Preconference Form

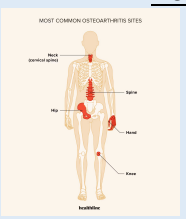
Student Name: Carolina Rodriguez

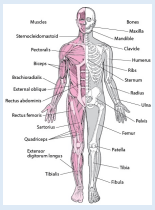
Medical Diagnosis/Disease: Osteoarthritis (OA)

NCLEX IV *(8)*: Physiological Integrity/Physiological Adaptation

Anatomy and Physiology

Normal Structures





- Synovial Joint (Diarthrosis): These are freely movable joints (like the hip and knee) characterized by a fluid-filled joint cavity. Their primary function is to allow extensive body movement while minimizing friction between articulating bones.
- Articular Cartilage: This is a thin layer of smooth, resilient hyaline cartilage that covers the ends of the articulating bones. Its main functions are to provide a lubricated surface for smooth movement (low friction) and to act as a shock absorber to protect the underlying bone tissue from compressive forces. Importantly, it is avascular (lacks blood vessels) and receives its nutrients via diffusion from the synovial fluid.
- Synovial Membrane (Synovium): This is the highly vascularized inner lining of the joint capsule. Its main function is to secrete synovial fluid.
- Synovial Fluid: This is a thick, viscous, egg white-like fluid found within the joint cavity. It contains hyaluronic acid and lubricin. Its three primary functions are lubrication (to reduce friction), shock absorption, and nutrient distribution to the avascular articular cartilage.
- Joint Capsule: This is the fibrous connective tissue structure that surrounds the joint, providing stability and containing the synovial fluid.
- A ball-and-socket joint, such as the hip, allows for the greatest range of motion, including rotation, flexion, extension, abduction, and adduction.

Pathophysiology of Disease

Osteoarthritis (OA) is a slowly progressive noninflammatory disorder of the diarthrodial (synovial) joints. It involves the gradual loss of articular cartilage.

- The healthy, smooth, white, translucent articular cartilage becomes dull, yellow, and granular as OA progresses.
- The cartilage steadily becomes softer and less elastic, making it less able to resist wear from heavy use.
- The collagen structure in the cartilage changes, causing the articular surfaces to become cracked and worn.
- As central cartilage becomes thinner, the cartilage at the joint edges becomes thicker, and bony outgrowths (spurs or osteophytes) form at the joint margins.
- The joint surfaces become uneven, which affects the distribution of stress across the joint and causes reduced motion.
- Although inflammation is not typical of OA, secondary synovitis (inflammation of the synovial membrane) may occur when phagocytes try to rid the joint of small pieces of cartilage torn from the joint surface.
- These changes cause early pain and stiffness. Pain in later disease occurs when articular cartilage is lost and the bony joint surfaces rub against each other.

NCLEX IV *(7)*: Reduction of Risk

Anticipated Diagnostics

Labs

- Erythrocyte sedimentation rate (ESR): Measures the rate at which red blood cells settle, acting as a non-specific marker to detect generalized inflammation in the body
- C-reactive protein (CRP):Measures a protein produced by the liver that rises rapidly in response to inflammation or infection, helping to distinguish inflammatory arthritis from OA
- Rheumatoid factor (RF): Detects an autoantibody that is highly associated with Rheumatoid Arthritis (RA), which is a key test to rule out RA as the cause of joint pain.
- Uric acid: Measures the amount of uric acid in the blood, which is the primary lab test used to diagnose and monitor Gout, another common cause of joint pain.
- CBC with diff: Evaluates red blood cells (to check for anemia), white blood cells (to check for infection), and platelets, providing a general assessment of overall patient health and medication side effects.
- CMP:A broad blood test that assesses kidney function (BUN and Creatinine), liver function (ALT/AST), and electrolyte balance, which is vital for monitoring the safety of medications used to treat OA.

Additional Diagnostics

- X-ray - showing bone changes like decreased joint space and bone spurs
- MRI - can reveal damage to ligaments, cartilage, and other soft tissues
- CT scan - visualization of size and location of bone spurs, subchondral cysts, and sclerosis
- Bone scan - detects areas of inflammation and bone turnover; identifies painful areas when the cause is unclear/rules out other conditions like infections, tumors, or stress fractures
- Ultrasound - uses sound waves to visualize soft tissues like tendons and ligaments, as well as inflammation and bone spurs
- Joint Aspiration - removing joint fluid helps identify crystals or signs of infection
- Arthroscopy - looks for internal damage and evaluate degenerative changes

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

Contributing Risk Factors

- Aging: the risk increases with age
- Obesity: the more you weigh, the greater the risk; adds stress to weight-bearing joints
- Previous joint injury or surgery: trauma or history of injury can lead to OA
- Repeated stress on joint: might develop due to repetitive stress on joint from sports
- Genetics: some people inherit a tendency to develop OA
- Bone deformities: some people are born with malformed joints or defective cartilage
- Gender: more common in women
- Certain metabolic diseases: these include diabetes and a condition in which your body has too much iron, called hemochromatosis

Signs and Symptoms

- Pain
- Stiffness
- Tenderness
- Loss of flexibility; decreased range of motion
- Grating sensation
- Bone spurs
- Swelling
- Functional/mobility issues (balance and gait problems)

NCLEX IV *(7)*: Reduction of Risk

Possible Therapeutic Procedures

Non-surgical

- Physical therapy - strengthen muscles and improve ROM
- Weight reduction
- Corticosteroid injections - reduce acute inflammation and pain
- Hyaluronic acid injections - restore joint lubrication

Surgical

Total Hip Arthroplasty (THA), or total hip replacement, provides significant relief of pain and improved function for patients with joint deterioration from osteoarthritis (OA) and other conditions. In THA, the prosthesis (implant) replaces the ball-and-socket joint formed by the upper shaft of the femur and the pelvis. Both the ball and socket components can be cemented in place with polymethyl methacrylate (PMMA), which bonds to the bone. Alternatively, the components may be inserted without cement (cementless). Cementless THA may provide longer stability by enabling the growth of new bone tissue into the porous surface coating of the prosthesis. Cementless devices are better for younger, more active patients and patients with good bone quality, as there is better bone growth into the components.

