Chapter 07: Care of Patients with Pain

MULTIPLE CHOICE

1. In order to provide the optimum nursing care, it is important for the nurse to know that the standard of pain and pain control is best determined by which person?
   a. Physician
   b. Nurse
   c. Patients family
   d. Patient
   
   ANS: D
   Only the patient knows when pain occurs and what remedy relieves it.
   DIF: Cognitive Level: Knowledge REF: 126 OBJ: 1 (theory)
   TOP: Pain Theory KEY: Nursing Process Step: Implementation
   MSC: NCLEX: Physiological Integrity: Basic Care and Comfort

2. The nurse clarifies the basics of the gate theory of pain control as:
   a. pain is perceived as opening a gate to pain symptoms.
   b. the gate can be closed to pain by the use of nonpainful stimuli.
   c. the gate swings back and forth, first allowing pain, then blocking it.
   d. the patient can be trained to close the gate to pain.
   
   ANS: B
   The sensorineural gate can be closed by applying a number of nonpharmacologic stimuli so that the pain is not perceived.
   DIF: Cognitive Level: Comprehension REF: 124-125 OBJ: 2 (theory)
   TOP: Gate Theory KEY: Nursing Process Step: Implementation
   MSC: NCLEX: Physiological Integrity: Basic Care and Comfort
3. When giving care to a 30-year-old Hispanic male, the nurse is aware that the young man will most likely:

a. be stoic about pain.

b. prefer a pill to an injection.

c. ignore somatic interventions such as heat and massage.

d. confess to pain, but refuse pain medication.

ANS: A

Hispanic males are frequently stoic regarding pain. They prefer injections to pills but may elect to use prayer, heat, or herbal remedies for pain relief.

DIF: Cognitive Level: Application REF: 131 | Cultural Considerations

OBJ: 4 (theory) TOP: Cultural Considerations

KEY: Nursing Process Step: Planning

MSC: NCLEX: Physiological Integrity: Basic Care and Comfort

4. The nurse is caring for a patient who is having constant nociceptor pain. The nurse can best address the patient's pain during the perception phase of pain with which intervention?

a. Administer nonsteroidal anti-inflammatory drugs (NSAIDs) for moderate pain.

b. Ask the physician if an opioid could be ordered to treat the patient's pain when severe.
c. Engage the patient in conversation regarding his family, hobbies, and plans following discharge from the facility.

d. Determine if the patient typically takes a neurotransmitter uptake blocker medication for pain control.

ANS: C

Nonpharmacologic interventions such as distraction and guided imagery are effective for pain relief during the perception phase. NSAIDs are most effective during the transduction phase of pain, opioids are most effective during the transmission phase, and drugs that block neurotransmitter uptake work best during the modulation phase.

DIF: Cognitive Level: Application REF: 125-126 OBJ: 3 (theory)

TOP: Pain Perception KEY: Nursing Process Step: Implementation

MSC: NCLEX: Physiological Integrity: Basic Care and Comfort

5. The patient is experiencing phantom pain following the amputation of her foot. Which type of pain is most associated with phantom pain?

a. Nociceptive

b. Mild

c. Uncontrollable

d. Neuropathic

ANS: D
Neuropathic pain is associated with a dysfunction of the nervous system that involves an abnormality in the processing of sensations such as phantom pain. Nociceptive pain is associated with pain stimuli from either somatic (body tissue) or visceral (organs) structures. Mild and uncontrollable refer to severity rather than classifications of pain.

DIF: Cognitive Level: Comprehension REF: 125| Table 7-1, 126
OBJ: 1 (theory) TOP: Neuropathic Pain
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Basic Care and Comfort

6. The nurse explains that the pain threshold and pain tolerance are different in that the pain threshold is the point at which:

a. pain is perceived.

b. the person responds to pain.

c. pharmacologic intervention is required.

d. signs such as grimacing or groaning are observed.

ANS: A

The pain threshold is the point at which the pain is perceived.

DIF: Cognitive Level: Comprehension REF: 127 OBJ: 1 (theory)
7. The patient who had abdominal surgery this morning refuses the opioid pain medication for fear of addiction. The most informative response by the nurse is:

a. Opioids are addictive, whereas nonsteroidal anti-inflammatory drugs (NSAIDs) are not.

b. Addiction is mainly a matter of attitude.

c. Fewer than 3% of people become addicted to drugs used for pain relief.

d. Although addiction does occur, it is quickly reversed.

