Perrin, *Understanding the Essentials of Critical Care Nursing*, 2/e
Chapter 2

Question 1
Type: MCSA

The nurse identifies a patient in the critical care unit as having "resiliency." What characteristic has the nurse identified in the patient?

1. Motivation to reduce anxiety through positive self-talk

2. Ability to bounce back quickly after an insult

3. Physical strength to endure extreme physical stressors

4. Ability to return to a state of equilibrium

Correct Answer: 2

Rationale 1: This is not a definition of resiliency.

Rationale 2: The correct definition of "resiliency" is the ability to bounce back quickly after an insult. The degree of resiliency is placed along a continuum between being unable to mount a response to having strong reserves.

Rationale 3: This is not a definition of resiliency.

Rationale 4: This is not a definition of resiliency.

Global Rationale:

Cognitive Level: Analyzing
Client Need: Safe Effective Care Environment
Client Need Sub: Management of Care
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: 2-1: Explain the characteristics of the critically ill patient described in the AACN Synergy Model.

Question 2
Type: MCSA

While caring for a patient in the critical care unit, the nurse realizes that the patient's care needs must be a balance between the patient's long-term prognosis and the family's expectations of recovery. Which of the AACN Synergy Model's characteristics does this situation describe?

1. Complexity

2. Predictability

3. Participation in care

4. Resource availability

Correct Answer: 1

Rationale 1: This situation describes the characteristic of complexity that is the intricate entanglement of two or more systems; for example, a patient's illness with complex family dynamics.

Rationale 2: This situation does not describe predictability.

Rationale 3: This situation does not describe participation in care.

Rationale 4: This situation does not described resource availability.

Global Rationale:

Cognitive Level: Analyzing
Client Need: Psychosocial Integrity
Client Need Sub:
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: 2-1: Explain the characteristics of the critically ill patient described in the AACN Synergy Model.

Question 3
Type: MCSA

The nurse realizes that which stressor is one of the primary concerns of critically ill patients and should be routinely included during assessments?

1. Inability to control elimination

2. Lack of family support

3. Hunger

4. Altered ability to communicate

Correct Answer: 4

Rationale 1: The inability to control elimination is not identified as a primary concern of critically ill patients.

Rationale 2: Lack of family support is not identified as a primary concern of critically ill patients.

Rationale 3: Hunger is not identified as a primary concern of critically ill patients.

Rationale 4: Altered ability to communicate is identified as a primary concern of critically ill patients.

Global Rationale:

Cognitive Level: Applying
Client Need: Psychosocial Integrity
Client Need Sub:
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: 2-2: Discuss the concerns expressed by critically ill patients.

Question 4
Type: MCMA

A patient has just completed a preoperative education session prior to undergoing coronary artery bypass surgery. Which patient statements indicate that teaching has been effective?

Note: Credit will be given only ***if all correct choices and no incorrect choices are selected.***

Standard Text: Select all that apply.

1. "I understand that I will have to blink my eyes to respond after the breathing tube is in my throat."

2. "I will be given frequent mouth care to help me when I am thirsty."

3. "I will be able to move about freely in bed and into the chair without help while connected to the electronic equipment for monitoring."

4. "I may need something to help me rest due to the unfamiliar lights and sounds of the ICU unit."

5. "I might not behave like my usual self after the surgery but it will be because of the medications and my illness."

Correct Answer: 1,2,4,5

Rationale 1: An alternate method of communication discussed in advance of tube placement will assist in better communication after the tube is inserted to aid the breathing process.

Rationale 2: While intubated, oral hygiene is needed to prevent mucosal drying due to the inability of the patient to take oral fluids.

Rationale 3: This statement indicates that additional teaching is required because the patient will not be able to move freely in bed and into a chair without assistance while being electronically monitored.

Rationale 4: Due to environmental lights, sounds, and difference in sleeping environment, additional aids, such as drug management, may be needed to assist the patient to rest at night.

Rationale 5: A patient concern in the critical care area is the inability to control self. This statement indicates the patient's understanding of the teaching.

Global Rationale:

Cognitive Level: Analyzing
Client Need: Safe Effective Care Environment
Client Need Sub: Management of Care
Nursing/Integrated Concepts: Nursing Process: Evaluation
Learning Outcome: 2-2: Discuss the concerns expressed by critically ill patients.