Prevention of Complications

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

- Chronic pain and reduced mobility - maintain healthy weight and engage in regular, low impact exercise
- Joint deformity/incorrect alignment - participate in physical therapy
- Increased risk of falls and fractures - wear nonskid footwear and use assistive devices; maintain adequate vitamin D and calcium intake
- Osteonecrosis (bone death) - limit or stop alcohol intake and smoking
- Pinched nerves - maintain good posture and use proper body mechanics
- Chondrolysis - control blood sugar levels, slow and controlled exercise
- Joint infection - antibiotics, inspect surgical site

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

Anticipated Medication Management

- **NSAIDs** are the first-line treatment for OA. They work by inhibiting cyclooxygenases (COX-1 and COX-2), which convert arachidonic acid into prostaglandins. Oral NSAID therapy typically starts with low-dose over-the-counter (OTC) strengths (e.g., ibuprofen 200 mg up to 4 times daily). Since COX-1 inhibition can cause negative gastrointestinal (GI) effects (like bleeding and irritation), an NSAID may be combined with a protective agent such as misoprostol (Cytotec) for at-risk patients. The COX-2 selective inhibitor celecoxib (Celebrex) is an alternative to traditional NSAIDs that may be used in selected patients. Aspirin is no longer a common treatment and should be used cautiously with NSAIDs, as both inhibit platelet function and prolong bleeding time. Systemic corticosteroids are not used as they may hasten the disease process
- **Topical agents** have short-acting effects and may need to be applied daily. Capsaicin cream (OTC/prescription, 0.025% to 0.075%) is a topical agent that works by locally interfering with substance P to inhibit the transmission of pain impulses. Other OTC products that contain camphor, eucalyptus oil, and menthol (e.g., Bengay, Arthricare), or topical salicylates (e.g., Aspercreme) may also provide temporary pain relief
- **Intra-articular corticosteroid injections** can be used to treat local inflammation and swelling; four or more injections without relief suggest the need for more intervention. Hyaluronic acid injection (viscosupplementation) has been a common treatment for knee OA, but it is no longer recommended by either the American College of Rheumatology (ACR) or the American Academy of Orthopaedic Surgeons (AAOS).

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

Non-Pharmacologic Care Measures

- Exercise and physical activity: regular, low impact exercises help strengthen muscles, maintain joint flexibility, and manage weight
- Weight management: relieves stress on weight-bearing joints
- Heat and cold application: ice can help reduce swelling if the patient has acute inflammation; heat is used for stiffness and it increases flexibility and improves blood flow to the area
- Assistive/adaptive devices: takes pressure off affected joint and improves balance/mobility (cane, walker, brace)
- Balancing rest and activity: prevent overuse and reduce stress on joints

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

What stressors might a patient with this diagnosis be experiencing?

- Financial burden/ loss of income
- Strain on relationships
- Social isolation
- Uncertainty and fear of future
- Negative self image
- Anger and resentment
- Feeling loss of independence
- Side effects of medication
- Reduced physical activity
- Fatigue
- Chronic pain
- Stiffness and limited mobility

Client/Family Education

List 3 potential teaching topics/areas

- Emphasize the importance of maintaining a healthy weight, using assistive devices (canes/walkers) as prescribed, and balancing activity with rest to prevent joint strain
- Encourage regular, low-impact exercise to strengthen supporting muscles and maintain flexibility, avoiding high-impact activities
- Educate on the correct use of oral and topical analgesics/NSAIDs, including potential side effects (e.g., stomach irritation with NSAIDs), and the proper use of heat and cold therapy

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)

- Orthopedic surgeon - performing THA
- Nursing staff - provides pre/post-operative care, monitors for complications and delivers patient education
- Physical therapist - develops and implements rehab programs to restore strength and mobility in hip
- Occupational therapist - focuses on helping the patient perform ADLs
- Anesthesiologist - manages pain and sedation during surgery
- Pharmacy - reviews medication regimens for potential drug interactions and manages pain medication

Nursing Problem Worksheet

Name: Carolina Rodriguez

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: Pain Reasoning: due to arthritic joint changes and associated therapy Goal: the patient's pain decreases to 3/10 by EOC Goal: the patient demonstrates the ability to perform ADLs with minimal discomfort by EOC	Assess patients understanding and use of pharmacologic and non-pharmacologic pain management strategies PRN q shift before/after implementation	Reinforce teaching (for example on proper use of heat vs cold), and introduce relaxation techniques
	Inspect the affected joint for signs of warmth, swelling, redness, or stiffness q 2 hours or when pain increases unexpectedly	Apply cold therapy to affected joint to reduce swelling and inflammation
	Assess how pain limits the patients mobility, sleep, mood, and ability to perform ADLs q 4 hours	Adjust timing of oral opioids, like oxycodone, to peak 30-60 minutes before planned activities to ensure adequate pain control during movement
	Assess RR and depth, and monitor for bowel movements and any signs of constipation q 1-2 hours after administering morphine sulfate	If RR is below 12 breaths/min, or patient is over-sedated, hold the opioid and notify healthcare provider
	Observe for non-verbal cues (guarding, restlessness, grimacing, moaning, rapid shallow breathing) with every patient interaction and during transfers/movement	Stop movement immediately and use non/ pharmacologic measures and the assess the need for an analgesic dose

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: Impaired mobility Reasoning: due to musculoskeletal impairment and need for adjustment to a new walking gait with assistive devices Goal: the patient will demonstrate appropriate use of assistive devices or flat/uneven surfaces by EOC Goal: the patient will perform muscle strengthening exercises by EOC	Assess muscle strength q 4 hours and with initial assessment	Collaborate with PT to implement exercises
	Assess ROM in affected joints q shift and during PT sessions	Encourage ROM exercises every 2-4 hours; apply heat/ cold therapy as prescribed 20 minutes before exercise
	Assess the patients walking pattern, stability, presence of limping, and ability to transfer PRN q shift	Initiate or reinforce the use of assistive devices and ensure the patient uses them correctly, via teach back or verbalization
	Inspect skin over bony prominences, as immobility increases pressure injuries q 2 hours	Implement a turning and positioning schedule and use pressure relieving devices
	Assess room for patient safety (patient is a fall risk due to immobility), assess call bell within reach, bed rails, bed side table and personal items within reach, bed lowered, and environment for clutter q shift during beginning and end of care	Provide education on fall prevention strategies and importance of call bell use

ACTIVE LEARNING TEMPLATE: *Medication*

STUDENT NAME Carolina Rodriguez

MEDICATION Morphine Sulfate (AVINza, Duramorph, Embeda, Infumorph, Mitigo, Morphabond ER, MS Contin, Roxanol

REVIEW MODULE CHAPTER

CATEGORY CLASS Therapeutic: opioid analgesics
Pharmacological: opioid agonists

PURPOSE OF MEDICATION

Expected Pharmacological Action

Morphine Sulfate binds with and activates opioid receptors (mainly mu receptors) in the brain and spinal cord. This action alters the perception of and response to painful stimuli, which produces analgesia (pain relief) and euphoria, while also causing generalized Central Nervous System (CNS) depression

