diagnosis should receive the highest priority when caring for a patient who is receiving total parenteral nutrition?
1. Infection, Risk for
2. Trauma, Risk for
3. Skin Integrity, Impaired
4. Fluid Volume, Risk for Imbalance
Answer: 1
Explanation: 1. The risk for infection is the greatest risk for the patient receiving parenteral nutrition due to the high glucose present, the central vein access route, and the declining nutritional status that the patient is in when this therapy is started.
2. Avoiding trauma at the site or other parts of the body should be routinely done to "do no harm" and avoid injury where possible. However, this is not the greatest risk for the patient receiving parenteral nutrition.
3. Skin integrity will be impaired due to poor nutritional intake, but preventive measures can be done to decrease the risk. This is not the greatest risk for the patient receiving parenteral nutrition.
4. Fluid volume imbalances are minimized by accurate regulators to limit fluid overload or to run at the appropriate rate to provide the essential nutrition needed. This is not the greatest risk for the patient receiving parenteral nutrition.
Cognitive Level: Applying
Client Need: Physiological Integrity
Client Need Sub: Physiological Adaptation
Nurs./Integ. Concepts: Nursing Process: Diagnosis
Learning Outcome: 2-3 Describe nursing actions to meet some of the basic physiologic needs of critically ill patients.

17) What should the nurse do to meet the needs of the critically ill patient's family members? Select all that apply.
Note: Credit will be given only if all correct choices and no incorrect choices are selected.
1. Express an attitude of hope, honesty, open communication, and caring
2. State specific facts about the patient's condition in a timely manner
3. Plan regular times for family visits throughout the day
4. Limit the number of visitors to significant others
5. Communicate to a single family member to cut down time wasted repeating information to all visitors
Answer: 1, 2, 3
Explanation: 1. This is an appropriate approach when meeting the family needs of the critically ill patient.
2. This is an appropriate approach when meeting the family needs of the critically ill patient.
3. This is an appropriate approach when meeting the family needs of the critically ill patient.
4. Although some number limitations are needed, the persons are not to be screened by staff. If the patient wants the visitor to come in, then the visit will be therapeutic for the patient. If the visitor (family or friend) increases problems with the patient, then the visitor should be restricted access until the condition improves.
5. Although communicating with a single person will minimize the repeating of information, a core group of individuals can be used to distribute information to other family members, particularly if a large population is present. Therefore, restricting to one person is too limiting, but a minimal core group can be helpful in other situations, especially if the nurse is needed at the bedside. A case manager, clergy, or staff support person could also be used to pass on information when the nursing staff is too busy caring for the patient.
Cognitive Level: Applying
Client Need: Psychosocial Integrity
Nurs./Integ. Concepts: Nursing Process: Implementation
Learning Outcome: 2-4 Discuss ways to identify and meet the needs of families of critically ill patients.

18) Which statement describing the needs of family members of critically ill patients has yet to be validated by research?
1. "Not knowing is the worst part" of waiting.
2. Families in the waiting room have no effect on patient outcomes.
3. "Hovering" in the proximity phase is characterized by confusion and tension.
4. A unified message from staff minimizes family stressors.
Answer: 2
Explanation: 1. This statement is supported by research and is accurate to the findings about the family needs of the critically ill patient.
2. This is an incorrect statement that is not supported by research. In fact, family support has been proven to improve clinical outcomes.
3. This statement is supported by research.
4. This statement is supported by research.
Cognitive Level: Analyzing
Client Need: Psychosocial Integrity
Nurs./Integ. Concepts: Nursing Process: Evaluation
Learning Outcome: 2-4 Discuss ways to identify and meet the needs of families of critically ill patients.

19) The nurse addresses the family needs of a critically ill patient. Which family need was not identified?
1. Proximity
2. Information
3. Assurance
4. Timeliness
Answer: 4
Explanation: 1. This need is identified in Leske's research findings.
2. This need is identified in Leske's research findings.
3. This need is identified in Leske's research findings.
4. Timeliness is not a need identified in Leske's research findings.
Cognitive Level: Understanding
Client Need: Psychosocial Integrity
Nurs./Integ. Concepts: Nursing Process: Implementation
Learning Outcome: 2-4 Discuss ways to identify and meet the needs of families of critically ill patients.