Question 5
Type: MCSA

When providing care to critically ill patients, whether they are responsive or unresponsive, the nurse should:

1. Clearly explain what care is to be done before starting the activity.

2. Perform the activity and then let the patient rest without explaining the care.

3. Make sure the patient always responds and is cooperative before giving care.

4. Explain to the family that the patient will not understand or remember any of the discomfort associated with care.

Correct Answer: 1

Rationale 1: By explaining to both the responsive and unresponsive patient, the nurse provides orientation, reassurance, respect, and assessment of the patient's mental status. Seeking permission and apologizing if discomfort is involved will also minimize the stress of the critically ill patient by allowing the patient to hear what is about to occur. Even the unresponsive patient has been known to explain procedures, conversations, and feelings once he or she has awakened.

Rationale 2: If the patient is not informed, autonomy and the right to choose have been violated; in addition, the stress of the unknown may be perceived incorrectly by the patient as an assault.

Rationale 3: Some unresponsive patients will never respond; therefore, the care would not be performed as needed. Cooperation is also not possible in some cases whereby the patient has altered thinking. Although the nurse desires these, the care should not be stopped just because they cannot be obtained. Explaining should still be done and the care should proceed as needed.

Rationale 4: The nurse cannot always reassure the family that the patient will not remember.

Global Rationale:

Cognitive Level: Applying
Client Need: Psychosocial Integrity

Client Need Sub:
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: 2-3: Describe strategies a nurse might utilize to communicate with a ventilated patient.

Question 6
Type: MCSA

Which communication strategy is most appropriate for a critical care nurse to use when communicating with a ventilated patient? The nurse should:

1. Use professional terminology and provide the patient with detailed information.

2. Use simple language and explain in other terms if the patient does not seem to understand.

3. Provide minimal information so the patient is not overwhelmed.

4. Discuss issues primarily with the family because the patient is unlikely to understand the information.

Correct Answer: 2

Rationale 1: Individuals who are not familiar with health care often do not understand professional language. Confusion and a lack of understanding often result if the information is presented only with professional terminology.

Rationale 2: Simple layman's language of information is better understood and repeating or rephrasing gives the patient a better understanding when in a stressful situation.

Rationale 3: Minimal disclosure of information will increase the stress of the patient by increasing confusion and concerns from the lack of understanding about the illness or treatment process. Complete disclosure is the right of the patient and the obligation of health care professionals.

Rationale 4: Disclosing information or communicating only with the patient's family denies the patient the right of choice and the respect or dignity expected. Legally and ethically, except under very specific restrictions, the patient has a right to know, and it is the health care professional’s responsibility to explain clearly for informed consent to occur.

Global Rationale:

Cognitive Level: Applying
Client Need: Psychosocial Integrity
Client Need Sub:
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: 2-3: Describe strategies a nurse might utilize to communicate with a ventilated patient.

Question 7
Type: MCSA

During an assessment, a ventilated patient begins to frown and wiggle about in bed. Which assessment strategy would be most helpful for the nurse to validate these observations?

1. Glasgow Scale

2. Maslow's hierarchy levels

3. Critical-Care Pain Observation Tool (CPOT)

4. Vital signs trends

Correct Answer: 3

Rationale 1: The Glasgow Coma Scale will identify the level of consciousness present to evaluate the sedation level that is used with patients who are intubated. But this scale does not identify the source of the problem that has increased the patient's facial changes or movement.

Rationale 2: Maslow's hierarchy of needs prioritizes needs based on essential to higher level functions in the body, and it would not help identify the source of the changes noted in the patient.

Rationale 3: The CPOT pain scale will identify if pain is present and the degree of effectiveness of drug management in a patient who cannot speak due to intubation.

Rationale 4: Vital signs might tell the nurse that a change has occurred but it does not indicate the source of the discomfort or problem.

Global Rationale:

Cognitive Level: Applying
Client Need: Physiological Integrity
Client Need Sub: Reduction of Risk Potential
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: 2-4: Explain the use of sedation, pain, and delirium scales with critically ill patients.

Question 8
Type: MCMA

Which parameters indicate that a patient in the intensive care unit being mechanically ventilated is ready for an interruption in sedation? The patient:

Note: Credit will be given only ***if all correct choices and no incorrect choices are selected.***

Standard Text: Select all that apply.

1. Had a MAP of 75 and heart rate of 76

2. Was sleeping but awakened with verbal stimuli

3. Frowned when turned but otherwise showed no muscular tension

4. Activated the ventilator alarms but the alarms stopped spontaneously

5. Is receiving neuromuscular blocking agents to ensure adequate ventilation

Correct Answer: 1,2,3,4

Rationale 1: Hemodynamic stability is one criterion that indicates daily weaning of sedatives should be automatically attempted.

Rationale 2: Awakening with verbal stimuli indicates that daily weaning of sedatives should be attempted.

Rationale 3: Control of pain is an indication that daily weaning of sedatives should be attempted.