Therapeutic Use

To relieve pain severe enough to require opioid treatment and for which alternative treatment options such as non-opioid analgesics or opioid combination products are inadequate or not tolerated

Complications

CV: bradycardia, cardiac arrest, edema, hypotension, orthostatic hypotension, palpitation, shock, tachycardia, vasodilation. **Derm:** diaphoresis, flushing, pruritus, rash, urticaria. **EENT:** blurred vision, diplopia, dry mouth, laryngeal or laryngospasm, miosis, nystagmus, rhinitis, taste or voice alteration. **ENDO:** adrenal insufficiency (rare), hypogonadism. **GI:** abdominal cramps or pain, anorexia, biliary tract spasm, constipation, diarrhea, dysphagia, elevated liver enzymes, flatulence, gastroenteritis, gastroesophageal reflux, hiccups, intestinal obstruction (including toxic megacolon), nausea, vomiting. **GU:** decreased ejaculatory potency, decreased libido, difficulty ejaculating, dysuria, impotence, infertility, irregular menses, oliguria, prolonged labor, urinary hesitancy, urinary retention. **Heme:** anemia, leukopenia, thrombocytopenia. **MS:** arthralgia, decreased bone mineral density, skeletal muscle rigidity. **Neuro:** agitation, anxiety, asthenia, ataxia, chills, confusion, coma, decreased concentration, delirium, depression, dizziness, dream abnormalities, drowsiness, euphoria, excitement, falls, gait disturbance, hallucinations, headache, increased intracranial pressure, insomnia, lethargy, lightheadedness, malaise, miosis, mood alterations, psychosis, restlessness, rigidity, seizures, sedation, syncope, thinking disturbances, tremor, uncoordinated muscle movements, unresponsiveness, vertigo. **Resp:** apnea, asthma exacerbation, atelectasis, bronchospasm, cough reflex depression, decreased oxygen saturation, hyperventilation, pulmonary edema, RESPIRATORY DEPRESSION (including central sleep apnea and sleep-related hypoxemia), wheezing. **Misc:** anaphylaxis and angioedema, allodynia, drug tolerance, injection site edema, opioid-induced hyperalgesia, pain (injection site), physical and psychological dependence

Contraindications/Precautions

Contraindications: 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 (extended release); Paralytic ileus (extended release).
Precautions: 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; Undiagnosed abdominal pain; Prostatic hyperplasia; Patients under-going procedures that rapidly ↓ pain (cordotomy, radiation); long-acting agents should be discontinued 24 hr before and replaced with short-acting agents; **OB:** Lactation: Use while breastfeeding only if potential maternal benefit justifies potential risk to infant ; **Pedi:** Neonates and infants <3 mo (more susceptible to respiratory depression); **Pedi:** Neonates (oral solution contains sodium benzoate, which can cause potentially fatal gasping syndrome); **Geri:** ↑ risk of respiratory depression in older adults; dose ↓ suggested.

Interactions

Drug-Drug: Use with extreme caution in patients receiving MAO inhibitors within 14 days prior; may result in unpredictable, severe reactions; ↓ initial dose of morphine to 25% of usual dose. Drugs that affect serotonergic neurotransmitter systems, including **tricyclic antidepressants**, **SSRIs**, **SNRIs**, **MAO inhibitors**, **TCAs**, **tramadol**, **trazodone**, **mirtazapine**, **5-HT$_3$ receptor antagonists**, **linezolid**, **methylene blue**, and **triptans**, may ↑ risk of serotonin syndrome. **Mixed agonist/antagonist analgesics**, including **nalbuphine** or **butorphanol**, and **partial agonist analgesics**, including **buprenorphine**, may ↓ morphine's analgesic effects and/or precipitate opioid withdrawal in physically dependent patients. May ↑ the anticoagulant effect of **warfarin**. **Cimetidine** may ↑ levels and risk of toxicity. IV morphine may ↓ levels and antiplatelet effects of **clopidogrel**, **prasugrel**, and **ticagrelor**; consider IV antiplatelet agent as alternative in patients with acute coronary syndrome if morphine concurrently used.
Drug-Natural Products: Kava-kava, **valerian**, or **chamomile** can ↑ risk of CNS depression.

Evaluation of Medication Effectiveness

- Decrease in severity of pain without a significant alteration in level of consciousness or respiratory status
- Decrease in symptoms of pulmonary edema

Medication Administration

- **PO, Rect (Adults ≥50 kg):** Usual starting dose for moderate to severe pain in opioid-naive patients: 30 mg every 3–4 hr initially or once 24-hr opioid requirement is determined, convert to extended-release morphine by administering total daily oral morphine dose every 24 hr (as ER capsules), 50% of the total daily oral morphine dose every 12 hr (as MS Contin), or 33% of the total daily oral morphine dose every 8 hr (as MS Contin).. Dose of ER capsules should not exceed 1600 mg/day because of fumaric acid in formulation.
- **PO, Rect (Adults and Children <50 kg):** Usual starting dose for moderate to severe pain in opioid-naive patients: 0.3 mg/kg every 3–4 hr initially.
- **PO (Children >1 mo):** Prompt-release tablets and solution: 0.2–0.5 mg/kg every 4–6 hr as needed. Controlled-release tablet: 0.3–0.6 mg/kg every 12 hr.
- **IM, IV, Subcut (Adults ≥50 kg):** Usual starting dose for moderate to severe pain in opioid-naive patients: 4–10 mg every 3–4 hr. MI: 8–15 mg, for very severe pain additional smaller doses may be given every 3–4 hr.
- **IM, IV, Subcut (Adults and Children <50 kg):** Usual starting dose for moderate to severe pain in opioid-naive patients: 0.05–0.2 mg/kg every 3–4 hr; maximum: 15 mg/dose.
- **IV, Subcut (Adults):** Continuous infusion: 0.8–10 mg/hr; may be preceded by a bolus of 15 mg (infusion rates vary greatly; up to 80 mg/hr have been used).
- **Epidural (Adults):** Intermittent injection: 5 mg/day (initially); if relief is not obtained at 60 min, 1–2 mg increments may be made (total dose not to exceed 10 mg/day). Continuous infusion: 2–4 mg/24 hr; may ↑ by 1–2 mg/day (up to 30 mg/day).
- **IT (Adults):** 0.2–1 mg. Use preservative-free formulation.

