Introduction to Critical Care Nursing 7th edition Sole Test Bank

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MULTIPLE CHOICE

1. Family members have a need for information. Which interventions best assist in meeting this need?
   a. Handing family members a pamphlet that explains all of the critical care equipment
   b. Providing a daily update of the patient's progress and facilitating communication with the intensivist
   c. Telling them that you are not permitted to give them a status report but that they can be present at 4:00 PM for family rounds with the intensivist
   d. Writing down a list of all new medications and doses and giving the list to family members during visitation

   ANS: B
   The nurse can give a status report related to the patient's condition and current treatment plan as well as ensure that the family has daily meeting time with the intensivist for an update on diagnoses, prognoses, and the like. Pamphlets are helpful; however, the nurse should also explain the equipment that is at this patient's bedside and not assume that everyone can read and understand written material. Limiting the information to that provided by the physician is unnecessary and will not meet the family's information needs. Most family members are concerned about the patient's general condition and treatment plan. They do not want or need a detailed list of medications, doses, or other treatments.

   DIF: Cognitive Level: Apply/Application REF: p. 23
   OBJ: Describe common family needs and family-centered nursing interventions.
   TOP: Nursing Process Step: Implementation
   MSC: NCLEX Client Needs Category: Psychosocial Integrity

2. The nurse is a member of a committee to design a critical care unit in a new building. Which design trend would best facilitate family-centered care?
   a. Ensure that the patient's room is large enough and has adequate space for a sleeper sofa and storage for family members' personal belongings.
   b. Include a diagnostic suite in close proximity to the unit so that the patient does not have to travel far for testing.
   c. Incorporate a large waiting room on the top floor of the hospital with a scenic view and amenities such as coffee and tea.
   d. Provide access to a scenic garden for meditation.

   ANS: A
   New unit design trends to promote family-centered care include patient rooms that provide a larger family space and comfortable furniture and storage to promote open visitation, including overnight stays in the patient's room. Ready access to diagnostic testing, including portable equipment, is an important trend; however, the purpose for this is to prevent the need for transport, not to foster family-centered care. A waiting room in close proximity to the unit with amenities is a nice feature; however, it does not need to be large if adequate space is incorporated into the patient's room. A scenic garden for meditation may assist in reducing family members' stress, but proximity to the patient is the greatest need.

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DIF: Cognitive Level: Apply/Application REF: p. 19
OBJ: Describe common family needs and family-centered nursing interventions.
TOP: Nursing Process Step: Planning
MSC: NCLEX Client Needs Category: Psychosocial Integrity

3. The nurse is caring for a patient who sustained a head injury and is unresponsive to painful stimuli. Which intervention is most appropriate while bathing the patient?
   a. Ask a family member to help you bathe the patient, and discuss the family structure with the family member during the procedure.
   b. Because the patient is unconscious, complete care as quickly and quietly as possible.
   c. Tell the patient the day and time, and that you are providing a bath. Reassure the patient that you are there.
   d. Turn the television on to the evening news so that you and the patient can be updated to current events.

   ANS: C
   Although unconscious, many patients can hear, understand, and respond to stimuli. Therefore, it is important to converse with the patient and reorient her to the environment. Some, but not all, family members may want to get involved in direct care; it is not known if this individual is a willing participant, and talking about who's who in the family is inappropriate while providing direct care to the patient. Although the patient is unconscious, communication and simple conversations remain important interventions. Use of the television to provide sensory input that the patient regularly enjoys is a nursing intervention, but turning on the news for the sake of the nurse is not appropriate.

   DIF: Cognitive Level: Apply/Application REF: p. 20
   OBJ: Describe stressors in the critical care environment and strategies to reduce them.
   TOP: Nursing Process Step: Implementation
   MSC: NCLEX Client Needs Category: Psychosocial Integrity

4. Sleep often is disrupted for critically ill patients. Which nursing intervention is most appropriate to promote sleep and rest?
   a. Consult with the pharmacist to adjust medication times to allow periods of sleep or rest between intervals.
   b. Encourage family members to talk with the patient whenever they are present in the room.
   c. Keep the television on to provide white noise and distraction.
   d. Leave the lights on in the room so that the patient is not frightened of his or her surroundings.