Rationale 4: Patient-ventilator synchrony is an indication that daily weaning of sedatives should be attempted.

Rationale 5: Receiving neuromuscular blocking agents indicates that daily weaning of sedatives should not be attempted.

Global Rationale:

Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub: Pharmacological and Parenteral Therapies
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: 2-4: Explain the use of sedation, pain, and delirium scales with critically ill patients.

Question 9
Type: MCSA

A patient scores positive on the Confusion Assessment Method of the Intensive Care Unit (CAM-ICU). Which nursing diagnosis would have the highest priority based on this positive score?

1. Injury, Risk for

2. Family Processes, Altered

3. Social Interaction, Impaired

4. Memory Impaired

Correct Answer: 1

Rationale 1: Injury falls into the Safety/Security level, which is the highest priority according to Maslow's hierarchy of needs.

Rationale 2: This nursing diagnosis would not be a priority for the patient in the intensive care unit.

Rationale 3: This nursing diagnosis would not be a priority for the patient in the intensive care unit.

Rationale 4: This nursing diagnosis would not be a priority for the patient in the intensive care unit.

Global Rationale:

Cognitive Level: Analyzing
Client Need: Safe Effective Care Environment
Client Need Sub: Management of Care
Nursing/Integrated Concepts: Nursing Process: Diagnosis
Learning Outcome: 2-4: Explain the use of sedation, pain, and delirium scales with critically ill patients.

Question 10
Type: MCSA

Which nursing actions would be appropriate when a nurse is initiating an infusion of morphine sulfate for a post-operative patient who is experiencing pain?

1. Anticipate that the patient will begin to experience the effect of the morphine 15 minutes after the start of the infusion.

2. Provide additional intermittent boluses of morphine sulfate if the patient experiences breakthrough pain.

3. Complete the Critical-Care Pain Observation Tool scale 5 minutes after increasing the infusion rate each time.

4. Begin the infusion at the lowest ordered dose and increase the rate every 30 minutes if the patient continues to have pain.

Correct Answer: 2

Rationale 1: The desired effects should become apparent 5 minutes after intravenous administration.

Rationale 2: A critically ill patient often will receive an IV bolus of an analgesic followed by an ongoing infusion of the pain medication with intermittent boluses and increases in infusion until the drug attains steady state and the patient experiences pain relief.

Rationale 3: Assessing the patient 5 minutes after increasing the infusion rate each time might be too soon to assess for pain control.

Rationale 4: When IV infusion rates are repeatedly increased versus the administration of intermittent boluses as a means of responding to acute pain, the risk for excessive analgesia dosing exists.

Global Rationale:

Cognitive Level: Applying
Client Need: Physiological Integrity
Client Need Sub: Pharmacological and Parenteral Therapies
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: 2-5: Evaluate the effectiveness of pharmacological and nonpharmacological management of sedation, pain, and delirium in the critically ill patient.

Question 11
Type: MCMA

Which strategies should the nurse include in the plan of care when trying to minimize sleep disruptions for a patient in an ICU?

Note: Credit will be given only ***if all correct choices and no incorrect choices are selected.***

Standard Text: Select all that apply.

1. Instituting a short course of therapy for sleeping agents

2. Accurate scoring and vigilance in sedation and sedation scoring

3. Managing the environment to reduce lighting, sounds, and so on

4. Minimizing staff interruptions during sleep periods

5. Scheduling treatments only during the day or at least 4 hours apart at night

Correct Answer: 1,2,3,4

Rationale 1: This is a strategy to minimize interruptions of sleep and to maximize the rest benefits that will shorten the duration of care based on research findings.

Rationale 2: This is a strategy to minimize interruptions of sleep and to maximize the rest benefits that will shorten the duration of care based on research findings.

Rationale 3: This is a strategy to minimize interruptions of sleep and to maximize the rest benefits that will shorten the duration of care based on research findings.

Rationale 4: This is a strategy to minimize interruptions of sleep and to maximize the rest benefits that will shorten the duration of care based on research findings.

Rationale 5: Planning the care for only the day hours or at least 4 hours is not practical to improve the outcomes of the patient, because some medications, therapies, and assessments need to be made around the clock for the greatest benefits to occur. The minimum time for resting that is suggested is to not interrupt less than 2 to 3 hours of sleep in order to minimize sleep fragmentation and improve restful sleep.

Global Rationale:

Cognitive Level: Analyzing
Client Need: Psychosocial Integrity
Client Need Sub:
Nursing/Integrated Concepts: Nursing Process: Planning
Learning Outcome: 2-5: Evaluate the effectiveness of pharmacological and nonpharmacological management of sedation, pain, and delirium in the critically ill patient.

