Chapter 3: Assessment and Care of Patients with Pain
Ignatavicius: Medical-Surgical Nursing, 8th Edition

MULTIPLE CHOICE

1. A student asks the nurse what is the best way to assess a client's pain. Which response by the nurse is best?
   a. Numeric pain scale
   b. Behavioral assessment
   c. Objective observation
   d. Client's self-report

   ANS: D
   Many ways to measure pain are in use, including numeric pain scales, behavioral assessments, and other objective observations. However, the most accurate way to assess pain is to get a self-report from the client.

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

2. A new nurse reports to the precepting nurse that a client requested pain medication, and when the nurse brought it, the client was sound asleep. The nurse states the client cannot possibly sleep with the severe pain the client described. What response by the experienced nurse is best?
   a. "Being able to sleep doesn't mean pain doesn't exist."
   b. "Have you ever experienced any type of pain?"
   c. "The client should be assessed for drug addiction."
   d. "You're right; I would put the medication back."

   ANS: A
   A client's description is the most accurate assessment of pain. The nurse should believe the client and provide pain relief. Physiologic changes due to pain vary from client to client, and assessments of them should not supersede the client's descriptions, especially if the pain is chronic in nature. Asking if the new nurse has had pain is judgmental and flippant, and does not provide useful information. This amount of information does not warrant an assessment for drug addiction. Putting the medication back and ignoring the client's report of pain serves no useful purpose.

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

3. The nurse in the surgery clinic is discussing an upcoming surgical procedure with a client. What information provided by the nurse is most appropriate for the client's long-term outcome?
   a. "At least you know that the pain after surgery will diminish quickly."

b. “Discuss acceptable pain control after your operation with the surgeon.”
c. “Opioids often cause nausea but you won’t have to take them for long.”
d. “The nursing staff will give you pain medication when you ask them for it.”

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

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

4. A nurse is assessing pain on a confused older client who has difficulty with verbal expression. What pain assessment tool would the nurse choose for this assessment?
a. Numeric rating scale
b. Verbal Descriptor Scale
c. FACES Pain Scale-Revised
d. Wong-Baker FACES Pain Scale

ANS: C
All are valid pain rating scales; however, some research has shown that the FACES Pain Scale-Revised is preferred by both cognitively intact and cognitively impaired adults.

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

5. The nurse is assessing a client’s pain and has elicited information on the location, quality, intensity, effect on functioning, aggravating and relieving factors, and onset and duration. What question by the nurse would be best to ask the client for completing a comprehensive pain assessment?
a. “Are you worried about addiction to pain pills?”
b. “Do you attach any spiritual meaning to pain?”
c. “How high would you say your pain tolerance is?”
d. “What pain rating would be acceptable to you?”

ANS: D
A comprehensive pain assessment includes the items listed in the question plus the client’s opinion on a functional goal, such as what pain rating would be acceptable to him or her. Asking about addiction is not warranted in an initial pain assessment. Asking about spiritual meanings for pain may give the nurse important information, but getting the basics first is more important. Asking about pain tolerance may give the client the idea that pain tolerance is being judged.

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

6. A nurse is assessing pain in an older adult. What action by the nurse is best?
   a. Ask only "yes-or-no" questions so the client doesn't get too tired.
   b. Give the client a picture of the pain scale and come back later.
   c. Question the client about new pain only, not normal pain from aging.
   d. Sit down, ask one question at a time, and allow the client to answer.

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

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

7. The nurse receives a hand-off report. One client is described as a drug seeker who is obsessed with even tiny changes in physical condition and is "on the light constantly" asking for more pain medication. When assessing this client's pain, what statement or question by the nurse is most appropriate?
   a. "Help me understand how pain is affecting you right now."
   b. "I wish I could do more; is there anything I can get for you?"
   c. "You cannot have more pain medication for 3 hours."
   d. "Why do you think the medication is not helping your pain?"

