Chapter 15, Opioid Analgesics

1. The nurse is assessing a client who is prescribed an opioid analgesic. The nurse will monitor the client for which reaction if the client reveals the chronic use of alcohol?
   A) Respiratory depression
   B) Central nervous system depression
   C) Hypotension
   D) Sedation

   Answer: B

   Rationale: The nurse should monitor the client for central nervous system depression. The nurse does not need to monitor the client for respiratory depression, hypotension, or sedation because these are the effects of the interaction of opioid analgesics with barbiturates, not effects of alcohol.
   Question Format: Multiple Choice
   Chapter: 15
   Learning Objective: 5
   Cognitive Level: Apply
   Client Needs: Physiological Integrity: Pharmacological Therapies
   Integrated Process: Clinical Problem-solving Process (Nursing Process)
   Reference: p. 193, Interactions

2. A nurse is assessing a client who is to receive an opioid analgesic. The nurse would contact the primary health care provider immediately if which events occur? Select all that apply.
   A) Respiratory rate of less than 10 breaths/min
   B) Decrease in pulse
   C) Increase in pulse
   D) Increase in blood pressure
   E) Blood pressure of 90/65 mm Hg

   Answer: A, B, C, E

   Rationale: The nurse should contact the primary health care provider immediately if any of the following occur while a client is receiving an opioid analgesic: significant decrease in respiratory rate or a respiratory rate less than 10 breaths/min; significant increase or decrease in the pulse rate or a change in the pulse quality; or significant decrease in blood pressure or a systolic blood pressure below 100 mm Hg.
   Question Format: Multiple Select
   Chapter: 15

Learning Objective: 3
Cognitive Level: Apply
Client Needs: Physiological Integrity: Reduction of Risk Potential
Integrated Process: Clinical Problem-solving Process (Nursing Process)
Reference: p. 199, Monitoring and Managing Client Needs

3. A client is receiving an opioid analgesic. Assessment reveals that the respiratory rate has dropped. Which steps would the nurse expect to implement? Select all that apply.
   A) Oxygen administration
   B) Coaching of the client to breathe
   C) Discontinuation of the opioid analgesic
   D) Naloxone administration
   E) Albuterol administration

Answer: B, D

Rationale: Coaching the client to breathe and administering naloxone (in severe cases) are appropriate measures used to treat a drop-in respiratory rate in a client receiving an opioid analgesic. Oxygen would have little effect if the client's rate has dropped. The opioid would not be discontinued. Albuterol would be used if the client were experiencing bronchospasms.
Question Format: Multiple Select
Chapter: 15
Learning Objective: 5
Cognitive Level: Apply
Client Needs: Physiological Integrity: Reduction of Risk Potential
Integrated Process: Clinical Problem-solving Process (Nursing Process)
Reference: p. 196, Fears of Respiratory Depression

4. A client with severe chronic pain is to receive an opioid analgesic agent. The nurse will monitor the client for signs of tolerance which can develop at different rates related to which factors? Select all that apply.
   A) Body weight
   B) Gender
   C) Dosage
   D) Route of administration
   E) Age

Answer: C, D

Rationale: The rate at which tolerance to an opioid analgesic develops varies according to dosage, the route of administration, and the individual.
Question Format: Multiple Select
Chapter: 15

Learning Objective: 3
Cognitive Level: Understand
Client Needs: Physiological Integrity: Pharmacological Therapies
Integrated Process: Clinical Problem-solving Process (Nursing Process)
Reference: p. 198, Tolerance Versus Dependence

5. A nurse is preparing to administer pain medications to various clients. The nurse anticipates administering an opioid analgesic to clients with which assessment finding? Select all that apply.
   A) Severe acute pain
   B) Mild acute pain
   C) Moderate chronic pain
   D) Mild chronic pain
   E) Opiate dependence

   Answer: A, C, E

   Rationale: Opioid analgesics are used primarily for the treatment of moderate to severe acute pain and chronic pain and in the treatment and management of opiate dependence.
   Question Format: Multiple Select
   Chapter: 15
   Learning Objective: 2
   Cognitive Level: Apply
   Client Needs: Physiological Integrity: Pharmacological Therapies
   Integrated Process: Clinical Problem-solving Process (Nursing Process)
   Reference: p. 190, Opioid Analgesics

6. A client is receiving an opioid analgesic following abdominal surgery. On assessment the nurse notes the client has been in a chair, ambulating with assistance, fluids and food intake is good with active bowel sounds with minimal bowel movement. Which nursing diagnosis would be most appropriate?
   A) Malnutrition: Less Than Body Requirements
   B) Constipation
   C) Injury Risk
   D) Deficient Knowledge

   Answer: B

Rationale: The client is most likely experiencing Constipation from the opioid therapy as well as from the lack of ambulation and activity. The client is eating, so Malnutrition is not necessarily a problem. The client is at Injury Risk if they are experiencing adverse reactions related to the opioid therapy, but this is not apparent. Although the client may have Deficient Knowledge about the drug, this, too, is not seen in this case.
Question Format: Multiple Choice
Chapter: 15
Learning Objective: 4
Cognitive Level: Analyze
Client Needs: Physiological Integrity: Physiological Adaptation
Integrated Process: Clinical Problem-solving Process (Nursing Process)
Reference: p. 199, Constipation

7. A client is prescribed a transdermal opioid. After teaching the client and family members how to administer this drug, the nurse determines that the teaching was successful when they make which statement?
   A) "The drug should be reapplied every 24 hours."
   B) "We should try to apply the patch to about the same site each time."
   C) "The site should only be cleaned with water before each application."
   D) "A hairy area, like the forearm, is an appropriate place to apply the patch."