Question 12
Type: MCSA

A nurse is confirming the medication orders and schedule for sedative administration to a patient with delirium. Which schedule would maximize the effectiveness of the drugs? Administration of medication:

1. Only in the early morning

2. Only at bedtime (HS)

3. Around the clock with higher dosages in the evening

4. Only on an as-needed (PRN) basis

Correct Answer: 3

Rationale 1: This schedule would not control the condition equally throughout the 24-hour period.

Rationale 2: This schedule would not control the condition equally throughout the 24-hour period.

Rationale 3: Timing medication given around the clock with a greater dosage in the evening will match the symptom of sundowning, when the symptoms appear the greatest later in the day.

Rationale 4: This schedule would not control the condition equally throughout the 24-hour period.

Global Rationale:

Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub: Pharmacological and Parenteral Therapies
Nursing/Integrated Concepts: Nursing Process: Evaluation
Learning Outcome: 2-5: Evaluate the effectiveness of pharmacological and nonpharmacological management of sedation, pain, and delirium in the critically ill patient.

Question 13
Type: MCMA

Which patients would be at risk for nutritional imbalances? The patient:

Note: Credit will be given only ***if all correct choices and no incorrect choices are selected.***

Standard Text: Select all that apply.

1. Who is a stable, post-myocardial infarction

2. With renal failure

3. With slightly elevated liver enzymes

4. Who is intubated and sedated

5. With burns or excessive trauma

Correct Answer: 1,2,4,5

Rationale 1: This patient is at risk for nutritional imbalances.

Rationale 2: This patient is at risk for nutritional imbalances.

Rationale 3: Although the liver does filter and alter the breakdown of drugs, nutrition is rarely modified just for slightly elevated liver enzymes. Severe liver damage or failure will result in restrictions of alcohol and fatty foods, and an increase of protein may be needed.

Rationale 4: This patient is at risk for nutritional imbalances.

Rationale 5: This patient is at risk for nutritional imbalances.

Global Rationale:

Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub: Reduction of Risk Potential
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: 2-6: Compare and contrast the use of enteral and parenteral nutrition in the critically ill patient.

Question 14
Type: MCSA

Members of the multidisciplinary care team are reviewing a patient's nutritional status and analyzing assessment values. Which value would need additional investigation?

1. A serum albumin of more than 3.5 g/dL or 35 g/L

2. A weight increase of 1.5 kg in a day

3. A serum hemoglobin of 11.7 g/dL or 117 mmol/L

4. A prealbumin level of 35 mg/dL

Correct Answer: 2

Rationale 1: This value would not need additional investigation.

Rationale 2: A weight change of 1.5 kg (approximately 3.3 lb) reflects approximately 1.5 liters of fluid. Additional assessment needs to be done to evaluate the cause and risks.

Rationale 3: This value is at the lower end of normal levels for an adult patient and would not need additional investigation.

Rationale 4: This value would not need additional investigation.

Global Rationale:

Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub: Reduction of Risk Potential
Nursing/Integrated Concepts: Nursing Process: Evaluation
Learning Outcome: 2-6: Compare and contrast the use of enteral and parenteral nutrition in the critically ill patient.

Question 15
Type: MCSA

A nurse has inserted a nasogastric tube and is planning to confirm placement of the tube prior to starting enteral feedings. What is the most accurate method for confirming placement?

1. Obtaining a radiological x-ray of the abdomen

2. Checking gastric aspirate for a pH of less than 7

3. Instilling 30 mL of air while listening with a stethoscope when placed over the fundus of the stomach

4. Determining the presence of carbon dioxide

Correct Answer: 1

Rationale 1: The appropriate method for identifying placement of the feeding tube in the stomach is visualizing the tube in the stomach on an abdominal x-ray.

Rationale 2: This is not the appropriate method for identifying placement of the feeding tube in the stomach.

Rationale 3: This is not the appropriate method for identifying placement of the feeding tube in the stomach.

Rationale 4: This is not the appropriate method for identifying placement of the feeding tube in the stomach.

Global Rationale:

Cognitive Level: Applying
Client Need: Physiological Integrity
Client Need Sub: Reduction of Risk Potential
Nursing/Integrated Concepts: Nursing Process: Planning
Learning Outcome: 2-6: Compare and contrast the use of enteral and parenteral nutrition in the critically ill patient.

Question 16
Type: MCSA

Which nursing diagnosis should receive the highest priority when caring for a patient who is receiving total parenteral nutrition?

1. Infection, Risk for

2. Trauma, Risk for

3. Skin Integrity, Impaired

4. Fluid Volume, Risk for Imbalance

Correct Answer: 1

Rationale 1: The risk for infection is the greatest risk for the patient receiving parenteral nutrition due to the high glucose present, the central vein access route, and the declining nutritional status that the patient is in when this therapy is started.

