

# [Answer last morphine injection was 1 hour](https://assignbuster.com/answer-last-morphine-injection-was-1-hour/)

Answer the following questions:

1.
List
at least two advantages to using morphine sulfate for pain control in the
postoperative critical care patient.

Morphine
compared to lipid- soluble opioids (morphine is Water-soluble):

·      " Slower onset of action and
longer duration" (Urden, Stacy, & Lough, 2018, p. 127)

When you ask Ms. Thomas if she is having pain, she indicates
that she is having 9/10 pain. Her last Morphine injection was 1 hour ago (4mg
IV). She is alert but appears anxious, heart rate is 95 beats per minute, blood
pressure is 155/90 and her respiratory rate is 20. Her skin is warm and dry.

2.
Determine
three interventions related to Ms. Thomas' pain (can be pharmacologic or
non-pharmacologic).

·      Give acetaminophen to help
reduce pain. (if prescribed)

·      Minimize stimulation to
promote rest, and relaxation therapy.

·      Ice therapy or massage
therapy. (Urden, Stacy, & Lough, 2018, p. 133)

3.
What
other members of the team could you involve in the care of Ms. Thomas to help
alleviate her pain?

·      Physical therapist can help
provide physical techniques such as ice therapy, and massage therapy.

·      Behavior therapist to help
with relaxation techniques.

(Urden, Stacy, & Lough, 2018, p. 133)

4.
What
other pain medications could be used in this case?

·      Acetaminophen

·      NSAIDS

·      Codeine

·      Lidocaine

·      Ketamine

(Urden, Stacy, & Lough, 2018, p. 127-130)

Ms. Thomas is becoming restless and is not responding well to
commands. She is looking around the room and not making eye contact.

5.
Would
you consider this delirium or agitation? Why?

Delirium, she seems to have changed in mental status
and can't pay attention.

(Urden, Stacy, & Lough,
2018, p. 141)

6.
Using
Figure 9. 2 in your text, determine Ms. Thomas' RASS score. How is this score
used (list the steps of the assessment)? What does it indicate?

Her
Rass score is +1 and she is CAM-ICU positive Delirium present.

1st step sedation
assessment- determine level of sedation- unarousable- combative. ( pt is
restless so score is +1)

2nd step delirium
assessment

1.
Is
there a change of mental status? Yes move on no- negative. (Pt has change in
status)

2.
Inattention:
tell patient to squeeze on letter A and spell SAVEAHAART (Pt is unresponsive
and will miss every A) more than 2 errors move on. 0-2- Negative.

3.
Altered
level of consciousness: if patients score from step one is above zero they are
Positive ( our patient is +1 so they are positive) If not move on to step 4

4.
Ask them to hold up the same number of fingers
as you. If they mess up more than once then they are positive, if not they are
negative.

This indicates that she is
Positive and Delirium is present.

(Urden,
Stacy, & Lough, 2018, p. 142)

7.
Determine
her ICDSC (figure 9. 3) (Just for this time period-one time).

She is in soft wrist restrains
so that is a +1

She can't follow
instructions so that is a +1

She is awake so she is a D
which is a 0

So she has a score of 2
points, because she cant be assessed for orientation, hallucinations,
inappropriate speech, sleep wake cycle or symptom fluctuation since she cant
respond or we don't have enough information.

(Urden,
Stacy, & Lough, 2018, p. 143)

8.
List
at least two possible causes of delirium/agitation.

" Pain,
anxiety, delirium, hypoxia, ventilator dyssynchrony, neurologic injury,
uncomfortable position, full bladder, sleep deprivation, alcohol withdrawal,
sepsis, medication reaction, and organ failure."

(Urden, Stacy, & Lough, 2018, p. 141)

9.
What
medication(s) is commonly used to treat agitation/delirium?

Haloperidol
– Agitation and Delirium

Benzodiazepine-
High SAS or RASS (extreme situation only)

(Urden, Stacy, & Lough, 2018, p. 141)

10.

Discuss common adverse effects of this medication.

" Confusion, headache,
hypertension, blurred vision, drowsiness, dry mouth, urinary retention," (Skidmore-Roth,
2017, pp. 579-580)

11.

What are some ways to reduce the incidence of delirium in ICU patients? (List
at least three).

·      Spontaneous awakening trials

·      Daily delirium monitoring

·      Early mobility

(Urden, Stacy, & Lough, 2018, p. 143)

## References:

Urden, L. D., Stacy, K. M., & Lough, M. E. (2018). Critical care nursing:
diagnosis and management. Maryland Heights, MO: Elsevier.

Skidmore-Roth, L.

(2017). Mosbys 2017 nursing
drug reference. St.

Louis, MO: Elsevier.