NURSING PROCESS FOCUS Clients Receiving Opioid Therapy

Assessment

- Obtain a complete health history including allergies, drug history, and possible drug interactions.
- Assess pain (quality, intensity, location, duration) and effect on sleep pattern.
- Assess respiratory function.
- Assess level of consciousness before and after administration.
- Obtain vital signs.

Potential Nursing Diagnoses

- Knowledge, Deficient , related to drug therapy
- Pain, Acute, related to injury, disease, or surgical procedure
- Breathing Pattern, Ineffective, related to action of medication
- Constipation, related to action of medication
- Sleep Pattern, Disturbed, related to surgical pain

Planning: Client Goals and Expected Outcomes

The client will:

- Report pain relief or a reduction in pain intensity.
- Demonstrate an understanding of the drug's action by accurately describing drug side effects and precautions.
- Immediately report rebound pain, restlessness, anxiety, depression, hallucination, nausea, dizziness, constipation, or itching.
- Be free of preventable adverse drug effects.

Implementation

Interventions and (Rationales)	Client Education/Discharge Planning
▪ Opioids may be administered PO, subcutaneously, IM, IV, or rectally. (Ensure that correct route is administered.)	Instruct client: ▪ That oral *capsules* may be opened and mixed with cool foods; extended-release *tablets*, however, may not be chewed, crushed, or broken. ▪ That oral solution given sublingually may be in a higher concentration than solution for swallowing.
▪ Opioids are Schedule II controlled substances. (Opioids produce both physical and psychological dependence.)	Instruct client to: ▪ Take necessary steps to safeguard drug supply. ▪ Avoid sharing medications with others.
▪ Monitor liver function tests. (Opioids are metabolized in the liver. Hepatic disease can increase blood levels of opioids to toxic levels.)	Instruct client to: ▪ Report nausea, vomiting, diarrhea, rash, jaundice, abdominal pain, tenderness or distention, or change in color of stool. ▪ Keep scheduled laboratory appointments for liver function tests as ordered by the healthcare provider.
▪ Monitor vital signs, especially depth and rate of respirations/pulse oximetry. (Opioids can cause respiratory depression.) ▪ Withhold the drug if the client's respiratory rate is below 10, and notify the healthcare provider. (Opioids can cause respiratory depression.)	Instruct client or caregiver to: ▪ Monitor vital signs regularly, particularly respirations. ▪ Withhold medication for any difficulty in breathing or respirations below 10 breaths per minute; report symptoms to the healthcare provider.
▪ Monitor neurological status; perform neurochecks regularly. (Opioids can cause changes in sensorium, sluggish papillary response, and seizures.)	Instruct client to: ▪ Report headache or any significant change in sensorium, such as an aura or other visual affects that may indicate an impending seizure. ▪ Recognize seizures and methods to ensure personal safety during a seizure. ▪ Report any seizure activity immediately.
▪ If ordered PRN, administer medication on client request or when nursing observations indicate client expressions of pain. (Administering pain medication promptly helps prevent pain from becoming severe.)	▪ Instruct client to immediately alert the healthcare provider when pain returns or increases.
▪ Monitor renal status and urine output. (These drugs may cause urinary retention, which may exacerbate existing symptoms of benign prostatic hyperplasia or cause urinary tract infection.)	Instruct client or caregiver to: ▪ Measure and monitor fluid intake and output. ▪ Report symptoms of dysuria (hesitancy, pain, diminished stream), changes in urine quality or scanty urine output, fever or flank pain.

(Continued)

NURSING PROCESS FOCUS Clients Receiving Opioid Therapy *(Continued)*

Implementation

Interventions and (Rationales)	Client Education/Discharge Planning
▪ Monitor for other side effects such as restlessness, dizziness, anxiety, depression, hallucinations, nausea, and vomiting. (Hives or itching may indicate an allergic reaction due to the production of histamine.)	Instruct client or caregiver to: ▪ Recognize side effects and symptoms of an allergic or anaphylactic reaction. ▪ Immediately report any shortness of breath, tight feeling in the throat, itching, hives or other rash, feelings of dysphoria, nausea, or vomiting. ▪ Avoid the use of sleep-inducing OTC antihistamines without first consulting the healthcare provider.
▪ Monitor for constipation. (Opioids slow peristalsis.)	Instruct client to: ▪ Maintain an adequate fluid and fiber intake to facilitate stool passage. ▪ Use a stool softener or laxative as recommended by the healthcare provider.
▪ Ensure client safety. (Opioids can cause changes in sensorioum, which may lead to falls.)	Instruct client to: ▪ Request assistance when getting out of bed. ▪ Avoid driving until effects of drug are known.
▪ Monitor frequency of requests and stated effectiveness of narcotic administered. (Opioids cause tolerance and dependence.)	Instruct client and caregiver: ▪ Regarding cross-tolerance issues. ▪ To monitor medication supply to observe for hoarding, which may signal an impending suicide attempt. ▪ That drug dependence in terminal illness must be viewed from the perspective of reduced life expectancy.

Evaluation of Outcome Criteria

Evaluate effectiveness of drug therapy by confirming that client goals and expected outcomes have been met (see "Planning").

- The client reports pain relief or a reduction in pain intensity.
- The client demonstrates an understanding of the drugs action by accurately describing side effects and precautions.
- The client immediately reports rebound pain, restlessness, anxiety, depression, hallucination, nausea, dizziness, constipation, or itching.
- The client is free of preventable adverse drug effects.

See Table 18.2 for a list of drugs to which these nursing actions apply.