Rationale 2: Avoiding trauma at the site or other parts of the body should be routinely done to "do no harm" and avoid injury where possible. However, this is not the greatest risk for the patient receiving parenteral nutrition.

Rationale 3: Skin integrity will be impaired due to poor nutritional intake, but preventive measures can be done to decrease the risk. This is not the greatest risk for the patient receiving parenteral nutrition.

Rationale 4: Fluid volume imbalances are minimized by accurate regulators to limit fluid overload or to run at the appropriate rate to provide the essential nutrition needed. This is not the greatest risk for the patient receiving parenteral nutrition.

Global Rationale:

Cognitive Level: Analyzing

Client Need: Physiological Integrity
Client Need Sub: Physiological Adaptation
Nursing/Integrated Concepts: Nursing Process: Diagnosis
Learning Outcome: 2-6: Compare and contrast the use of enteral and parenteral nutrition in the critically ill patient.

Question 17
Type: MCMA

When planning care to meet the needs of family members of a critically ill patient, the nurse should include:

Note: Credit will be given only ***if all correct choices and no incorrect choices are selected.***

Standard Text: Select all that apply.

1. Expressing an attitude of hope, honesty, open communication, and caring

2. Stating specific facts about the patient's condition in timely manner

3. Planning regular times for family visits throughout the day

4. Limiting the number of visitors to significant others

5. Communicating to a single family member to cut down time wasted repeating information to all visitors

Correct Answer: 1,2,3

Rationale 1: This is an appropriate approach when meeting the family needs of the critically ill patient.

Rationale 2: This is an appropriate approach when meeting the family needs of the critically ill patient.

Rationale 3: This is an appropriate approach when meeting the family needs of the critically ill patient.

Rationale 4: Although some number limitations are needed, the persons are not to be screened by staff. If the patient wants the visitor to come in, then the visit will be therapeutic for the patient. If the visitor (family or friend) increases problems with the patient, then the visitor should be restricted access until the condition improves.

Rationale 5: Although communicating with a single person will minimize the repeating of information, a core group of individuals can be used to distribute information to other family members, particularly if a large population is present. Therefore, restricting to one person is too limiting but a minimal core group can be helpful in other situations, especially if the nurse is needed at the bedside. A case manager, clergy, or staff support person could also be used to pass on information when the nursing staff is too busy caring for the patient.

Global Rationale:

Cognitive Level: Applying

Client Need: Psychosocial Integrity
Client Need Sub:
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: 2-7: Discuss ways to identify and meet the needs of families of critically ill patients.

Question 18
Type: MCSA

Which statement describing the needs of family members of critically ill patients has not been validated by research?

1. "Not knowing is the worst part" of waiting.

2. Families in the waiting room have no effect on patient outcomes.

3. "Hovering" in the proximity phase is characterized by confusion and tension.

4. A unified message from staff minimizes family stressors.

Correct Answer: 2

Rationale 1: This statement is supported by research and is accurate to the findings about the family needs of the critically ill patient.

Rationale 2: This is an incorrect statement that is not supported by research. In fact the family support has been proven to clinical outcomes.

Rationale 3: This statement is supported by research.

Rationale 4: This statement is supported by research.

Global Rationale:

Cognitive Level: Analyzing
Client Need: Psychosocial Integrity
Client Need Sub:
Nursing/Integrated Concepts: Nursing Process: Evaluation
Learning Outcome: 2-7: Discuss ways to identify and meet the needs of families of critically ill patients.

Question 19
Type: MCSA

The nurse is addressing the family needs of a critically ill patient. Which family need was not identified?

1. Proximity

2. Information

3. Assurance

4. Timeliness

Correct Answer: 4

Rationale 1: This need is identified in Leske's research findings.

Rationale 2: This need is identified in Leske's research findings.

Rationale 3: This need is identified in Leske's research findings.

Rationale 4: Timeliness is not a need identified in Leske's research findings.

Global Rationale:

Cognitive Level: Applying
Client Need: Psychosocial Integrity
Client Need Sub:
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: 2-7: Discuss ways to identify and meet the needs of families of critically ill patients.

Question 20
Type: MCMA

When planning care to meet the needs of families of critically ill patients, the nurse would include which strategies by Miracle (2006)?

Note: Credit will be given only ***if all correct choices and no incorrect choices are selected.***

Standard Text: Select all that apply.