   ANS: A
   Planning care to promote periods of uninterrupted rest is important. Consulting with the pharmacist to adjust a medication schedule is an excellent example of this intervention. It is important for family members to communicate with the patient; however, rest periods must be scheduled. Family members can be present in the room while remaining quiet during these scheduled times. The television may be useful if it is part of the patient's normal routine for sleep; however, it does not consistently provide white noise or distraction. Lights should be dimmed during scheduled rest periods and at night to facilitate sleep and rest.

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DIF: Cognitive Level: Apply/Application REF: p. 20
OBJ: Discuss the impact of critical care hospitalization on the patient and family.
TOP: Nursing Process Step: Implementation
MSC: NCLEX Client Needs Category: Physiological Integrity—Basic Care and Comfort

5. Family assessment is essential to meet family needs. Which of the following must be assessed first to assist the nurse in providing family-centered care?
   a. Assessment of patient and family's developmental stages and needs
   b. Description of the patient's home environment
   c. Identification of immediate family, extended family, and decision makers
   d. Observation and assessment of how family members function with each other

   ANS: C
   Assessment of the family structure is the first step and is essential before specific interventions can be designed. It identifies immediate family, extended family, and decision makers in the family. Structural assessment also includes ethnicity and religion. The developmental assessment is done after the structural assessment and includes the developmental stages of the patient and family. Functional assessment is also important to assess how family members function with each other; however, it is not done first. Assessment of the home environment is important when identifying discharge planning needs.

   DIF: Cognitive Level: Apply/Application REF: p. 21
   OBJ: Discuss the impact of critical care hospitalization on the patient and family.
   TOP: Nursing Process Step: Assessment
   MSC: NCLEX Client Needs Category: Psychosocial Integrity

6. Critical illness often results in family conflicts. Which scenario is most likely to result in the greatest conflict?
   a. A 21-year-old college student of divorced parents hospitalized with multiple trauma. She resides with her mother. The parents are amicable with each other and have similar values. The father blames the daughter's boyfriend for causing the accident.
   b. A 36-year-old male admitted for a ruptured cerebral aneurysm. He has been living with his 34-year-old girlfriend for 8 years, and they have a 4-year-old daughter. He does not have a written advance directive. His parents arrive from out-of-state and are asked to make decisions about his health care. He has not seen them in over a year.
   c. A 58-year-old male admitted for coronary artery bypass surgery. He has been living with his same-sex partner for 20 years in a committed relationship. He has designated his sister, a registered nurse, as his health care proxy in a written advance directive.
   d. A 78-year-old female admitted with gastrointestinal bleeding. Her hemoglobin is decreasing to a critical level. She is a Jehovah's Witness and refuses the treatment of a blood transfusion. She is capable of making her own decisions and has a clearly written advance directive declining any transfusions. Her son is upset with her and tells her she is "committing suicide."

   ANS: B

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Each of these situations may result in family conflict. The situation with the unmarried 36-year-old male without a written advance directive results in his distant parents being legally responsible for his health care decisions. Because of his long-standing commitment with his partner and lack of recent contact with his parents, this scenario is likely to cause the most conflict. The parents may make decisions based on their wishes, as they may not be knowledgeable of the patient's wishes. The supportive parents of the college student may create conflict with the boyfriend, but the parents' ongoing friendship and shared values will assist in reducing conflict. The male admitted for bypass surgery, although in a same-sex relationship, has clearly identified whom he wants to make health care decisions for him. The elderly female may have conflict with her son; however, she is capable of making her own decisions and has a written advance directive to support her decisions.