   ANS: A
   This is an example of therapeutic communication. A client who is preoccupied with physical symptoms and is "demanding" may have some psychosocial impact from the pain that is not being addressed. The nurse is providing the client the chance to explain the emotional effects of pain in addition to the physical ones. Saying the nurse wishes he or she could do more is very empathetic, but this response does not attempt to learn more about the pain. Simply telling the client when the next medication is due also does not help the nurse understand the client's situation. "Why" questions are probing and often make clients defensive, plus the client may not have an answer for this question.

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

8. A nurse on the medical-surgical unit has received a hand-off report. Which client should the nurse see first?
   a. Client being discharged later on a complicated analgesia regimen

b. Client with new-onset abdominal pain, rated as an 8 on a 0-to-10 scale
c. Postoperative client who received oral opioid analgesia 45 minutes ago
d. Client who has returned from physical therapy and is resting in the recliner

ANS: B
Acute pain often serves as a physiologic warning signal that something is wrong. The client with new-onset abdominal pain needs to be seen first. The postoperative client needs 45 minutes to an hour for the oral medication to become effective and should be seen shortly to assess for effectiveness. The client going home requires teaching, which should be done after the first two clients have been seen and cared for, as this teaching will take some time. The client resting comfortably can be checked on quickly before spending time teaching the client who is going home.

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

9. A nurse uses the Checklist of Nonverbal Pain Indicators to assess pain in a nonverbal client with advanced dementia. The client scores a zero. What action by the nurse is best?
a. Assess physiologic indicators and vital signs.
b. Do not give pain medication as no pain is indicated.
c. Document the findings and continue to monitor.
d. Try a small dose of analgesic medication for pain.

ANS: A
Assessing pain in a nonverbal client is difficult despite the use of a scale specifically designed for this population. The nurse should next look at physiologic indicators of pain and vital signs for clues to the presence of pain. Even a low score on this index does not mean the client does not have pain; he or she may be holding very still to prevent more pain. Documenting pain is important but not the most important action in this case. The nurse can try a small dose of analgesia, but without having indices to monitor, it will be difficult to assess for effectiveness. However, if the client has a condition that could reasonably cause pain (i.e., recent surgery), the nurse does need to treat the client for pain.

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

10. A student nurse asks why several clients are getting more than one type of pain medication instead of very high doses of one medication. What response by the registered nurse is best?
a. “A multimodal approach is the preferred method of control.”
b. “Doctors are much more liberal with pain medications now.”
c. “Pain is so complex it takes different approaches to control it.”
d. “Clients are consumers and they demand lots of pain medicine.”

ANS: C

Pain is a complex phenomenon and often responds best to a regimen that uses different types of analgesia. This is called a multimodal approach. Using this terminology, however, may not be clear to the student if the terminology is not understood. Doctors may be more liberal with pain medications, but that is not the best reason for this approach. Saying that clients are consumers who demand medications sounds as if the nurse is discounting their pain experiences.

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

11. A client who had surgery has extreme postoperative pain that is worsened when trying to participate in physical therapy. What intervention for pain management does the nurse include in the client's care plan?
    a. As-needed pain medication after therapy
    b. Client-controlled analgesia with a basal rate
    c. Pain medications prior to therapy only
    d. Round-the-clock analgesia with PRN analgesics

    ANS: D
    Severe pain related to surgery or tissue trauma is best managed with round-the-clock dosing. Breakthrough pain associated with specific procedures is managed with additional medication. An as-needed regimen will not control postoperative pain. A client-controlled analgesia pump might be a good idea but needs basal (continuous) and bolus (intermittent) settings to accomplish adequate pain control. Pain control needs to be continuous, not just administered prior to therapy.