1. Information about how to contact the primary doctor if needed

2. Frequent verbal communication to clarify the purpose of unit, equipment, procedures, waiting areas, phones, and so on

3. Regular family conferences to meet patient goals and progress

4. A consistent nurse, and unified staff responses if that nurse is not available

5. A way to contact family through a specific family member by phone if needed

Correct Answer: 1,3,4

Rationale 1: This is a strategy to minimize stress and maximize communication to meet the family needs of the critically ill patient.

Rationale 2: Written communication, pamphlets, rules, and regulations are better received and retained more than verbal instructions. Written communications can be reread and clearly understood as a cross-reference by the family during the stressful period of waiting for their patient's recovery. Frequently repeating information is better for retention but often is a waste of the nurse's time for basic information that remains the same for all patients. By printing information, this allows the nurse to give more information about the patient's condition rather than focusing on basic rules and regulations.

Rationale 3: This is a strategy to minimize stress and maximize communication to meet the family needs of the critically ill patient.

Rationale 4: This is a strategy to minimize stress and maximize communication to meet the family needs of the critically ill patient.

Rationale 5: This is not a strategy to minimize stress and maximize communication to meet the family needs of the critically ill patient.

Global Rationale:

Cognitive Level: Applying
Client Need: Psychosocial Integrity
Client Need Sub:
Nursing/Integrated Concepts: Nursing Process: Planning
Learning Outcome: 2-7: Discuss ways to identify and meet the needs of families of critically ill patients.

Question 21
Type: MCSA

A physician suggests that a ventilated patient needing immediate transport to CT scan and having severe pain be given IV fentanyl (Sublimaze) rather than morphine sulfate for pain management. One reason the physician might recommend the use of fentanyl (Sublimaze) is:

1. Rapid administration does not have any hemodynamic consequences.

2. It has a more rapid onset and a shorter duration of action.

3. Weaning of a continuous infusion is never needed due to its short half-life.

4. It is not likely to cause respiratory depression.

Correct Answer: 2

Rationale 1: The blood pressure, respiratory rate, and heart rate should be monitored frequently when providing this medication.

Rationale 2: Fentanyl is 100 times more potent than morphine. It has a faster onset of action than morphine and a shorter duration of action.

Rationale 3: Standard weaning protocols will be followed with this medication.

Rationale 4: Respiratory rate is to be monitored when providing this medication.

Global Rationale:

Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub: Pharmacological and Parenteral Therapies
Nursing/Integrated Concepts: Nursing Process: Planning
Learning Outcome: 2-5: Evaluate the effectiveness of pharmacological and nonpharmacological management of sedation, pain, and delirium in the critically ill patient.

Question 22
Type: MCSA

A ventilated patient is receiving midazolam (Versed) for sedation. The nurse would recognize that the patient is receiving an appropriate dose of midazolam when the patient is:

1. Awake with a respiratory rate of 38 and a heart rate of 132

2. Asleep but withdrawing to noxious stimuli with a heart rate of 80

3. Awake with a heart rate of 124 and attempting to pull out the IV

4. Asleep but awakening to light touch with a heart rate of 72

Correct Answer: 4

Rationale 1: These findings would not indicate appropriate sedation.

Rationale 2: These findings would not indicate appropriate sedation.

Rationale 3: These findings would not indicate appropriate sedation.

Rationale 4: These findings indicate appropriate sedation.

Global Rationale:

Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub: Pharmacological and Parenteral Therapies
Nursing/Integrated Concepts: Nursing Process: Evaluation

Learning Outcome: 2-5: Evaluate the effectiveness of pharmacological and nonpharmacological management of sedation, pain, and delirium in the critically ill patient.

Question 23
Type: MCSA

A nurse is caring for a ventilated post-operative patient who might be experiencing pain. Which method of assessing the patient's pain level should the nurse try first?

1. Attempting an analgesic trial

2. Asking the patient if he is in pain

3. Observing the patient's face for grimacing

4. Asking a family member if the patient is in pain

Correct Answer: 2

Rationale 1: The nurse should not provide an analgesic without assessing for pain first.

Rationale 2: If the patient is responsive, the nurse should ask the patient about presence of pain.

Rationale 3: This could be done if the patient is not responsive.

Rationale 4: This can be done; however, it is not the first method that the nurse would use to assess the patient's pain level.

Global Rationale:

Cognitive Level: Applying
Client Need: Physiological Integrity
Client Need Sub: Physiological Adaptation
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: 2-5: Evaluate the effectiveness of pharmacological and nonpharmacological management of sedation, pain, and delirium in the critically ill patient.

Question 24
Type: MCSA

A nurse is administering haldoperidol (Haldol) via IV push to a delirious patient. What is most important for the nurse to monitor in this patient?

