Interventions for the Newly Licensed Practical Nurse

Education Module
Title: Interventions

Learning Objectives:

Upon completion of this education module, the newly licensed practical nurse will:

- Describe a head to toe and a focused assessment.
- Perform and document a head to toe and focused assessment.
- Develop an assessment and data collection guide for personal use.
- Discuss safe medication administration.
- Demonstrate safe medication administration to a group of patients.
- Select pain management strategies to be used in your practice.
- Determine if pain management strategies were successful.

Interactive Exercises:

1. View the information that follows with your preceptor.
2. Explore the websites listed and discuss with your preceptor.
3. Develop a head to toe assessment tool with the guidance of your preceptor or use one already developed and used by your facility.
4. Observe head to toe and focused assessments of several patients as they are done by your preceptor.
   a. Discuss the techniques used, variations of the techniques, and the documentation process.
   b. The newly licensed practical nurse will repeat all or part of the assessment (if possible) and compare and contrast the findings with the preceptor.
5. Perform head to toe and focused assessments on several patients assigned by your preceptor.
   a. The preceptor will observe and offer constructive feedback.
   b. Complete the documentation process and review it with your preceptor.
6. Discuss pain assessment scales to include verbal and non-verbal scales with your preceptor.
7. Administer medications to a group of patients.
8. Implement pain management strategies with select patients and evaluate those strategies to include pharmacologic and non-pharmacologic pain interventions.
9. Complete a select group of nursing interventions appropriate to the unit or facility under the supervision of the preceptor. Examples of interventions may include, administration of enteral feedings, insertion of a catheter, giving an enema, wet-to-dry dressing, and assessment of blood sugar using a glucometer, etc. These interventions should be observed by the preceptor who can offer constructive feedback to the new LPN.
a. The newly licensed practical nurse will locate the policy and procedure prior to completion of the intervention; review it, and discuss any concerns.

b. Locate and obtain all necessary equipment.

c. Interventions to be selected might be ones that the newly licensed practical nurse has not completed independently during her education experience.

Interventions

Assessment: assessments are the basis for all nursing interventions.

Head to toe assessment: should be completed in 10-20 minutes; a shorter focused assessment should be completed in 5 minutes; it begins when you enter the room and introduce yourself.

- Begin with vital signs: this gives you crucial information and if abnormal you may need to move to a more focused assessment and immediate interventions if needed.
- Ask the patient how they feel: Pain? Dyspnea? Any changes that need immediate attention?
- HEENT/Neurological: Orientation (time, place, person, and purpose)? Can your patient speak clearly? PERRLA? Can they hear you and respond appropriately? Do they have any congestion or trouble breathing through their nose? Condition of mucous membranes? Can they swallow and chew? Tracheal deviation? Jugular venous distention?
- Skin is assessed immediately through observation when first meeting the patient and in more detail as you move through the systems of the body. Turgor? Any breaks in the skin or discolorations? Temperature? Color? Moisture?
- Chest and Thorax: Lung sounds? Heart sounds? (anterior and posterior)
- Tubes, dressings, etc.: note the function and drainage of any tubes or dressings the patient may have.

What are your personal beliefs about pain? Is it “real”? Is it the same in everyone? How do you describe pain you have had in the past? How do feel when patients tell you they are in pain?

Pain assessment: considered the 5th vital sign – many factors affect pain including

- Our own beliefs and attitudes toward pain
- Cultural influences.
- Nurses cannot rely on their judgment in pain assessment: take what the patient says as an accurate interpretation of the pain they are experiencing.
- Assess both before and after the administration of analgesics or other pain relief methods.
  - Pain scales should be used (either verbal or nonverbal) to measure pain.
  - Documentation of pain and pain relief is a crucial component of nursing care.
- Reliable pain scales:
  1. Numeric rating scale (NRS): asks a patient to rate pain on a scale from 0 (no pain) to 10 (worst pain imaginable).
  2. Verbal descriptor scale: asks a patient to describe pain either as no pain, mild pain, moderate pain, severe pain, or pain as bad as it can be.
3. Faces pain scale (FPS): visual scale in which a patient chooses the depiction of a facial expression that best corresponds with their pain.

What pain assessment tools are used in the facility? Are they available in Spanish or other languages?

- Pain Assessment in the Older Adult: many older adults have under-treated pain. Pain should not be thought of as a normal part of aging that should just be endured.
- If a patient suffers from dementia and cannot accurately verbalize their pain there is a tool to evaluate the pain based on careful nursing assessment: pain assessment in advanced dementia scale (PAINAD); it is a 5 item observational tool that assesses
  1. breathing,
  2. negative vocalization,
  3. facial expression,
  4. body language, and
  5. consolability.