Nursing Interventions

- Assess pain (type, location, intensity) before administration and at peak effect (20 min IV; 1 hr other routes). Titrate doses by 25–50% increments until satisfactory relief is achieved. Administer short-acting breakthrough doses as needed (boluses for infusions; 10–20% of total daily dose for ER). Use an equianalgesic chart when changing administration routes or switching opioids.
- Monitor frequently for RESPIRATORY DEPRESSION, especially in older adults and children. Have naloxone immediately available and be prepared to administer it using the specified titration protocol if overdose is suspected.
- Advise and assist the patient with ambulation due to dizziness and sedation. Instruct the patient to change positions slowly to prevent orthostatic hypotension.
- Routinely assess bowel function and aggressively prevent constipation by encouraging fluids/bulk and administering stimulant laxatives routinely (if use exceeds 2–3 days).
- Monitor for tolerance and Opioid-Induced Hyperalgesia (OIH); address OIH by decreasing the current dose or switching opioids. Monitor lab work for increased amylase and lipase.
- Encourage the patient to turn, cough, and deep breathe every 2 hours to prevent lung complications (atelectasis). Address dry mouth with oral hygiene and sugarless products.
- Educate the patient on strict safety protocols: storing the medication securely (out of children's reach), avoiding alcohol and CNS depressants, and reporting all medications taken. Instruct the patient to notify the provider if pain control is inadequate or if severe/persistent side effects occur.

Client Education

- Explain purpose and side effects of morphine to patient. Instruct them to take medication as directed
- Medication may cause drowsiness or dizziness. Advise patient to call for assistance when ambulating and to avoid driving or other activities that require alertness until response to the medication is known
- Advise patient that morphine is a drug with known abuse potential. Protect it from theft, and never give to anyone other than the individual for whom it was prescribed
- Educate patients and caregivers on how to recognize respiratory depression and emphasize the importance of calling 911 or getting emergency medical help right away in the event of a known or suspected overdose
- Advise patient to notify health care provider if pain control is not adequate or if severe or persistent side effects occur
- Advise patient to change positions slowly to minimize orthostatic hypotension
- Emphasize the importance of aggressive prevention of constipation with the use of morphine
- Caution patient to avoid concurrent use of alcohol or other CNS depressants with this medication
- Encourage patients who are immobilized or on prolonged bedrest to turn, cough, and breathe deeply every 2 hr to prevent atelectasis
- Advise patient that good oral hygiene, frequent mouth rinses, and sugarless gum or candy may decrease dry mouth

ACTIVE LEARNING TEMPLATE: *Medication*

STUDENT NAME Carolina Rodriguez

MEDICATION oxyCODONE (Xtampza ER) (Controlled substance schedule: II) REVIEW MODULE CHAPTER

CATEGORY CLASS Therapeutic: opioid analgesics
Pharmacologic: opioid agonists, opioid agonists/non-opioid analgesic combinations

PURPOSE OF MEDICATION

Expected Pharmacological Action

Oxycodone binds to opiate receptors in the Central Nervous System (CNS), which alters the perception of and emotional response to painful stimuli at the spinal cord and higher levels of the CNS. It achieves this by blocking the release of inhibitory neurotransmitters (such as acetylcholine and gamma-aminobutyric acid), while also producing generalized CNS depression.

Therapeutic Use

To relieve pain severe enough to require opioid treatment and for which alternative treatment options such as non-opioid analgesics or opioid combination products are inadequate or not tolerated

Complications

CV: orthostatic hypotension, bradycardia, chest pain, hypotension, palpitations. **Derm:** flushing, diaphoresis, pruritus, rash. **EENT:** blurred vision, diplopia, miosis, choking or difficulty swallowing tablets, dry eyes or mouth, lens opacities. **Endo:** adrenal insufficiency (rare), syndrome of inappropriate antidiuretic hormone secretion. **GI:** constipation, GI obstruction, nausea, vomiting, abdominal pain, anorexia, diarrhea, dyspepsia, elevated liver enzymes, gastritis, hiccups. **GU:** urinary retention, amenorrhea, decreased libido, erectile dysfunction/impotence, infertility. **Neuro:** confusion, sedation, dizziness, dysphoria, euphoria, floating feeling, hallucinations, headache, unusual dreams, anxiety, asthenia, chills, excitation, insomnia, nervousness, seizures, somnolence, syncope, twitching. **Resp:** RESPIRATORY DEPRESSION (INCLUDING CENTRAL SLEEP APNEA AND SLEEP-RELATED HYPOXEMIA), DYSPNEA. **Misc:** allodynia, opioid-induced hyperalgesia and allodynia, anaphylaxis, drug tolerance, hyponatremia, physical and psychological dependence, withdrawal symptoms

Contraindications/Precautions

Contraindications: Hypersensitivity; Some products contain alcohol or bisulfites and should be avoided in patients with known intolerance or hypersensitivity; Significant respiratory depression; Paralytic ileus; Acute or severe bronchial asthma; Acute, mild, intermittent, or postoperative pain (extended release). **Precautions:** Personal or family history of substance use disorder or mental illness; Head trauma; ↑ intracranial pressure; Severe renal impairment; Severe hepatic impairment; Hypothyroidism; Adrenal insufficiency; Seizure disorders; Undiagnosed abdominal pain; Prostatic hyperplasia; Difficulty swallowing or GI disorders that may predispose patient to obstruction (↑ risk for GI obstruction); **OB:** Lactation: Use while breastfeeding only if potential maternal benefit justifies potential risk to infant; **Pedi :** Children <11 yr (safety and effectiveness of ER products not established); **Geri :** ↑ risk of respiratory depression in older adults; initial dose ↓ recommended.

Interactions

Drug-Drug: Use with caution in patients receiving MAO inhibitors; may result in unpredictable reactions; ↓ initial dose of oxycodone to 25% of usual dose. **Mixed agonist/antagonist analgesics**, including **nalbuphine** or **butorphanol**, and **partial agonist analgesics**, including **buprenorphine**, may ↓ oxycodone's analgesic effects and/or precipitate opioid withdrawal in physically dependent patients. **CYP3A4 inducers**, including **carbamazepine**, **efavirenz**, **corticosteroids**, **modafinil**, **nevirapine**, **oxcarbazepine**, **phenobarbital**, **phenytoin**, **rifabutin**, or **rifampin**, may ↓ levels and analgesia; if inducers are discontinued or dosage ↓, patients should be monitored for signs of opioid toxicity, and necessary dose adjustments should be made. **CYP2D6 inhibitors** may ↑ levels and risk of opioid toxicity. Drugs that affect serotonergic neurotransmitter systems, including **tricyclic antidepressants**, **SSRIs**, **SNRIs**, **MAO inhibitors**, **TCAs**, **tramadol**, **trazodone**, **mirtazapine**, **5-HT3 receptor antagonists**, **linezolid**, **methylene blue**, and **triptans**, may ↑ risk of serotonin syndrome.

