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.

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