Berman/Snyder, Test Bank for *Skills in Clinical Nursing* 8th Edition
Chapter 9

Question 1
Type: MCSA

The client with a sprained ankle is complaining of pain in the injured area. Which term will the nurse use when documenting this client's pain?

1. Visceral pain

2. Somatic pain

3. Physiological pain

4. Neuropathic pain

Correct Answer: 2

Rationale 1: Somatic pain originates in the skin, muscles, bone, or connective tissue, and would best describe this client's pain. Somatic pain is a subclassification of physiological pain, so it would be less specific to call it physiological as opposed to somatic. Visceral pain tends to be poorly located, resulting from activation of pain receptors in the organs and/or hollow viscera. Neuropathic pain results from damaged or malfunctioning nerves.

Rationale 2: Somatic pain originates in the skin, muscles, bone, or connective tissue, and would best describe this client's pain. Somatic pain is a subclassification of physiological pain, so it would be less specific to call it physiological as opposed to somatic. Visceral pain tends to be poorly located, resulting from activation of pain receptors in the organs and/or hollow viscera. Neuropathic pain results from damaged or malfunctioning nerves.

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Global Rationale: Somatic pain originates in the skin, muscles, bone, or connective tissue, and would best describe this client's pain. Somatic pain is a subclassification of physiological pain, so it would be less specific to call it physiological as opposed to somatic. Visceral pain tends to be poorly located, resulting from activation of pain receptors in the organs and/or hollow viscera. Neuropathic pain results from damaged or malfunctioning nerves.

Cognitive Level: Applying
Client Need: Physiological Integrity
Client Need Sub: Basic Care and Comfort

QSEN Competencies: I.A.3. Demonstrate comprehensive understanding of the concepts of pain and suffering, including physiological models of pain and comfort.
AACN Essential Competencies: III.1. Explain the interrelationships among theory, practice, and research
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Define key terms used in the skills of pain management.
Page Number: p. 239

Question 2
Type: MCSA

When documenting the maximum amount of pain a client can tolerate, which term is the most appropriate for the nurse to use?

1. Pain threshold

2. Hyperalgesia

3. Pain tolerance

4. Allodynia

Correct Answer: 3

Rationale 1: Pain tolerance is the maximum amount of pain a client can tolerate. Pain threshold is the lowest amount of stimuli needed for a person to label a sensation as pain. Hyperalgesia, or hyperpathia, denotes a heightened response to painful stimuli. Allodynia is pain produced by nonpainful stimuli, such as the touch of wind to the area.

Rationale 2: Pain tolerance is the maximum amount of pain a client can tolerate. Pain threshold is the lowest amount of stimuli needed for a person to label a sensation as pain. Hyperalgesia, or hyperpathia, denotes a heightened response to painful stimuli. Allodynia is pain produced by nonpainful stimuli, such as the touch of wind to the area.

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Learning Outcome: Define key terms used in the skills of pain management.
Page Number: p. 239

Question 3
Type: MCSA

The nurse is using a nonpharmacologic method to manage a client's pain, and applies a unit that applies low-voltage electrical stimulation directly over the pain area. When documenting this intervention, which term is the most appropriate for the nurse to use?

1. TENS unit

2. Nerve block

3. Functional restoration

4. Cutaneous stimulation

Correct Answer: 1

Rationale 1: The unit described is a TENS unit, or transcutaneous electrical nerve stimulator, which is a form of cutaneous stimulation. However, TENS would be the specific name of this treatment, whereas cutaneous stimulation would be a more general term. Nerve block is a pharmacologic treatment injecting an analgesic or steroid into the site of pain. Functional restoration is a form of social therapy.

Rationale 2: The unit described is a TENS unit, or transcutaneous electrical nerve stimulator, which is a form of cutaneous stimulation. However, TENS would be the specific name of this treatment, whereas cutaneous stimulation would be a more general term. Nerve block is a pharmacologic treatment injecting an analgesic or steroid into the site of pain. Functional restoration is a form of social therapy.

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Cognitive Level: Applying
Client Need: Physiological Integrity
Client Need Sub: Basic Care and Comfort
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Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Define key terms used in the skills of pain management.
Page Number: p. 265

Question 4
Type: MCSA

The client has pain in the lower back that radiates down the leg as the result of a herniated disk compressing the sciatic nerve that began 4 months ago. When documenting this client's pain, which term will the nurse use?

1. Acute somatic pain

2. Acute visceral pain

3. Chronic neuropathic pain

4. Acute neuropathic pain

Correct Answer: 4

Rationale 1: The pain is considered acute because it has lasted less than 6 months, which is the NANDA-accepted definition of chronic pain. It is neuropathic pain because it is caused by damage to the sciatic nerve.

Rationale 2: The pain is considered acute because it has lasted less than 6 months, which is the NANDA-accepted definition of chronic pain. It is neuropathic pain because it is caused by damage to the sciatic nerve.

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Cognitive Level: Applying

Client Need: Physiological Integrity
Client Need Sub: Basic Care and Comfort
QSEN Competencies: I.A.3. Demonstrate comprehensive understanding of the concepts of pain and suffering, including physiological models of pain and comfort.
AACN Essential Competencies: III.1. Explain the interrelationships among theory, practice, and research
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: Describe the various types of pain.
Page Number: p. 239

Question 5
Type: MCMA

The nurse working on the labor and delivery unit has noticed how differently each client responds to the pain associated with labor. Which reasons does the nurse attribute to these various responses to pain?

Standard Text: Select all that apply.

1. Ethnic and cultural values

2. Developmental stage

3. Past experience with pain

4. Physiological functioning of the brain

5. Meaning of pain

Correct Answer: 1,2,3,5

Rationale 1: Clients with different ethnic and cultural values are socialized to respond to pain in different manners. The developmental stage determines the client's ability to cope and report the pain. Past experience, including the effectiveness of the treatment plan in the past, with pain will have an impact on how the client deals with pain. Pain has different meaning to different clients, with some clients believing it is a punishment from a higher power or an opportunity to show how strong they are. Physiological functioning affects how pain is felt but does not affect the pain experience.

Rationale 2: Clients with different ethnic and cultural values are socialized to respond to pain in different manners. The developmental stage determines the client's ability to cope and report the pain. Past experience, including the effectiveness of the treatment plan in the past, with pain will have an impact on how the client deals with pain. Pain has different meaning to different clients, with some clients believing it is a punishment from a higher power or an opportunity to show how strong they are. Physiological functioning affects how pain is felt but does not affect the pain experience.

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Cognitive Level: Analyzing
Client Need: Psychosocial Integrity
Client Need Sub:
QSEN Competencies: I.A.3. Demonstrate comprehensive understanding of the concepts of pain and suffering, including physiological models of pain and comfort.
AACN Essential Competencies: III.1. Explain the interrelationships among theory, practice, and research
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: Describe factors that affect the pain experience.
Page Number: pp. 240-243

Question 6
Type: MCMA

The nurse is caring for a preschool-aged client who is in pain secondary to a compound fracture resulting from a motor vehicle crash. The nurse recognizes which items as true when providing care to this client?

Standard Text: Select all that apply.

1. It is best for the nurse to reason with the child in managing the pain.

2. The child will often respond with crying and anger because he perceives pain as a threat to security.

3. Try to avoid touching or holding the child to reduce the level of pain.

4. Appeal to the child's belief in magic by using a magic blanket to take away pain.

5. The child might consider pain a punishment for previous misbehaviors.

Correct Answer: 2,4,5

Rationale 1: The preschool-aged client does not have the vocabulary or logic skills to perceive pain as a physiological response, so he will often respond with crying and anger because he sees the pain as threatening his security. A child at this stage of development has a strong belief in magic, which can be used as a pain management tool. Children often perceive pain as a punishment, so it is important for the nurse to reassure the child that it is not his fault. It is not possible to reason with a child at this stage of development, because he does not have the necessary cognitive ability. Holding and comforting the child is a useful pain management tool.

Rationale 2: The preschool-aged client does not have the vocabulary or logic skills to perceive pain as a physiological response, so he will often respond with crying and anger because he sees the pain as threatening his security. A child at this stage of development has a strong belief in magic, which can be used as a pain management tool. Children often perceive pain as a punishment, so it is important for the nurse to reassure the child that it is not his fault. It is not possible to reason with a child at this stage of development, because he does not have the necessary cognitive ability. Holding and comforting the child is a useful pain management tool.

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Client Need: Psychosocial Integrity

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Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: Describe factors that affect the pain experience.
Page Number: p. 242

Question 7
Type: MCSA

The nurse has a multicultural practice, seeing clients from a variety of ethnic backgrounds. The nurse recognizes that people from what culture are most likely to believe that enduring pain is a sign of strength?

1. Mexican Americans

2. Puerto Ricans

3. Asian Americans

4. African Americans

Correct Answer: 1

Rationale 1: Mexican Americans might tend to view pain as a part of life and as an indicator of the seriousness of an illness, believing that enduring pain is a sign of strength. Puerto Ricans tend to be loud and outspoken in their expressions of pain as a socially learned way to cope. The Chinese culture values silence, the Japanese client might have a stoic response to pain, whereas the Filipino client might believe pain is God's will. African American clients believe pain and suffering is part of life, and is to be endured.

Rationale 2: Mexican Americans might tend to view pain as a part of life and as an indicator of the seriousness of an illness, believing that enduring pain is a sign of strength. Puerto Ricans tend to be loud and outspoken in their expressions of pain as a socially learned way to cope. The Chinese culture values silence, the Japanese client might have a stoic response to pain, whereas the Filipino client might believe pain is God's will. African American clients believe pain and suffering is part of life, and is to be endured.