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

12. A nurse on the postoperative inpatient unit receives a hand-off report on four clients using patient-controlled analgesia (PCA) pumps. Which client should the nurse see first?
    a. Client who appears to be sleeping soundly
    b. Client with no bolus request in 6 hours
    c. Client who is pressing the button every 10 minutes
    d. Client with a respiratory rate of 8 breaths/min

    ANS: D

Continuous delivery of opioid analgesia can lead to respiratory depression and extreme sedation. A respiratory rate of 8 breaths/min is below normal, so the nurse should first check this client. The client sleeping soundly could either be overly sedated or just comfortable and should be checked next. Pressing the button every 10 minutes indicates the client has a high level of pain, but the device has a lockout determining how often a bolus can be delivered. Therefore, the client cannot overdose. The nurse should next assess that client's pain. The client who has not needed a bolus of pain medicine in several hours has well-controlled pain.

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

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

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

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

14. A client is put on twice-daily acetaminophen (Tylenol) for osteoarthritis. What finding in the client's health history would lead the nurse to consult with the provider over the choice of medication?
    a. 25–pack-year smoking history
    b. Drinking 3 to 5 beers a day
    c. Previous peptic ulcer
    d. Taking warfarin (Coumadin)

    ANS: B
    The major serious side effect of acetaminophen is hepatotoxicity and liver damage. Drinking 3 to 5 beers each day may indicate underlying liver disease, which should be investigated prior to taking chronic acetaminophen. The nurse should relay this information to the provider. Smoking is not related to acetaminophen side effects. Acetaminophen does not cause bleeding, so a previous peptic ulcer or taking warfarin would not be a problem.

    DIF: Applying/Application REF: 35
    KEY: Acetaminophen| pharmacologic pain management

MSC: Integrated Process: Communication and Documentation
NOT: Client Needs Category: Physiological Integrity: Pharmacological and Parenteral Therapies

15. A nurse is preparing to give a client ketorolac (Toradol) intravenously for pain. Which assessment findings would lead the nurse to consult with the provider?
    a. Bilateral lung crackles
    b. Hypoactive bowel sounds
    c. Self-reported pain of 3/10
    d. Urine output of 20 mL/2 hr

    ANS: D
    Drugs in this category can affect renal function. Clients should be adequately hydrated and demonstrate good renal function prior to administering ketorolac. A urine output of 20 mL/2 hr is well below normal, and the nurse should consult with the provider about the choice of drug. Crackles and hypoactive bowel sounds are not related. A pain report of 3 does not warrant a call to the physician. The medication may be part of a round-the-clock regimen to prevent and control pain and would still need to be given. If the medication is PRN, the nurse can ask the client if he or she still wants it.

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

16. A hospitalized client uses a transdermal fentanyl (Duragesic) patch for chronic pain. What action by the nurse is most important for client safety?
    a. Assess and record the client's pain every 4 hours.
    b. Ensure the client is eating a high-fiber diet.
    c. Monitor the client's bowel function every shift.
    d. Remove the old patch when applying the new one.

    ANS: D
    The old fentanyl patch should be removed when applying a new patch so that accidental overdose does not occur. The other actions are appropriate, but not as important for safety.

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

17. A hospitalized client has a history of depression for which sertraline (Zoloft) is prescribed. The client also has a morphine allergy and a history of alcoholism. After surgery, several opioid analgesics are prescribed. Which one would the nurse choose?
    a. Hydrocodone and acetaminophen (Lorcet)
    b. Hydromorphone (Dilaudid)
    c. Meperidine (Demerol)
    d. Tramadol (Ultram)

ANS: B
Hydromorphone is a good alternative to morphine for moderate to severe pain. The nurse should not choose Lorcet because it contains acetaminophen (Tylenol) and the client has a history of alcoholism. Tramadol should not be used due to the potential for interactions with the client's sertraline. Meperidine is rarely used and is often restricted.

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

18. A client has received an opioid analgesic for pain. The nurse assesses that the client has a Pasero Scale score of 3 and a respiratory rate of 7 shallow breaths/min. The client's oxygen saturation is 87%. What action should the nurse perform first?
    a. Apply oxygen at 4 L/min.
    b. Attempt to arouse the client.
    c. Give naloxone (Narcan).
    d. Notify the Rapid Response Team.

