Clinical Journal Entry #2

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**Introduction**

The situation occurred on the Orthopedics unit, to a patient who had undergone an extensive spinal fusion surgery that required the patient to wear an Aspen Collar neck brace at all times, and a Clamshell back brace when not lying in bed. The patient was told to lie only on her back and never her side, and to not twist to turn under any circumstance. After speaking to the patient and her husband, I found that this was not the first spinal fusion surgery the patient had undergone. The patient had previously undergone the same surgery but the patient said that the fusion did not “take” properly as her bones were too soft from osteoporosis. After speaking with she and her husband throughout the day, however, I discovered that the patient had largely been noncompliant in wearing her brace properly after the first surgery, as her husband mentioned that he would frequently come up behind her to tighten the straps properly. The patient was in the hospital for a correction to the first spinal fusion surgery, and mentioned that the doctor had told her that if this surgery was unsuccessful in correcting the problem, then there was nothing more that he could do for her. Although the patient said that she was going to make sure this surgery had a positive outcome, I found her to continue to be noncompliant in many ways unless her husband was in the room to check on her.

**Problem Statement**

The patient was in a considerable amount of pain, which she frequently stated was only alleviated through the administration of Dilaudid. The patient was on scheduled pain medications as well as scheduled muscle relaxers, and was given PRN orders of Dilaudid, Norco, Robaxin, and Valium. I found it difficult to accurately assess the patient’s pain level due to the fact that no matter if I had recently given a scheduled dose of pain medication, or if she had called me back to her room for breakthrough pain medication, her “patient stated” pain level was always a 10. Always a 10, that is, unless I had given her Dilaudid, in which case her pain level would drop to a 9. No matter how much I repositioned the patient, no matter how many friends and family visited her, and no matter how many different distraction measures I helped her employ, such as deep breathing exercises and finding something enjoyable on television, the patient stated no relief of pain at any time. As much as I wanted to be able to alleviate her pain through additional pain medication, I became increasingly concerned with the patient’s orientation-level, especially after administrating the Dilaudid. After a preliminary physical examination, and after getting to know my patient the first day, I noted that the patient was slow in speech and lethargic though fully oriented to herself and her surroundings. I discussed this fact with my preceptor and we agreed to administer the Norco instead of the Dilaudid until the patient was ready to go to physical therapy. After administering the Dilaudid before therapy, the physical therapists let me know that the patient had become confused during therapy and was unable to identify where she was and what she was doing there. I became concerned, and my preceptor and I decided to hold further Dilaudid administration, and instead only give PRN Norco or Valium. Each time the patient called for more pain medication thereafter, and was given Norco or Valium instead of Dilaudid, the patient became upset and would tell me “this stuff doesn’t work” even though she would take the pills. Not surprisingly, each time I followed up on her pain level, she would tell me there had been no change.

**Gaining knowledge**

Between the time I left the first day and when I came back to the unit on the second day, the doctor had visited the patient. My preceptor had mentioned to the doctor that she was concerned with the patient’s orientation-ability, so after the doctor checked on the patient, he informed my preceptor that he was not concerned with the patient’s orientation as he believed it to be a direct result of the many different muscle relaxers and pain killers she was taking. On day two, the patient had been given a PRN of Norco by the night nurse about 30 minutes before she was to take a scheduled pain killer. My preceptor advised me to hold the scheduled pain medication for about an hour, or until the patient called for more pain medication. Around an hour passed, and I was called into my patient’s room because she was requesting additional pain medication. When I got ready to administer the scheduled PO medication, the patient became very upset and began crying as she asked for Dilaudid. She flat out refused to take the PO medication at that time. After discussing this with my preceptor, she told me to go ahead and administer Dilaudid to the patient. Throughout the day before, I had to remind my patient of things I had said the last time I was in the room, as she seemed to have a very short-term memory. So on the second day, I made sure to tell the patient after I administered the Dilaudid that she could only have it every four hours, and wrote the time on the board that she could have her next dose if she needed it. Even though I frequently had to point to the board throughout the day to remind the patient of when she could next have Dilaudid, I found that the patient was more compliant with taking scheduled pain medications when I reminded her that the time of her next dose of Dilaudid was written on the board. Even though I still struggled with getting my patient to take her scheduled pain medications since she believed them to be ineffective, I found her to be more happy overall on the second day as she believed me to be taking her pain seriously. Clearly, the patient had come to believe that her pain was being taken seriously only if the nurse was willing to administer Dilaudid. This problem was difficult to deal with properly because although the doctor had reassured us that the patient’s orientation-level was not a concern, the patient required frequent reminders of the type of care that had already been performed for her in regards to medication administration, meals delivered, and daily hygienic measures provided. The second day was especially difficult because the patient’s husband was at work the whole day, and wasn’t able to remind and reorient the patient as he had the day before. When the patient had cried the first day because she wasn’t being given Dilaudid, the husband had gently consoled her and reminded her that the nurses and doctors were only there to help her and not to harm her, and that she needed to trust them that withholding Dilaudid at that time was for her own good.