DIF: Cognitive Level: Analyze/Analysis REF: p. 22
OBJ: Discuss the impact of critical care hospitalization on the patient and family.
TOP: Nursing Process Step: Assessment
MSC: NCLEX Client Needs Category: Psychosocial Integrity

7. Which nursing interventions would best support the family of a critically ill patient?
   a. Encourage family members to stay all night in case the patient needs them.
   b. Give a condition update each morning and whenever changes occur.
   c. Limit visitation from children into the critical care unit.
   d. Provide beverages and snacks in the waiting room.

ANS: B
The need for information is one of the highest identified by family members of critically ill patients. A planned condition update helps the family know what to expect. New room designs provide space for family members to spend the night if desired; however, if the patient is stable, family members should be encouraged to sleep at home to ensure that they are well rested and can support the patient. Restriction of children in the critical care unit is not supported by research evidence. Child visitation should be individualized based on the needs and wishes of the patient and family. Beverages and snacks are important but not as important as information.

DIF: Cognitive Level: Analyze/Analysis REF: p. 23
OBJ: Describe common family needs and family-centered nursing interventions.
TOP: Nursing Process Step: Implementation
MSC: NCLEX Client Needs Category: Psychosocial Integrity

8. Which intervention is appropriate to assist the patient in coping with admission to the critical care unit?
   a. Allowing unrestricted visiting by several family members at one time
   b. Explaining all procedures in easy-to-understand terms
   c. Providing back massage and mouth care
   d. Turning down the alarm volume on the cardiac monitor

ANS: B
Communication and explanations of procedures are priority interventions to help patients cope with admission. Comfort is an important intervention but not the priority. Noise control is an important intervention but not the priority. Open visitation is recommended; however, the number of family members may need to be limited to promote rest and sleep.

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DIF: Cognitive Level: Analyze/Analysis REF: p. 20
OBJ: Describe stressors in the critical care environment and strategies to reduce them.
TOP: Nursing Process Step: Implementation
MSC: NCLEX Client Needs Category: Psychosocial Integrity

9. The constant noise of a ventilator, monitor alarms, and infusion pumps predisposes the patient to:
   a. anxiety.
   b. pain.
   c. powerlessness.
   d. sensory overload.

   ANS: D
   Constant noise is a source of sensory overload. Pain and lack of information contribute to anxiety. Noise does not cause physical pain. Lack of involvement in care causes powerlessness.

   DIF: Cognitive Level: Remember/Knowledge REF: p. 18
   OBJ: Describe stressors in the critical care environment and strategies to reduce them.
   TOP: Nursing Process Step: Assessment
   MSC: NCLEX Client Needs Category: Psychosocial Integrity

10. Which of the following statements about family assessment is false?
    a. Assessment of structure (who comprises the family) is the last step in assessment.
    b. Interaction among family members is assessed.
    c. It is important to assess communication among family members to understand roles.
    d. Ongoing assessment is important, because family functioning may change during the course of illness.

    ANS: A
    Assessment of structure should be done first so that the nurse can identify such things as who comprises the family and who assumes leadership and decision-making responsibilities. This assessment also assists in identifying which individuals are most important to the patient and how many people may be seeking information. Family member interaction must be assessed, so this answer is true. Family member communication must be assessed, so this answer is true. Ongoing assessment of family is necessary as functions may change, so this answer is true.

    DIF: Cognitive Level: Remember/Knowledge REF: p. 21
    OBJ: Describe common family needs and family-centered nursing interventions.
    TOP: Nursing Process Step: Assessment
    MSC: NCLEX Client Needs Category: Psychosocial Integrity

11. Which intervention about visitation in the critical care unit is true?
    a. The majority of critical care nurses implement restricted visiting hours to allow the patient to rest.
    b. Children should never be permitted to visit a critically ill family member.
    c. Visitation that is individualized to the needs of patients and family members is ideal.
    d. Visiting hours should always be unrestricted.