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Cognitive Level: Applying
Client Need: Psychosocial Integrity
Client Need Sub:
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Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: Describe factors that affect the pain experience.
Page Number: p. 241

Question 8
Type: MCSA

The nurse is caring for a client who had extensive surgery, and is now 6 days postoperative and getting out of bed for the first time later this morning. When the nurse assesses the client for pain, the client responds, "It hurts, but I don't want to take any more drugs. I don't want to end up addicted." Which response by the nurse is the most appropriate?

1. "If you don't take the pain medication on a regular schedule, you won't get addicted."

2. "People who have real pain are unlikely to become addicted to analgesics provided to treat the pain."

3. "You are wise to be concerned, and after 6 days it is probably time to stop taking narcotics if you can manage the pain in other ways."

4. "Don't worry about getting addicted. I will make sure you don't get addicted."

Correct Answer: 2

Rationale 1: Many clients worry about becoming addicted to narcotic analgesics if they are required for more than a few days. It is important for the nurse to reassure the client by providing truthful information. Option 1 is not true. Option 3 agrees with the client and is also untrue. Option 4 takes the control away from the client, where it belongs, and puts it in the hands of the nurse.

Rationale 2: Many clients worry about becoming addicted to narcotic analgesics if they are required for more than a few days. It is important for the nurse to reassure the client by providing truthful information. Option 1 is not true. Option 3 agrees with the client and is also untrue. Option 4 takes the control away from the client, where it belongs, and puts it in the hands of the nurse.

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Client Need: Physiological Integrity
Client Need Sub: Basic Care and Comfort
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Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: List barriers to pain management.
Page Number: pp. 243-244

Question 9
Type: MCSA

The nurse working in a surgical center is caring for a client who had an abdominal nevus removed. The client is complaining of intense pain. Which action by the nurse is the most appropriate?

1. Administer a nonnarcotic analgesic because the client had minor surgery.

2. Attempt to divert the client without administering an analgesic because the surgery was so minor.

3. Administer the stronger analgesic ordered by the primary care provider.

4. Notify the health care provider that the client's pain is excessive for the minor surgery performed.

Correct Answer: 3

Rationale 1: Pain perception is what the client says it is, and the nurse should medicate the client based on the client's description of the pain, not what the nurse anticipates. If the client reports severe pain, the nurse should administer strong analgesics. Clients who have minor surgery can still experience severe pain, and administering weaker analgesics when the client reports severe pain would not be responsible practice. Diverting the client most likely will not be effective alone, although diversion might be possible after administering the analgesic. There is

no need to notify the health care provider unless the nurse's assessment indicates there is something unusual occurring.

Rationale 2: Pain perception is what the client says it is, and the nurse should medicate the client based on the client's description of the pain, not what the nurse anticipates. If the client reports severe pain, the nurse should administer strong analgesics. Clients who have minor surgery can still experience severe pain, and administering weaker analgesics when the client reports severe pain would not be responsible practice. Diverting the client most likely will not be effective alone, although diversion might be possible after administering the analgesic. There is no need to notify the health care provider unless the nurse's assessment indicates there is something unusual occurring.

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Client Need Sub: Basic Care and Comfort
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Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: List barriers to pain management.
Page Number: pp. 244-245

Question 10
Type: MCSA

The nurse is working on a surgical unit, and overhears another nurse say, "That client is asking for pain medication again. He is constantly on the call bell, always reporting how severe his pain is, and I think he's just drug-seeking. I'm going to make him wait the full 4 hours before I give this medication again." Which action by the nurse is the most appropriate in this situation?

1. Ignoring the situation because the client in question is not this nurse's responsibility

2. Entering the nurses' station, reprimanding the nurse, and completing an incident or variance report

3. Pulling the second nurse aside and providing a reminder that the sensation of pain is subjective, and that professionals have a duty to believe clients' reports of their symptoms

4. Informing the charge nurse of what was overheard

Correct Answer: 3

Rationale 1: It is every nurse's responsibility to speak up and advocate for the client when situations arise that place the client at risk of incorrect treatment. However, the nurse would address the situation privately, and not in front of others at the nurses' station. Informing the charge nurse would only be necessary if the nurse who was overheard did not respond constructively to the nurse's correction.

Rationale 2: It is every nurse's responsibility to speak up and advocate for the client when situations arise that place the client at risk of incorrect treatment. However, the nurse would address the situation privately, and not in front of others at the nurses' station. Informing the charge nurse would only be necessary if the nurse who was overheard did not respond constructively to the nurse's correction.

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Cognitive Level: Analyzing
Client Need: Safe and Effective Care Environment
Client Need Sub: Management of Care
QSEN Competencies: I.B.6. Elicit expectations of client & family for relief of pain, discomfort, or suffering
AACN Essential Competencies: III.1. Explain the interrelationships among theory, practice, and research
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care
Nursing/Integrated Concepts: Nursing Process: Implementation

Learning Outcome: Identify key factors in pain management.
Page Number: pp. 244-245

Question 11
Type: MCMA

The nurse is working on the orthopedic unit, and is caring for a client who complains of back pain. Which responses by the nurse would be appropriate when caring for this client?

Standard Text: Select all that apply.

1. "I'm sorry you're hurting. I want to make you feel better."

2. "People with back pain experience very different symptoms. Tell me more about your back."

3. "You had medication for your pain at 4 p.m., so I can't give you any more until 8 p.m., because the health care provider ordered it every 4 hours."

4. "Does anything other than your back hurt?"

5. "Why don't you try another position to make it feel better until it's time for more pain medication?"

Correct Answer: 1,2,4

Rationale 1: The nurse should inform the client that she will work to make the client feel better, seek more information about the type of pain the client is experiencing, and question any other discomforts the client may be experiencing. Allowing the client to remain in pain would not be prudent practice, and would be lacking in caring.

Rationale 2: The nurse should inform the client that she will work to make the client feel better, seek more information about the type of pain the client is experiencing, and question any other discomforts the client may be experiencing. Allowing the client to remain in pain would not be prudent practice, and would be lacking in caring.

Rationale 3: The nurse should inform the client that she will work to make the client feel better, seek more information about the type of pain the client is experiencing, and question any other discomforts the client may be experiencing. Allowing the client to remain in pain would not be prudent practice, and would be lacking in caring.

Rationale 4: The nurse should inform the client that she will work to make the client feel better, seek more information about the type of pain the client is experiencing, and question any other discomforts the client may be experiencing. Allowing the client to remain in pain would not be prudent practice, and would be lacking in caring.

Rationale 5: The nurse should inform the client that she will work to make the client feel better, seek more information about the type of pain the client is experiencing, and question any other discomforts the client may be experiencing. Allowing the client to remain in pain would not be prudent practice, and would be lacking in caring.

Global Rationale: The nurse should inform the client that she will work to make the client feel better, seek more information about the type of pain the client is experiencing, and question any other discomforts the client may be experiencing. Allowing the client to remain in pain would not be prudent practice, and would be lacking in caring.

Cognitive Level: Analyzing

Client Need: Physiological Integrity
Client Need Sub: Basic Care and Comfort
QSEN Competencies: I.B.6. Elicit expectations of client & family for relief of pain, discomfort, or suffering
AACN Essential Competencies: III.1. Explain the interrelationships among theory, practice, and research
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Identify key factors in pain management.
Page Number: pp. 244-245

Question 12
Type: MCSA

The hospice nurse is making a home visit to a client with terminal cancer. The client reports poor pain control, and the client's spouse says, "I'm giving such big doses of medication, I'm afraid she is going to overdose if I give her more." Which response by the nurse is the most appropriate?

1. "You're wise to be concerned. These are very strong medications you're administering."

2. "You want her to be comfortable but you don't want to endanger her life. Let's talk about the medication you're giving and warning signs you'll see if the dosage you're administering is too high."

3. "I hear what you're saying, but you're not giving enough pain medication, so she is in severe pain. You need to give more."

4. "You aren't giving adequate pain relief, and she is in severe pain as a result."

Correct Answer: 2

Rationale 1: It is not unusual for a family caregiver to withhold medication out of fear of overdosing the cancer client. It is important for the nurse to inform the caregiver that his feelings are not unusual, and then provide him with the information he needs to make an informed and appropriate decision that will make the client more comfortable. Telling the spouse it is wise to be concerned is untrue. The other options make the caregiver feel guilty, and do not provide him with the information he needs to perform better.

Rationale 2: It is not unusual for a family caregiver to withhold medication out of fear of overdosing the cancer client. It is important for the nurse to inform the caregiver that his feelings are not unusual, and then provide him with the information he needs to make an informed and appropriate decision that will make the client more comfortable. Telling the spouse it is wise to be concerned is untrue. The other options make the caregiver feel guilty, and do not provide him with the information he needs to perform better.

Rationale 3: It is not unusual for a family caregiver to withhold medication out of fear of overdosing the cancer client. It is important for the nurse to inform the caregiver that his feelings are not unusual, and then provide him with the information he needs to make an informed and appropriate decision that will make the client more comfortable. Telling the spouse it is wise to be concerned is untrue. The other options make the caregiver feel guilty, and do not provide him with the information he needs to perform better.

Rationale 4: It is not unusual for a family caregiver to withhold medication out of fear of overdosing the cancer client. It is important for the nurse to inform the caregiver that his feelings are not unusual, and then provide him

with the information he needs to make an informed and appropriate decision that will make the client more comfortable. Telling the spouse it is wise to be concerned is untrue. The other options make the caregiver feel guilty, and do not provide him with the information he needs to perform better.

