

Nursing Problem Worksheet

Name: Alexa Dolan

Anticipated Patient Problem and Goals	Relevant Assessments (Prework) What assessments pertain to your patient's problem? Include frequencies	Multidisciplinary Team Intervention (Prework) What will you do if your assessment is abnormal?
Problem: <u>Impaired Physical Mobility</u> Reasoning: - OA, Hip replacement Joint pain Goal: pt will be able to demonstrate 1 exercise that pertains to healing by end of the week. Pt will achieve safe ambulation w/ assistive devices by the end of the week.	Assess ROM q2 hrs Assess balance & gait q4 hr Assess pain level on scale of 1-10 q4 hr	Introduce 2 exercises every 2 hrs to improve ROM. Offer assistive devices to help mobilize the body. Offer Oxycodone 5mg PO q4-hr to decrease pain & increase movement

Anticipated Patient Problem and Goals	Relevant Assessments (Prework) What assessments pertain to your patient's problem? Include frequencies	Multidisciplinary Team Intervention (Prework) What will you do if your assessment is abnormal?
Problem: <u>Difficulty Coping</u> Reasoning: - Undergoing surgery - not able to move as freely Goal: pt will demonstrate willingness when participating in PT by the end of each session. Goal: pt will verbalize effective coping mechanisms by discharge.	Assess pt knowledge of procedure upon admission Assess pt willingness to participate in activities q2 hr Assess pt ability & reaction to stress q4 hrs	Encourage pt to verbalize fears, emotions & feelings about recovery process. Set small achievable goals every 2 hrs to bring back self control Offer information on support groups & pamphlets to breed effective coping mechanisms.

Student Name: Alexa Dolan  
Clinical Instructor: Mrs. Wingate

ATI Real Life THA Virtual Clinical Reflection Questions

- 1) What was Dale's fall risk score? Is that score considered low, medium, or high risk? What interventions in Dale's care should you be implementing?  
(Use your resources from class and clinical Fall Risk Score Interventions)
  - a. 49
  - b. High Risk
  - c. Using call bell to get up out of bed, using non skid socks
- 2) From the pre-op exercises teaching scenario, pick one that Dale demonstrated incorrectly and explain how you would teach the correct technique.
  - a. Hip adduction - move entire leg out to the side & away from midline
- 3) Dale receives morphine sulfate for his hip pain. The morphine order is for 2-4mg IV Q 3-4 hours for severe or breakthrough pain. What is wrong with this order?
  - a. The order does not have a specific amount to administer.
  - b. Morphine is dispensed in 2mg/ml concentration. If Merryll gave 4 mg, how many ml's of morphine did she administer? 2 mL
- 4) Dale is assessed for skin integrity on his heel. What are some interventions the nurse could implement to protect his skin? What are the concerns if no interventions are implemented?
  - a. Elevate heels on a pillow
  - b. Pressure ulcers can occur
- 5) Identify three ways that the nursing team demonstrated the promotion of patient safety?
  - a. Use call light to get up
  - b. ensure safety locks were on, on assistive devices
  - c. used multiple people to
- 6) Do you feel the nurse and medical team utilized therapeutic communication techniques when interacting with individuals, families, and health team members of all cultural backgrounds?
  - a. If yes, describe:  
yes because they all gave reports & communicated efficiently w/ the pt & partner when explaining procedural conversation.
  - b. If no, describe:  
\_\_\_\_\_  
\_\_\_\_\_

Reflection

- 1) Go back to your Preconference Form:
  - a. Indicate (circle, star, highlight) the components of your preconference form that you saw applied to the care of this virtual patient.
- 2) Review your Nursing Problem Worksheet: Did you select a correct priority nursing problem?

a. If yes, write it here: YES

b. If no, write what you now understand the priority nursing problem to be:

3) Review your Nursing Problem Worksheet: Did you see many of your anticipated nursing assessments and interventions used?

a. Indicate (circle, star, highlight) the ones you saw utilized during the scenario.

b. Were there interventions you included that were not used in the scenario that could help this patient?

i. If yes, describe:

ii. If no, describe:

All of my impaired physical mobility interventions were used

4) Often patient care will take a different direction than we anticipated at the beginning of our shift. Did that happen here? NO

a. How did that impact the nursing care delivered?