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ANS: C
Visiting should be based on the needs of patients and their families. There may be times when visiting needs to be limited (e.g., to allow the patient to rest); however, it is important to individualize visitation. Sometimes it is appropriate for children to visit; research has not found child visitation to be harmful to either the patient or the child. Visiting should be adjusted to patient needs.

DIF: Cognitive Level: Remember/Knowledge REF: p. 24
OBJ: Describe common family needs and family-centered nursing interventions.
TOP: Nursing Process Step: Assessment
MSC: NCLEX Client Needs Category: Psychosocial Integrity

12. Elderly patients who require critical care treatment are at risk for increased mortality, functional decline, or decreased quality of life after hospitalization. Assuming each of these patients was discharged from the hospital, which of the following patients is at greatest risk for decreased functional status and quality of life?
    a. A 70-year-old man who had coronary artery bypass surgery. He developed complications after surgery and had difficulty being weaned from mechanical ventilation. He required a tracheostomy and gastrostomy. He is being discharged to a long-term acute care hospital. He is a widower.
    b. A 79-year-old woman admitted for exacerbation of heart failure. She manages her care independently but needed diuretic medications adjusted. She states that she is compliant with her medications but sometimes forgets to take them. She lives with her 82-year-old spouse. Both consider themselves to be independent and support each other.
    c. A 90-year-old man admitted for a carotid endarterectomy. He lives in an assisted living facility (ALF) but is cognitively intact. He is the "social butterfly" at all of the events at the ALF. He is hospitalized for 4 days and discharged to the ALF.
    d. An 84-year-old woman who had stents placed to treat coronary artery occlusion. She has diabetes that has been managed, lives alone, and was driving prior to hospitalization. She was discharged home within 3 days of the procedure.

    ANS: A
    Although he is younger, the 70-year-old with the complicated critical care course, limited social support, and a transfer to a long-term acute care facility is at greatest risk for decreased quality of life and functional decline. He will continue to need high-level nursing care and support for rehabilitation. The other cases are examples of individuals with shorter hospital stays, uncomplicated courses, and social support systems.

    DIF: Cognitive Level: Analyze/Analysis REF: p. 21
    OBJ: Discuss the impact of critical care hospitalization on the patient and family.
    TOP: Nursing Process Step: Evaluation
    MSC: NCLEX Client Needs Category: Health Promotion and Maintenance

13. Patients often have recollections of the critical care experience. Which is likely to be the most common recollection of patients who required endotracheal intubation and mechanical ventilation?
    a. Difficulty in communicating
    b. Inability to get comfortable
    c. Pain
    d. Sleep disruption

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ANS: A
Although the patient may recall all of these potential experiences, recollection of difficult communication is most likely secondary to the endotracheal tube placement.

DIF: Cognitive Level: Analyze/Analysis REF: p. 20
OBJ: Discuss the impact of critical care hospitalization on the patient and family.
TOP: Nursing Process Step: Evaluation
MSC: NCLEX Client Needs Category: Psychosocial Integrity

14. Many critically ill patients experience anxiety. The nurse can reduce anxiety with which approach?
    a. Ask family members to limit their visitation to 2-hour periods in morning, afternoon, and evening.
    b. Explain the unit routine.
    c. Explain procedures before and while you are doing them.
    d. Suction Mr. J.'s endotracheal tube immediately when he starts to cough.

ANS: C
Anxiety is reduced when procedures are explained before completing them and when the nurse continues to talk to the patient during them. Limiting visitation has not been demonstrated by research to benefit patients. Explaining the unit routine is important but is not as specific to the patient as explaining a procedure right before doing it. Providing physical care is vital to critically ill patients, but may or may not reduce anxiety.

DIF: Cognitive Level: Analyze/Analysis REF: p. 20
OBJ: Describe stressors in the critical care environment and strategies to reduce them.
TOP: Nursing Process Step: Implementation
MSC: NCLEX Client Needs Category: Psychosocial Integrity

15. The intensive care nurse is working on a committee to reduce noise in the unit. Which recommendation should the nurse propose first?
    a. Change telephones to blinking lights instead of audible ringtones.
    b. Invest in call lights that page the nursing staff instead of beeping.
    c. Recommend that nurses turn off cardiac monitors on stable patients.
    d. Soundproof the pneumatic tube system.