Global Rationale: It is not unusual for a family caregiver to withhold medication out of fear of overdosing the cancer client. It is important for the nurse to inform the caregiver that his feelings are not unusual, and then provide him with the information he needs to make an informed and appropriate decision that will make the client more comfortable. Telling the spouse it is wise to be concerned is untrue. The other options make the caregiver feel guilty, and do not provide him with the information he needs to perform better.

Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub: Basic Care and Comfort
QSEN Competencies: I.B.6. Elicit expectations of client and family for relief of pain, discomfort, or suffering
AACN Essential Competencies: III.1. Explain the interrelationships among theory, practice, and research
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Identify key factors in pain management.
Page Number: p. 256

Question 13
Type: MCSA

The nurse enters the postoperative client's room and finds the client perspiring with fists clenched. As the nurse administers routine medications and provides care, the client is pleasant and cooperative. Which action by the nurse is the most appropriate?

1. Documenting "no complaints of pain offered" and assessing that the client is comfortable

2. Asking the client if pain is being experienced

3. Informing the client that he looks uncomfortable and asking him to describe his pain

4. Instructing the client to use the call bell if he experiences pain

Correct Answer: 3

Rationale 1: It is the nurse's responsibility to assess for pain and not wait for the client to mention it. Some clients might feel that admitting to pain is a sign of weakness, and might not bring it up unless the nurse specifically refers to the client's apparent discomfort and asks him to describe his pain and indicates the client's apparent discomfort. The client's body language indicates the likelihood of pain. Instructing the client to use the call bell puts the responsibility for pain assessment on the client instead of on the nurse.

Rationale 2: It is the nurse's responsibility to assess for pain and not wait for the client to mention it. Some clients might feel that admitting to pain is a sign of weakness, and might not bring it up unless the nurse specifically refers to the client's apparent discomfort and asks him to describe his pain and indicates the client's apparent discomfort. The client's body language indicates the likelihood of pain. Instructing the client to use the call bell puts the responsibility for pain assessment on the client instead of on the nurse.

Rationale 3: It is the nurse's responsibility to assess for pain and not wait for the client to mention it. Some clients might feel that admitting to pain is a sign of weakness, and might not bring it up unless the nurse specifically refers to the client's apparent discomfort and asks him to describe his pain and indicates the client's apparent discomfort. The client's body language indicates the likelihood of pain. Instructing the client to use the call bell puts the responsibility for pain assessment on the client instead of on the nurse.

Rationale 4: It is the nurse's responsibility to assess for pain and not wait for the client to mention it. Some clients might feel that admitting to pain is a sign of weakness, and might not bring it up unless the nurse specifically refers to the client's apparent discomfort and asks him to describe his pain and indicates the client's apparent discomfort. The client's body language indicates the likelihood of pain. Instructing the client to use the call bell puts the responsibility for pain assessment on the client instead of on the nurse.

Global Rationale: It is the nurse's responsibility to assess for pain and not wait for the client to mention it. Some clients might feel that admitting to pain is a sign of weakness, and might not bring it up unless the nurse specifically refers to the client's apparent discomfort and asks him to describe his pain and indicates the client's apparent discomfort. The client's body language indicates the likelihood of pain. Instructing the client to use the call bell puts the responsibility for pain assessment on the client instead of on the nurse.

Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub: Basic Care and Comfort
QSEN Competencies: I.B.4. Assess presence and extent of pain and suffering
AACN Essential Competencies: IX.1. Conduct comprehensive and focused physical, behavioral, psychological, spiritual, socioeconomic, and environmental assessments of health and illness parameters in clients, using developmentally and culturally appropriate approaches
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Describe the two major components of pain assessment.
Page Number: pp. 245-251

Question 14
Type: MCSA

The nurse is caring for a client who is experiencing acute pain. Which action by the client, noted by the nurse during the assessment, is considered an associated symptom of pain?

1. Changing position

2. Crying

3. Grimacing

4. Vomiting

Correct Answer: 4

Rationale 1: Symptoms that are often associated with pain include nausea, vomiting, and dizziness. Changing position, crying, and grimacing are manners of expressing pain.

Rationale 2: Symptoms that are often associated with pain include nausea, vomiting, and dizziness. Changing position, crying, and grimacing are manners of expressing pain.

Rationale 3: Symptoms that are often associated with pain include nausea, vomiting, and dizziness. Changing position, crying, and grimacing are manners of expressing pain.

Rationale 4: Symptoms that are often associated with pain include nausea, vomiting, and dizziness. Changing position, crying, and grimacing are manners of expressing pain.

Global Rationale: Symptoms that are often associated with pain include nausea, vomiting, and dizziness. Changing position, crying, and grimacing are manners of expressing pain.

Cognitive Level: Remembering
Client Need: Physiological Integrity
Client Need Sub: Physiological Adaptation
QSEN Competencies: I.B.4. Assess presence and extent of pain and suffering
AACN Essential Competencies: IX.1. Conduct comprehensive and focused physical, behavioral, psychological, spiritual, socioeconomic, and environmental assessments of health and illness parameters in clients, using developmentally and culturally appropriate approaches
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: Describe the two major components of pain assessment.
Page Number: p. 251

Question 15
Type: MCSA

The nurse is obtaining a pain history. The client reports pain in the right ear. Which response by the nurse is the most appropriate?

1. "Is the pain minor?"

2. "Do you have anything else that hurts?"

3. "Tell me more about the pain and what you do for it when it hurts."

4. "I'll note that in the record. Is there anything else I should know?"

Correct Answer: 3

Rationale 1: When the client reports pain, the nurse should seek more information. When assessing pain, the nurse should assesss all aspects of the pain, including character, onset, location, duration, exacerbation, relief, and radiation.

Rationale 2: When the client reports pain, the nurse should seek more information. When assessing pain, the nurse should assesss all aspects of the pain, including character, onset, location, duration, exacerbation, relief, and radiation.

Rationale 3: When the client reports pain, the nurse should seek more information. When assessing pain, the nurse should assesss all aspects of the pain, including character, onset, location, duration, exacerbation, relief, and radiation.

Rationale 4: When the client reports pain, the nurse should seek more information. When assessing pain, the nurse should assesss all aspects of the pain, including character, onset, location, duration, exacerbation, relief, and radiation.

Global Rationale: When the client reports pain, the nurse should seek more information. When assessing pain, the nurse should assesss all aspects of the pain, including character, onset, location, duration, exacerbation, relief, and radiation.

Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub: Basic Care and Comfort
QSEN Competencies: I.B.4. Assess presence and extent of pain and suffering
AACN Essential Competencies: IX.1. Conduct comprehensive and focused physical, behavioral, psychological, spiritual, socioeconomic, and environmental assessments of health and illness parameters in clients, using developmentally and culturally appropriate approaches
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: Identify data to collect and analyze when obtaining a comprehensive pain history.
Page Number: pp. 251-252

Question 16
Type: MCSA

When conducting a pain history, which data is not essential for the nurse to obtain regarding the client's pain?

1. Intensity, quality, and patterns

2. Precipitating factors, alleviating factors, and associated symptoms

3. Effects on activities of daily living, coping resources, and affective responses

4. Significant other's assessment of the pain

Correct Answer: 4

Rationale 1: During a pain history, it is the client's description of the pain that is most important, not the significant other's. The nurse should determine all of the other factors in order to put a plan of care in place that will help the client address and treat the pain effectively.

Rationale 2: During a pain history, it is the client's description of the pain that is most important, not the significant other's. The nurse should determine all of the other factors in order to put a plan of care in place that will help the client address and treat the pain effectively.

Rationale 3: During a pain history, it is the client's description of the pain that is most important, not the significant other's. The nurse should determine all of the other factors in order to put a plan of care in place that will help the client address and treat the pain effectively.

Rationale 4: During a pain history, it is the client's description of the pain that is most important, not the significant other's. The nurse should determine all of the other factors in order to put a plan of care in place that will help the client address and treat the pain effectively.

Global Rationale: During a pain history, it is the client's description of the pain that is most important, not the significant other's. The nurse should determine all of the other factors in order to put a plan of care in place that will help the client address and treat the pain effectively.

Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub: Basic Care and Comfort
QSEN Competencies: I.B.4. Assess presence and extent of pain and suffering
AACN Essential Competencies: IX.1. Conduct comprehensive and focused physical, behavioral, psychological, spiritual, socioeconomic, and environmental assessments of health and illness parameters in clients, using developmentally and culturally appropriate approaches
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: Identify data to collect and analyze when obtaining a comprehensive pain history.
Page Number: pp. 246-249

Question 17
Type: MCSA

When caring for an older adult client who does not speak English, which assessment tool is the most appropriate for the nurse to use to assess this client’s pain?

1. The FACES rating scale

2. An interpreter

3. The client's affect

4. The client's vital signs

Correct Answer: 1

Rationale 1: An interpreter might not always be readily available, so the FACES rating scale can be used because it is not necessary to use language. If an interpreter is available the nurse can ask the interpreter to discuss the pain in more detail, but the FACES rating scale will help the nurse to respond to the client's pain appropriately and quickly without waiting for an interpreter. Affect and vital signs might not be accurate indicators of the client's discomfort.

Rationale 2: An interpreter might not always be readily available, so the FACES rating scale can be used because it is not necessary to use language. If an interpreter is available the nurse can ask the interpreter to discuss the pain in more detail, but the FACES rating scale will help the nurse to respond to the client's pain appropriately and

quickly without waiting for an interpreter. Affect and vital signs might not be accurate indicators of the client's discomfort.

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Global Rationale: An interpreter might not always be readily available, so the FACES rating scale can be used because it is not necessary to use language. If an interpreter is available the nurse can ask the interpreter to discuss the pain in more detail, but the FACES rating scale will help the nurse to respond to the client's pain appropriately and quickly without waiting for an interpreter. Affect and vital signs might not be accurate indicators of the client's discomfort.