    ANS: B
    The Pasero Opioid-Induced Sedation Scale is used to assess for unwanted opioid-associated sedation. A Pasero Scale score of 3 is unacceptable but is managed by trying to arouse the client in order to take deep breaths and staying with the client until he or she is more alert. Administering oxygen will not help if the client's respiratory rate is 7 breaths/min. Giving naloxone and calling for a Rapid Response Team would be appropriate for a higher Pasero Scale score.

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

19. An older adult has diabetic neuropathy and often reports unbearable foot pain. About which medication would the nurse plan to educate the client?
    a. Desipramine (Norpramin)
    b. Duloxetine (Cymbalta)
    c. Morphine sulfate
    d. Nortriptyline (Pamelor)

    ANS: B
    Antidepressants and anticonvulsants often are used for neuropathic pain relief. Morphine would not be used for this client. However, older adults do not tolerate tricyclic antidepressants very well, which eliminates desipramine and nortriptyline. Duloxetine would be the best choice for this older client.

    DIF: Applying/Application REF: 45
    KEY: Neuropathic pain| pharmacologic pain management
    MSC: Integrated Process: Nursing Process: Analysis

NOT: Client Needs Category: Physiological Integrity: Pharmacological and Parenteral Therapies

20. An emergency department (ED) manager wishes to start offering clients nonpharmacologic pain control methodologies as an adjunct to medication. Which strategy would be most successful with this client population?
    a. Listening to music on a headset
    b. Participating in biofeedback
    c. Playing video games
    d. Using guided imagery

    ANS: A
    Listening to music on a headset would be the most successful cognitive-behavioral pain control method for several reasons. First, in the ED, the nurse does not have time to teach clients complex modalities such as guided imagery or biofeedback. Second, clients who are anxious and in pain may not have good concentration, limiting the usefulness of video games. Playing music on a headset only requires the client to wear the headset and can be beneficial without strong concentration. A wide selection of music will make this appealing to more people.

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

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

    ANS: D
    All these activities are appropriate when discharging a client whose needs will continue after discharge. A home safety assessment would be most important to ensure the safety of this older client.

    DIF: Remembering/Knowledge REF: 48
    KEY: Safety| older adult| opioid analgesics
    MSC: Integrated Process: Communication and Documentation
    NOT: Client Needs Category: Safe and Effective Care Environment: Safety and Infection Control

22. A nurse is caring for four clients receiving pain medication. After the hand-off report, which client should the nurse see first?
    a. Client who is crying and agitated
    b. Client with a heart rate of 104 beats/min
    c. Client with a Pasero Scale score of 4
    d. Client with a verbal pain report of 9

ANS: C

The Pasero Opioid-Induced Sedation Scale has scores ranging from S to 1 to 4. A score of 4 indicates unacceptable somnolence and is an emergency. The nurse should see this client first. The nurse can delegate visiting with the crying client to a nursing assistant; the client may be upset and might benefit from talking or a comforting presence. The client whose pain score is 9 needs to be seen next, or the nurse can delegate this assessment to another nurse while working with the priority client. A heart rate of 104 beats/min is slightly above normal, and that client can be seen after the other two clients are cared for.

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

23. A nurse is caring for a client on an epidural patient-controlled analgesia (PCA) pump. What action by the nurse is most important to ensure client safety?
    a. Assess and record vital signs every 2 hours.
    b. Have another nurse double-check the pump settings.
    c. Instruct the client to report any unrelieved pain.
    d. Monitor for numbness and tingling in the legs.

    ANS: B

    PCA-delivered analgesia creates a potential risk for the client. Pump settings should always be double-checked. Assessing vital signs should be done per agency policy and nurse discretion, and may or may not need to be this frequent. Unrelieved pain should be reported but is not vital to client safety. Monitoring for numbness and tingling in the legs is an important function but will manifest after something has occurred to the client; monitoring does not prevent the event from occurring.

