

**COMPETENCY OPTIMIZING REVIEW (CORc)  
GUIDED NLE REVIEW**

**DIAGNOSTIC EXAMINATION III**

**SITUATION: PAIN**

1. Nursing interventions can greatly help a patient experiencing pain. As a nurse, you decided to utilize the cognitive and behavioral interventions. Which of the following is not related to cognitive-behavioral pain management?

- a. Asking the patient to do deep breathing exercise because it reduces muscle tension.
- b. Asking the patient to sit comfortably and meditate.
- c. Distracting the attention of the patient away from the painful sensation.
- d. Give patient a back rub because it makes the patient relax and may lessen pain sensation.

**ANSWER: D**

Cognitive-behavioral interventions include deep breathing exercises, music, guided imagery, biofeedback, distraction, therapeutic touch, meditation, hypnosis and humor. Physical interventions include cutaneous stimulation, massage, heat and cold application, TENS, acupuncture and acupressure. Therefore, choice D is not included in cognitive-behavioral intervention.

Reference: Medical-Surgical Nursing by Joyce Black, 8th edition, p. 379-382.

2. You have decided to use hypnosis in relieving the client's pain. To reduce pain, you induce the patient to a hypnotic state by following a certain procedure. Which of the following is not included in the procedure?

- a. Anesthesia and analgesia for superficial and deep sensation.
- b. Body disorientation and dissociation.
- c. Assess the client's energy field.
- d. Suggestion to alter the character of the pain or one's attitude to it.

**ANSWER: C**

Options A, B, and D are procedures included in induction of hypnotic state. Choice C is included in therapeutic touch.

Therapeutic touch has three steps: center or focus client on meditative state, assess client energy field, use hands to rearrange the client's energy field.

Reference: Medical-Surgical Nursing by Joyce Black, 8th edition, p. 381.

3. Nurse Isabelle is assessing a client for pain. If the client denies having pain, Nurse Hannah will consider monitoring the client's vital signs for sympathetic responses to pain, such as:

- a. Increased blood pressure, increased pulse, increased respiratory rate
- b. Decreased blood pressure, decreased pulse, increased respiratory rate
- c. Increased blood pressure, decreased pulse, increased respiratory rate
- d. Decreased blood pressure, decreased pulse, decreased respiratory rate

d. Decreased blood pressure, decreased pulse, decreased respiratory rate

**ANSWER: A**

The sympathetic nervous system controls blood pressure, pulse, and respiration and is stimulated during pain. These responses are short lived as the body adapts to stress.

Reference: Brunner and Suddarth's Medical Surgical Nursing 11th edition Page 273

4. Nurse Hannah is teaching a client with cancer about opioid management for intractable pain and tolerance related side effects. Nurse Hannah should prepare the client for which side effect that is most likely to persist during long-term use of opioids?

- a. Sedation b. Constipation c. Urinary retention d. Respiratory depression

**ANSWER: B**

The client should be prepared to implement measures for constipation which is the most likely persistent side effect related to opioid use. Tolerance to opiate narcotics is common, and the client may experience less sedation and respiratory depression as analgesic use continues. Opioids increase the tone in the urinary bladder sphincter, which causes retention but may subside.

Reference: Brunner and Suddarth's Medical Surgical Nursing 11th edition

5. Two patients are hospitalized with the same diagnosis, but one is 23 years old, with acute recent pain from an injury, and the other is 64 years old, with pain of long-standing duration of several years. The difference in anticipated assessment is which of the following?

- a. Acute pain for young patients is more intense at the same level, but these patients experience few changes in vital signs.
- b. Young patients with acute pain exhibit fewer changes in vital signs but still report true levels of pain at levels 8 to 10.
- c. Older adult patients with chronic pain exhibit increased changes in vital signs and report levels lower than reality.
- d. Older adult patients with chronic pain usually report lower levels of pain much less severe than they really are.

**ANSWER: D**

Older adult patients with chronic pain do not report pain as severe at the same level as younger patients for several reasons. For example, older adult patients believe that pain comes with old age, or they do not want to bother the staff. Chronic pain of long standing frequently does not change vital sign normal values.

Reference: Brunner and Suddarth's Medical Surgical Nursing 11th edition 268

6. A patient who uses a fentanyl (Duragesic) patch for chronic cancer pain complains to the nurse of the rapid onset of pain at a level 9 (of a 0-10 scale) and requests "something for pain that will work quickly." The best way for the nurse to document this information is as

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