ANS: C

This patient is not experiencing chronic pain that will require ongoing pain medication, and addiction occurs in fewer than 3% of people who take pain medication. Any medication can be addictive. Addiction is often not merely a matter of attitude. Finally, addictions typically require long-term therapy.

DIF: Cognitive Level: Application REF: 134 | Table 7-4

OBJ: 5 (theory) TOP: False Perception about Pain

8. The student nurse understands proper documentation of a pain assessment as evidenced by which note in the patients record?
a. Pt. complains of local sharp pain (4/5) in lower abdomen upon standing.

b. Pt. complains of stomach pain after eating (3/5).

c. Pt. reports standing makes his stomach hurt.

d. Pt. reports sharp pain in stomach.

ANS: A

The recorded assessment should include location, characteristics, quantity, severity based on a pain scale, and pattern.

DIF: Cognitive Level: Application REF: 132-133 OBJ: 2 (clinical)

TOP: Pain Assessment KEY: Nursing Process Step: Assessment

MSC: NCLEX: Physiological Integrity: Basic Care and Comfort

9. The nurse stresses to the home health patient that the acetaminophen pain medication should be taken:

a. as frequently as needed.

b. before pain is severe.

c. when pain becomes unbearable.

d. sparingly and with caution.
ANS: B

Taking medication before pain becomes severe controls pain best. Once taken, the medication should be taken on the prescribed schedule until pain is well controlled.

DIF: Cognitive Level: Application REF: 133 | Patient Teaching

OBJ: 6 (theory) TOP: Pain Medication

KEY: Nursing Process Step: Implementation

MSC: NCLEX: Physiological Integrity: Pharmacological Therapies

10. While bathing the patient, the nurse notes that a transdermal patch that was meant to be on the patient for 3 days is now gone on the second day. The nurse should:

a. document the loss and apply a fresh patch to be replaced in 3 days.

b. report the loss to the charge nurse.

c. document the loss, replace the patch, and continue with the original schedule for replacement.

d. remind the patient that, until the patch is replaced in 24 hours, oral pain relief will be available.

ANS: A

The patch should be replaced after the loss is documented, and the schedule should be changed. There is no need for the patient to wait for a new patch to be applied in 24 hours.

DIF: Cognitive Level: Analysis REF: 136 OBJ: 6 (theory)
11. The patient on frequent doses of meperidine (Demerol) complains of constipation. The initial intervention the nurse should make is:

a. offer fruit such as prunes or apricots.

b. request an order for an enema.

c. report the condition to the charge nurse.

d. increase oral fluid intake.

ANS: D

Increasing fluid intake is the best initial approach because additional fluid allows the body to correct the problem naturally. Fruits can be offered, but increasing the fluid intake is the most effective and priority intervention. An enema is invasive and is not an early intervention for constipation. The nurse should be able to implement proper care without reporting the constipation to the charge nurse.
12. Because of the threat of lowering the seizure threshold, the home health nurse would suggest that the 85-year-old patient limit the use of the pain medication:

a. ibuprofen (Motrin).

b. naproxen (Aleve).

c. tramadol (Ultram).

d. acetaminophen (Tylenol).

ANS: D

Tramadol (Ultram) is associated with a lowered seizure threshold in the older adult.

DIF: Cognitive Level: Comprehension REF: 138 | Elder Care Points

OBJ: 3 (clinical) TOP: Common Side Effects

KEY: Nursing Process Step: Implementation

MSC: NCLEX: Physiological Integrity: Pharmacological Therapies

13. The home health nurse cautions the 75-year-old patient that the warm compresses that are used on his swollen elbow should be left in place only for _____ minutes.

a. 5 to 10

b. 15 to 20
c. 25 to 30

d. 35 to 40

ANS: B

Applications of heat should only be left in place for 15 to 20 minutes.

DIF: Cognitive Level: Comprehension REF: 138 OBJ: 4 (clinical)

TOP: Nonpharmacologic Approaches KEY: Nursing Process Step: Implementation

MSC: NCLEX: Physiological Integrity: Basic Care and Comfort

14. The hospitalized postsurgical patient is reluctant to take the opioid pain medication because of drowsiness. The most informative response made by the nurse would be that:

a. mental stimulation after the medication will keep the patient more alert.

b. sleep and analgesia promote healing.

c. drowsiness is an undesirable side effect.

d. the medication should be taken only before bedtime.