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

24. A postoperative client is reluctant to participate in physical therapy. What action by the nurse is best?
    a. Ask the client about pain goals and if they are being met.
    b. Ask the client why he or she is being uncooperative with therapy.
    c. Increase the dose of analgesia given prior to therapy sessions.
    d. Tell the client that physical therapy is required to regain function.

    ANS: A

A comprehensive pain management plan includes the client's goals for pain control. Adequate pain control is necessary to allow full participation in therapy. The first thing the nurse should do is to ask about the client's pain goals and if they are being met. If not, an adjustment to treatment can be made. If they are being met, the nurse can assess for other factors influencing the client's behavior. Asking the client why he or she is being uncooperative is not the best response for two reasons. First, "why" questions tend to put people on the defensive. Second, labeling the behavior is inappropriate. Simply increasing the pain medication may not be advantageous. Simply telling the client that physical therapy is required does not address the issue.

DIF: Applying/Application REF: 46 KEY: Pain goals| pain
MSC: Integrated Process: Nursing Process: Assessment
NOT: Client Needs Category: Physiological Integrity: Reduction of Risk Potential

25. A client is being discharged from the hospital after surgery on hydrocodone and acetaminophen (Lorcet). What discharge instruction is *most* important for this client?
    a. "Call the doctor if the Lorcet does not relieve your pain."
    b. "Check any over-the-counter medications for acetaminophen."
    c. "Eat more fiber and drink more water to prevent constipation."
    d. "Keep your follow-up appointment with the surgeon as scheduled."

    ANS: B
    All instructions are appropriate for this client. However, advising the client to check over-the-counter medications for acetaminophen is an important safety measure. Acetaminophen is often found in common over-the-counter medications and should be limited to 3000 mg/day.

    DIF: Applying/Application REF: 35
    KEY: Pharmacologic pain management| opioid analgesics
    MSC: Integrated Process: Teaching/Learning
    NOT: Client Needs Category: Physiological Integrity: Pharmacological and Parenteral Therapies

MULTIPLE RESPONSE

1. A faculty member explains to students the process by which pain is perceived by the client. Which processes does the faculty member include in the discussion? **(Select all that apply.)**
    a. Induction
    b. Modulation
    c. Sensory perception
    d. Transduction
    e. Transmission

    ANS: B, C, D, E
    The four processes involved in making pain a conscious experience are modulation, sensory perception, transduction, and transmission.

    DIF: Remembering/Knowledge REF: 26
    KEY: Pain transmission| pain MSC: Integrated Process: Teaching/Learning

NOT: Client Needs Category: Physiological Integrity: Physiological Adaptation

2. A faculty member explains the concepts of addiction, tolerance, and dependence to students. Which information is accurate? **(Select all that apply.)**
   a. Addiction is a chronic physiologic disease process.
   b. Physical dependence and addiction are the same thing.
   c. Pseudoaddiction can result in withdrawal symptoms.
   d. Tolerance is a normal response to regular opioid use.
   e. Tolerance is said to occur when opioid effects decrease.

   ANS: A, D, E
   Addiction, tolerance, and dependence are important concepts. Addiction is a chronic, treatable disease with a neurologic and biologic basis. Tolerance occurs with regular administration of opioid analgesics and is seen when the effect of the analgesic decreases (either therapeutic effect or side effects). Dependence and addiction are not the same; dependence occurs with regular administration of analgesics and can result in withdrawal symptoms when they are discontinued abruptly. Pseudoaddiction is the mistaken diagnosis of addictive disease.

