Introduction to Critical Care Nursing 8th edition Sole Test Bank

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MULTIPLE CHOICE

1. Family members have a need for information. Which intervention best assists 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 primary health care provider 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: Analysis
   OBJ: Describe common family needs and family-centered nursing interventions.
   TOP: Nursing Process Step: Implementation
   MSC: NCLEX: 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 be implemented to facilitate family-centered care?
   a. Ensuring that the patient's room is large enough to include a sleeper sofa and storage for family members' personal belongings.
   b. Including a diagnostic suite in close proximity to the unit so that the patient does not have to travel far for testing.
   c. Incorporating a large waiting room on the top floor of the hospital with a scenic view and amenities such as coffee and tea.
   d. Providing access to a scenic garden for meditation.

   ANS: A
   New unit design trends to promote family-centered care include larger patient rooms that include 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 medication may assist in reducing family members' stress, but proximity to the patient is the greatest need.

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DIF: Cognitive Level: Analysis
OBJ: Describe common family needs and family-centered nursing interventions.
TOP: Nursing Process Step: Planning MSC: NCLEX: 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. Inform the patient of the day and time, and what kind of care you are providing.
   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 them 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 not appropriate while providing direct care to the patient. Although is 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: Application
   OBJ: Describe stressors in the critical care environment and strategies to reduce them.
   TOP: Nursing Process Step: Implementation
   MSC: NCLEX: 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.

   DIF: Cognitive Level: Analysis
   OBJ: Discuss the impact of critical care hospitalization on the patient and family.

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TOP: Nursing Process Step: Implementation
MSC: NCLEX: Psychosocial Integrity

5. Family assessment is essential in order 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: Analysis
   OBJ: Discuss the impact of critical care hospitalization on the patient and family.
   TOP: Nursing Process Step: Assessment MSC: NCLEX: 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 written advance directives. 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 healthcare 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 couple without written advance directives results in the distant parents being legally responsible for his healthcare 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 their 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 who he wants to make healthcare decisions for him. The elderly female may have conflict with her son; however, she is capable of making her own decisions and has written advance directives to support her decisions.

DIF: Cognitive Level: Analysis
OBJ: Discuss the impact of critical care hospitalization on the patient and family.
TOP: Nursing Process Step: Assessment MSC: NCLEX: Psychosocial Integrity

7. Which nursing interventions would best support the family of a critically ill patient?
   a. Encouraging family members to stay all night in case the patient needs them.
   b. Giving a condition update each morning and whenever changes occur.
   c. Limiting visitation from children into the critical care unit.
   d. Providing 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. 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: Analysis
OBJ: Describe common family needs and family-centered nursing interventions.
TOP: Nursing Process Step: Implementation
MSC: NCLEX: Psychosocial Integrity

8. Which intervention is appropriate to assist the patient to cope 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.

DIF: Cognitive Level: Analysis
OBJ: Describe stressors in the critical care environment and strategies to reduce them.

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TOP: Nursing Process Step: Implementation
MSC: NCLEX: Psychosocial Integrity

9. The constant noise of a ventilator, monitor alarms, and infusion pumps predisposes the patient to what form of stress?
   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: Understand
   OBJ: Describe stressors in the critical care environment and strategies to reduce them.
   TOP: Nursing Process Step: Assessment MSC: NCLEX: Psychosocial Integrity

10. Which statement 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: Understand
    OBJ: Describe common family needs and family-centered nursing interventions.
    TOP: Nursing Process Step: Assessment MSC: NCLEX: 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.

    ANS: C

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Visiting should be based on the needs of patients and their families. There may be times that 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: Analysis
OBJ: Describe common family needs and family-centered nursing interventions.
TOP: Nursing Process Step: Assessment MSC: NCLEX: Psychosocial Integrity

12. Assuming each of these patients was discharged from the hospital, which older adult patient is at greatest risk for decreased functional status and quality of life?
    a. A 70-year-old who had coronary artery bypass surgery developed complications after surgery and had difficulty being weaned from mechanical ventilation. The patient required a tracheostomy and gastrostomy and is now being discharged to a long-term, acute care hospital. The patient lost their significant other 3 years ago.
    b. A 79-year-old admitted for exacerbation of heart failure manages health care independently but needs diuretic medications adjusted. The patient states being compliant with prescribed medications but sometimes forgets to take them. The patient and 82-year-old spouse consider themselves to be independent and support each other.
    c. A 90-year-old admitted for a carotid endarterectomy lives in an assisted living facility (ALF) but is cognitively intact and claims to be the "social butterfly" at all of the events at the ALF. The patient is hospitalized for 4 days and discharged to the ALF.
    d. An 84-year-old who had stents placed to treat coronary artery occlusion has diabetes that has been managed, lives alone since losing significant other 10 years ago, and was driving prior to hospitalization. The patient 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, with limited social support, who is being discharged to a long-term acute care facility, is at greatest risk for decreased quality of life and functional decline. This patient 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: Analysis
OBJ: Discuss the impact of critical care hospitalization on the patient and family.
TOP: Nursing Process Step: Evaluation MSC: NCLEX: Growth and Development

13. Which is likely the most common recollection from a patient who required endotracheal intubation and mechanical ventilation?
    a. Difficulty communicating
    b. Inability to get comfortable
    c. Pain
    d. Sleep disruption

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.