ANS: B

Effective analgesia and adequate rest and sleep promote healing. Mental stimulation after taking an opioid will most likely not be effective for keeping the patient alert; drowsiness is an expected effect; and the medication should be taken as prescribed, not just before bedtime.
15. To help with pain control, the nurse plans distraction activities for a patient to be timed to:

a. coincide with mealtimes.

b. bridge the time between administration and onset.

c. be just previous to bedtime.

d. diminish drowsiness and sleep. ANS: B

Distraction is helpful with pain control between administration of the analgesia and its onset. Mealtimes, bedtime, and sleep should not be interrupted with distraction activities.

16. When a patient reports pain relief after having received a placebo, the nurse concludes that the patient:
a. was not experiencing pain.

b. is relieved of the anxiety that there is no ready source of pain remedy.

c. is demonstrating attention-seeking behavior.

d. is being manipulative.

ANS: B

Much pain is associated with anxiety that there will be no pain remedy available. The delivery of a placebo relieves pain as it relieves the anxiety.

DIF: Cognitive Level: Application REF: 134 | Table 7-4

OBJ: 6 (theory) TOP: False Perception about Pain

KEY: Nursing Process Step: Assessment

MSC: NCLEX: Physiological Integrity: Basic Care and Comfort

17. The nurse takes into consideration that the 45-year-old male Arab patient who is in pain will probably:

a. not request pain medication.

b. call for pain relief to control pain.

c. become irritable and demanding.
d. hide pain from his family.

ANS: B

Individuals of Arab descent generally view pain as something to be controlled and will probably call for pain remedy frequently and expect prompt response. Arabs will express pain to their family.

DIF: Cognitive Level: Application REF: 131 | Cultural Considerations

OBJ: 4 (theory) TOP: Cultural Beliefs about Pain

KEY: Nursing Process Step: Planning

MSC: NCLEX: Physiological Integrity: Basic Care and Comfort

18. When the patient receiving morphine sulfate intravenously breaks out in hives and begins to itch, the nurse should initially:

a. slow the flow rate of the morphine.

b. stop the IV drip.

c. report the condition to the charge nurse.

d. give prescribed antihistamine.

ANS: B
The drug should be stopped immediately. Reporting the condition to the charge nurse and administering prescribed antihistamine are additional interventions that may be initiated after the morphine infusion has been discontinued.

DIF: Cognitive Level: Application REF: 137 OBJ: 3 (clinical)

TOP: Allergy KEY: Nursing Process Step: Implementation

MSC: NCLEX: Physiological Integrity: Reduction of Risk Potential

19. The nurse instructing a family member in the technique of massage will stress that he should use:

a. heat and a mild menthol cream for comfort.

b. progressively intense pounding with sides of the hands.

c. gentle massage of areas of inflammation.

d. long, firm strokes.

ANS: D

Long, firm, smooth strokes on areas that are not inflamed will direct the patients attention away from the painful area. Heat and menthol cream used together may cause a burn.

DIF: Cognitive Level: Application REF: 139 OBJ: 4 (clinical)

TOP: Massage KEY: Nursing Process Step: Implementation

MSC: NCLEX: Physiological Integrity: Basic Care and Comfort
20. The nurse explains that acupressure and acupuncture are effective pain relief modalities that focus on specific body areas called:

a.

triangulation.

b.

hot spots.

c.

meridians.

d.

zones.

ANS: C

The Asian therapies of acupuncture and acupressure use body areas called meridians.

DIF: Cognitive Level: Knowledge REF: 139 OBJ: 5 (theory)

TOP: Acupuncture and Acupressure KEY: Nursing Process Step: Implementation

MSC: NCLEX: Physiological Integrity: Basic Care and Comfort
21. The nurse is caring for a patient who is 1-day postoperative following a colon resection. The patient has degenerative joint disease and uses a pain medication patch to control this chronic pain. When planning care for this patient, the nurse:

a. anticipates that the pain medication patch will control the postoperative pain.

b. knows that this patient will most likely require more pain medication than most patients undergoing a colon resection.

c. realizes that the patient will be afraid to ask for additional pain medication for fear of being viewed as addicted to pain medicine.

d. expects the patient to forget about the pain caused from the degenerated joint disease.

ANS: B

Patients who are being treated for chronic pain often require higher doses of pain medication to treat postoperative pain. The patient’s pain medication patch will not likely treat the postoperative pain. There is no indication that the patient will be afraid to ask for additional pain medication, and the patient is not likely to forget about the postoperative pain.
22. The nurse anticipates the needs of several patients being cared for. The nurse is correct in anticipating that the patient who may experience the highest level of pain is a:

a. 23 year old experiencing pain related to a broken femur.

b. 45 year old experiencing pain following a laparoscopic cholecystectomy.

c. 67 year old experiencing chronic back pain.

d. 89 year old experiencing pain related to osteoarthritis.