   DIF: Remembering/Knowledge REF: 38
   KEY: Dependence| tolerance| addiction MSC: Integrated Process: Teaching/Learning
   NOT: Client Needs Category: Physiological Integrity: Physiological Adaptation

3. A postoperative client has an epidural infusion of morphine and bupivacaine (Marcaine). What actions does the nurse delegate to the unlicensed assistive personnel (UAP)? **(Select all that apply.)**
   a. Ask the client to point out any areas of numbness or tingling.
   b. Determine how many people are needed to ambulate the client.
   c. Perform a bladder scan if the client is unable to void after 4 hours.
   d. Remind the client to use the incentive spirometer every hour.
   e. Take and record the client's vital signs per agency protocol.

   ANS: C, D, E
   The UAP can assess and record vital signs, perform a bladder scan and report the results to the nurse, and remind the client to use the spirometer. The nurse is legally responsible for assessments and should ask the client about areas of numbness or tingling, and assess if the client is able to bear weight and walk.

   DIF: Applying/Application REF: 42
   KEY: Epidural| pharmacologic pain management| opioid analgesics
   MSC: Integrated Process: Nursing Process: Implementation
   NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

4. A client with a broken arm has had ice placed on it for 20 minutes. A short time after the ice was removed, the client reports that the effect has worn off and requests pain medication, which cannot be given yet. What actions by the nurse are most appropriate? **(Select all that apply.)**
   a. Ask for a physical therapy consult.
   b. Educate the client on cold therapy.
   c. Offer to provide a heating pad.

d. Repeat the ice application.
e. Teach the client relaxation techniques.

ANS: B, D, E
Nonpharmacologic pain management can be very effective. These modalities include ice, heat, pressure, massage, vibration, and transcutaneous electrical stimulation. Since the client is unable to have more pain medication at this time, the nurse should focus on nonpharmacologic modalities. First the client must be educated; the effects of ice wear off quickly once it is removed, and the client may have had unrealistic expectations. The nurse can repeat the ice application and teach relaxation techniques if the client is open to them. A physical therapy consult will not help relieve acute pain. Heat would not be a good choice for this type of injury.

DIF: Applying/Application REF: 47
KEY: Ice| physical modalities| nonpharmacologic pain management
MSC: Integrated Process: Nursing Process: Implementation
NOT: Client Needs Category: Physiological Integrity: Basic Care and Comfort

5. A student nurse learns that there are physical consequences to unrelieved pain. Which factors are included in this problem? **(Select all that apply.)**
   a. Decreased immune response
   b. Development of chronic pain
   c. Increased gastrointestinal (GI) motility
   d. Possible immobility
   e. Slower healing

   ANS: A, B, D, E
   There are many physiologic impacts of unrelieved pain, including decreased immune response; development of chronic pain; decreased GI motility; immobility; slower healing; prolonged stress response; and increased heart rate, blood pressure, and oxygen demand.

   DIF: Remembering/Knowledge REF: 25
   KEY: Pain| Unrelieved pain MSC: Integrated Process: Teaching/Learning
   NOT: Client Needs Category: Physiological Integrity: Reduction of Risk Potential

6. A nursing student is studying pain sources. Which statements accurately describe different types of pain? **(Select all that apply.)**
   a. Neuropathic pain sometimes accompanies amputation.
   b. Nociceptive pain originates from abnormal pain processing.
   c. Deep somatic pain is pain arising from bone and connective tissues.
   d. Somatic pain originates from skin and subcutaneous tissues.
   e. Visceral pain is often diffuse and poorly localized.

   ANS: A, C, D, E
   Neuropathic pain results from abnormal pain processing and is seen in amputations and neuropathies. Somatic pain can arise from superficial sources such as skin, or deep sources such as bone and connective tissues. Visceral pain originates from organs or their linings and is often diffuse and poorly localized. Nociceptive pain is normal pain processing and consists of somatic and visceral pain.