Evaluation of Medication Effectiveness

Decrease in severity of pain without a significant alteration in level of consciousness or respiratory status.

Medication Administration

PO (Adults ≥50 kg): Opioid-naive patients: 5–10 mg (immediate release) every 3–4 hr initially, as needed. Once optimal analgesia is obtained, patients with chronic pain may be converted to an equivalent 24-hr dose given in 2 divided doses as ER tablets every 12 hr.
PO (Adults <50 kg): Opioid-naive patients: 0.2 mg/kg (IR) every 3–4 hr initially, as needed. Once optimal analgesia is obtained, patients with chronic pain may be converted to an equivalent 24-hr dose given in 2 divided doses as ER tablets every 12 hr.
PO (Children ≥11 yr): 0.05–0.15 mg/kg (IR) every 4–6 hr as needed, as immediate-release product. Once optimal analgesia is obtained, patients with chronic pain may be converted to an equivalent 24-hr dose given in 2 divided doses as ER tablets every 12 hr.
Rect (Adults): 10–40 mg 3–4 times daily initially, as needed.
Hepatic Impairment PO (Adults): ↓ initial dose by 50–66%.

Nursing Interventions

- Assessment & Timing: Assess the patient's pain (type, location, and intensity) before giving the medication and 1 hour after administration (which is usually the peak effect).
- Titration: When increasing the opioid dose, raise it by 25–50% until the patient reports either a 50% reduction in pain or satisfactory relief. A second dose can be given safely at the peak time if the first dose was ineffective and side effects were minimal.
- Breakthrough Pain: Patients taking extended-release (ER) tablets can also be given supplemental doses of short-acting opioid for sudden, severe breakthrough pain.
- Changing Opioids: Always use an equianalgesic chart when switching the patient between different opioids or changing the route of administration to ensure proper dosing.
- (Geri/Pedi): Assess older adults and pediatric patients frequently because they are more sensitive to opioid effects and may experience side effects and respiratory problems more often.
- Dependence and Tolerance: Prolonged use can lead to physical and psychological dependence and tolerance, which means higher doses may be needed over time. However, this should not prevent the patient from receiving adequate pain relief. Long-term use should be reserved for severe pain where alternatives have failed, and acute pain usually requires only a few days of treatment.
- Bowel Function: Routinely assess bowel function due to the high risk of constipation. A prevention plan must be started immediately, including increased fluids and bulk.
- Laxatives: Stimulant laxatives should be administered routinely if the opioid use lasts more than 2–3 days, unless there is a contraindication. Consider medications specifically for opioid-induced constipation if necessary.
- Lab Test Considerations: The medication may increase amylase and lipase levels (enzymes often checked for pancreatic issues).
- Toxicity and Overdose: The antidote for respiratory depression or coma caused by an overdose is naloxone (an opioid antagonist). The correct procedure is to dilute the standard 0.4-mg naloxone ampule and administer it slowly (0.5 mL/0.02 mg every 2 minutes) by IV push, titrating the dose to reverse the respiratory depression while avoiding severe pain or withdrawal. Specific, lower dosing is used for children and patients weighing less than 40 kg.

Client Education

- Encourage patient to turn, cough, and breathe deeply every 2 hr to prevent atelectasis.
- Advise patient that good oral hygiene, frequent mouth rinses, and sugarless gum or candy may decrease dry mouth.
- Advise patient to make position changes slowly to minimize orthostatic hypotension.
- Emphasize the importance of aggressive prevention of constipation with the use of oxycodone.
- Advise patient to avoid concurrent use of alcohol or other CNS depressants with this medication; may cause overdose.
- Advise patient to notify health care provider if pain control is not adequate or if severe or persistent side effects occur.
- Medication may cause drowsiness or dizziness. Advise patient to call for assistance when ambulating and to avoid driving or other activities that require alertness until response to the medication is known.
- Advise patients taking Oxycontin tablets that empty matrix tablets may appear in stool.
- Advise patient that oxycodone is a drug with known abuse potential.
- Explain purpose and side effects of oxycodone to patient. Instruct them to take medication as directed and when to ask for pain medication. Do not share medication with others, even if they have similar symptoms; may be harmful. Keep out of children's reach.
- Educate patients and caregivers on how to recognize respiratory depression and emphasize the importance of calling 911 or getting emergency medical help right away in the event of a known or suspected overdose.

Module Report

Tutorial: Real Life RN Medical Surgical 4.0

Module: Total Hip Arthroplasty

Individual Name: **Carolina Rodriguez-Herrera**

Institution: **Margaret H Rollins SON at Beebe Medical Center**

Program Type: **Diploma**

Standard Use Time and Score

	Date/Time (ET)	Time Use	Score
Total Hip Arthroplasty	10/7/2025 12:47:51 PM	1 hr 31 min	Satisfactory

Reasoning Scenario Details
Total Hip Arthroplasty - Use on 10/7/2025 11:17:03 AM ET

Reasoning Scenario Performance Related to Outcomes:

*See Score Explanation and Interpretation below for additional details.

Body Function	Strong	Satisfactory	Needs Improvement
Cardiac Output and Tissue Perfusion	100%		
Cognition and Sensation	100%		
Immunity	100%		
Ingestion, Digestion, Absorption & Elimination	100%		
Mobility	100%		
Oxygenation	100%		
Regulation and Metabolism	75%	25%	

NCLEX RN	Strong	Satisfactory	Needs Improvement
RN Management of Care	100%		
RN Safety and Infection Control	100%		
RN Health Promotion and Maintenance	100%		
RN Basic Care and Comfort	100%		

RN Pharmacological and Parenteral Therapies	100%		
RN Reduction of Risk Potential	90%	10%	
RN Physiological Adaptation	100%		

QSEN	Strong	Satisfactory	Needs Improvement
Safety	83.3%	16.7%	
Patient-Centered Care	100%		
Evidence Based Practice	100%		
Teamwork and Collaboration	100%		

Thinking Skills	Strong	Satisfactory	Needs Improvement
Clinical Application	100%		
Clinical Judgment	92.9%	7.1%	

Decision Log:

Scenario	The preoperative consult nurse is identifying the risk factors associated with postoperative complications.
Question	Nurse Amani is reviewing Dale's medical record. Which of the following findings should Amani identify as a risk factor for postoperative complications?
Selected Ordering	BMIHemoglobinTobacco useAgeBlood pressure history
Rationale	Nurse Amani should identify that Dale's blood pressure and history of hypertension pose a risk factor postoperatively. Clients who have hypertension are more likely to experience and respiratory and cardiac complications following surgery.