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DIF: Cognitive Level: Analysis
OBJ: Discuss the impact of critical care hospitalization on the patient and family.
TOP: Nursing Process Step: Evaluation MSC: NCLEX: Psychosocial Integrity

14. Many critically ill patients experience anxiety. The nurse can reduce anxiety with which approach?
    a. Asking family members to limit their visitation to 2-hour periods in morning, afternoon, and evening. You know that this is the best approach to ensure uninterrupted rest time for the patient. Tell the patient, "Your family is in the waiting room. They will be permitted to come in at 2:00 PM after you take a short nap."
    b. Explaining the unit routine. "Assessments are done every 4 hours; patients are bathed on the night shift around 5:00 AM; family members are permitted to visit you after the physicians make their morning rounds. They can spend the day. Lights are out every night at 10:00 PM."
    c. Stating, "It's time to turn you. I am going to ask another nurse to come in and help me. We will turn you to your left side. During the turn, I'm going to inspect the skin on your back and rub some lotion on your back. This should help to make you feel better."
    d. Suctioning the endotracheal tube immediately when the patient starts to cough. Sharing, "Your tube needs suctioned; you should feel better after I'm done."

    ANS: C
    Anxiety is reduced when procedures are explained prior to completing them. In this example, the nurse clearly explains what will be done and what the patient can expect during turning. Limiting family members, especially if they are already present in the hospital, is not an approach that will reduce anxiety. Family members can be present in the room while allowing the patient to rest. It is important to orient the patient to the unit, but the explanation of a "unit routine" does not give the patient any control over things such as bathing, sleep times, and visitors. Suctioning is important, but only when indicated, which might not be with every coughing episode. Additionally, it is important to explain the procedure and tell the patient what to expect.

    DIF: Cognitive Level: Application
    OBJ: Describe stressors in the critical care environment and strategies to reduce them.
    TOP: Nursing Process Step: Implementation
    MSC: NCLEX: Psychosocial Integrity

15. Which statement is a likely response from someone who has survived a stay in the critical care unit?
    a. "I don't remember much about being in the ICU, but if I had to be treated there again, it would be okay. I'm glad I can see my grandchildren again."
    b. "If I get that sick again, do not take me to the hospital. I would rather die than go through having a breathing tube put in again."
    c. "My family is thrilled that I am home. I know I need some extra attention, but my children have rearranged their schedules to help me out."
    d. "Since I have been transferred out of the ICU, I cannot get enough to eat. They didn't let me eat in the ICU, so I'm making up for it now."

    ANS: A

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Survivors of critical illness express a variety of concerns; however, most identify a willingness to undergo critical care treatment to prolong survival. Most survivors are not going to decline treatment for future hospitalizations (B). Although the patient's family may be thrilled that he or she is home, challenges to family dynamics often occur, especially if family member's schedules and routines are disrupted (C). Many patients have poor appetites after discharge from critical care, not ravenous ones (D).

DIF: Cognitive Level: Analysis
OBJ: Discuss the impact of critical care hospitalization on the patient and family.
TOP: Nursing Process Step: Assessment MSC: NCLEX: Psychosocial Integrity

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?
    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 that you know is fluent in the native language and ask him if he can come up to the unit.
    d. Use a young family member 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 contact the interpreter services of the agency. These individuals are trained and knowledgeable. If the nurse conducted a search on the computer, there is no way to know if the information retrieved was valid or to 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 abilities to translate. In addition, his availability is likely to be limited. Although the child might be able to translate, the nurse cannot ensure that the child is translating healthcare concepts correctly.

DIF: Cognitive Level: Analysis
OBJ: Discuss the impact of critical care hospitalization on the patient and family.
TOP: Nursing Process Step: Implementation
MSC: NCLEX: 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

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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: Application
OBJ: Discuss the impact of critical care hospitalization on the patient and family.
TOP: Nursing Process Step: Implementation
MSC: NCLEX: Psychosocial Integrity

18. The wife 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. She states, "I want you to reassign my husband to another nurse. His current nurse is not in the room enough to make sure he is okay." The nurse recognizes that this response most likely is due to what unspoken need?
    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 not known if she had a prior negative experience or not.

    DIF: Cognitive Level: Analysis
    OBJ: Discuss the impact of critical care hospitalization on the patient and family.
    TOP: Nursing Process Step: Implementation
    MSC: NCLEX: Psychosocial Integrity

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

    ANS: C

Open visitation is recommended by both the Society of Critical Care Medicine (SCCM) and the American Association of Critical-Care Nurses. SCCM suggests developing visitation schedules in collaboration with the patient and family. Animals do not need to be limited to therapy animals. Many patients benefit by the presence of their personal pets that are brought to the unit according to hospital policy. Although many units restrict visitation during report and rounds, the organizations encourage that such restrictions be loosened. Many institutions encourage family participation during report and rounds. Children should not be banned arbitrarily from the unit or have hours limited.