ANS: D
The pneumatic tube system is extremely loud at 88dB[A] and should be the first proposal as it will have the biggest impact on noise on the unit. Call light systems typically ring at the 48–63 dB[A] range and are also a significant cause of noise, but not as much as the pneumatic tube system. Telephones are also noisy, ringing at 60–67 dB[A]. Nurses should never shut off monitor alarms as this is a patient safety issue.

DIF: Cognitive Level: Apply/Application REF: p. 19
OBJ: Discuss how to safely reduce the noise level on the unit floor.
TOP: Nursing Process Step: Planning
MSC: NCLEX Client Needs Category: Safe and Effective Care Environment—Management of Care

16. The nurse is assigned to care for a patient who is a non–native English speaker. What is the best way to communicate with the patient and family to provide updates and explain procedures?

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a. Conduct a Google search on the computer to identify resources for the patient and family in their native language. Print these for their use.
b. Contact the hospital's interpreter service for someone to translate.
c. Get in touch with one of the residents who you know is fluent in the native language and ask him if he can come up to the unit.
d. Use the patient's 8-year-old child who is fluent in both English and the native language to translate for you.

ANS: B
The best approach when communicating with someone whose primary language is not English is to use the interpreter services of the agency. These individuals are trained and knowledgeable. If the nurse conducted a search on the computer, he or she would not know if the information retrieved was valid, nor would the nurse know if the patient or family can read in their native language. Although one of the residents might be fluent in the language, you do not know his or her abilities to translate. In addition, the resident's availability is likely to be limited. Although the child might be able to translate, the nurse cannot ensure that the child is translating health care concepts correctly.

DIF: Cognitive Level: Analyze/Analysis REF: p. 22
OBJ: Discuss the impact of critical care hospitalization on the patient and family.
TOP: Nursing Process Step: Implementation
MSC: NCLEX Client Needs Category: Psychosocial Integrity

17. Family assessment can be challenging, and each nurse may obtain additional information regarding family structure and dynamics. What is the best way to share this information from shift to shift?
a. Create an informal family information sheet that is kept on the bedside clipboard. That way, everyone can review it quickly when needed.
b. Develop a standardized reporting form for family information that is incorporated into the patient's medical record and updated as needed.
c. Require that the charge nurse have a detailed list of information about each patient and family member. Thus, someone on the unit is always knowledgeable about potential issues.
d. Try to remember to discuss family structure and dynamics as part of the change-of-shift report.

ANS: B
A standardized method for gathering data about family structure and function and recording it in an official document is the best approach. This strategy ensures that data are collected and kept in the medical record. Data are also easily retrievable by anyone who needs to know this information. Informal documentation is often kept to assist in follow-up and change-of-shift reporting; however, this strategy is not recommended, as data collected are likely to vary and not be part of a permanent record. Although the charge nurse often has some information regarding families, the primary responsibility for assessment and follow-up belongs to the bedside nurse. Family information should be shared at change of shift using a standardized format, not "try to remember to discuss…."

DIF: Cognitive Level: Analyze/Analysis REF: p. 22
OBJ: Discuss the impact of critical care hospitalization on the patient and family.
TOP: Nursing Process Step: Implementation
MSC: NCLEX Client Needs Category: Psychosocial Integrity

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18. The spouse of a patient who is hospitalized in the critical care unit following resuscitation for a sudden cardiac arrest at work demands to meet with the nursing manager. The spouse demands, "I want you to reassign us to another nurse. His current nurse is not in the room enough to make sure everything is okay." The nurse recognizes that this response most likely is due to the spouse's
    a. desire to pursue a lawsuit if the assignment is not changed.
    b. inability to participate in the husband's care.
    c. lack of prior experience in a critical care setting.
    d. sense of loss of control of the situation.