Optimal Decision	
Scenario	Dale is returning demonstration of each of the postoperative exercises.
Question	Nurse Amani is observing Dale return demonstration of the postoperative exercises. Which of the following demonstrations by Dale indicate the teaching has been effective?
Selected Option	Client correctly performed the ankle pumps exercise
Rationale	Dale correctly performed the ankle pumps exercise which involves moving the ankle so that the foot alternately dorsiflexes and plantar flexes. This exercise should be performed at least 10 times every hour while awake. It promotes blood flow to the lower leg by contracting and relaxing the muscles in the calf.

Optimal Decision

Scenario	Amani is reviewing Dale’s home medications and instructing them which home medication to take on the day of surgery.
Question	Nurse Amani is reviewing Dale’s electronic medication record (EMR). Based on the provider's prescriptions, Amani should instruct Dale to take which of the following medications on the morning of surgery?
Selected Option	Amlodipine
Rationale	Nurse Amani should recognize that the provider’s prescription indicates the medication to manage hypertension should be taken the morning of surgery. Amlodipine is a calcium channel blocker which is used to manage hypertension. Therefore, Nurse Amani should instruct Dale to take this medication the day of surgery.

Optimal Decision	
Scenario	The preoperative holding nurse evaluates the data and determines next steps.
Question	Nurse Bobby Lee has obtained and reviewed Dale’s vital signs. Based on these findings, which of the following actions should Bobby Lee take?
Selected Option	Measure Dale’s legs for compression stockings
Rationale	Nurse Bobby Lee should identify that Dale’s vital signs are within their expected reference ranges. Therefore, they should proceed with preparing Dale for surgery by measuring Dale’s calf for the compression stockings.

Optimal Decision	
Scenario	The nurse is selecting the appropriate size of compression stockings for the client.
Question	Nurse Bobby Lee has measured Dale’s legs for the compression stockings and documented the findings in the preoperative checklist. Using the graph below, which of the following sizes should Bobby Lee select? **Compression Stocking Sizing Chart** **Size Calf Circumference**L39.4 to 45.7 cmXL43.2 to 48.3 cmXXL45.7 to 53.3 cmXXXL53.3 to 66 cm **Length Leg Length**Regular40.6 to 45.7 cmLong45.7 to 50.8 cm
Selected Option	XL Regular
Rationale	Nurse Bobby Lee should identify that the conversion of inches to centimeters requires multiplying the values in inches by 2.54. Therefore, Dale’s calf circumference would be 48 cm and the length would be 45.47 cm. Bobby Lee should select an XL Regular pair of compression stockings.

Optimal Decision	
Scenario	The nurse is reviewing the provider’s preoperative orders and is completing the preoperative checklist.
Question	Nurse Bobby Lee is completing the preoperative checklist to prepare Dale for surgery. Which of the following tasks is the priority for Bobby Lee to complete?
Selected Option	Insert peripheral IV access

Rationale	When using the airway, breathing, circulation priority framework, Nurse Bobby Lee should first initiate IV access to provide fluids to Dale, who is NPO to avoid hypovolemia, as well as prescribed IV antibiotics to reduce the risk of infection.

Optimal Decision	
Scenario	The acute care nurse is reviewing the postoperative orders for the client.
Question	Nurse Merryll is completing a review of Dale's postoperative prescriptions. Which of the actions should Merryll plan to take?
Selected Option	Administer the cefazolin at 1815
Rationale	According to Dr. Claw's prescription this medication is to be administered every 8 hr for 24 hr postoperatively. Nurse Merryll should plan to administer the cephazolin to Dale via intermittent IV bolus at 1815, which is 8 hours after the dose received in the operating room.

Optimal Decision	
Scenario	Merryll must determine which assessment findings requires further action.
Question	Nurse Merryll is reviewing the findings from the postoperative assessment completed for Dale. Which of the following findings should Merryll address?
Selected Option	Vital Signs
Rationale	Nurse Merryll should identify that Dale's vital signs are not all within the expected reference range and requires further action.

Optimal Decision	
Scenario	Nurse Merryll is identifying actions to implement first.
Question	Nurse Merryll is planning care for Dale. Which of the following actions should Merryll take first to address Dale's temperature?
Selected Option	Apply a warm blanket.
Rationale	When using the evidence-based practice priority framework, Nurse Merryll should identify that the first action to take to address Dale's postoperative temperature is to apply a warm blanket. This reduces heat loss and provides warmth to a large body surface area, effectively bringing Dale's temperature up to the expected reference range.

Optimal Decision	
Scenario	Merryll is determining which actions to take based upon the neurovascular assessment.
Question	Nurse Merryll has entered the information from the neurovascular assessment of Dale's right lower extremity. Based on the assessment findings, which of the following actions should Merryll take?
Selected Option	Obtain Dale's right pedal pulse using a doppler.

Rationale	Nurse Merryll should identify that Dale's right pedal pulse was not palpable, which could indicate an alteration in perfusion to their right leg. Therefore, Merryll should take further actions to determine the presence of a pedal pulse by using a doppler device.

Optimal Decision	
Scenario	Merryll is determining which medication to administer to Dale to address their pain.
Question	Nurse Merryll is reviewing Dale’s EMR to determine which pain medication should be administered to manage Dale’s current pain level. Which of the following medications should Merryll prepare to administer?
Selected Option	Morphine
Rationale	Nurse Merryll should identify that Dale is experiencing severe pain in their right hip. Therefore, Merryll should administer morphine IV, which is an opioid analgesic that is used to manage moderate to severe pain. This medication can be administered every 2 hr and is available for administration at this time.

Optimal Decision	
Scenario	Merryll and Shannon are assisting Dale back to bed.
Question	Nurse Merryll and assistive personnel Shannon are preparing to assist Dale with transferring back to bed. After reviewing Yoshi's progress note, which of the following videos demonstrate the actions Merryll should take?
Selected Option	Nurse and AP assist client to chair with gait belt and use of walker
Rationale	Nurse Merryll and AP Shannon observed safety measures and correct body mechanics when assisting Dale in transferring from the chair to the bed. Nurse Merryll applied a gait belt, which provides stability for the client and reduces the risk for injury. While assisting with the transfer, they used a wide base of support with their legs, which provides stability and reduces the risk for injury and falls.