The impact of nursing care was delivered safely to the pt. The patient was able to go home.

b. What new, additional priority nursing problem (diagnosis) did you identify? (Refer to your NANDA list)

i. Write it here:

Impaired skin integrity

What was your biggest "take-away" from participating in the care of this patient? How did this impact your nursing practice?

My biggest take away was that so many people & interventions are involved w/ care for a patient w/ IHA. The team needed to communicate effectively to get things completed in order for the patient to go home safely.

Preconference Form

Student Name : Alexa Dolan

Medical Diagnosis/Disease: **Osteoarthritis** – procedure is **THA**

NCLEX IV (8): Physiological Integrity/Physiological Adaptation

Anatomy and Physiology

Normal Structures

Function of the Musco skeletal system is to support and protect internal organs, voluntary organs, movement, mineral storage and hematopoiesis. The structure of the bone includes bone cells, protein matrix, and mineral deposits. Some of the bone cells are osteocytes (support daily cellular activities), osteoblast (cells that form the bone and synthesize collagen), osteoclast (reabsorb the tissue of the bone and balances activity of osteoblasts). The protein matrix gives bones elasticity and is 98% collagen and is considered non-living. The mineral deposits include Calcium. Bones can be categorized into two types of structures. Cortical bone is compact and dense- it has a hard outer layer and is thicker in the diaphysis( central shaft) then epiphysis( widened ends) . protects and supports long bones that are weight bearing. Haversian system which are cylindrical structural units fit closely together which makes the bone dense. The cancellous bone is spongy and porous. This includes many large spaces filled with red and yellow marrow, has a rich blood supply, and has no haversian canals. This type of bone oversees the short, flat and irregular location of muscle attachment and these are the ends, diaphysis is the main shaft that provides structural support, metaphysis is between the epiphysis and diaphysis, the epiphyseal plate is the cartilage between the epiphysis and the metaphysis which is the growth plate. The periosteum is a tiny fibrous connective tissue that covers the bone. And the marrow is the cavity in the center of the bone (diaphysis) which contain yellow and red marrow( red- flat bones, yellow- involved in hematopoiesis when blood cells are needed. There are multiple types of bones- long(femur and humerus- central shaft and two widened ends) , short(carpals, tarsals- cube shape and have spongy inner core cover by thin layer of compact bone) , flat(sternum,ribs,skul,scapula- protect delicate organs and allow attachment to large muscles, 2 outer plates separated by spongy inner layer) and irregular bones( vertebrae, ilieum,mandible-connected to several other bones to aloe movement and has an inner core of spongy bone and outer of compact bone) . And there are 206 bones in the body. The blood and nerve supply to the bone provides oxygen and nutrients and is received through the arterioles of the haversian canals, vessels in the periosteum and in the marrow and bone ends. The nerve endings in the periosteum connect with the CNS. Joints are the junction of 2 or more bones and are classified by movement. Synarthroses joints are no movement and the bone is connected to fibrous cartilage/tissue (skull) . Amphiarthroses – slightly moveable, no joint cavity but has cartilage between bones (intervertebral joints). Diarthroses- free moveable (synovial) this makes up most joints in the body, consists of an articular cavity which is lined w the synovium, synovium produces synovial fluid for lubrication, the cavity id enclosed by capsule of fibrous articular cartilage. Ligaments reinforce the capsule and help limit motion. Types include hinge(concave surface fits into convex surface, knee), pivot- one surface rotates around peg/pivot( ulnar and radial), ball and socket( permits full freedom of movement), gliding(both articular surfaces are flat), Condylloid/ellipsoidal| oval condyle fits into a elliptical cavity, wrist-flex, extend, adduct,abduct,circumduction), saddle( concave end fits onto a convex surface of another bone – metacarpal). Joint motion include flexion, extension, hyperextension, abduction, adduction, rotation, circumduction, supination, pronation, eversion, inversion, elevation, depression, protraction and retraction. Cartilage supports soft tissue, provides surface for joint movement, and protects underlying tissue. cartilage is rigid connective tissue with fibrous covering and they are avascular making the slow to reproduce and heal. Hyaline is most common and has moderate amount of collagen fibers, elastic cartilage contains collagen and elastic fibers, fibrocartilage is mostly collagen and is tough tissue and is a shock absorber. Muscle is about 50% of body weight and has a rich vascular supply, bones cannot move w/muscle contraction. Cardiac muscles are found in the heart they are involuntary and controlled by the ANS. Smooth muscle is found in the walls of hollow structure (gi tract, bladder uterus) and also involuntary. Skeletal muscle us striated bands that are voluntary and attached to bones which provide movement, posture and produce heat. The structure of the muscle is as thick and thin filaments in sarcomere slide past each other, the sarcomere shortens and muscle contracts. They are made up of muscle fibers held together and supported by connective tissue. Types of contractions muscles can have are tonic, isotonic, isometric,twitch, and tetany, fibrillation and convulsion. Ligaments and tendons attach muscle to bone and connects bones to bones at the joints. Fascia is layers of connective tissue that separate one muscle from another to provide strength. Bursae are small sacs of connective tissue wherever pressure is exerted over moving parts (usually at the joints)

