

Nursing Problem Worksheet

Name: Emily Johnson

Anticipated Patient Problem and Goals	Relevant Assessments (Prewrite) What assessments pertain to your patient's problem? Include frequencies	Multidisciplinary Team Intervention (Prewrite) What will you do if your assessment is abnormal?
Problem: Impaired physical mobility Reasoning: Limited range of motion, need for assistive devices, weakness Goal: pt will demonstrate use of ambulatory devices by teach-back method during my care Goal: pt will ambulate to BA with assistance by the end of my care	assess pt need for using the BA	Encourage assistance to the BA to promote ambulation
	assess pt for dizziness or weakness before ambulation	encourage pt to rest and provide water
	assess pt Pain Score level	administer oxycodone for pain relief
	assess pt knowledge & education of ambulatory devices	demonstrate proper use of assistive devices
	assess pt strength and range of motion	provide passive range of motion to lower extremities

Anticipated Patient Problem and Goals	Relevant Assessments (Prewrite) What assessments pertain to your patient's problem? Include frequencies	Multidisciplinary Team Intervention (Prewrite) What will you do if your assessment is abnormal?
Problem: risk for infection Reasoning: Surgical incision, Presence of prosthetic implant, Goal: pt incision will remain clean and intact during my care Goal: pt will show no signs of infection (no redness, swelling, drainage fever) during my shift	assess pt surgical incision dressing	change, clean, & place new dressing
	assess pt linens for dirtiness	change linen & replace with clean linen
	assess pt vital signs	contact provider for possible antibiotics
	assess pt input & output	encourage fluids & eating of meal trays
	assess pt skin integrity	change pt position q2hr to prevent from pressure wounds

ACTIVE LEARNING TEMPLATE: Medication

STUDENT NAME Emily Johnson

MEDICATION Morphine Sulfate (IVP)

REVIEW MODULE CHAPTER _____

CATEGORY CLASS Opioid, Controlled Substance Schedule II

PURPOSE OF MEDICATION

Expected Pharmacological Action

binds with and activates opioid receptors in the brain & spinal cord and alters the perception of and response to painful stimuli while producing generalized CVS depression

Therapeutic Use

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

Complications / Side effects / adverse reactions

• hypotension, bradycardia, constipation, blurred vision, confusion, sedation, respiratory depression, adrenal insufficiency, coma, seizures, bronchospasm, pulmonary edema, asthma exacerbation

Contraindications / Precautions

• acute or severe bronchial asthma in an unmonitored setting. Products that contain tartrazine, bisulfites, or alcohol should be avoided in pts with known hypersensitivity. Paralytic ileus
• Personal or family hx of substance use or mental illness, head trauma, severe hepatic impairment, seizure disorder, severe pulmonary disease

Interactions

Drug-natural: kava-kava, Valerian, chamomile
Drug-drug: Use with extreme caution in pts receiving MAO inhibitors within 14 days prior, may result in unpredictable reactions. Drugs that affect serotonergic neurotransmitter systems like, tricyclic antidepressants, SSRIs, trazodone, mirtazapine, mixed agonist/antagonist analgesics including nalbuphine, or buprenorphine, and partial agonist analgesics including buprenorphine. may ↑ anticoagulant effect of warfarin

Evaluation of Medication Effectiveness

• Decrease in the severity of the pt's pain without significant change in level of consciousness or respiratory status
• Decrease in symptoms of pulmonary edema

IV/PO: administer slowly at 2.5-15mg over 5min, do not dilute prior to administration

Medication Administration

• Larger doses may be required during chronic therapy
PO, Rect (adults ≥ 50kg): starting dose 30mg every 3-4hrs initially or once 24hr opioid requirement is determined
• capsules should not exceed 1600mg/day
IM, IV, Subcut (adults ≥ 50kg): starting dose 4-10mg every 3-4hr. MI-8-15mg for very severe pain additional smaller doses may be given every 3-4hrs
Epidural adults: 5mg/day do not exceed 10mg/day - intermittently

Nursing Interventions

• assess pt pain scale & score
• assess pt comfort
• assess pt alertness, need to use the bathroom
• ask the pt if they are having any suicidal thoughts or hx
- monitor vitals,
- auscultate lung sounds