    ANS: D
    Demanding behaviors often occur when the family member has a sense of loss of control or has had adverse outcomes in a previous hospitalization. Prevention of a lawsuit is not relevant to this scenario. No information is provided regarding whether the family member is participating in care or not. It is unknown whether the spouse had a prior negative experience.

    DIF: Cognitive Level: Analyze/Analysis REF: p. 22
    OBJ: Discuss the impact of critical care hospitalization on the patient and family.
    TOP: Integrated Process: Communication and Documentation
    MSC: NCLEX Client Needs Category: Psychosocial Integrity

19. Open visitation policies are expected by many professional organizations. Which statement reflects adherence to current recommendations?
    a. Allow animals on the unit; however, these can only be "therapy" animals through the hospital's pet therapy program.
    b. Allow family visitation throughout the day except at change of shift and during rounds.
    c. Determine, in collaboration with the patient and family, who can visit and when. Facilitate open visitation policies.
    d. Permit open visitation by adults 18 years of age and older; limit visits of children to 1 hour.

    ANS: C
    Open visitation is considered best practice. Limiting visitation is not supported by research. Facilities should develop visitation schedules in collaboration with the patient and family. Animals do not need to be limited to therapy animals. Many patients benefit from the presence of personal pets brought to the unit according to hospital policy. Although many units restrict visitation during report and rounds for confidentiality, family-centered facilities will encourage family participation during report and rounds. Children should not be banned arbitrarily from the unit or have hours limited.

    DIF: Cognitive Level: Remember/Knowledge REF: p. 24
    OBJ: Identify strategies for promoting visitation and family presence in the critical care setting.
    TOP: Nursing Process Step: Implementation
    MSC: NCLEX Client Needs Category: Psychosocial Integrity

20. The VALUE mnemonic is a helpful strategy to enhance communication with family members of critically ill patients. Which of the following statements describes a VALUE strategy?
    a. View the family as guests on the unit.
    b. Acknowledge family emotions.

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c. Learn as much as you can about family structure and function.
d. Use a trained interpreter if the family does not speak English.

ANS: B
The VALUE mnemonic includes the following:
V—Value what the family tells you.
A—Acknowledge family emotions.
L—Listen to the family members.
U—Understand the patient as a person.
E—Elicit (ask) questions of family members.

DIF: Cognitive Level: Remember/Knowledge REF: p. 25
OBJ: Describe common family needs and family-centered nursing interventions.
TOP: Nursing Process Step: Implementation
MSC: NCLEX Client Needs Category: Psychosocial Integrity

21. Changing visitation policies can be challenging. The nurse manager recognizes which of the following as an effective strategy for promoting changes in practice?
    a. Ask the clinical nurse specialist to lead a journal club on open visitation after each nurse is tasked to read one research article about visitation.
    b. Discuss the pros and cons of open visitation at the next staff meeting.
    c. Invite the nurses with the most experience to develop a revised policy.
    d. Task the unit-based nurse practice council to invite volunteers to serve on the council to revise the current policy toward more liberal visitation.

    ANS: D
    Changes in policy are most effective through willing champions as part of a unit-based, staff-led practice council. Discussion of evidence-based findings is important, but it is not logical to expect every nurse to read a research article and share findings. Discussion of pros and cons at a staff meeting is likely to be prolonged and based on opinion rather than evidence. Nurses with the most experience are not necessarily the ones to develop a new policy. They may be the least likely to change; therefore, it is important to solicit volunteers from all staff members, not just the experienced ones.

    DIF: Cognitive Level: Apply/Application REF: p. 25
    OBJ: Identify strategies for promoting visitation and family presence in the critical care setting.
    TOP: Nursing Process Step: Implementation
    MSC: NCLEX Client Needs Category: Psychosocial Integrity

MULTIPLE RESPONSE

1. Nursing strategies to help families cope with the stress of critical illness include: (*Select all that apply.*)
    a. asking the family to leave during the morning bath to promote the patient's privacy.
    b. encouraging family members to make notes of questions they have for the physician during family rounds.
    c. if possible, providing continuity of nursing care.
    d. providing a daily update of the patient's condition to the family spokesperson.
    e. ensuring that a waiting room stocked with snacks is nearby.

