# HESI PN COMPREHENSIVE PREDICTOR EXAM

1. The nurse is caring for a patient to ease modifiable factors that contribute to pain. Which areas did the nurse focus on with this patient?

a. Age and gender

b. Anxiety and fear

c. Culture and ethnicity

d. Previous pain experiences and cognitive abilities

ANS: B

Some examples of modifiable contributors to pain are anxiety and fear. The nurse can take measures to ease the patient's anxiety and fear related to pain. Age, gender, culture, ethnicity, cognitive abilities, and previous pain experience are all nonmodifiable factors that the nurse can help the patient to understand, but the nurse cannot alter them.

2. The nurse is evaluating the effectiveness of guided imagery for pain management as used for a patient who has second- and third-degree burns and needs extensive dressing changes. Which finding **best** indicates the effectiveness of guided imagery?

a. The patient's facial expressions are stoic during the procedure.

b. The patient rates pain during the dressing change as a 6 on a scale of 0 to 10.

c. The patient's need for analgesic medication decreases during the dressing changes.

d. The patient asks for pain medication during the dressing changes only once throughout the procedure.

ANS: C

If the patient needs less pain medication during dressing changes, then guided imagery is helping to manage the patient's pain. The purpose of guided imagery is to allow the patient to alter the perception of pain. Guided imagery works in conjunction with analgesic medications, potentiating their effects. A rating of 6 on a 0 to 10 scale indicates that the patient is having moderate pain and shows that this patient is not experiencing pain relief at this time. A

person who is stoic is not showing feelings, which makes it difficult to know whether or not the patient is experiencing pain. Having to ask for pain medication during the dressing changes indicates the guided imagery is not effective.

19.A nurse is providing medication education to a patient who just started taking ibuprofen. Which information will the nurse include in the teaching session?

a. Ibuprofen helps to depress the central nervous system to decrease pain perception.
b. Ibuprofen reduces anxiety, which will help you cope with your pain.
c. Ibuprofen binds with opiate receptors to reduce your pain.
d. Ibuprofen inhibits the production of prostaglandins.

ANS: D

NSAIDs like ibuprofen likely work by inhibiting the synthesis of prostaglandins to inhibit cellular responses to inflammation. Ibuprofen does not depress the central nervous system, nor does it enhance coping with pain.

Opioids bind with opiate receptors to modify perceptions of pain.

20.The nurse has brought a patient the scheduled pain medication. The patient asks the nurse to wait to give pain medication until the time for the dressing change, which is 2 hours away. Which response by the nurse is **most** therapeutic?

a. "This medication will still be providing you relief at the time of your dressing change."
b. "OK, swallow this pain pill, and I will return in a minute to change your dressing."
c. "Would you like medication to be given for dressing changes in addition to your regularly scheduled medication?"
d. "Your medication is scheduled for this time, and I can't adjust the time for you. I'm sorry, but you must take your pill right now."

ANS: C

Additional doses of medication can be given to patients in certain circumstances, as with an extensive dressing change, when the health care provider is notified that more medication is needed. It is the nurse's responsibility to communicate with the provider and with the patient about a pain-control plan that works for both. By asking to hold off on the dose, the patient is indicating that the dressing changes are extremely painful. The regularly scheduled dose might not be as effective for the patient 2 hours later

when the dressing change is scheduled.

Oral medications take 30 to 60 minutes to take effect. If the nurse began the dressing change right then, the medication would not have been absorbed yet. The patient has the right to refuse to take a medication.

21.A nurse receives an order from a health care provider to administer hydrocodone and acetaminophen (Vicodin ES 7.5/750), to a patient who is experiencing 8/10 postsurgical pain. The order is to give 2 tablets every 6 hours by mouth as needed for pain. What is the nurse's next **best** action?

a. Give the Vicodin ES to the patient immediately because the patient is experiencing severe pain.
b. Ask the health care provider for a nonsteroidal antiinflammatory drug (NSAID) order.
c. Ask the health care provider to verify the dosage and frequency of the medication.
d. Give the Vicodin ES in addition to playing soothing music for the patient.

ANS: C

The maximum 24-hour dosage for acetaminophen is 4 grams. If the patient took 2 tablets of Vicodin ES every 6 hours, the patient would take in 6 grams of acetaminophen in 24 hours (2 tablets = 750 + 750 = 1500 4 [could have 4 doses in 24 hours every 6 hours] = 6000 mg = 6 g). This exceeds the safe dosage of acetaminophen, so the best action is to question this order. Giving the medication as ordered would possibly result in the patient's taking more acetaminophen than is considered a safe dose. Acetaminophen overdose can result in liver failure. NSAIDs are used to treat mild to moderate pain. At this moment, the patient is experiencing severe pain. Implementing music therapy is a nursing intervention and is an independent nursing action that can be instituted with pain medication, but the possible acetaminophen dose is the priority.

22.The nurse is caring for a 4-year-old child who has pain. Which technique will the nurse use to **best** assess pain in this child?

a. Use the FACES scale.
b. Check to see what previous nurses have charted.
c. Ask the parents if they think their child is in pain.
d. Have the child rate the level of pain on a 0 to 10 pain scale.



ANS: A