DIF: Cognitive Level: Analysis
OBJ: Identify strategies for promoting visitation and family presence in the critical care setting.
TOP: Nursing Process Step: Implementation
MSC: NCLEX: 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.
    c. Learn as much as you can about family structure and function.
    d. Use a trained interpreter if the family does not speak English.
    e. Evaluate each encounter with the family.

    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: Comprehension
    OBJ: Describe common family needs and family-centered nursing interventions.
    TOP: Nursing Process Step: Implementation
    MSC: NCLEX: Psychosocial Integrity

21. The nurse manager recognizes which action as an effective strategy for promoting changes in practice?
    a. Asking 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. Discussing pros and cons of open visitation at the next staff meeting.
    c. Inviting the nurses with the most experience to develop a revised policy.
    d. Tasking 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

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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: Analysis
OBJ: Identify strategies for promoting visitation and family presence in the critical care setting.
TOP: Nursing Process Step: Implementation
MSC: NCLEX: Psychosocial Integrity

MULTIPLE RESPONSE

1. What nursing strategies help families cope with the stress of critical illness? *(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. When possible, providing continuity of nursing care.
   d. Providing a daily update of the patient's condition to the family spokesperson.
   e. Asking the family member to assist with passive range of motion exercises when appropriate.

   ANS: B, C, D, E
   Encouraging families to formulate questions assists in family care. Continuity of nursing care with consistent staff members assists in reducing stress. Communication of patient condition update meets the need for information. Family members often want to assist with simple activities of patient care, so limiting participation is the exception to this list.

   DIF: Cognitive Level: Application
   OBJ: Describe common family needs and family-centered nursing interventions.
   TOP: Nursing Process Step: Implementation
   MSC: NCLEX: Psychosocial Integrity

2. Which findings have been reported in the literature as benefits of allowing family to be present during resuscitation and invasive procedures? *(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 feel a sense of connection with their loved one.

   ANS: A, B, E

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Families benefit from witnessing procedures and resuscitation. Being present helps family members to remove doubt about the condition, feeling connected with their loved one, and witnessing that everything was done, and decrease 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.

DIF: Cognitive Level: Analysis
OBJ: Identify strategies for promoting visitation and family presence in the critical care setting.
TOP: Nursing Process Step: Implementation
MSC: NCLEX: 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. Asking the family to bring in the patient's i-Pod or other device with favorite music.
   b. Inviting the volunteer harpist to play on the unit on a regular basis.
   c. Remodeling the unit to have two-patient rooms to facilitate nursing care.
   d. Remodeling the unit to install acoustical ceiling tiles.
   e. Turning the volume of equipment alarms as low as they can be adjusted, and "off" if possible.

ANS: A, B, D
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: Analysis
OBJ: Describe stressors in the critical care environment and strategies to reduce them.
TOP: Nursing Process Step: Implementation
MSC: NCLEX: Psychosocial Integrity

4. 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. Be sure to consult with the charge nurse before making any patient care decisions.
   c. Provide informal conversation by discussing your plans for after work.
   d. Explain how to communicate for assistance.
   e. Respond promptly to call bells

ANS: A, D, E
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.

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DIF: Cognitive Level: Analysis
OBJ: Describe stressors in the critical care environment and strategies to reduce them.
TOP: Nursing Process Step: Implementation
MSC: NCLEX: Psychosocial Integrity

5. The critical care environment is often stressful to a critically ill patient. Identify stressors that are commonly stressful for the critically ill patient. *(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 nursing needs

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

   DIF: Cognitive Level: Comprehension
   OBJ: Describe stressors in the critical care environment and strategies to reduce them.
   TOP: Nursing Process Step: Assessment MSC: NCLEX: Psychosocial Integrity

6. The family members are excited about being transferring their loved one from the critical care unit to the intermediate care unit. However, they are also fearful of the change in environment and nursing staff. To reduce relocation stress, the nurse can implement what intervention? *(Select all that apply.)*
   a. Arranging for the nurses on the intermediate care unit to give the family a tour of the new unit.
   b. Contacting the primary care provider to see if the patient can stay one additional day in the critical care unit so that the family can adjust better to the idea of a transfer.
   c. Ensuring that the patient will be located near the nurse's station in the new unit.
   d. Inviting 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. Assuring the family the patient is well enough to be transferred.

   ANS: A, D
   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. Although the patient and his family may feel safer in a room near the nurse's 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 once a bed on the intermediate care unit is available. Assuring the family of the patient's health condition is not likely to provide them with the assurance they require.

   DIF: Cognitive Level: Analysis
   OBJ: Describe stressors in the critical care environment and strategies to reduce them.
   TOP: Nursing Process Step: Implementation

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MSC: NCLEX: 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. Require visitation to occur when physical care is completed.

   ANS: A, B, D
   Manipulation of the environment, such as adjusting 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. Visitation should be planned for with the patient's needs and preferences in mind. Conversations about other patients are private and should take place away from other patients.

   DIF: Cognitive Level: Application
   OBJ: Describe stressors in the critical care environment and strategies to reduce them.
   TOP: Nursing Process Step: Implementation
   MSC: NCLEX: Psychosocial Integrity

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