Cognitive Level: Applying
Client Need: Physiological Integrity
Client Need Sub: Basic Care and Comfort
QSEN Competencies: I.B.4. Assess presence and extent of pain and suffering
AACN Essential Competencies: IX.1. Conduct comprehensive and focused physical, behavioral, psychological, spiritual, socioeconomic, and environmental assessments of health and illness parameters in clients, using developmentally and culturally appropriate approaches
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: Identify data to collect and analyze when obtaining a comprehensive pain history.
Page Number: pp. 247-248

Question 18
Type: MCSA

The pain management team individualizes the analgesic regimen by guiding the adjustment of medication, dose, time intervals, and route of administration. When discussing this method of treating pain, which term is the most appropriate for the nurse to use?

1. Polypharmacy

2. Equianalgesia

3. Analgesia

4. Dose-reduction pharmacology

Correct Answer: 2

Rationale 1: The term equianalgesia refers to the relative potency of various opioid analgesics compared to a standard dose of parenteral morphine (gold standard opioid). This tool helps professionals individualize the analgesic regimen by guiding the adjustment of medication, dose, time interval, and route of administration. Polypharmacy is a generic term for multiple medication administration, often used with elders who are on many medications. Analgesia is a classification of medication used for pain control. Dose-reduction pharmacology is not a real term.

Rationale 2: The term equianalgesia refers to the relative potency of various opioid analgesics compared to a standard dose of parenteral morphine (gold standard opioid). This tool helps professionals individualize the analgesic regimen by guiding the adjustment of medication, dose, time interval, and route of administration. Polypharmacy is a generic term for multiple medication administration, often used with elders who are on many medications. Analgesia is a classification of medication used for pain control. Dose-reduction pharmacology is not a real term.

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Rationale 4: The term equianalgesia refers to the relative potency of various opioid analgesics compared to a standard dose of parenteral morphine (gold standard opioid). This tool helps professionals individualize the analgesic regimen by guiding the adjustment of medication, dose, time interval, and route of administration. Polypharmacy is a generic term for multiple medication administration, often used with elders who are on many medications. Analgesia is a classification of medication used for pain control. Dose-reduction pharmacology is not a real term.

Global Rationale: The term equianalgesia refers to the relative potency of various opioid analgesics compared to a standard dose of parenteral morphine (gold standard opioid). This tool helps professionals individualize the analgesic regimen by guiding the adjustment of medication, dose, time interval, and route of administration. Polypharmacy is a generic term for multiple medication administration, often used with elders who are on many medications. Analgesia is a classification of medication used for pain control. Dose-reduction pharmacology is not a real term.

Cognitive Level: Remembering
Client Need: Physiological Integrity
Client Need Sub: Pharmacologic and Parenteral Therapies
QSEN Competencies: I.B.7. Initiate effective treatments to relieve pain and suffering in light of client values, preferences, and expressed needs
AACN Essential Competencies: IX.3. Implement holistic, client-centered care that reflects an understanding of human growth and development, pathophysiology, pharmacology, medical management and nursing management across the health-illness continuum, across life span, and in all health care settings
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Describe pharmacologic pain management, including classifications of medications and routes for opioid delivery.
Page Number: p. 258

Question 19
Type: MCMA

According to the World Health Organization Three-Step Approach, if the nurse is caring for a client complaining of mild pain that persists after using full doses of step 1 medications, which medications can the nurse administer?

Standard Text: Select all that apply.

1. Codeine

2. Fentanyl

3. Oxycodone with acetaminophen

4. Hydrocodone with ibuprofen

5. Morphine

Correct Answer: 1,3,4

Rationale 1: For mild pain, a nonopioid analgesic is the appropriate starting point. If the pain persists or the pain is moderate, the second step is a weak opioid, or a combination of opioid and nonopioid medicine can be used. If moderate pain persists or the pain is severe, stronger opiates are provided.

Rationale 2: For mild pain, a nonopioid analgesic is the appropriate starting point. If the pain persists or the pain is moderate, the second step is a weak opioid, or a combination of opioid and nonopioid medicine can be used. If moderate pain persists or the pain is severe, stronger opiates are provided.

Rationale 3: For mild pain, a nonopioid analgesic is the appropriate starting point. If the pain persists or the pain is moderate, the second step is a weak opioid, or a combination of opioid and nonopioid medicine can be used. If moderate pain persists or the pain is severe, stronger opiates are provided.

Rationale 4: For mild pain, a nonopioid analgesic is the appropriate starting point. If the pain persists or the pain is moderate, the second step is a weak opioid, or a combination of opioid and nonopioid medicine can be used. If moderate pain persists or the pain is severe, stronger opiates are provided.

Rationale 5: For mild pain, a nonopioid analgesic is the appropriate starting point. If the pain persists or the pain is moderate, the second step is a weak opioid, or a combination of opioid and nonopioid medicine can be used. If moderate pain persists or the pain is severe, stronger opiates are provided.

Global Rationale: For mild pain, a nonopioid analgesic is the appropriate starting point. If the pain persists or the pain is moderate, the second step is a weak opioid, or a combination of opioid and nonopioid medicine can be used. If moderate pain persists or the pain is severe, stronger opiates are provided.

Cognitive Level: Applying
Client Need: Physiological Integrity
Client Need Sub: Pharmacologic and Parenteral Therapies
QSEN Competencies: I.B.7. Initiate effective treatments to relieve pain and suffering in light of client values, preferences, and expressed needs

AACN Essential Competencies: IX.3. Implement holistic, client-centered care that reflects an understanding of human growth and development, pathophysiology, pharmacology, medical management, and nursing management across the health-illness continuum, across life span, and in all health care settings
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Describe pharmacologic pain management, including classifications of medications and routes for opioid delivery.
Page Number: pp. 254-258

Question 20
Type: MCMA

The nurse administers a nonsteroidal anti-inflammatory drug (NSAID) to a client who is experiencing chronic pain. When teaching the client about this medication, which effects will the nurse include in the session?

Standard Text: Select all that apply.

1. Anti-inflammatory effects

2. Analgesic effects

3. Antipyretic effects

4. Sedating effects

5. Anesthetic effects

Correct Answer: 1,2,3

Rationale 1: Nonsteroidal anti-inflammatory drugs (NSAIDs) have anti-inflammatory, analgesic, and antipyretic effects. These medications do not have sedating or anesthetic effects in most clients, although some clients might report being able to fall asleep more easily once pain is reduced.

Rationale 2: Nonsteroidal anti-inflammatory drugs (NSAIDs) have anti-inflammatory, analgesic, and antipyretic effects. These medications do not have sedating or anesthetic effects in most clients, although some clients might report being able to fall asleep more easily once pain is reduced.

Rationale 3: Nonsteroidal anti-inflammatory drugs (NSAIDs) have anti-inflammatory, analgesic, and antipyretic effects. These medications do not have sedating or anesthetic effects in most clients, although some clients might report being able to fall asleep more easily once pain is reduced.

Rationale 4: Nonsteroidal anti-inflammatory drugs (NSAIDs) have anti-inflammatory, analgesic, and antipyretic effects. These medications do not have sedating or anesthetic effects in most clients, although some clients might report being able to fall asleep more easily once pain is reduced.

Rationale 5: Nonsteroidal anti-inflammatory drugs (NSAIDs) have anti-inflammatory, analgesic, and antipyretic effects. These medications do not have sedating or anesthetic effects in most clients, although some clients might report being able to fall asleep more easily once pain is reduced.

Global Rationale: Nonsteroidal anti-inflammatory drugs (NSAIDs) have anti-inflammatory, analgesic, and antipyretic effects. These medications do not have sedating or anesthetic effects in most clients, although some clients might report being able to fall asleep more easily once pain is reduced.

Cognitive Level: Remembering
Client Need: Physiological Integrity
Client Need Sub: Pharmacologic and Parenteral Therapies
QSEN Competencies: I.B.7. Initiate effective treatments to relieve pain and suffering in light of client values, preferences, and expressed needs
AACN Essential Competencies: IX.3. Implement holistic, client-centered care that reflects an understanding of human growth and development, pathophysiology, pharmacology, medical management, and nursing management across the health-illness continuum, across life span, and in all health care settings
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care
Nursing/Integrated Concepts: Nursing Process: Planning
Learning Outcome: Describe pharmacologic pain management, including classifications of medications and routes for opioid delivery.
Page Number: p. 254

Question 21
Type: MCSA

The nurse would administer acetaminophen instead of ibuprofen if which effect was not desired?

1. Anti-inflammatory effects

2. Analgesic effects

3. Antipyretic effects

4. Antipyretic and anti-inflammatory effects

Correct Answer: 1

Rationale 1: Acetaminophen, unlike ibuprofen, does not have anti-inflammatory effects. However, both acetaminophen and ibuprofen have analgesic and antipyretic effects.

Rationale 2: Acetaminophen, unlike ibuprofen, does not have anti-inflammatory effects. However, both acetaminophen and ibuprofen have analgesic and antipyretic effects.

Rationale 3: Acetaminophen, unlike ibuprofen, does not have anti-inflammatory effects. However, both acetaminophen and ibuprofen have analgesic and antipyretic effects.

Rationale 4: Acetaminophen, unlike ibuprofen, does not have anti-inflammatory effects. However, both acetaminophen and ibuprofen have analgesic and antipyretic effects.

Global Rationale: Acetaminophen, unlike ibuprofen, does not have anti-inflammatory effects. However, both acetaminophen and ibuprofen have analgesic and antipyretic effects.