Client Education

• Educate pt & family on how to identify respiratory distress (monitor RR, SpO₂, effort)
• may cause drowsiness or dizziness
• do not drink alcohol or use antidepressant
• call for assistance when trying to walk or get up
• take med as directed, it has

abuse potential, never give it to anyone other than who it is prescribed for

ACTIVE LEARNING TEMPLATE: Medication

STUDENT NAME Emily Johnson

MEDICATION Oxycodone (Roxicodone, Roxycodone, Xtampza ER) REVIEW MODULE CHAPTER _____

CATEGORY CLASS Therapeutic: Opioid analgesics pharmacologic: opoid
Schedule II

PURPOSE OF MEDICATION

Expected Pharmacological Action

Alters perception of and emotional response to pain at spinal cord and higher levels of CNS by blocking release of inhibitory neurotransmitters, like acetylcholine and gamma-aminobutyric acid

Therapeutic Use / Indications

Pain severe enough to require daily around the clock long term opioid treatment for which alternative treatment

Complications / adverse reactions / Side effects

CNS: abnormal dreams, anxiety, chills, dizziness, euphoria, seizures, syncope
CV: orthostatic hypotension, bradycardia, ENDO: adrenal insufficiency, Drug Tolerance
RESP: respiratory depression, Anaphylaxis
• hyponatremia

Contraindications/Precautions 2.

1. Some products contain alcohol, bisulfites & should be avoided w/ pt's known intolerance & hypersensitivity, paralytic ileus, acute or severe bronchial asthma
2nd. head trauma, ↑ intracranial pressure, severe hepatic impairment, hypothyroidism, seizure disorders

Interactions

• Drug-Drug: pts receiving MAO inhibitors - results in unpredicted reactions. mixed agonist/antagonist analgesics like nalbuphine may ↓ analgesic effects and/or precipitate opioid withdrawal in physically dependent pts.
S-HT₂ receptor antagonists.

Evaluation of Medication Effectiveness

• decrease in pain score
• no respiratory depression or dizziness reported

Medication Administration

*PO (adults) initial dose by 50-60%
• Larger doses may be required during chronic therapy. ER capsules are NOT bioequivalent to ER tablets
• PO (adults ≥ 50kg): 5-10mg every 3-4hrs PRN, As w/ chronic pain may be converted to a 24hr dose
• PO (adults < 50kg) 0.2mg/kg every 3-4hr initially PRN, then converted to 24hr

Nursing Interventions

• Consider Lab tests for ↑ amylase & lipase
• frequent respiratory vitals
• Check med administration ex accurately

Client Education

• Explain therapeutic value of med prior to administration
• Explain how drug can lead to abuse, addiction overdose

Student Name: Emily JohnsonMedical Diagnosis/Disease: OsteoarthritisMusculoskeletal System

NCLEX IV (8): Physiological Integrity/Physiological Adaptation

Anatomy and PhysiologyNormal Structures

Made up of bone, joints, muscles, ligaments, tendons, cartilage. The purpose is to protect body organs, provide support and stability for the body, store minerals, and allow coordinated movement.

Bone: Function is to support, protect internal organs, voluntary movement, blood cell production, and mineral storage. They allow the body to bear weight etc. bones serve as a point of attachment for muscles and ligaments. muscles are connected to bones by tendons. Ligaments provide stability to joints, bone marrow contains the tissues responsible for making red and white blood cells & stores minerals like calcium & phosphate. contains 206 bones in the body & are classified by shape

Pathophysiology of Disease

• Osteoarthritis is the gradual loss of articular cartilage w/ formation of bony outgrowths (spurs of osteophytes) at the joint margins
 • Genetic, metabolic, and local factors interact to cause cartilage deterioration from damage at the level of the chondrocytes. Cartilage becomes dull, yellow, and granular as OA progresses and continues to get softer & less elastic.
 • The body's attempts at repairing cartilage cannot keep up with the damage of OA. As cartilage structure changes, articular surfaces become cracked and worn. While central cartilage becomes thinner, cartilage at joint edges becomes thicker and osteophytes form. Joint surfaces become uneven, which affects distribution of stress across the joint and causes reduced motion

NCLEX IV (7): Reduction of Risk

Anticipated DiagnosticsLabs

- CBC
- Synovial fluid assessment/analysis
- Liver function tests (BUN, creatinin)
- ESR Labs

Additional Diagnostics

- Xrays
- Bone scan
- CT scan
- MRI

NCLEX II (3): Health Promotion and Maintenance

Contributing Risk Factors

- Aging
- Joint instability
- Mechanical stress
- Hematologic or endocrine problems (chronic hemarthrosis)
- Trauma
- Drugs that stimulate collagen digesting enzymes in joint synovium