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ANS: B, C, D
Encouraging families to formulate questions assists in family care. Continuity of nursing care with consistent staff members assists in reducing stress. Communicating daily updates of the patient's condition meets the family's need for information. Family members often want to assist with simple activities of patient care, so limiting participation is the exception to this list. A comfortable waiting room is necessary; however, it may or may not impact the family's stress level.

DIF: Cognitive Level: Apply/Application REF: pp. 23-24
OBJ: Describe common family needs and family-centered nursing interventions.
TOP: Nursing Process Step: Implementation
MSC: NCLEX Client Needs Category: Psychosocial Integrity

2. Family presence is encouraged during resuscitation and invasive procedures. Which findings about this practice have been reported in the literature? (*Select all that apply.*)
   a. Families benefit by witnessing that everything possible was done.
   b. Families report reduced anxiety and fear about what is being done to the patient.
   c. Presence encourages family members to seek litigation for improper care.
   d. Presence reduces nurses' involvement in explaining things to the family.
   e. Families report that staff conversations during this time were distressing.

   ANS: A, B
   Families benefit from witnessing procedures and resuscitation. The presence of family members removes doubt about the patient's condition, allows them to witness that everything was done, and decreases anxiety about what is occurring. Increased litigation has not been associated with family presence. Policies and procedures are needed to facilitate family presence. A facilitator is needed, and it may initially require more nursing involvement. It does not eliminate nurses' responsibility for communicating with the family. The literature does not report that families have reported feelings of distress over staff conversations during these times.

   DIF: Cognitive Level: Remember/Knowledge REF: p. 26
   OBJ: Identify strategies for promoting visitation and family presence in the critical care setting.
   TOP: Integrated Process: Caring
   MSC: NCLEX Client Needs Category: Psychosocial Integrity

3. Noise in the critical care unit can have negative effects on the patient. Which of the following interventions assists in reducing noise levels in the critical care setting? (*Select all that apply.*)
   a. Ask the family to bring in the patient's iPod or other device with favorite music.
   b. Invite a volunteer harpist to play on the unit on a regular basis.
   c. Remodel the unit to have two-patient rooms to facilitate nursing care.
   d. Remodel the unit to install acoustical ceiling tiles.
   e. Turn the volume of equipment alarms as low as they can be adjusted, and "off" if possible.

   ANS: A, B, D

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A personal device with favorite music and headphones can be helpful in reducing ambient unit noise. Music therapy programs, such as harpists, can provide soothing sedative music that is often comforting to both patients and family members. Acoustical tiles help to reduce noise in the critical care setting and should be included in remodeling plans as well as new unit construction. Multiple patients in a single room would increase noise levels and contribute to an increased risk of infection. Alarms on critical equipment must never be turned off. The volume should be loud enough that the alarm can be heard by the nurse if outside the room. The lowest setting may not be loud enough, depending on the unit layout and patient assignment.

DIF: Cognitive Level: Apply/Application REF: p. 19
OBJ: Describe stressors in the critical care environment and strategies to reduce them.
TOP: Nursing Process Step: Implementation
MSC: NCLEX Client Needs Category: Psychosocial Integrity

4. It is important for critically ill patients to feel safe. Which nursing strategies help the patient to feel safe in the critical care setting? (*Select all that apply.*)
   a. Allow family members to remain at the bedside.
   b. Consult with the charge nurse before making any patient care decisions.
   c. Provide informal conversation by discussing your plans for after work.
   d. Respond promptly to call bells or other communication for assistance.
   e. Inform the patient that you have cared for many similar patients.