20) When planning care to meet the needs of families of critically ill patients, the nurse should include which strategies by Miracle (2006)? Select all that apply.
Note: Credit will be given only if all correct choices and no incorrect choices are selected.
1. Information about how to contact the primary doctor if needed
2. Frequent verbal communication to clarify the purpose of unit, equipment, procedures, waiting areas, phones, and so on
3. Regular family conferences to meet patient goals and progress
4. A consistent nurse, and unified staff responses if that nurse is not available
5. A way to contact family through a specific family member by phone if needed
Answer: 1, 3, 4
Explanation: 1. This is a strategy to minimize stress and maximize communication to meet the family needs of the critically ill patient.
2. Written communication, pamphlets, rules, and regulations are better received and retained than verbal instructions. Written communications can be reread and clearly understood as a cross-reference by the family during the stressful period of waiting for their patient's recovery. Frequently repeating information is better for retention but often is a waste of the nurse's time for basic information that remains the same for all patients. Printing information allows the nurse to give more information about the patient's condition rather than focusing on basic rules and regulations.
3. This is a strategy to minimize stress and maximize communication to meet the family needs of the critically ill patient.
4. This is a strategy to minimize stress and maximize communication to meet the family needs of the critically ill patient.
5. This is not a strategy to minimize stress and maximize communication to meet the family needs of the critically ill patient.
Cognitive Level: Applying
Client Need: Psychosocial Integrity
Nurs./Integ. Concepts: Nursing Process: Planning
Learning Outcome: 2-4 Discuss ways to identify and meet the needs of families of critically ill patients.

21) A physician suggests that a patient being mechanically ventilated, needing immediate transport to CT scan, and having severe pain be given IV fentanyl (Sublimaze) rather than morphine sulfate for pain management. Why is fentanyl (Sublimaze) preferred?
1. Rapid administration does not have any hemodynamic consequences.
2. It has a more rapid onset and a shorter duration of action.
3. Weaning of a continuous infusion is never needed due to its short half-life.
4. It is not likely to cause respiratory depression.
Answer: 2
Explanation: 1. The blood pressure, respiratory rate, and heart rate should be monitored frequently when providing this medication.
2. Fentanyl is 100 times more potent than morphine. It has a faster onset of action than morphine and a shorter duration of action.
3. Standard weaning protocols will be followed with this medication.
4. Respiratory rate is to be monitored when providing this medication.
Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub: Pharmacological and Parenteral Therapies
Nurs./Integ. Concepts: Nursing Process: Planning
Learning Outcome: 2-3 Describe nursing actions to meet some of the basic physiologic needs of critically ill patients.

22) A patient being mechanically ventilated receives midazolam (Versed) for sedation. What findings indicate to the nurse that the patient is receiving an appropriate dose of this medication?
1. Awake with a respiratory rate of 38 and a heart rate of 132
2. Asleep but withdrawing from noxious stimuli with a heart rate of 80
3. Awake with a heart rate of 124 and attempting to pull out the IV
4. Asleep but awakening to light touch with a heart rate of 72
Answer: 4
Explanation: 1. These findings would not indicate appropriate sedation.
2. These findings would not indicate appropriate sedation.
3. These findings would not indicate appropriate sedation.
4. These findings indicate appropriate sedation.
Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub: Pharmacological and Parenteral Therapies
Nurs./Integ. Concepts: Nursing Process: Evaluation
Learning Outcome: 2-3 Describe nursing actions to meet some of the basic physiologic needs of critically ill patients.

23) The nurse cares for a patient recovering from surgery who is being mechanically ventilated and experiencing pain. Which approach should the nurse use first to assess this patient's pain?
1. Attempt an analgesic trial
2. Ask the patient if he or she is in pain
3. Observe the patient's face for grimacing
4. Ask a family member if the patient is in pain
Answer: 2
Explanation: 1. The nurse should not provide an analgesic without assessing for pain first.
2. If the patient is responsive, the nurse should ask the patient about presence of pain.
3. This could be done if the patient is not responsive.
4. This can be done; however, it is not the first method that the nurse would use to assess the patient's pain level.
Cognitive Level: Applying
Client Need: Physiological Integrity
Client Need Sub: Physiological Adaptation
Nurs./Integ. Concepts: Nursing Process: Assessment
Learning Outcome: 2-3 Describe nursing actions to meet some of the basic physiologic needs of critically ill patients.