Signs and Symptoms

- Joint pain
- Loss of function or disability
- Hard to sit up or down
- Joint stiffness
- Joint swelling
- Crepitation
- Affects joints on only 1 side of body

NCLEX IV (7): Reduction of Risk

Possible Therapeutic ProceduresNon-surgical

- acupuncture
- TENS
- Physical therapy

Surgical

- reconstructive joint surgery
- hip & knee replacements

Prevention of Complications

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

- avoid smoking
- promptly treat any joint injury
- maintain healthy weight & diet
- Exercise regularly, strength & endurance training

NCLEX IV (6): Pharmacological and Parenteral Therapies

Anticipated Medication Management

- nonsteroidal anti-inflammatory drugs (NSAIDs)
- Capsaicin cream
- Diclofenac gel
- intraarticular corticosteroid injections
- hyaluronic acid injections

NCLEX IV (5): Basic Care and Comfort

Non-Pharmacologic Care Measures

- assistive & supportive devices
- Heat and cold therapy
- Exercise & activity modification
- Weight management
- Joint protection

NCLEX III (4): Psychosocial/Holistic Care Needs

What stressors might a patient with this diagnosis be experiencing?

- Pain during ADLs
- Progress of treatment
- coming to terms that it is not curable

Client/Family Education

List 3 potential teaching topics/areas

- Demonstrate correct use of ambulatory devices
- Educate on joint protection & safe environment at home
- Encourage nutritional improvement

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)

- rheumatologist
- occupational therapist
- physical therapist
- family HCP
- ortho surgeon

Normal Patho continued:

Bone structure includes cortical (compact & dense) cancellous (spongy). The diaphysis is the main shaft of the long bone & the epiphysis is the widened area at each end of the long bone. osteoclasts breakdown bone tissue. osteoblasts create & form bone. osteocytes are mature bone cells

Joints: a joint (articulation) is a place where the ends of 2 bones are close and move in relation to each other. joints are classified by the movement they allow.

-diarthrodial (synovial) is the most common joint & most freely moveable. a joint is enclosed in a capsule of fibrous connective tissue that joins two bones together to make a cavity. The capsule is lined by a synovial membrane that secretes synovial fluid that lubricates the joint to reduce friction that allows surfaces to slide smoothly

Cartilage:

3 types of cartilage include hyaline, elastic, and fibrous. cartilage in synovial joints serves as support for soft tissue and provides articular surfaces for joint movement & protects underlying tissues. articular cartilage is avascular and must receive nourishment by diffusion of material from synovial fluid. not having direct blood supply contributes to slow metabolism of cartilage cells & slow repair of cartilage tissue. functions as shock absorber

Muscle:

Cardiac, smooth, and skeletal muscle. Cardiac muscle is only found in the heart, contains spontaneous muscle contractions which are involuntary. smooth muscle is found in airway, arteries, GI tract, bladder, and uterus and is controlled by hormonal & neuronal influenced muscle contractions. skeletal muscle requires neuronal contractions and covers bones.

Ligaments & tendons:

composed of dense, fibrous, connective tissue with bundles of collagen fibers. tendons attach muscles to bones as an extension of the muscle sheath that adheres to the periosteum. Ligaments connect bones to bones & have a higher elastic content than tendons

Total Hip Arthroplasty research:

Primary indications: End-stage hip OA, pain and functional loss after conservative care, inflammatory arthritis, hip fractures/deformity.

What is it?: A hip replacement & it is replaced with a prosthetic joint made of metal, ceramic & plastic.

• The hip is a ball & socket joint, the top of the thigh bone (femoral head = the ball) fits into a socket in the pelvis (acetabulum)

• The surgeon places a metal stem down into the thigh bone and socket into pelvis after the removal of the diseased bones & joints & are fixed in place by cement or by creating a way that bone will grow into the surfaces

risks: infection, dislocation, fracture during surgery, differences in leg length, damage to nerves & tissues around hip

recovery: Physical therapy will be needed, assistive devices until able to ambulate alone, 1-2 nights or more in hospital post-surgery. older pts tend to take longer to recover

disease Patho continued:

Secondary synovitis may occur when phagocytes try to rid the joint of small pieces of cartilage torn from the joint surface. these changes cause early pain & stiffness. Pain later on occurs when the articular cartilage is lost, and bony joint surfaces rub each other