Optimal Decision	
Scenario	Merryll is identifying findings that require further action.
Question	Nurse Merryll is reviewing Dale's EMR. Which of the following findings should Nurse Merryll plan to address?
Selected Option	Skin integrity
Rationale	Nurse Merryll should identify that Dale's heels require further assessment. The information in Dale’s EMR indicate that their skin integrity is a potential concern.

Optimal Decision	
Scenario	Merryll is completing an assessment of Dale.
Question	Nurse Merryll is performing an assessment of Dale. For which of the following findings should Nurse Merryll take further action?
Selected Option	Lung sounds

Rationale	Nurse Merryll should identify crackles during auscultation of Dale's lungs. This is often caused by the partial obstruction or collapse of the alveoli and requires further action.

Optimal Decision	
Scenario	Merryll is reviewing the client’s EMR to identify actions to take.
Question	Nurse Merryll has documented Dale's assessment findings. After reviewing Dale's EMR, which of the following actions should Nurse Merryll take? (Select all that apply.)
Selected Ordering	Assist with using incentive spirometerEncourage cough and deep breathing exercisesPromote fluid intakeAdminister oxycodone Encourage ambulation
Rationale	Nurse Merryll should identify specific interventions that should be taken to address Dale's atelectasis. Managing pain will make it more likely that Dale will be comfortable with ambulation, which promotes lung expansion.

Optimal Decision	
Scenario	Merryll is reviewing hip precautions with Dale.
Question	Nurse Merryll is discussing hip precautions with Dale. Which of the following statements by Dale indicate an understanding of the precautions? (select all that apply)
Selected Ordering	"I should avoid standing with my toes pointed inward.""I should sit in chairs that allow my right knee to be lower than my hip.""I should get up from sitting by putting weight on my left leg."
Rationale	Nurse Merryll should identify that Dale understands hip precautions when they make a statement about rising from a sitting to a standing position by placing their weight on their nonoperative leg.

Optimal Decision	
Scenario	Merryll is completing Dale’s daily VTE risk assessment screening tool.
Question	Nurse Merryll is reviewing the VTE screening tool and completing the information pertaining to Dale. Based upon Dale’s history, what score should Merryll assign to Dale regarding the risk for VTE? (Refer to the electronic medical records to review the VTE screening tool.)
Selected Option	10
Rationale	Merryll should identify that based upon Dale’s history; they have the following risk factors for VTE:Age 61-74 = 2 ptBMI > 25 = 1 ptElective Arthroplasty (Lower extremity) = 5 ptMajor surgery > 45 min = 2 ptThese factors indicate Dale has a high risk for the development of VTE with a total risk factor score of 10.

Optimal Decision	
Scenario	Merryll is reviewing Dale’s EMR for nutritional recommendations.

Question	Nurse Merryll is reviewing Dale's EMR. Based upon Dale's history and laboratory results, which of the following nutritional recommendations should Merryll make?
Selected Option	Encourage Dale to increase their protein intake.
Rationale	After reviewing Dale's EMR, Nurse Merryll should identify that Dale's is at risk for delayed wound healing because of their BMI. Adipose tissue can impair circulation and delivery of essential nutrients and antibodies needed for wound healing. Protein is an important and essential macronutrient to replace blood lost during the surgical procedure and to promote healing. It is important for each phase of the wound healing process. Therefore, Nurse Merryll should encourage Dale to increase their intake of protein.

Optimal Decision	
Scenario	Merryll is participating in interprofessional rounds about Dale and is reviewing their EMR.
Question	While discussing Dale's care with Nurse Case Manager Terry, Merryll reviews Dale's EMR. Which of the following findings should Nurse Merryll identify as indicators for inpatient rehabilitation? (Select all that apply.)
Selected Ordering	Ambulation distanceFunctional self-care abilityHome safety
Rationale	After reviewing Dale's EMR, Nurse Merryll should identify that home safety is a finding that indicates the need for inpatient rehabilitation.

Individual Report – Score Explanation and Interpretation

Reasoning Scenario Information:

Reasoning Scenario Information provides the date, time and duration of use, along with the score earned for each attempt. A Reasoning Scenario Performance score of Strong, Satisfactory, or Needs Improvement is provided for each attempt. This information is also provided for the Optimal Decision Mode if it has been enabled.

Reasoning Scenario Performance Scores:

Strong	Exhibits optimal reasoning that results in positive outcomes in the care of clients and resolution of problems.
Satisfactory	Exhibits reasoning that results in mildly helpful or neutral outcomes in the care of clients and resolution of problems.
Needs Improvement	Exhibits reasoning that results in harmful or detrimental outcomes in the care of clients and resolution of problems.

Reasoning Scenario Performance Related to Outcomes:

A clinical reasoning performance score related to each outcome is provided. Outcomes associated with student responses are listed in the report. The number across from each outcome indicates the percentage of responses associated with the level of performance of that outcome.

NCLEX® Client Need Categories:

Management of Care	Providing integrated, cost-effective care to clients by coordinating, supervising, and/or collaborating with members of the multi-disciplinary health care team.
Safety and Infection Control	Incorporating preventative safety measures in the provision of client care that provides for the health and well-being of clients, significant others, and members of the health care team.
Health Promotion and Maintenance	Providing and directing nursing care that encourages prevention and early detection of illness, as well as the promotion of health.
Psychosocial Integrity	Promoting mental, emotional, and social well-being of clients and significant others through the provision of nursing care.
Basic Care and Comfort	Promoting comfort while helping clients perform activities of daily living.
Pharmacological and Parenteral Therapies	Providing and directing administration of medication, including parenteral therapy.
Reduction of Risk Potential	Providing nursing care that decreases the risk of clients developing health-related complications.

Physiological Adaptation	Providing and directing nursing care for clients experiencing physical illness.

Quality and Safety Education for Nurses (QSEN)

Safety	The minimization of risk factors that could cause injury or harm while promoting quality care and maintaining a secure environment for clients, self, and others.
Patient-Centered Care	The provision of caring and compassionate, culturally sensitive care that is based on a client's physiological, psychological, sociological, spiritual, and cultural needs, preferences, and values
Evidence Based Practice	The use of current knowledge from research and other credible sources, upon which clinical judgment and client care are based.
Informatics	The use of information technology as a communication and information gathering tool that supports clinical decision making and scientifically based nursing practice.
Quality Improvement	Care related and organizational processes that involve the development and implementation of a plan to improve health care services and better meet the needs of clients.
Teamwork and Collaboration	The delivery of client care in partnership with multidisciplinary members of the health care team, to achieve continuity of care and positive client outcomes.