Pathophysiology of Disease

Slowly progressing non-inflammatory disease of synovial joints. OA involves the loss of articular cartilage w/ formation of bony outgrowths at the joint margins. Most adults are affected by the age of 40. It is caused by an known event and that directly damages the cartilage leading to joint instability. For women – menopause decreases estrogen which can contribute to OA . Obesity affects hip and knee OA, it increases pressure and stress on the joints. Genetic, metabolic and local factors interact causing the deterioration of cartilage stem from damages to chondrocytes. The cartilage becomes dull yellow and granular, softer an less elastic. The bodies cartilage cannot keep up with repairing due to the destruction, the fibers in the cartilage become cracked, worn , central cartilage becomes thin and joint edges become thicker. The joint surfaces become uneven and causes reduced motion.

NCLEX IV (7): Reduction of Risk

Anticipated Diagnostics

Labs

ESR- shows normal unless there is an acute flair up, **CBC,Renal and LFT** are useful for screening for alike conditions/baseline , synovial fluid analysis- distinguish they type of OA

Additional Diagnostics

Bone scan, MRI, CT scan, XRAY, **H&P**

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### NCLEX II (3): Health Promotion and Maintenance

#### Contributing Risk Factors

Drug use, endocrine disorders, **joint instability**, mechanical stress, neurologic disorders, skeletal deformities, trauma, **obesity**.

#### Signs and Symptoms

**Joint pain**  
Pain at rest  
Trouble sleeping  
Pain with severe weather  
Disability and loss of function  
**Early morning stiffness**  
Joint swelling  
Bow legged  
Knock knee

#### Possible Therapeutic Procedures

##### Non-surgical

PT, weight management, aquatic therapy, **low impact exercises**, **assistive devices** (possibly stem cell therapy)

##### Surgical

Arthroscopy, partial and total joint replacements, osteotomy, joint fusion, cartilage grafting,

#### Prevention of Complications

(What are some potential complications associated with this disease process)

**Obesity, type 2 diabetes, cardiovascular diseases, osteoporosis, fibromyalgia**

### NCLEX IV (6): Pharmacological and Parenteral Therapies

#### Anticipated Medication Management

Acetaminophen, NSAIDs, intraarticular corticosteroids, **opioids**, topical analgesics

### NCLEX IV (5): Basic Care and Comfort

#### Non-Pharmacologic Care Measures

Acupuncture, massages, tai chi, **nutritional supplements** (fish oil, ginger) weight reduction program, **heat and cold applications**, using **assistive devices**

### NCLEX III (4): Psychosocial/Holistic Care Needs

#### What stressors might a patient with this diagnosis be experiencing?

Guilt- letting the weight affect overall health, **stress** due to current state of health, **discomfort- not being able to freely move**

### Client/Family Education

#### List 3 potential teaching topics/areas

- avoid forceful repetitive joint movements
- **use good posture and body mechanics**
- maintain healthy weight

### NCLEX I (1): Safe and Effective Care Environment

#### Multidisciplinary Team Involvement

(Which other disciplines do you expect to share in the care of this patient)

**PT, OT, Nutrition/dietitian, surgical team, case management, home health, pharmacy**

ACTIVE LEARNING TEMPLATE: *Medication*

STUDENT NAME alexa dolan

MEDICATION morphine sulfate

REVIEW MODULE CHAPTER \_\_\_\_\_

CATEGORY CLASS opiod analgesic schedule 2

**PURPOSE OF MEDICATION**

**Expected Pharmacological Action**

Binds to opiate receptors in the CNS. Alters the perception of and response to painful stimuli while producing generalized CNS depression.