24) The nurse administers haloperidol (Haldol) via IV push to a patient experiencing delirium. What is most important for the nurse to monitor in this patient?
1. Heart rate
2. QT interval
3. PR interval
4. Respiratory rate
Answer: 2
Explanation: 1. This is not the most important for the nurse to monitor.
2. The patient needs to be monitored for adverse effects as QT prolongation and dysrhythmias (torsades de pointes), which can result in sudden death, especially if the drug is administered via IV push.
3. This is not the most important for the nurse to monitor.
4. This is not the most important for the nurse to monitor.
Cognitive Level: Applying
Client Need: Physiological Integrity
Client Need Sub: Pharmacological and Parenteral Therapies
Nurs./Integ. Concepts: Nursing Process: Assessment
Learning Outcome: 2-3 Describe nursing actions to meet some of the basic physiologic needs of critically ill patients.

25) The nurse assesses a critically ill patient utilizing the AACN Synergy Model's characteristics. Which characteristics are identified as impacting the outcome of a critically ill patient? Select all that apply.
Note: Credit will be given only if all correct choices and no incorrect choices are selected.
1. Participation in care
2. Resource availability
3. Stability
4. Complexity
5. Level of consciousness
Answer: 1, 2, 3, 4
Explanation: 1. This is a characteristic identified by the Synergy Model.
2. This is a characteristic identified by the Synergy Model.
3. This is a characteristic identified by the Synergy Model.
4. This is a characteristic identified by the Synergy Model.
5. This is not a characteristic identified by the Synergy Model.
Cognitive Level: Understanding
Client Need: Physiological Integrity
Client Need Sub: Reduction of Risk Potential
Nurs./Integ. Concepts: Nursing Process: Assessment
Learning Outcome: 2-1 Explain the characteristics of the critically ill patient described in the AACN Synergy Model.

26) The nurse plans care for a critically ill patient. What should the nurse include to address the patient's major areas of concern? Select all that apply.
Note: Credit will be given only if all correct choices and no incorrect choices are selected.
1. Explain the purpose of the tube in the nose.
2. Explain the purpose of the tube in the mouth.
3. Determine a method of communication.
4. Explain the purpose of the intravenous tubes.
5. Ensure that the room lights will be turned off and alarms set to low volume.
Answer: 1, 2, 3, 4
Explanation: 1. This is considered a stressor for the patient in intensive care and should be addressed by the nurse.
2. This is considered a stressor for the patient in intensive care and should be addressed by the nurse.
3. This is considered a stressor for the patient in intensive care and should be addressed by the nurse.
4. This is considered a stressor for the patient in intensive care and should be addressed by the nurse.
5. This is not considered a stressor for the patient in intensive care and does not need to be addressed by the nurse.
Cognitive Level: Applying
Client Need: Psychosocial Integrity
Nurs./Integ. Concepts: Nursing Process: Planning
Learning Outcome: 2-2 Plan nursing responses to the concerns most commonly expressed by critically ill patients.

27) The nurse providing care to a patient who is unresponsive and being mechanically ventilated uses unintentional distractions. What is the nurse doing when providing care? Select all that apply.
Note: Credit will be given only if all correct choices and no incorrect choices are selected.
1. Singing
2. Humming
3. Joking
4. Talking to a colleague
5. Apologizing for causing pain
Answer: 1, 2, 3
Explanation: 1. This is an unintentional distraction.
2. This is an unintentional distraction.
3. This is an unintentional distraction.
4. This could cause the patient distress and should not be done.
5. This is not an unintentional distraction.
Cognitive Level: Applying
Client Need: Psychosocial Integrity
Nurs./Integ. Concepts: Nursing Process: Implementation
Learning Outcome: 2-3 Describe nursing actions to meet some of the basic physiologic needs of critically ill patients.

28) What strategies should the nurse use to communicate with an older adult patient who is intubated and being mechanically ventilated? Select all that apply.
Note: Credit will be given only if all correct choices and no incorrect choices are selected.
1. Make sure the patient is wearing eyeglasses.
2. Speak slowly.
3. Decide on which gestures mean "yes" and "no."
4. Have questions and possible answers ready so the patient can point to the response.
5. Ask several questions at a time to limit interruptions in rest periods.
Answer: 1, 2, 3, 4
Explanation: 1. This will maximize communication with the older patient.
2. This will maximize communication with the older patient.
3. This will maximize communication with the older patient.
4. This will maximize communication with the older patient.
5. This will not maximize communication with the older patient.
Cognitive Level: Applying
Client Need: Psychosocial Integrity
Nurs./Integ. Concepts: Nursing Process: Implementation
Learning Outcome: 2-3 Describe nursing actions to meet some of the basic physiologic needs of critically ill patients.