1. Heart rate

2. QT interval

3. PR interval

4. Respiratory rate

Correct Answer: 2

Rationale 1: This is not the most important for the nurse to monitor.

Rationale 2: The patient needs to be monitored for such adverse effects as QT prolongation and dysrhythmias (torsades de pointes), which can result in sudden death, especially if the drug is administered via IV push.

Rationale 3: This is not the most important for the nurse to monitor.

Rationale 4: This is not the most important for the nurse to monitor.

Global Rationale:

Cognitive Level: Applying
Client Need: Physiological Integrity
Client Need Sub: Pharmacological and Parenteral Therapies
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: 2-5: Evaluate the effectiveness of pharmacological and nonpharmacological management of sedation, pain, and delirium in the critically ill patient.

Question 25
Type: MCMA

The nurse is assessing a critically ill patient utilizing the AACN Synergy Model's characteristics. Which characteristics are identified as impacting the outcome of a critically ill patient?

Note: Credit will be given only ***if all correct choices and no incorrect choices are selected.***

Standard Text: Select all that apply.

1. Participation in care

2. Resource availability

3. Stability

4. Complexity

5. Level of consciousness

Correct Answer: 1,2,3,4

Rationale 1: This is a characteristic identified by the Synergy Model.

Rationale 2: This is a characteristic identified by the Synergy Model.

Rationale 3: This is a characteristic identified by the Synergy Model.

Rationale 4: This is a characteristic identified by the Synergy Model.

Rationale 5: This is not a characteristic identified by the Synergy Model.

Global Rationale:

Cognitive Level: Applying
Client Need: Physiological Integrity
Client Need Sub: Reduction of Risk Potential
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: 2-1: Explain the characteristics of the critically ill patient described in the AACN Synergy Model.

Question 26
Type: MCMA

The nurse is planning care for a patient in the critical care area. What will the nurse include to address major areas of concern for the patient?

Note: Credit will be given only ***if all correct choices and no incorrect choices are selected.***

Standard Text: Select all that apply.

1. Explain the purpose of the tube in the nose.

2. Explain the purpose of the tube in the mouth.

3. Determine a method of communication.

4. Explain the purpose of the intravenous tubes.

5. Ensure that the room lights will be turned off and alarms set to low volume.

Correct Answer: 1,2,3,4

Rationale 1: This is considered a stressor for the patient in intensive care and should be addressed by the nurse.

Rationale 2: This is considered a stressor for the patient in intensive care and should be addressed by the nurse.

Rationale 3: This is considered a stressor for the patient in intensive care and should be addressed by the nurse.

Rationale 4: This is considered a stressor for the patient in intensive care and should be addressed by the nurse.

Rationale 5: This is not considered a stressor for the patient in intensive care and does not need to be addressed by the nurse.

Global Rationale:

Cognitive Level: Applying
Client Need: Psychosocial Integrity
Client Need Sub:
Nursing/Integrated Concepts: Nursing Process: Planning
Learning Outcome: 2-2: Discuss the concerns expressed by critically ill patients.

Question 27
Type: MCMA

The nurse, providing care to an unresponsive ventilated patient, is using unintentional distractions. What is the nurse doing when providing care?

Note: Credit will be given only ***if all correct choices and no incorrect choices are selected.***

Standard Text: Select all that apply.

1. Singing

2. Humming

3. Joking

4. Talking to a colleague

5. Apologizing for causing pain

Correct Answer: 1,2,3

Rationale 1: This is an unintentional distraction.

Rationale 2: This is an unintentional distraction.

Rationale 3: This is an unintentional distraction.

Rationale 4: This could cause the patient distress and should not be done.

Rationale 5: This is not an unintentional distraction.

Global Rationale:

Cognitive Level: Applying
Client Need: Psychosocial Integrity
Client Need Sub:
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: 2-3: Describe strategies a nurse might utilize to communicate with a ventilated patient.

Question 28
Type: MCMA

What strategies would the nurse utilize to optimize communication with an older adult who is intubated and mechanically ventilated?

Note: Credit will be given only ***if all correct choices and no incorrect choices are selected.***

Standard Text: Select all that apply.

1. Make sure the patient is wearing eyeglasses.

2. Speak slowly.

3. Decide on which gestures mean "yes" and "no."

4. Have questions and possible answers ready so the patient can point to the response.

5. Ask several questions at a time to limit interruptions in rest periods.

Correct Answer: 1,2,3,4

Rationale 1: This will maximize communication with the older patient.

Rationale 2: This will maximize communication with the older patient.

Rationale 3: This will maximize communication with the older patient.

Rationale 4: This will maximize communication with the older patient.

Rationale 5: This will not maximize communication with the older patient.