DIF: Remembering/Knowledge REF: 28
KEY: Pain| Nociceptive pain| neuropathic pain
MSC: Integrated Process: Teaching/Learning
NOT: Client Needs Category: Physiological Integrity: Physiological Adaptation

7. A nurse on the postoperative unit administers many opioid analgesics. What actions by the nurse are best to prevent unwanted sedation as a complication of these medications? **(Select all that apply.)**
   a. Avoid using other medications that cause sedation.
   b. Delay giving medication if the client is sleeping.
   c. Give the lowest dose that produces good control.
   d. Identify clients at high risk for unwanted sedation.
   e. Use an oximeter to monitor clients receiving analgesia.

   ANS: A, C, D, E
   Sedation is a side effect of opioid analgesics. Some sedation can be expected, but protecting the client against unwanted and dangerous sedation is a critical nursing responsibility. The nurse should identify clients at high risk for unwanted sedation and give the lowest possible dose that produces satisfactory pain control. Avoid using other sedating medications such as antihistamines to treat itching. An oximeter can alert the nurse to a decrease in the client's oxygen saturation, which often follows sedation. A postoperative client frequently needs to be awakened for pain medication in order to avoid waking to out-of-control pain later.

   DIF: Applying/Application REF: 45
   KEY: Sedation| opioid analgesics
   MSC: Integrated Process: Nursing Process: Implementation
   NOT: Client Needs Category: Physiological Integrity: Reduction of Risk Potential

8. A client reports a great deal of pain following a fairly minor operation. The surgeon leaves a prescription for the nurse to administer a placebo instead of pain medication. What actions by the nurse are most appropriate? **(Select all that apply.)**
   a. Consult with the prescriber and voice objections.
   b. Delegate administration of the placebo to another nurse.
   c. Give the placebo and reassess the client's pain.
   d. Notify the nurse manager of the physician's request.
   e. Tell the client what the prescriber ordered.

   ANS: A, D
   Nurses should never give placebos to treat a client's pain (unless the client is in a research study). This practice is unethical and, in many states, illegal. The nurse should voice concerns with the prescriber and, if needed, contact the nurse manager. The nurse should not delegate giving the placebo to someone else, nor should the nurse give it. The nurse should not tell the client unless absolutely necessary (the client asks) as this will undermine the prescriber-client relationship.

   DIF: Applying/Application REF: 45 KEY: Placebo
   MSC: Integrated Process: Communication and Documentation
   NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

SHORT ANSWER

1. A client is to receive 4 mg morphine sulfate IV push. The pharmacy delivers 5 mg in a 2-mL vial. How much should the nurse administer for one dose? (*Record your answer using a decimal rounded to the nearest tenth.*) ____ mL

   ANS:
   1.6 mL

   $$\frac{5\text{ mg}}{2\text{ mL}} = \frac{4\text{ mg}}{x\text{ mL}}$$

   $5x = 8$ mL
   $x = 1.6$ mL

   DIF: Applying/Application REF: 42
   KEY: Medication administration| drug calculation
   MSC: Integrated Process: Nursing Process: Implementation
   NOT: Client Needs Category: Physiological Integrity: Pharmacological and Parenteral Therapies

2. A nurse is preparing to give an infusion of acetaminophen (Ofirmev). The pharmacy delivers a bag containing 50 mL of normal saline and the Ofirmev. At what rate does the nurse set the IV pump to deliver this dose? (*Record your answer using a whole number.*) ____ mL/hr

   ANS:
   200 mL/hr
   Intravenous acetaminophen (Ofirmev) is approved for treatment of pain and fever in adults and children ages 2 years and older and is given by a 15-minute infusion. To deliver 50 mL in 15 minutes, set the IV pump for 200 mL/hr. To run 50 mL in 60 minutes, the pump would be set for 50 mL/hr. To run this volume in one quarter of the time, divide by 4: 200 ÷ 4 = 50.

   DIF: Applying/Application REF: 42
   KEY: Medication administration| drug calculation
   MSC: Integrated Process: Nursing Process: Implementation
   NOT: Client Needs Category: Physiological Integrity: Pharmacological and Parenteral Therapies