29) A patient in the critical care unit demonstrates increasing agitation. What should the nurse use to assess this patient's agitation level? Select all that apply.
Note: Credit will be given only if all correct choices and no incorrect choices are selected.
1. Sedation Assessment Scale (SAS)
2. Richmond Agitation-Sedation Scale (RASS)
3. Glasgow Scale
4. Reaction Level Scale
5. Ventilator Adjusted Motor Assessment Scoring Scale
Answer: 1, 2
Explanation: 1. This scale is commonly used to assess for agitation.
2. This scale is commonly used to assess for agitation.
3. This scale is not used to assess for agitation.
4. This scale is not used to assess for agitation.
5. This scale is not used to assess for agitation.
Cognitive Level: Applying
Client Need: Psychosocial Integrity
Nurs./Integ. Concepts: Nursing Process: Assessment
Learning Outcome: 2-3 Describe nursing actions to meet some of the basic physiologic needs of critically ill patients.

30) The nurse plans to use music therapy to help reduce a critically ill patient's level of anxiety. What should the nurse do when using this complementary and alternative therapy? Select all that apply.
Note: Credit will be given only if all correct choices and no incorrect choices are selected.
1. Ask family members to identify the patient's preferred music.
2. Plan for the music to be played for 30 uninterrupted minutes.
3. Listen to the music in advance to make sure it does not have lyrics.
4. Ensure that the music beats are between 60 to 80 per minute.
5. Play the music from a CD player on the bedside table.
Answer: 1, 2, 3, 4
Explanation: 1. The patient's preferred music should be used.
2. Evidence-based music therapy calls for a critically ill patient to listen to at least 30 minutes of music.
3. It is most beneficial if the music is without words.
4. It is most beneficial if the music is approximately 60 to 80 beats per minute.
5. The music should be provided through headphones.
Cognitive Level: Applying
Client Need: Psychosocial Integrity
Nurs./Integ. Concepts: Nursing Process: Implementation
Learning Outcome: 2-3 Describe nursing actions to meet some of the basic physiologic needs of critically ill patients.

31) The nurse assesses the nutritional needs of a patient in the intensive care unit. What information is essential for the nurse to obtain during this assessment? Select all that apply.
Note: Credit will be given only if all correct choices and no incorrect choices are selected.
1. Patient's current height and weight
2. Food allergies
3. Use of nutritional supplements
4. If the patient can swallow
5. Amount of water consumed each day
Answer: 1, 2, 3, 4
Explanation: 1. This information is essential for the nurse to obtain.
2. This information is essential for the nurse to obtain.
3. This information is essential for the nurse to obtain.
4. This information is essential for the nurse to obtain.
5. This information is not essential for the nurse to obtain.
Cognitive Level: Applying
Client Need: Physiological Integrity
Client Need Sub: Basic Care and Comfort
Nurs./Integ. Concepts: Nursing Process: Assessment
Learning Outcome: 2-3 Describe nursing actions to meet some of the basic physiologic needs of critically ill patients.

32) The nurse is a member of a committee that is designing improvements to the critical care waiting areas. What improvements should the nurse suggest to enhance the comfort of family members of critical care patients? Select all that apply.
Note: Credit will be given only if all correct choices and no incorrect choices are selected.
1. Plan for a large space to be used for the waiting areas.
2. Provide coffee and soft drinks in the waiting area.
3. Place televisions and DVD players in the waiting area.
4. Find space for sleeping rooms.
5. Use dark paint and minimal lighting in the waiting areas.
Answer: 1, 2, 3, 4
Explanation: 1. A larger area that is less cramped would enhance the comfort of families of critical care patients.
2. Providing coffee and soft drinks in the waiting area would enhance the comfort of families of critical care patients.
3. Placing television and DVD players in the waiting areas would enhance the comfort of families of critical care patients.
4. Finding space for sleeping rooms would enhance the comfort of families of critical care patients.
5. Using dark paint and minimal lighting in the waiting areas would not enhance the comfort of families of critical care patients.
Cognitive Level: Applying
Client Need: Psychosocial Integrity
Nurs./Integ. Concepts: Nursing Process: Implementation
Learning Outcome: 2-4 Discuss ways to identify and meet the needs of families of critically ill patients.