Cognitive Level: Applying

Client Need: Physiological Integrity
Client Need Sub: Pharmacologic and Parenteral Therapies
QSEN Competencies: I.B.7. Initiate effective treatments to relieve pain and suffering in light of client values, preferences, and expressed needs
AACN Essential Competencies: IX.3. Implement holistic, client-centered care that reflects an understanding of human growth and development, pathophysiology, pharmacology, medical management, and nursing management across the health-illness continuum, across life span, and in all health care settings
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care
Nursing/Integrated Concepts: Nursing Process: Planning
Learning Outcome: Describe pharmacologic pain management, including classifications of medications and routes for opioid delivery.
Page Number: pp. 254-255

Question 22
Type: MCSA

After administering an opioid analgesic, the nurse assesses the client using the sedation scale and finds the client sleeping and arousable, but the client drifts off to sleep during conversation. Which level of sedation is appropriate for the nurse to document for this client in the medical record?

1. 1

2. 2

3. 3

4. 4

Correct Answer: 3

Rationale 1: Level 3 is frequently drowsy, arousable, and drifts off to sleep during conversation. Level 1 is awake and alert, level 2 is slightly drowsy but arousable, and level 4 is somnolent, minimal-to-no response to physical stimulation.

Rationale 2: Level 3 is frequently drowsy, arousable, and drifts off to sleep during conversation. Level 1 is awake and alert, level 2 is slightly drowsy but arousable, and level 4 is somnolent, minimal-to-no response to physical stimulation.

Rationale 3: Level 3 is frequently drowsy, arousable, and drifts off to sleep during conversation. Level 1 is awake and alert, level 2 is slightly drowsy but arousable, and level 4 is somnolent, minimal-to-no response to physical stimulation.

Rationale 4: Level 3 is frequently drowsy, arousable, and drifts off to sleep during conversation. Level 1 is awake and alert, level 2 is slightly drowsy but arousable, and level 4 is somnolent, minimal-to-no response to physical stimulation.

Global Rationale: Level 3 is frequently drowsy, arousable, and drifts off to sleep during conversation. Level 1 is awake and alert, level 2 is slightly drowsy but arousable, and level 4 is somnolent, minimal-to-no response to physical stimulation.

Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub: Physiological Adaptation
QSEN Competencies: I.B.7. Initiate effective treatments to relieve pain and suffering in light of client values, preferences, and expressed needs
AACN Essential Competencies: IX.3. Implement holistic, client-centered care that reflects an understanding of human growth and development, pathophysiology, pharmacology, medical management, and nursing management across the health-illness continuum, across life span, and in all health care settings
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: Describe pharmacologic pain management, including classifications of medications and routes for opioid delivery.
Page Number: p. 257

Question 23
Type: MCSA

The client reports difficulty sleeping related to anxiety. Which nonpharmacologic pain management intervention might the nurse consider performing in order to relax the client?

1. Acupuncture

2. Acupressure

3. Massage

4. Distraction

Correct Answer: 3

Rationale 1: Massage is used for relaxation, and can be effective in helping the client who is anxious. Distraction, acupressure, and acupuncture are not used for relaxation, although they can be effective in helping the client cope with pain.

Rationale 2: Massage is used for relaxation, and can be effective in helping the client who is anxious. Distraction, acupressure, and acupuncture are not used for relaxation, although they can be effective in helping the client cope with pain.

Rationale 3: Massage is used for relaxation, and can be effective in helping the client who is anxious. Distraction, acupressure, and acupuncture are not used for relaxation, although they can be effective in helping the client cope with pain.

Rationale 4: Massage is used for relaxation, and can be effective in helping the client who is anxious. Distraction, acupressure, and acupuncture are not used for relaxation, although they can be effective in helping the client cope with pain.

Global Rationale: Massage is used for relaxation, and can be effective in helping the client who is anxious. Distraction, acupressure, and acupuncture are not used for relaxation, although they can be effective in helping the client cope with pain.

Cognitive Level: Applying
Client Need: Physiological Integrity
Client Need Sub: Basic Care and Comfort
QSEN Competencies: I.B.7. Initiate effective treatments to relieve pain and suffering in light of client values, preferences, and expressed needs
AACN Essential Competencies: IX.17. Develop a beginning understanding of complementary and alternative modalities and their role in health care
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care
Nursing/Integrated Concepts: Nursing Process: Planning
Learning Outcome: Describe nonpharmacologic pain management interventions.
Page Number: p. 265

Question 24
Type: MCSA

The nurse administered an oral analgesic to a client complaining of a mild-to-moderate headache. Which activity would the nurse consider to help relieve the client's discomfort until the analgesic takes effect?

1. Reading or watching TV

2. Video or computer games

3. Slow rhythmic breathing

4. Crossword puzzles

Correct Answer: 3

Rationale 1: Slow rhythmic breathing would be an effective distraction technique for a client with a headache. Reading, watching TV, video games, and crossword puzzles might exacerbate the symptoms because the client with a headache is often more comfortable in a dark, low-stimuli environment.

Rationale 2: Slow rhythmic breathing would be an effective distraction technique for a client with a headache. Reading, watching TV, video games, and crossword puzzles might exacerbate the symptoms because the client with a headache is often more comfortable in a dark, low-stimuli environment.

Rationale 3: Slow rhythmic breathing would be an effective distraction technique for a client with a headache. Reading, watching TV, video games, and crossword puzzles might exacerbate the symptoms because the client with a headache is often more comfortable in a dark, low-stimuli environment.

Rationale 4: Slow rhythmic breathing would be an effective distraction technique for a client with a headache. Reading, watching TV, video games, and crossword puzzles might exacerbate the symptoms because the client with a headache is often more comfortable in a dark, low-stimuli environment.

Global Rationale: Slow rhythmic breathing would be an effective distraction technique for a client with a headache. Reading, watching TV, video games, and crossword puzzles might exacerbate the symptoms because the client with a headache is often more comfortable in a dark, low-stimuli environment.

Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub: Basic Care and Comfort
QSEN Competencies: I.B.7. Initiate effective treatments to relieve pain and suffering in light of client values, preferences, and expressed needs
AACN Essential Competencies: IX.17. Develop a beginning understanding of complementary and alternative modalities and their role in health care
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care
Nursing/Integrated Concepts: Nursing Process: Planning
Learning Outcome: Describe nonpharmacologic pain management interventions.
Page Number: p. 269

Question 25
Type: MCSA

Which can the nurse safely delegate to the unlicensed assistive personnel (UAP)?

1. Initial assessment of pain

2. Regular reassessment of pain

3. Providing a massage and repositioning the client in pain

4. Administration of an oral analgesic

Correct Answer: 3

Rationale 1: Assessment is never delegated to the client and a UAP cannot administer oral analgesics. The UAP can safely provide a massage and reposition the client.

Rationale 2: Assessment is never delegated to the client and a UAP cannot administer oral analgesics. The UAP can safely provide a massage and reposition the client.

Rationale 3: Assessment is never delegated to the client and a UAP cannot administer oral analgesics. The UAP can safely provide a massage and reposition the client.

Rationale 4: Assessment is never delegated to the client and a UAP cannot administer oral analgesics. The UAP can safely provide a massage and reposition the client.

Global Rationale: Assessment is never delegated to the client and a UAP cannot administer oral analgesics. The UAP can safely provide a massage and reposition the client.

Cognitive Level: Applying
Client Need: Safe and Effective Care Environment

Client Need Sub: Management of Care
QSEN Competencies: II.A.2. Describe scopes of practice and roles of health care team members
AACN Essential Competencies: IX.14. Demonstrate clinical judgment and accountability for client outcomes when delegating to and supervising other members of the health care team
NLN Competencies: Teamwork: Manage delegation effectively.
Nursing/Integrated Concepts: Nursing Process: Planning
Learning Outcome: Recognize when it is appropriate to delegate pain management skills to unlicensed assistive personnel.
Page Number: p. 268

Question 26
Type: MCSA

The unlicensed assistive personnel (UAP) informs the nurse that the client is complaining of severe postoperative pain and requests pain medication. Which action would be appropriate for the nurse to perform?

1. Give the client an analgesic.

2. Assess the client's pain and respond as indicated.

3. Ask the UAP for more data regarding the client's pain.

4. Tell the UAP to inform the client that the nurse will be in as soon as possible.

Correct Answer: 2

Rationale 1: When the UAP reports a problem, the nurse should assess the client thoroughly before acting. Giving the client an analgesic without a thorough assessment by the nurse would be dangerous. Asking the UAP for more information is not efficient because the nurse should talk directly to the client. Delaying response to the client's needs would not be effective nursing practice.

Rationale 2: When the UAP reports a problem, the nurse should assess the client thoroughly before acting. Giving the client an analgesic without a thorough assessment by the nurse would be dangerous. Asking the UAP for more information is not efficient because the nurse should talk directly to the client. Delaying response to the client's needs would not be effective nursing practice.

Rationale 3: When the UAP reports a problem, the nurse should assess the client thoroughly before acting. Giving the client an analgesic without a thorough assessment by the nurse would be dangerous. Asking the UAP for more information is not efficient because the nurse should talk directly to the client. Delaying response to the client's needs would not be effective nursing practice.

Rationale 4: When the UAP reports a problem, the nurse should assess the client thoroughly before acting. Giving the client an analgesic without a thorough assessment by the nurse would be dangerous. Asking the UAP for more information is not efficient because the nurse should talk directly to the client. Delaying response to the client's needs would not be effective nursing practice.