Go to the following website and view the video (you will be asked to enter an e-mail address before viewing the video).  http://links.lww.com/A251

Pain Interventions
- Pharmacologic
  1. Acetaminophen (caution: maximum safe dose less than 4g/24 hours)
  2. NSAIDs (major adverse effect is GI)
  3. Opioids (can be given via many different routes but watch closely for adverse reactions)
  4. For continuous pain, medications should be provided around the clock – always assess for breakthrough pain and notify the health care provider if your patient’s pain is not controlled.

- Nonpharmacologic
  1. Physical therapy
  2. Biofeedback
  3. Massage therapy
  4. Heat and cold application
  5. Guided imagery

Safe Medication Administration
- Review of the Six Rights
  1. Right patient
  2. Right drug
  3. Right time
  4. Right route
  5. Right dose
  6. Right documentation

Safe Medication Administration
- True or false – Most medication errors occur when a nurse neglects to follow the six rights of medication administration. (Answer at the end of this information.)
- With the increased use of tools and technology such as barcoding, computerized prescriber order entry and preprinted medication order forms errors can be greatly decreased.
- True or false – A parenteral syringe (without a needle) can be used to administer oral liquid medications.
• True or false – If a dose of a patient’s medication is missing from their medication box, it is appropriate to borrow the drug from another patient’s medication box or an automated dispensing machine.

• Compare the patient’s medication administration record (MAR) against two patient specific identifiers before giving any medication. The use of identifiers is a Joint Commission National Patient Safety Goal. Examples of patient specific identifiers are:
  1. Ask the patient to state their name
  2. An assigned identification number (not their room number)
  3. The patient’s birth date
  4. Bar coding with two of the above patient identifiers is acceptable.

• If the facility has a unit dose packaging system for medications, do not open the package until in the patient’s room and ready to administer.

• Take the MAR into the patient’s room when administering medications and document immediately after administration.

• Double check patient allergies before administering medication.

Practice recommendations for administration of medications through an enteral access device (from the Journal of Parenteral and Enteral Nutrition):
• Do not add medication directly to an enteral feeding formula.
• Avoid mixing medications intended for administration through an enteral feeding tube.
• Each medication should be administered separately through an appropriate access.
• Liquid dosage forms should be used when available, and if appropriate.
• Grind simple compressed tablets to a fine powder and mix with sterile water – open hard gelatin capsules and mix powder with sterile water.
• Only immediate-release solid dosage forms may be substituted.
• Prior to administering medication, stop the feeding and flush the tube with at least 15 mL of water. Dilute the solid or liquid medication as appropriate and administer using a clean oral syringe.
• Flush the tube between medications with at least 15 mL water, taking into account the patient’s fluid volume status – flush the tube one final time with at least 15 mL water (less for pediatric patients).
• Use only oral/enteral syringes labeled with “for oral use only” to measure and administer medication through an enteral feeding tube.

Go to the following website: [http://www.ismp.org](http://www.ismp.org). Under medication safety tools and resources click on the error prone abbreviation list and the “Do Not Crush” list and view both of these files.

The Institute for Healthcare Improvement has a 5 Million Lives Campaign – read about it at: [http://www.ihi.org/IHI/Programs/Campaign](http://www.ihi.org/IHI/Programs/Campaign)
• One of the new interventions is to prevent harm from high alert medications:
  1. Anticoagulants
  2. Sedatives
  3. Narcotics
  4. Insulin

Safe Injection Practices -- go to the following website: [www.oneandonlycampaign.org](http://www.oneandonlycampaign.org)
• Watch the safe injection practices video and click on the tab to learn about safe injection practices. The incident described occurred in a Fremont NE medical facility.
Question #1: Answer is false. The majority of medication administration errors are related to system failure. Medication administration systems are for the nurse to use and can never replace the nurse who is the final step in the safety check before a patient is given a medication. If you receive a verbal or telephone order for a medication (or any order) write it directly on the patient’s medical record and read it back to the prescriber (drug, dose, and route) for clarification. Do not skip this step. Remember, verbal or telephone orders should be used as infrequently as possible.

Question #2: Answer is false. Oral liquid medications that need to be drawn up in a syringe should be administered with a syringe designed for oral medications. Using a parenteral medication syringe has resulted in oral medications being given via the intravenous route.

Question #3: Answer is false. Medications should never be borrowed from another patient’s medication box or an automated dispensing machine without checking why the drug is not there. Call the supervisor or pharmacist to determine why the drug is missing.
References