Body Function

Cardiac Output and Tissue Perfusion	The anatomical structures (heart, blood vessels, and blood) and body functions that support adequate cardiac output and perfusion of body tissues.
Cognition and Sensation	The anatomical structures (brain, central and peripheral nervous systems, eyes and ears) and body functions that support perception, interpretation, and response to internal and external stimuli.
Excretion	The anatomical structures (kidney, ureters, and bladder) and body functions that support filtration and excretion of liquid wastes, regulate fluid and electrolyte and acid-base balance.
Immunity	The anatomic structures (spleen, thymus, bone marrow, and lymphatic system) and body functions related to inflammation, immunity, and cell growth.
Ingestion, Digestion, Absorption and Elimination	The anatomical structures (mouth, esophagus, stomach, gall bladder, liver, small and large bowel, and rectum) and body functions that support ingestion, digestion, and absorption of food and elimination of solid wastes from the body.
Integument	The anatomical structures (skin, hair, and nails) and body functions related to protecting the inner organs from the external environment and injury.
Mobility	The anatomical structures (bones, joints, and muscles) and body functions that support the body and provide its movement.

Oxygenation	The anatomical structures (nose, pharynx, larynx, trachea, and lungs) and body functions that support adequate oxygenation of tissues and removal of carbon dioxide.
Regulation and Metabolism	The anatomical structures (pituitary, thyroid, parathyroid, pancreas, and adrenal glands) and body functions that regulate the body's internal environment.
Reproduction	The anatomical structures (breasts, ovaries, fallopian tubes, uterus, vagina, vulva, testicles, prostate, scrotum, and penis) and body functions that support reproductive functions.

Decision Log

Information related to each question answered in a scenario attempt is listed in the report. A brief description of the scenario, question, selected option and rationale for that option are provided for each question answered. The words "Optimal Decision" appear next to the question when the most optimal option was selected.

The rationale for each selected option may be used to guide remediation. A variety of learning resources may be used in the review process, including related ATI Review Modules.

Student Name: Carolina Rodriguez
Clinical Instructor: Emily Petito

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?
   Dale's fall risk score was a 45, which is considered high risk and means that high risk fall prevention interventions will be implemented.

   What interventions in Dale's care should you be implementing?

   (Use your resources from class and clinical Fall Risk Score Interventions)

   a. Use assistive devices (cane, walker, gait belt) when ambulating
   b. Always place call bell and bedside table with personal items within reach
   c. Use non-skid socks and walking shoes
2) From the pre-op exercises teaching scenario, pick one that Dale demonstrated incorrectly and explain how you would teach the correct technique.
   a. Dale demonstrated how to use the incentive spirometer incorrectly. I would teach the correct technique by explaining, as well as demonstrating. First, I would open the packaging and extend the tube. Then I would set a goal on the incentive spirometer with the marker on the side. Then I would sit up straight while holding the spirometer. I would then exhale completely and place the mouthpiece in my mouth. I would breathe in slowly and as deep as I could, making sure to keep the indicator on the side within normal range, and hold it for a few seconds, then exhale slowly. I would allow myself to rest between breaths, making sure I do this at least 10 times every hour.
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. Something that's wrong with this order is that the nurse administered 1.5mg IV and not 2-4mg, meaning it's not within the ordered range.
   b. Morphine is dispensed in 2mg/ml concentration. If Merryll gave 4 mg, how many ml's of morphine did she administer? 2 mL's
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. Some interventions could include using waffle boots and repositioning Dale at least every two hours.
   b. A concern would be that Dale would be at a high risk for developing pressure injuries if no interventions are implemented.
5) Identify three ways that the nursing team demonstrated the promotion of patient safety?
   a. Nurse Bobby lowered bed to lowest position before assisting to bathroom
   b. Nurse Meryll and Assistive personnel Shannon used a gait belt and a walker to transfer Dale back to bed
   c. Frequently reviewed hip and fall precautions with Dale and DeVon, understanding was shown via verbalization

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, the nurse and medical team utilized therapeutic communication techniques. I observed active listening, there were many open-ended questions, direct questions, and the medical team also gave information to the patient. Some examples of all of these would be when the nurse asked Dale to rate his pain, informed both patient and partner about the procedure and any medications and fall precautions.
    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: _____
    b. If **no,** write what you now understand the priority nursing problem to be: I don't think I selected a correct priority nursing problem. My priority problem was pain, which wasn't priority in this simulation in my opinion, and my second problem was impaired mobility. In my opinion, risk for falls was the priority. I say this because the nurses kept emphasizing fall precautions and having Dale teach it back to them via verbalization, many times.
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:
        Some interventions that I included that were not used in the scenario that could have helped the patient are assessing ROM, muscle strength, and walking pattern/stability.
        ii. If **no**, describe:
        _____
        _____
4) Often patient care will take a different direction than we anticipated at the beginning of our shift. Did that happen here? Yes
    a. How did that impact the nursing care delivered?
    It impacted nursing care because the patient developed impaired skin integrity. This emphasizes how important it is to do a thorough assessment, and if unsure always re-check. Another important aspect of this is the interventions applied. For example, if impaired skin integrity is found, like Dale's heel, a waffle boot should be put on, or some pillows for elevation, to prevent further damage. Failure in implementing any interventions could result in a pressure injury, which is what we don't want.
    b. What new, additional priority nursing problem (diagnosis) did you identify? (Refer to your NANDA list)
        i. Write it here: Risk for falls

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

My biggest takeaway from participating in the care of this patient is how much care goes into it. You must be sure of what you’re doing, and if you’re not, ask because otherwise you’d be putting the patient at risk. Something else I caught myself doing was having to constantly go back and check the EMR, this showed me to always triple check EVERYTHING, especially orders on medications. I also learned the importance of patient/family teaching. It’s importantly to teach thoroughly and ask them to teach it back to you or verbalize it, so you’re certain they understood as well. Something else I took away was using therapeutic communication techniques, as well as applying verbal/non-verbal techniques. For example, active listening and appropriate tone/ facial expressions. By using therapeutic techniques, good rapport is established, as well as a relationship between the nurse and the patient/family. This impacted my nursing practice because I now understand how to identify the priority problem. I must also be comfortable being able to pivot my care/focus in case a new problem arises or something goes wrong. I also learned the importance of assessing and implementing nursing interventions.