Global Rationale: When the UAP reports a problem, the nurse should assess the client thoroughly before acting. Giving the client an analgesic without a thorough assessment by the nurse would be dangerous. Asking the UAP

for more information is not efficient because the nurse should talk directly to the client. Delaying response to the client's needs would not be effective nursing practice.

Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub: Basic Care and Comfort
QSEN Competencies: II.A.2. Describe scopes of practice and roles of health care team members
AACN Essential Competencies: IX.14. Demonstrate clinical judgment and accountability for client outcomes when delegating to and supervising other members of the health care team
NLN Competencies: Teamwork: Manage delegation effectively.
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Recognize when it is appropriate to delegate pain management skills to unlicensed assistive personnel.
Page Number: pp. 251-252

Question 27
Type: MCSA

The nurse is assessing a client's chronic pain. The client indicates the pain is in the upper right quadrant of the abdomen, rates the pain as a 9 on a 1–10 scale, and describes the pain as sharp and continuous. What else would the nurse assess regarding this client's pain?

1. Onset, duration, and recurrence

2. Location

3. Intensity

4. Quality

Correct Answer: 1

Rationale 1: The nurse would question when the pain began, how long it has lasted, and what causes the pain to recur, if it is intermittent. The client has already indicated the location (upper right quadrant), intensity (9 on a 1–10 scale), and quality (sharp and continuous).

Rationale 2: The nurse would question when the pain began, how long it has lasted, and what causes the pain to recur, if it is intermittent. The client has already indicated the location (upper right quadrant), intensity (9 on a 1–10 scale), and quality (sharp and continuous).

Rationale 3: The nurse would question when the pain began, how long it has lasted, and what causes the pain to recur, if it is intermittent. The client has already indicated the location (upper right quadrant), intensity (9 on a 1–10 scale), and quality (sharp and continuous).

Rationale 4: The nurse would question when the pain began, how long it has lasted, and what causes the pain to recur, if it is intermittent. The client has already indicated the location (upper right quadrant), intensity (9 on a 1–10 scale), and quality (sharp and continuous).

Global Rationale: The nurse would question when the pain began, how long it has lasted, and what causes the pain to recur, if it is intermittent. The client has already indicated the location (upper right quadrant), intensity (9 on a 1–10 scale), and quality (sharp and continuous).

Cognitive Level: Applying
Client Need: Physiological Integrity
Client Need Sub: Basic Care and Comfort
QSEN Competencies: I.B.7. Initiate effective treatments to relieve pain and suffering in light of client values, preferences, and expressed needs
AACN Essential Competencies: IX.8. Implement evidence-based nursing interventions as appropriate for managing the acute and chronic care of clients and promoting health across the life span
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: Verbalize the steps used in:
a. Assessing the client in pain.
b. Managing pain with a client-controlled analgesia pump.
c. Managing a transcutaneous electrical nerve stimulation unit.
d. Providing a back massage.
e. Teaching progressive muscle relaxation.
f. Assisting with guided imagery.
Page Number: pp. 245-250

Question 28
Type: MCSA

The nurse is initiating a client-controlled anesthesia (PCA) pump delivering morphine sulfate for an older school-age client post-appendectomy. Prior to connecting the PCA tubing to the client's IV fluid line, which action by the nurse is the priority?

1. Clamping the PCA tubing

2. Delivering the loading dose

3. Setting the safety parameters for the infusion on the PCA pump

4. Clamping the client's primary IV fluid line

Correct Answer: 1

Rationale 1: Before connecting the PCA to the client's IV line, the nurse should make sure the PCA tubing is clamped to avoid an accidental administration of narcotics. The loading dose is administered after properly programming the PCA pump. After connecting the PCA tubing to the client's IV line, the nurse would set the safety parameters. Clamping the client's primary IV line could result in occlusion of the IV catheter.

Rationale 2: Before connecting the PCA to the client's IV line, the nurse should make sure the PCA tubing is clamped to avoid an accidental administration of narcotics. The loading dose is administered after properly programming the PCA pump. After connecting the PCA tubing to the client's IV line, the nurse would set the safety parameters. Clamping the client's primary IV line could result in occlusion of the IV catheter.

Rationale 3: Before connecting the PCA to the client's IV line, the nurse should make sure the PCA tubing is clamped to avoid an accidental administration of narcotics. The loading dose is administered after properly programming the PCA pump. After connecting the PCA tubing to the client's IV line, the nurse would set the safety parameters. Clamping the client's primary IV line could result in occlusion of the IV catheter.

Rationale 4: Before connecting the PCA to the client's IV line, the nurse should make sure the PCA tubing is clamped to avoid an accidental administration of narcotics. The loading dose is administered after properly programming the PCA pump. After connecting the PCA tubing to the client's IV line, the nurse would set the safety parameters. Clamping the client's primary IV line could result in occlusion of the IV catheter.

Global Rationale: Before connecting the PCA to the client's IV line, the nurse should make sure the PCA tubing is clamped to avoid an accidental administration of narcotics. The loading dose is administered after properly programming the PCA pump. After connecting the PCA tubing to the client's IV line, the nurse would set the safety parameters. Clamping the client's primary IV line could result in occlusion of the IV catheter.

Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub: Pharmacologic and Parenteral Therapies
QSEN Competencies: I.B.7. Initiate effective treatments to relieve pain and suffering in light of client values, preferences, and expressed needs
AACN Essential Competencies: IX.8. Implement evidence-based nursing interventions as appropriate for managing the acute and chronic care of clients and promoting health across the life span
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Verbalize the steps used in:
a. Assessing the client in pain.
b. Managing pain with a client-controlled analgesia pump.
c. Managing a transcutaneous electrical nerve stimulation unit.
d. Providing a back massage.
e. Teaching progressive muscle relaxation.
f. Assisting with guided imagery.
Page Number: pp. 262-264

Question 29
Type: MCSA

The nurse is applying a TENS unit to a client in pain. Prior to applying the electrodes, which action by the nurse is the most appropriate?

1. Turning the unit on

2. Washing, rinsing, and drying the designated area with soap and water

3. Increasing the amplitude to the desired setting

4. Changing the battery

Correct Answer: 2

Rationale 1: Washing, rinsing, and drying the area will help to improve the contact of the electrodes to the skin. The unit should not be turned on until the electrodes are in place, to avoid injuring the client. The amplitude is slowly increased once the electrodes are in place to determine the level that is most effective for the client. The battery is changed when the unit is removed.

Rationale 2: Washing, rinsing, and drying the area will help to improve the contact of the electrodes to the skin. The unit should not be turned on until the electrodes are in place, to avoid injuring the client. The amplitude is slowly increased once the electrodes are in place to determine the level that is most effective for the client. The battery is changed when the unit is removed.

Rationale 3: Washing, rinsing, and drying the area will help to improve the contact of the electrodes to the skin. The unit should not be turned on until the electrodes are in place, to avoid injuring the client. The amplitude is slowly increased once the electrodes are in place to determine the level that is most effective for the client. The battery is changed when the unit is removed.

Rationale 4: Washing, rinsing, and drying the area will help to improve the contact of the electrodes to the skin. The unit should not be turned on until the electrodes are in place, to avoid injuring the client. The amplitude is slowly increased once the electrodes are in place to determine the level that is most effective for the client. The battery is changed when the unit is removed.

Global Rationale: Washing, rinsing, and drying the area will help to improve the contact of the electrodes to the skin. The unit should not be turned on until the electrodes are in place, to avoid injuring the client. The amplitude is slowly increased once the electrodes are in place to determine the level that is most effective for the client. The battery is changed when the unit is removed.

Cognitive Level: Applying
Client Need: Safe and Effective Care Environment
Client Need Sub: Management of Care
QSEN Competencies: I.B.7. Initiate effective treatments to relieve pain and suffering in light of client values, preferences, and expressed needs
AACN Essential Competencies: IX.8. Implement evidence-based nursing interventions as appropriate for managing the acute and chronic care of clients and promoting health across the life span
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Verbalize the steps used in:
a. Assessing the client in pain.
b. Managing pain with a client-controlled analgesia pump.
c. Managing a transcutaneous electrical nerve stimulation unit.
d. Providing a back massage.
e. Teaching progressive muscle relaxation.
f. Assisting with guided imagery.
Page Number: pp. 266-267

Question 30
Type: SEQ

The nurse is administering a back massage to the client. Place the steps in the proper order of performance.

Standard Text: Click on the down arrow for each response in the right column and select the correct choice from the list.

Response 1. Massage the areas over the right and left iliac crests.

Response 2. Move your hands up the center of the back.

Response 3. Massage the sacral area using smooth, circular strokes.

Response 4. Massage both scapulae.

Response 5. Move your hands down the side of the back.

Correct Answer: 3,2,4,5,1

Rationale 1: When administering a back massage, the nurse begins over the sacral area, using smooth, circular strokes, and then slides the hands up the center of the back, massaging over both scapulae. Slide the hands down the side of the back to massage over both iliac crests.

Rationale 2: When administering a back massage, the nurse begins over the sacral area, using smooth, circular strokes, and then slides the hands up the center of the back, massaging over both scapulae. Slide the hands down the side of the back to massage over both iliac crests.

Rationale 3: When administering a back massage, the nurse begins over the sacral area, using smooth, circular strokes, and then slides the hands up the center of the back, massaging over both scapulae. Slide the hands down the side of the back to massage over both iliac crests.

Rationale 4: When administering a back massage, the nurse begins over the sacral area, using smooth, circular strokes, and then slides the hands up the center of the back, massaging over both scapulae. Slide the hands down the side of the back to massage over both iliac crests.

Rationale 5: When administering a back massage, the nurse begins over the sacral area, using smooth, circular strokes, and then slides the hands up the center of the back, massaging over both scapulae. Slide the hands down the side of the back to massage over both iliac crests.