Global Rationale:

Cognitive Level: Applying
Client Need: Psychosocial Integrity
Client Need Sub:
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: 2-3: Describe strategies a nurse might utilize to communicate with a ventilated patient.

Question 29
Type: MCMA

A patient in the critical care unit is demonstrating increasing agitation. What can the nurse use to assess this patient's agitation level?

Note: Credit will be given only ***if all correct choices and no incorrect choices are selected.***

Standard Text: Select all that apply.

1. Ramsey Scale

2. Riker Scale

3. Glasgow Scale

4. Reaction Level Scale

5. Ventilator Adjusted Motor Assessment Scoring Scale

Correct Answer: 1,2

Rationale 1: This scale is commonly used to assess for agitation.

Rationale 2: This scale is commonly used to assess for agitation.

Rationale 3: This scale is not used to assess for agitation.

Rationale 4: This scale is not used to assess for agitation.

Rationale 5: This scale is not used to assess for agitation.

Global Rationale:

Cognitive Level: Applying
Client Need: Psychosocial Integrity
Client Need Sub:
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: 2-4: Explain the use of sedation, pain, and delirium scales with critically ill patients.

Question 30
Type: MCMA

The nurse is planning to use music therapy to help reduce a critically ill patient's level of anxiety. What will the nurse do when using this complementary and alternative therapy?

Note: Credit will be given only *if all correct choices and no incorrect choices are selected.*

Standard Text: Select all that apply.

1. Ask family members to identify the patient's preferred music.

2. Plan for the music to be played for 30 uninterrupted minutes.

3. Listen to the music in advance to make sure it does not have lyrics.

4. Ensure that the music beats are between 60 to 80 per minute.

5. Play the music from a tape recorder on the bedside table.

Correct Answer: 1,2,3,4

Rationale 1: The patient's preferred music should be used.

Rationale 2: Evidence based music therapy calls for a critically ill patient to listen to at least 30 minutes of music.

Rationale 3: It is most beneficial if the music is without words.

Rationale 4: It is most beneficial if the music is approximately 60 to 80 beats per minute.

Rationale 5: The music should be provided through headphones.

Global Rationale:

Cognitive Level: Applying
Client Need: Psychosocial Integrity
Client Need Sub:
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: 2-5: Evaluate the effectiveness of pharmacological and nonpharmacological management of sedation, pain, and delirium in the critically ill patient.

Question 31
Type: MCMA

The nurse is assessing a critically ill patient's nutritional needs. What information is essential for the nurse to obtain during this assessment?

Note: Credit will be given only *if all correct choices and no incorrect choices are selected.*

Standard Text: Select all that apply.

1. Patient's current height and weight

2. Food allergies

3. Use of nutritional supplements

4. If the patient can swallow

5. Amount of water consumed each day

Correct Answer: 1,2,3,4

Rationale 1: This information is essential for the nurse to obtain.

Rationale 2: This information is essential for the nurse to obtain.

Rationale 3: This information is essential for the nurse to obtain.

Rationale 4: This information is essential for the nurse to obtain.

Rationale 5: This information is not essential for the nurse to obtain.

Global Rationale:

Cognitive Level: Applying
Client Need: Physiological Integrity
Client Need Sub: Basic Care and Comfort
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: 2-6: Compare and contrast the use of enteral and parenteral nutrition in the critically ill patient.

Question 32
Type: MCMA

The nurse is a member of a committee that is designing improvements to the critical care waiting areas. What improvements will the nurse suggest to enhance the comfort of family members of critical care patients?

Note: Credit will be given only ***if all correct choices and no incorrect choices are selected.***

Standard Text: Select all that apply.

1. Plan for a large space to be used for the waiting areas.

2. Provide coffee and soft drinks in the waiting area.

3. Place televisions and videocassette players in the waiting area.

4. Find space for sleeping rooms.

5. Use dark paint and minimal lighting in the waiting areas.

Correct Answer: 1,2,3,4

Rationale 1: A larger area that is less cramped would enhance the comfort of families of critical care patients.

Rationale 2: Providing coffee and soft drinks in the waiting area would enhance the comfort of families of critical care patients.

Rationale 3: Placing television and videocassette players in the waiting areas would enhance the comfort of families of critical care patients.

Rationale 4: Finding space for sleeping rooms would enhance the comfort of families of critical care patients.

Rationale 5: Using dark paint and minimal lighting in the waiting areas would not enhance the comfort of families of critical care patients.

Global Rationale:

Cognitive Level: Applying
Client Need: Psychosocial Integrity
Client Need Sub:
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: 2-7: Discuss ways to identify and meet the needs of families of critically ill patients.