   ANS: A, D
   Patients feel safe when nurses exhibit technical competence, meet their needs, and provide reorientation. Family member presence may also contribute to feeling safe. Consulting with the charge nurse before making decisions may be interpreted as incompetence or insecurity. The nurse's personal activities should never be discussed with patients. Simply informing the patient that you have cared for many similar patients may or may not cause the patient to feel safer; the patient may feel this is condescending.

   DIF: Cognitive Level: Apply/Application REF: p. 23
   OBJ: Describe stressors in the critical care environment and strategies to reduce them.
   TOP: Nursing Process Step: Implementation
   MSC: NCLEX Client Needs Category: Psychosocial Integrity

5. The critical care environment is often stressful to a critically ill patient. Identify stressors that are common. (*Select all that apply.*)
   a. Alarms that sound from various devices
   b. Bright fluorescent lighting
   c. Lack of day-night cues
   d. Sounds from the mechanical ventilator
   e. Visiting hours tailored to meet individual needs

   ANS: A, B, C, D
   Adjustment of visiting hours to meet the needs of patients and families assists in reducing the stress of critical illness. All other responses are environmental stressors that may increase anxiety or affect sleep.

   DIF: Cognitive Level: Understand/Comprehension REF: pp. 19-20
   OBJ: Describe stressors in the critical care environment and strategies to reduce them.

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TOP: Nursing Process Step: Assessment
MSC: NCLEX Client Needs Category: Psychosocial Integrity

6. To reduce relocation stress in patients transferring out of the intensive care unit, the nurse can (*Select all that apply.*)
   a. ask the nurses on the intermediate care unit to give the family a tour of the new unit.
   b. contact the intensivist to see if the patient can stay one additional day in the critical care unit so that he and his family can adjust better to the idea of a transfer.
   c. ensure that the patient will be located near the nurses' station in the new unit.
   d. invite the nurse who will be assuming the patient's care to meet with the patient and family in the critical care unit prior to transfer.
   e. help the patient and family focus on the positive meaning of a transfer.

   ANS: A, D, E
   Patients often have stress when they are moved from the safety of the critical care unit. Introducing the patient and his family to the nurse who will assume care and to the new environment are strategies to reduce relocation stress. Encouraging the patient and family to see the transfer as a positive sign of healing might lessen the stress they feel. Although the patient and his family may feel safer in a room near the nurses' station, bed placement is determined by a variety of factors and cannot be guaranteed. Beds in the critical care unit are at a premium, and once the physician has determined that the patient no longer meets critical care admission requirements, it is essential that transfers be made as soon as a bed on the intermediate care unit is available.

   DIF: Cognitive Level: Apply/Application REF: p. 20
   OBJ: Describe stressors in the critical care environment and strategies to reduce them.
   TOP: Nursing Process Step: Implementation
   MSC: NCLEX Client Needs Category: Psychosocial Integrity

7. The critical care environment is stressful to the patient. Which interventions assist in reducing this stress? (*Select all that apply.*)
   a. Adjust lighting to promote normal sleep-wake cycles.
   b. Provide clocks, calendars, and personal photos in the patient's room.
   c. Talk to the patient about other patients you are caring for on the unit.
   d. Tell the patient the day and time when you are providing routine nursing interventions.
   e. Allow unlimited visitation tailored to the patient's individual needs.

   ANS: A, B, E
   Manipulation of the environment, such as the adjustment of lighting, is helpful in promoting sleep and rest. Clocks, calendars, photos, and other personal items promote orientation and personalize the environment; telling the patient the day and time and other current events assists in maintaining the patient's orientation. Allowing visitation that best meets the patient's needs will reduce stress as the patient's support systems are present. Conversations about other patients are private and should take place away from other patients.

   DIF: Cognitive Level: Apply/Application REF: pp. 22-24
   OBJ: Describe stressors in the critical care environment and strategies to reduce them.
   TOP: Nursing Process Step: Implementation
   MSC: NCLEX Client Needs Category: Psychosocial Integrity

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