Global Rationale: When administering a back massage, the nurse begins over the sacral area, using smooth, circular strokes, and then slides the hands up the center of the back, massaging over both scapulae. Slide the hands down the side of the back to massage over both iliac crests.

Cognitive Level: Applying
Client Need: Physiological Integrity
Client Need Sub: Basic Care and Comfort
QSEN Competencies: I.B.7. Initiate effective treatments to relieve pain and suffering in light of client values, preferences, and expressed needs
AACN Essential Competencies: IX.8. Implement evidence-based nursing interventions as appropriate for managing the acute and chronic care of clients and promoting health across the life span
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Verbalize the steps used in:
a. Assessing the client in pain.
b. Managing pain with a client-controlled analgesia pump.
c. Managing a transcutaneous electrical nerve stimulation unit.

d. Providing a back massage.
e. Teaching progressive muscle relaxation.
f. Assisting with guided imagery.
Page Number: p. 268

Question 31
Type: MCSA

The nurse is teaching progressive muscle relaxation techniques to the client. Which rationale will the nurse include in the teaching session for progressive muscle relaxation?

1. It is a form of diversion that keeps your mind off of your stress.

2. By releasing muscle tension, the negative effects of stress can be lessened.

3. By relaxing the muscles, the pain the client is experiencing will cease.

4. It is a good form of exercise that will help you get into better shape so you won't experience any more pain.

Correct Answer: 2

Rationale 1: The rationale for progressive muscle relaxation is to release muscle tension and minimize the negative effects of stress. It is not just a form of diversion, and will not completely eliminate pain, although it might reduce the pain experience.

Rationale 2: The rationale for progressive muscle relaxation is to release muscle tension and minimize the negative effects of stress. It is not just a form of diversion, and will not completely eliminate pain, although it might reduce the pain experience.

Rationale 3: The rationale for progressive muscle relaxation is to release muscle tension and minimize the negative effects of stress. It is not just a form of diversion, and will not completely eliminate pain, although it might reduce the pain experience.

Rationale 4: The rationale for progressive muscle relaxation is to release muscle tension and minimize the negative effects of stress. It is not just a form of diversion, and will not completely eliminate pain, although it might reduce the pain experience.

Global Rationale: The rationale for progressive muscle relaxation is to release muscle tension and minimize the negative effects of stress. It is not just a form of diversion, and will not completely eliminate pain, although it might reduce the pain experience.

Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub: Basic Care and Comfort
QSEN Competencies: I.B.7. Initiate effective treatments to relieve pain and suffering in light of client values, preferences, and expressed needs
AACN Essential Competencies: IX.8. Implement evidence-based nursing interventions as appropriate for managing the acute and chronic care of clients and promoting health across the life span
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe

client care
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Verbalize the steps used in:
a. Assessing the client in pain.
b. Managing pain with a client-controlled analgesia pump.
c. Managing a transcutaneous electrical nerve stimulation unit.
d. Providing a back massage.
e. Teaching progressive muscle relaxation.
f. Assisting with guided imagery.
Page Number: pp. 271-272

Question 32
Type: MCSA

The nurse is assisting the client with the use of guided imagery. Which action by the nurse is the most appropriate when initiating guided imagery?

1. Asking the client to take slow, full diaphragmatic/abdominal breaths

2. Asking the client to use progressive muscle relaxation exercises

3. Guiding the client toward a most beautiful or peaceful place

4. Suggesting a place where the client will find peace

Correct Answer: 1

Rationale 1: The nurse begins by helping the client to relax using slow breaths. After deep breathing, the client may be asked to use progressive muscle relaxation exercises, and then the nurse will guide the client toward a peaceful place. The nurse should never suggest a peaceful place, but should allow the client to choose the place where he finds peace.

Rationale 2: The nurse begins by helping the client to relax using slow breaths. After deep breathing, the client may be asked to use progressive muscle relaxation exercises, and then the nurse will guide the client toward a peaceful place. The nurse should never suggest a peaceful place, but should allow the client to choose the place where he finds peace.

Rationale 3: The nurse begins by helping the client to relax using slow breaths. After deep breathing, the client may be asked to use progressive muscle relaxation exercises, and then the nurse will guide the client toward a peaceful place. The nurse should never suggest a peaceful place, but should allow the client to choose the place where he finds peace.

Rationale 4: The nurse begins by helping the client to relax using slow breaths. After deep breathing, the client may be asked to use progressive muscle relaxation exercises, and then the nurse will guide the client toward a peaceful place. The nurse should never suggest a peaceful place, but should allow the client to choose the place where he finds peace.

Global Rationale: The nurse begins by helping the client to relax using slow breaths. After deep breathing, the client may be asked to use progressive muscle relaxation exercises, and then the nurse will guide the client toward

a peaceful place. The nurse should never suggest a peaceful place, but should allow the client to choose the place where he finds peace.

Cognitive Level: Applying
Client Need: Physiological Integrity
Client Need Sub: Basic Care and Comfort
QSEN Competencies: I.B.7. Initiate effective treatments to relieve pain and suffering in light of client values, preferences, and expressed needs
AACN Essential Competencies: IX.8. Implement evidence-based nursing interventions as appropriate for managing the acute and chronic care of clients and promoting health across the life span
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Verbalize the steps used in:
a. Assessing the client in pain.
b. Managing pain with a client-controlled analgesia pump.
c. Managing a transcutaneous electrical nerve stimulation unit.
d. Providing a back massage.
e. Teaching progressive muscle relaxation.
f. Assisting with guided imagery.
Page Number: pp. 272-273

Question 33
Type: MCSA

The postoperative client has been noting a steady decline in the amount of pain experienced over the past week. Today, upon awakening, the pain is far more severe even at rest. Which priority intervention should the nurse perform for this client?

1. Assessing the client fully and notifying the health care provider

2. Explaining to the client that it is not unusual to have a recurrence of severe pain in the rehabilitative phase of recovery

3. Administering stronger opioid analgesics and documenting in the client's medical record

4. Explaining that the extra activity the client has been performing is the cause of the increased discomfort

Correct Answer: 1

Rationale 1: A sudden increase in pain can indicate infection or other complications, so the nurse's priority intervention is to assess the client fully and notify the health care provider prior to administering an analgesic, in case the description of the pain is required for the primary care provider to determine cause. It is unusual for the recurrence of pain in the rehabilitative phase. Administering a strong analgesic without proper assessment is not appropriate. Telling the client that the increased discomfort is caused by extra activity is incorrect as it ignores the importance of the symptoms reported by the client.

Rationale 2: A sudden increase in pain can indicate infection or other complications, so the nurse's priority intervention is to assess the client fully and notify the health care provider prior to administering an analgesic, in

case the description of the pain is required for the primary care provider to determine cause. It is unusual for the recurrence of pain in the rehabilitative phase. Administering a strong analgesic without proper assessment is not appropriate. Telling the client that the increased discomfort is caused by extra activity is incorrect as it ignores the importance of the symptoms reported by the client.

Rationale 3: A sudden increase in pain can indicate infection or other complications, so the nurse's priority intervention is to assess the client fully and notify the health care provider prior to administering an analgesic, in case the description of the pain is required for the primary care provider to determine cause. It is unusual for the recurrence of pain in the rehabilitative phase. Administering a strong analgesic without proper assessment is not appropriate. Telling the client that the increased discomfort is caused by extra activity is incorrect as it ignores the importance of the symptoms reported by the client.

Rationale 4: A sudden increase in pain can indicate infection or other complications, so the nurse's priority intervention is to assess the client fully and notify the health care provider prior to administering an analgesic, in case the description of the pain is required for the primary care provider to determine cause. It is unusual for the recurrence of pain in the rehabilitative phase. Administering a strong analgesic without proper assessment is not appropriate. Telling the client that the increased discomfort is caused by extra activity is incorrect as it ignores the importance of the symptoms reported by the client.

Global Rationale: A sudden increase in pain can indicate infection or other complications, so the nurse's priority intervention is to assess the client fully and notify the health care provider prior to administering an analgesic, in case the description of the pain is required for the primary care provider to determine cause. It is unusual for the recurrence of pain in the rehabilitative phase. Administering a strong analgesic without proper assessment is not appropriate. Telling the client that the increased discomfort is caused by extra activity is incorrect as it ignores the importance of the symptoms reported by the client.

Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub: Basic Care and Comfort
QSEN Competencies: VI.B.4. Document and plan client care in an electronic health record
AACN Essential Competencies: IV.5. Use standardized terminology in a care environment that reflects nursing's unique contribution to client outcomes
NLN Competencies: Quality and Safety: Carefully maintain and use electronic and/or written health records
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Demonstrate appropriate documentation and reporting of pain assessment and interventions.
Page Number: p. 252

Question 34
Type: MCMA

The nurse documents the assessment and interventions performed to relieve the client's pain on a pain management flow sheet. Why is this documentation important?

Standard Text: Select all that apply.

1. Reduces time spent on documentation.

2. Clarifies and communicates each client's pain experience.

3. Accurately documents the pain management efforts performed by the nurse.

4. Enhances pain relief efforts.

5. Ensures continuity of care.

Correct Answer: 2,4,5

Rationale 1: The pain management flow sheet helps to clarify and communicate each client's pain experience to other members of the health care team, enhances pain management effectiveness, and ensures that other care providers will recognize what has worked for pain relief in the past, ensuring continuity of care. It is not used to reduce time spent on documentation, although this can be a pleasant side effect. Pain management should be accurately documented no matter what form is used.