**Responding**

 I have had patients in the past who have seemingly abused Dilaudid in such a way that the nurses working with them have simply rolled their eyes whenever they got called in for the fourth time that day to give their patients IV push Dilaudid. At the same time, I have been taught from day one in this program that pain is a subjective experience. I really struggled in this situation I was in, with a patient who felt that Dilaudid was the only pain medication that helped her even though she was also on many other scheduled medications, because as much as I wanted to help alleviate her pain, I also wanted to keep her from becoming addicted to a medication. I read an article that seemed to speak to this exact problem, as its’ title was “Navigating Clinical Care at the Intersection of Pain and Addiction.” Many of the questions and struggles I was having in the situation with this patient were brought up in this article, and it helped me see that this is a common problem nurses have in providing pain management to their patients. Though many times our motives are pure, as we do not want our patients to become “drug-seekers” and addicted to pain medication, we swing too far the other way and do not even provide relief of pain to our patients. This is a complicated issue, but it was a wakeup call for me to realize how common a problem this is, and how quickly my personal biases can become a barrier to providing adequate pain relieving measures for my patients. I certainly do not want to become jaded and assume that my patients are unable to accurately describe their pain and relief of pain to me, but I also do not want to be unwise in the administration of strong medications that do legitimately contain addictive qualities in them. With time and experience, I hope to become better at figuring out the right paths to take for my patients in figuring out which PRN medications to give, or when to call the doctor because the pain management medications prescribed are insufficient. The other resource I used was simply additional information about Dilaudid and what it is used for, which was useful in that I had forgotten that Dilaudid was a drug not useful for chronic pain management due to its short-term pain relieving qualities. For that reason, it is no wonder why patients find Dilaudid such a “miracle” pain reliever, though patients with chronic pain are prescribed long-acting drugs such as oxycodone to really manage their pain. I have never seen Dilaudid prescribed in any other way than PRN because it is useful only for breakthrough pain.

**Evaluation of Clinical Situation**

By the end of the second day, I had developed a strong enough relationship with my patient that after I had administered Dilaudid and reminded her that she wasn’t able to receive another dose for another four hours, she told me that she trusted me to do what was right for her. I administered Dilaudid almost three hours before I left the unit, and didn’t get a call from her room for additional pain medication during that whole time. Also difficult in this situation was for me to check my personal bias about the situation at the door, as I believed the patient had come to rely on Dilaudid as her only real method of pain control. Though I have no doubt that the patient was in serious pain, I found it difficult to believe that none of the other pain medications she was on had the ability to affect her pain-level in any way, and had an internal struggle with pushing Dilaudid each time because I felt that even though the Dilaudid probably helped, it had possibly become her crutch as well. I had to continually remind myself that pain was a subjective experience, and even though I was happy that the patient’s stated pain-level had decreased from 10s the previous day to 7s on the second day, I was still concerned that the patient had become addicted to Dilaudid in her mind. Honestly, for the sake of the patient not becoming too addicted to Dilaudid, I was relieved that the night nurse who took over my patient’s care stated that he would not be pushing Dilaudid that night unless absolutely necessary, and was fully prepared to give “tough love” to my patient through the administration of her other PRN medications Norco and Valium.

**Self-Reflection**

I really struggled with this patient situation, because as much as I wanted to provide measures that would alleviate my patient’s pain, I also know there is an extremely delicate balance between causing patients to become addicted to pain medication and administering just the right amount of pain medication to achieve a therapeutic outcome. I also knew that I did not want my personal opinions to get in the way of providing pain relief for my patient, and while I may handle things differently in the future, I know that I learned a valuable lesson regarding patient pain management and my own personal biases in situations like the one I was in.

**References**

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