33) The nurse uses the Synergy Model patient characteristics to plan care for a patient in the intensive care area. Which observations indicate that these actions were effective? Select all that apply.
Note: Credit will be given only if all correct choices and no incorrect choices are selected.
1. Patient extubated two days earlier than expected
2. Patient expresses dissatisfaction with morning care
3. Patient states that he or she is feeling better and is eager to return home
4. Patient thanks the nursing staff for help with basic care needs
5. Patient rests between procedures and medication administration
Answer: 1, 3, 4, 5
Explanation: 1. Healing is a positive outcome that indicates the Synergy Model characteristics have been met.
2. Expressing dissatisfaction with care indicates that the Synergy Model characteristics have not been met.
3. Feeling better and eager to return home indicates that the Synergy Model characteristics have been met.
4. Expressing satisfaction with care indicates that the Synergy Model characteristics have been met.
5. Being comfortable indicates that the Synergy Model characteristics have been met.
Cognitive Level: Analyzing
Client Need: Safe, Effective Care Environment
Client Need Sub: Management of Care
Nurs./Integ. Concepts: Nursing Process: Evaluation
Learning Outcome: 2-1 Explain the characteristics of the critically ill patient described in the AACN Synergy Model.

34) A critically ill patient is prescribed enteral feedings to begin after placement of the nasogastric tube is verified. What should the nurse identify as the goal for this method of nutrition?
1. Prevent infection
2. Avoid aspiration pneumonia
3. Enhance respiratory excursion
4. Reduce the need for pain medication
Answer: 1
Explanation: 1. Enteral feeding is the preferred route for nutritional supplementation because it is associated with significantly lower rates of infection than parenteral nutrition. This lower infection rate may occur because enteral feeding prevents translocation of bacteria from the GI tract, which can occur when the GI tract is inactive. The recommendation to start feeding early, at 24 to 48 hours after admission, is not only to provide adequate nutrition immediately but also to decrease the likelihood of infection.
2. A potential adverse effect of enteral feedings is aspiration pneumonia. Starting the feedings early will not avoid the development of this potential adverse effect.
3. Enteral feedings do not directly impact respiratory excursion.
4. Enteral feedings do not impact or influence pain level.
Cognitive Level: Applying
Client Need: Safe, Effective Care Environment
Client Need Sub: Safety and Infection Control
Nurs./Integ. Concepts: Nursing Process: Planning
Learning Outcome: 2-2 Plan nursing responses to the concerns most commonly expressed by critically ill patients.

35) A newly admitted patient receiving sedation is prescribed parenteral nutrition via a central line. Which action should the nurse take to prevent overfeeding of this patient?
1. Monitor daily weights
2. Use an infusion pump
3. Evaluate albumin levels
4. Question the order to infuse lipids
Answer: 4
Explanation: 1. Daily weights are used to evaluate fluid balance. Although a patient who is overfed may have a weight gain, a change in daily weights would not reflect an actual body weight change caused by too many calories.
2. The use of an infusion pump would ensure that the solution is being provided at the prescribed rate to maintain fluid balance.
3. An albumin level evaluates protein status. This laboratory value does not help determine if the patient is being overfed.
4. Due to the high concentration of glucose and lipids, overfeeding can occur with parenteral nutrition. Patients who are receiving propofol for sedation should not receive lipids in their parenteral nutrition during the first week of hospitalization.
Cognitive Level: Applying
Client Need: Safe, Effective Care Environment
Client Need Sub: Safety and Infection Control
Nurs./Integ. Concepts: Nursing Process: Planning
Learning Outcome: 2-3 Describe nursing actions to meet some of the basic physiologic needs of critically ill patients.

36) Weekly group meetings are scheduled every Wednesday afternoon for the families of current intensive care patients. What should the nurse prepare in anticipation of the next meeting?
1. Visiting hours for the unit
2. Location of the waiting area
3. Equipment and treatments the patients receive
4. The schedule of when to telephone for patient status updates
Answer: 3
Explanation: 1. Visiting hours for the unit would be considered informational material.
2. Location of the waiting area would be considered informational material.
3. Weekly family group meetings help improve communication with the families of critically ill patients. Content of these meetings can include equipment in the care area along with the types of treatments the patient will be receiving.
4. Providing a schedule of the best times to telephone for patient status updates would not meet the families' communication needs. Waiting for news about the patient is time consuming and anxiety provoking for families. Family members might not be able to telephone the care area according to the schedule, which could increase anxiety.
Cognitive Level: Applying
Client Need: Psychosocial Integrity
Nurs./Integ. Concepts: Nursing Process: Planning
Learning Outcome: 2-4 Discuss ways to identify and meet the needs of families of critically ill patients.