Rationale 2: The pain management flow sheet helps to clarify and communicate each client's pain experience to other members of the health care team, enhances pain management effectiveness, and ensures that other care providers will recognize what has worked for pain relief in the past, ensuring continuity of care. It is not used to reduce time spent on documentation, although this can be a pleasant side effect. Pain management should be accurately documented no matter what form is used.

Rationale 3: The pain management flow sheet helps to clarify and communicate each client's pain experience to other members of the health care team, enhances pain management effectiveness, and ensures that other care providers will recognize what has worked for pain relief in the past, ensuring continuity of care. It is not used to reduce time spent on documentation, although this can be a pleasant side effect. Pain management should be accurately documented no matter what form is used.

Rationale 4: The pain management flow sheet helps to clarify and communicate each client's pain experience to other members of the health care team, enhances pain management effectiveness, and ensures that other care providers will recognize what has worked for pain relief in the past, ensuring continuity of care. It is not used to reduce time spent on documentation, although this can be a pleasant side effect. Pain management should be accurately documented no matter what form is used.

Rationale 5: The pain management flow sheet helps to clarify and communicate each client's pain experience to other members of the health care team, enhances pain management effectiveness, and ensures that other care providers will recognize what has worked for pain relief in the past, ensuring continuity of care. It is not used to reduce time spent on documentation, although this can be a pleasant side effect. Pain management should be accurately documented no matter what form is used.

Global Rationale: The pain management flow sheet helps to clarify and communicate each client's pain experience to other members of the health care team, enhances pain management effectiveness, and ensures that other care providers will recognize what has worked for pain relief in the past, ensuring continuity of care. It is not used to reduce time spent on documentation, although this can be a pleasant side effect. Pain management should be accurately documented no matter what form is used.

Cognitive Level: Applying
Client Need: Safe and Effective Care Environment
Client Need Sub: Management of Care
QSEN Competencies: VI.B.4. Document and plan client care in an electronic health record
AACN Essential Competencies: IV.5. Use standardized terminology in a care environment that reflects nursing's unique contribution to client outcomes

NLN Competencies: Quality and Safety: Carefully maintain and use electronic and/or written health records
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Demonstrate appropriate documentation and reporting of pain assessment and interventions.
Page Number: p. 248

Question 35
Type: MCSA

Pain is a complex phenomenon that affects both the physical and mental areas. When teaching the client about pain, which statement made by the client would indicate appropriate understanding?

1. "Cancer pain usually only lasts a short time."

2. "Acute pain is usually rapid and can vary in intensity."

3. "Chronic pain may be acute, chronic, or intermittent."

4. "Chronic pain usually only lasts a little while."

Correct Answer: 2

Rationale 1: Pain associated with cancer can be both acute and chronic and indicates the need for further education.

Rationale 2: This is one definition of acute pain and shows that the client understands about this type of pain.

Rationale 3: This statement defines cancer pain, not chronic pain, and indicates the need for further education.

Rationale 4: This statement describes acute pain, not chronic pain, and indicates the need for further education.

Global Rationale: Acute pain can be described as rapid and can vary in intensity. This statement indicates an appropriate understanding of the teaching session. The other statements indicate that the client requires further education.

Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub: Basic Care and Comfort
QSEN Competencies: I.A.3. Demonstrate comprehensive understanding of the concepts of pain and suffering, including physiological models of pain and comfort.
AACN Essential Competencies: III.1. Explain the interrelationships among theory, practice, and research
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care
Nursing/Integrated Concepts: Nursing Process: Evaluation
Learning Outcome: Describe the various types of pain.
Page Number: p. 239

Question 36
Type: MCSA

Nurses must be aware of cultural considerations when assisting clients with pain tolerance. Which statement made by the nurse indicates an understanding of cultural awareness?

1. "Nurses must know that all pain is the same no matter what culture the client comes from."

2. "Nurses must not ask probing questions about the client's pain, as this is considered inappropriate."

3. "Nurses should treat all clients the same regardless of cultural differences."

4. "Nurses must understand that different cultures deal with pain in very different ways. Nurses must not judge the client based on any misconceptions of pain and treatment of pain."

Correct Answer: 4

Rationale 1: Pain is a subjective experience. This statement is not an accurate way in which to determine the client's pain level.

Rationale 2: Nurses must be able to ask the appropriate questions when assessing the client in pain.

Rationale 3: The nurse should treat all clients as individuals, taking into account their culture and preferences.

Rationale 4: Nurses must be culturally aware of the client's beliefs when taking care of the medical conditions that cause the client pain.

Global Rationale: Nurses must be culturally aware of the client's beliefs when taking care of the medical conditions that cause them pain. The other statements do not accurately illustrate an understanding of cultural awareness.

Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub: Basic Care and Comfort
QSEN Competencies: I.B.6. Elicit expectations of client and family for relief of pain, discomfort, or suffering
AACN Essential Competencies: III.1. Explain the interrelationships among theory, practice, and research
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Identify key factors in pain management.
Page Number: pp. 240-241

Question 37
Type: MCSA

Many clients have misconceptions regarding assessment and treatment of pain. Which statement by the client indicates the need for additional clarification?

1. "If I don't report pain, it does not necessarily mean that I don't have any pain."

2. "I can have a back rub and think of relaxing thoughts to help decrease the amount of medication I take for pain."

3. "The best judge of the existence and severity of pain is the nurse who is taking care of me."

4. "I will be asked to rate my pain on a predetermined scale."

Correct Answer: 3

Rationale 1: Clients often do not want to be seen as complainers and will not report being in pain. This is a true statement.

Rationale 2: The use of nonpharmacologic measures is a good option when taking care of clients experiencing pain. This is a true statement.

Rationale 3: The client's self-report, not the nurse's assessment of pain, is the most reliable indicator of the existence and severity of the pain. This statement indicates the need for further education.

Rationale 4: Rating pain on a predetermined scale is one of the ways in which to establish a baseline of pain intensity. This is a true statement.

Global Rationale: The client's self-report, not the nurse's assessment of pain, is the most reliable indicator of the existence and severity of the pain. This statement indicates the need for further education. The other statements are true and do not require further intervention by the nurse.

Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub: Basic Care and Comfort
QSEN Competencies: I.B.6. Elicit expectations of client and family for relief of pain, discomfort, or suffering
AACN Essential Competencies: III.1. Explain the interrelationships among theory, practice, and research
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Identify key factors in pain management.
Page Number: pp. 237-239

Question 38
Type: MCSA

The nurse is instructing the client on how to use the client-controlled analgesia (PCA) pump. Which statement made by the client indicates an appropriate understanding of the nurse's instructions regarding the use of the PCA pump?

1. "I will push the button continually until I am pain free."

2. "I will likely overdose on pain medication with the use of the button."

3. "I will let my family control my pain medicine by allowing them to push the button."

4. "I will push the button when the pain becomes severe."

Correct Answer: 4

Rationale 1: Pushing the button continuously will not make the client receive more pain medication. This statement indicates the need for more education.

Rationale 2: The use of a PCA pump actually decreases the likelihood of an overdose. This statement indicates the need for further education.

Rationale 3: The family should not be in control of the client's pain medication. This statement indicates the need for further education.

Rationale 4: The client is taught to push the button when the pain becomes severe. This statement indicates an appropriate understanding of the teaching session.

Global Rationale: The client is taught to push the button when the pain becomes severe. This statement indicates an appropriate understanding of the teaching session. The other statements indicate the need for more education regarding the use of the PCA pump.

Cognitive Level: Remembering
Client Need: Physiological Integrity
Client Need Sub: Pharmacologic and Parenteral Therapies
QSEN Competencies: I.B.7. Initiate effective treatments to relieve pain and suffering in light of client values, preferences, and expressed needs
AACN Essential Competencies: IX.8. Implement evidence-based nursing interventions as appropriate for managing the acute and chronic care of clients and promoting health across the life span
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Verbalize the steps used in:
a. Assessing the client in pain.
b. Managing pain with a client-controlled analgesia pump.
c. Managing a transcutaneous electrical nerve stimulation unit.
d. Providing a back massage.
e. Teaching progressive muscle relaxation.
f. Assisting with guided imagery.
Page Number: pp. 262-263

Question 39
Type: MCSA

A client who recently had surgery is medicated prior to return to the nursing unit. Which assessment finding warrants the need for a more in-depth assessment when determining the client's score on the sedation scale?

1. The client is sleeping but is easy to arouse.

2. The client is somnolent, with minimal or no response to physical stimulation.

3. The client is slightly drowsy, but arouses easily with minimal physical stimulation.

4. The client is awake and alert visiting with family at the bedside.

Correct Answer: 2

Rationale 1: The client who is sleeping but is easy to arouse is scored as a 2 on the sedation scale, which is normal for this level of analgesia.

Rationale 2: The client who is somnolent, with minimal or no response to physical stimulation, requires further assessment with immediate action to reverse the cause.

Rationale 3: The client who is slightly drowsy, but arouses easily with minimal physical stimulation, is considered a 3 on the sedation scale, which is normal for this level of sedation.

Rationale 4: The client who is awake and alert visiting with family at the bedside is considered a 1 on the sedation scale, which is considered normal.

Global Rationale: The client who is somnolent, with minimal or no response to physical stimulation, requires further assessment with immediate action to reverse the cause. The other assessment findings are normal and do not require further assessment and treatment by the nurse.

Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub: Basic Care and Comfort
QSEN Competencies: I.B.4. Assess presence and extent of pain and suffering
AACN Essential Competencies: IX.1. Conduct comprehensive and focused physical, behavioral, psychological, spiritual, socioeconomic, and environmental assessments of health and illness parameters in clients, using developmentally and culturally appropriate approaches
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: Describe the two major components of pain assessment.
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