Chapter 2 Critical Thinking Activities

You can review additional information regarding these answers in the corresponding section in which the Critical Thinking activities appear.

Critical Thinking Activity Section 2.2a

Before administering the medications with similar mechanisms of action, the nurse should notify both providers to clarify the orders and advocate for patient safety.

Critical Thinking Activity Section 2.2b

The nurse should provide verbal education regarding when to take medication, side effects to watch for, and potential adverse effects. The patient should also be educated on any restrictions related to diet, over-the-counter medications, and herbal supplements.

Critical Thinking Activity Section 2.3a

The nurse should clarify the medication order with the provider before administration because pneumonia is not listed as an indication for levofloxacin in the Black Box Warning. Notification of the provider and the provider’s response should be recorded in the patient’s medical record.

Critical Thinking Activity Section 2.3b

1. The nurse should educate the patient that medications should never be shared with others. Sharing medications is not only illegal but also dangerous. The nurse should describe the dangers to the patient, including potential drug
interactions, dietary interactions, loss of consciousness, or death if inappropriate drugs or dosages are used.

2. An impaired nurse may endanger the lives of their patients or harm themselves. It is a nurse’s professional and ethical responsibility to report a colleague’s suspected drug use to their nurse manager or supervisor and, in some states or jurisdictions, to the board of nursing.

**Critical Thinking Activities Section 2.3c**

1. The five rights the nurse checks before administering any medication include right patient, right medication, right dose, right route, and right time. Checking allergies and the expiration date of the medication are also included when checking the five rights.

2. Nurses confirm patient identification prior to administering medication by asking the patient their name and date of birth, checking the patient’s identification band, and by scanning bar codes on the medication and patient’s armband. In long-term care settings where patients don’t wear armbands and may not be able to recall their name and date of birth, the nurse may use alternative methods of identification, such as using a patient’s picture in the medication record or asking another staff member to confirm the patient’s identity.

3. Prior to the administration of morphine, an opioid medication, the nurse should assess the patient’s pain level, level of consciousness, respiratory rate, and oxygenation status. If the patient exhibits a decreased respiratory rate, decreased oxygenation level, or an increased sedation, the medication should be withheld and appropriate interventions implemented.

4. After administering an opioid medication, the nurse should evaluate the effectiveness of the medication in treating the pain, as well as continuing to monitor respiratory rate, oxygenation level, and sedation status.

5. The nurse should teach the patient about common side effects, such as constipation and drowsiness.

6. The shift handoff report should include the location of the patient’s pain, the reported pain level, pain medications administered during the shift, the time of medication administration, and the patient’s response to the medication.

**Critical Thinking Activity Section 2.3d**

The colleague can share information about the Professional Assistance Procedure in Wisconsin that provides support to nurses who are committed to their own recovery. It is important to emphasize that the nurse jeopardizes patient safety when practicing under the influence of a substance.

**Critical Thinking Activity Section 2.4**

The nurse should suggest the mother obtain an oral syringe from the pharmacist to ensure accurate measurement of the medication. Errors can occur when families use spoons in their home to administer medication.

**Critical Thinking Activity Section 2.5a**

The nurse can use alternative sources of medication information when the patient cannot recall their home medication and it is not available in the electronic medical health records. A common intervention is to ask the patient to bring all of
their medications to their appointment, including prescribed medications, over-the-counter medications, vitamins, and herbal supplements. Family members, such as a spouse or adult children, can also provide valid information with the patient’s permission. After determining the patient’s current medications, the nurse should print a copy of the list of medications and instruct the patient to bring it with them to all of the healthcare providers and update it as needed.

**Critical Thinking Activity Section 2.5b**

In addition to verifying the 5 rights of medication administration, the nurse should confirm the blood glucose level, insulin type, concentration, and the date the insulin vial was opened. The nurse should draw up the dose and confirm correct dosing with another RN prior to administration. The nurse should be aware of onset, peak, and duration of action and monitor for potential side effects such as hypoglycemia.