**Therapeutic Use**

alter pain perception, emotional responses to pain

**Complications**

hypotension, bradycardia, flushing, itching, sweating, lurred vision, diplopia, miosis, constipation, nausea, vomiting, confusion, sedation, dizziness, dysphoria, euphoria, floating feeling, hallucinations, headache, unusual dreams, Respiratory depression and sleep apnea

**Medication Administration**

IV administration is to administer 0.1 to 0.2 mg/kg IV every 4 hours PRN for pain. give slowly over 4-5 mins. main-tenance IV infusion is 0.8 to 80 mg/hour; higher doses may be needed.

**Contraindications/Precautions**

c- Hypersensitivity; Some products contain tartrazine, bisulfites, or alcohol and should be avoided in patients with known hypersensitivity; Acute, mild, intermittent, or postoperative pain (extended/sustained release); Significant respiratory depression (extended release); Acute or severe bronchial asthma  
p- Personal or family history of substance use disorder or mental illness; Head trauma; intracranial pressure; Severe renal impairment; Severe hepatic impairment; Severe pulmonary disease; Hypothyroidism; Seizure disorder; Adrenal insufficiency

**Nursing Interventions**

moniter vital signs 5-10 mins after IV administration, be alert for respirations decreased, moniter daily BM,

**Interactions**

drug- Alvimopan, anticholenergics, diureics, MAO inhibitors, mixed agonist opiod analgesics, alcohol use  
lab- increase amylase, decrease sodium and Hgb levels, abnormal LFT

**Client Education**

-Advise patient to take drug exactly as prescribed and to use lowest dose possible for shortest time needed.  
-Encourage patient to report all medications being taken, including prescription and OTC medications and supplements.

**Evaluation of Medication Effectiveness**

pain level has decreased and diminished or absent

ACTIVE LEARNING TEMPLATE: *Medication*

STUDENT NAME Alexa Dolan

MEDICATION Oxycodone

CATEGORY CLASS opiod agonist schedule 2

REVIEW MODULE CHAPTER \_\_\_\_\_

**PURPOSE OF MEDICATION**

**Expected Pharmacological Action**

binds w opiod receptors w/in cns causing inhibition of ascending pain pathway

**Therapeutic Use**

alters perception of emotional response to pain

**Complications**

drowsiness, dizziness, hypotension, anorexia, confusion, sweating, facial flush, constipation, dry mouth, urinary retention, n/v, depression, paradoxical cns hyperactivity, restlessness in debilitated pt. adverse- respiratory depression, clammy skin, muscle flaccidity, cyanosis, physical dependance.

**Medication Administration**

give w/ food, swallow whole do not crush, chew, break pill. 5-10 mg prn q4-6hr then 5-15 mg q4-6 hr prn. max dose 15mg

**Contraindications/Precautions**

c- acute/severe asthma, hypercarbia, paralytic iliyus, GI obstruction, respiratory distress  
p- cns depression, anorexia, seziures, alcoholism, elevated ICP, renal/hepatic imparement, coma, biliary tract disease, hypothyroidism, copd, etc.

**Nursing Interventions**

-palpate bladder for urinary retenion, monitior daily bm, initiate deep breathing, monitor pain releif, RR, mental status, BP, LOC. screen for drug misuse.

**Interactions**

drug- alcohol, cns depressants increase cns effect, respiratory distress and hypotension. CYP3A4 inhibitors increase toxiclty. CYP3A4 inducers decrease concentration, MAOIs- increase serotonin syndrome.  
herbal- herbals w/ seditive properties increase cns depression  
food- grapefruit products increase respiratory distress  
lab- increase amylyse and lipase.

**Client Education**

- may cause dry mouth  
- avoid task that require alertness, motor skills  
- avoid alcohol

**Evaluation of Medication Effectiveness**

perception of pain is absent or diminished.