ANS: D

While pain is always dependent on the individual patients perception, the older adult tends to be less tolerant to pain due to factors such as having more than one chronic ailment and having fewer resources for tolerating pain.
23. The nurse using the gate theory as a guide to pain management will offer: (Select all that apply.)

a. massage.

b. social activities.

c. music.

d. interactive distraction.

e. a quiet environment.
ANS: A, B, D

Music is not effective as a gate closer. High levels of sensory stimulation are more effective for decreasing pain according to the gate theory.

DIF: Cognitive Level: Comprehension REF: 124-125 OBJ: 2 (theory)

TOP: Gate Control Theory KEY: Nursing Process Step: Planning

MSC: NCLEX: Physiological Integrity: Basic Care and Comfort

24. The functions of endorphins are believed to be: (Select all that apply.)

a.

inhibition of unpleasant

stimuli. b.

diminished

anxiety. c.

relief of

pain. d.

feeling of euphoria.
increased blood pressure.

ANS: A, B, C, D

Endorphins are thought to diminish unpleasant stimuli and pain, reduce anxiety, and give feelings of euphoria.

DIF: Cognitive Level: Comprehension REF: 125 OBJ: 3 (theory)

TOP: Endorphins KEY: Nursing Process Step: Planning

MSC: NCLEX: Physiological Integrity: Physiological Adaptation

25. The nurse explains to the patient with neuropathic pain that the most effective pain control will be achieved through the use of: (Select all that apply.)

a. analgesics.

b. opioids.

c. antidepressants.
d. anti-inflammatory agents.

e. anticonvulsants.

ANS: C, D, E

Neuropathic pain is best relieved by antidepressants, anti-inflammatory agents, and anticonvulsants. Analgesics and opioids generally do not alleviate neuropathic pain.

DIF: Cognitive Level: Comprehension REF: 126 OBJ: 3 (theory)

TOP: Neuropathic Pain KEY: Nursing Process Step: Implementation

MSC: NCLEX: Physiological Integrity: Pharmacological Therapies

26. Although the patient with a kidney stone denies pain, the nurse assesses cues that indicate that pain is perceived. These cues include: (Select all that apply.)

a. increased pulse rate.

b. decreased respiratory rate.
c.

sweating.

d.

muscle tension.

e.

nausea.

ANS: A, C, D, E

The respiratory rate increases in patients in acute pain.

DIF: Cognitive Level: Comprehension REF: 128-129 OBJ: 7 (theory)

TOP: Assessment of Acute Pain KEY: Nursing Process Step: Assessment

MSC: NCLEX: Physiological Integrity: Basic Care and Comfort

COMPLETION

27. Pain receptors in the skin, connective tissue, bone, joints, and muscles are classified as __________.

ANS:

nociceptors
Pain receptors in the skin, connective tissue, bone, joints, and muscles are nociceptors.

DIF: Cognitive Level: Knowledge REF: 125 OBJ: 3 (theory)

TOP: Nociceptor Receptors KEY: Nursing Process Step: NA

MSC: NCLEX: Physiological Integrity: Physiological Adaptation

MATCHING

Arrange the sequence of nociceptive pain in the order in which the process occurs.

a. Transmission

b. Modulation

c. Transduction

d. Perception

28. Step 1

29. Step 2

30. Step 3

31. Step 4
28. ANS: C DIF: Cognitive Level: Comprehension REF: 126 | Figure 7-2

OBJ: 3 (theory) TOP: Nociceptive Pain Perception KEY: Nursing Process Step: NA

MSC: NCLEX: Physiological Integrity: Physiological Adaptation

29. ANS: A DIF: Cognitive Level: Comprehension REF: 126 | Figure 7-2

OBJ: 3 (theory) TOP: Nociceptive Pain Perception KEY: Nursing Process Step: NA

MSC: NCLEX: Physiological Integrity: Physiological Adaptation

30. ANS: D DIF: Cognitive Level: Comprehension REF: 126 | Figure 7-2

OBJ: 3 (theory) TOP: Nociceptive Pain Perception KEY: Nursing Process Step: NA

MSC: NCLEX: Physiological Integrity: Physiological Adaptation

31. ANS: B DIF: Cognitive Level: Comprehension REF: 126 | Figure 7-2

OBJ: 3 (theory) TOP: Nociceptive Pain Perception KEY: Nursing Process Step: NA

MSC: NCLEX: Physiological Integrity: Physiological Adaptation