   Answer: C

   Rationale: Only water is used to clean the site because soap and other substances may irritate the skin. The patch is applied for 72 hours and sites should be rotated. Any site that is used should be free of hair.
   Question Format: Multiple Choice
   Chapter; 15
   Learning Objective: 5
   Cognitive Level: Analyze
   Client Needs: Physiological Integrity: Pharmacological Therapies
   Integrated Process: Teaching/Learning
   Reference: p. 198, Using Transdermal System Pain Management

8. A client with an opioid addiction is to begin methadone. Which factor will the nurse include in the teaching to the client?
   A) Dosages vary according to length of the client's addiction.
   B) Methadone is discontinued on an outpatient basis.
   C) Dosages vary according to the client's weight.
   D) Male clients are prescribed higher doses than female clients.

   Answer: A

Rationale: The nurse must keep in mind that dosages vary with clients, the length of addiction, and the average amount of drug used each day. Dosages do not vary according to clients' weights. Methadone is not discontinued on an outpatient basis. Clients enrolled in an outpatient methadone program for detoxification or maintenance therapy on methadone must continue to receive methadone when hospitalized. Male clients are not prescribed higher doses than females.
Question Format: Multiple Choice
Chapter: 15
Learning Objective: 02
Cognitive Level: Apply
Client Needs: Physiological Integrity: Pharmacological Therapies
Integrated Process: Clinical Problem-solving Process (Nursing Process)
Reference: p. 200, Management of Opioid Dependence

9. A nurse is teaching a client about the use of a PCA infusion pump. The nurse determines the teaching is successful when the client correctly indicates which factor about the system?
   A) Pain relief should occur 1 hour after pushing the control button.
   B) The control button and the button to call the nurse are the same.
   C) The control button activates administration of the drug.
   D) The machine delivers the drug every time the control button is used.

Answer: C

Rationale: The nurse should inform the client that the control button activates administration of the drug. Pain relief occurs shortly after, and not an hour after, pushing the button. The nurse should educate the client on the difference between the control button and the button to call the nurse, especially when they are similar in appearance and feel. The machine does not deliver the drug every time the control button is used; the machine regulates the dose of the drug as well as the time interval between doses. If the control button is used too soon after the last dose, the machine will not deliver the drug until the correct time.
Question Format: Multiple Choice
Chapter: 15
Learning Objective: 5
Cognitive Level: Understand
Client Needs: Physiological Integrity: Pharmacological Therapies
Integrated Process: Teaching/Learning
Reference: p. 197, Relieving Acute Pain

10. A client with chronic pain has been prescribed an epidural analgesia. Which possible reaction should the nurse prioritize for treatment?
   A) Abdominal pain
   B) Respiratory depression
   C) Fever
   D) Nervousness

Answer: B

Rationale: The most serious adverse reaction associated with the epidurally administered opioids is respiratory depression. The nurse should closely monitor the client for respiratory depression after insertion of the epidural catheter and throughout the therapy. Clients using epidural analgesics for chronic pain are monitored for respiratory problems with an apnea monitor. The client may also experience sedation, confusion, nausea, pruritus, or urinary retention. The nurse does not need to monitor the client for abdominal pain, fever, and nervousness because these reactions do not occur as a result of the administration of epidural analgesia.
Question Format: Multiple Choice
Chapter: 15
Learning Objective: 5
Cognitive Level: Apply
Client Needs: Physiological Integrity: Pharmacological Therapies
Integrated Process: Clinical Problem-solving Process (Nursing Process)
Reference: p. 199, Using Epidural Pain Management

11. A nurse has administered an opioid to a client. Which activities should the nurse encourage the client to do?
    A) Cough and breathe every 2 hours.
    B) Restrict consumption of liquids.
    C) Maintain complete bed rest.
    D) Get up and walk once every hour.

Answer: A

Rationale: The nurse should encourage the client to cough and breathe deeply every 2 hours if the client shows a decrease in respirations after the administration of opioid analgesics. The nurse does not need to instruct the client to restrict consumption of liquids to help cope with the effects of an ineffective breathing pattern. The nurse should perform tasks such as getting the client out of bed and encouraging therapeutic activities such as leg exercises (when ordered); therefore, the nurse should not instruct the client to avoid any kind of exercise or to take complete bed rest.
Question Format: Multiple Choice
Chapter: 15
Learning Objective: 5
Cognitive Level: Apply
Client Needs: Physiological Integrity: Reduction of Risk Potential
Integrated Process: Clinical Problem-solving Process (Nursing Process)
Reference: p. 199, Altered Breathing Pattern

12. A nurse is performing a preadministration assessment of a client who is to receive an opioid analgesic. Which activity should the nurse prioritize?
    A) Document description of pain and an estimate of when the pain began.
    B) Obtain client's blood pressure and pulse within 5 to 10 minutes.
    C) Monitor the client for symptoms of respiratory depression.
    D) Record each bowel movement and its appearance, color, and consistency.

    Answer: A

    Rationale: The nurse should document the description of pain and an estimate of when the pain began as part of the preadministration assessment. Obtaining blood pressure and pulse within 5 to 10 minutes, monitoring the client for symptoms of respiratory depression, and recording bowel movements are part of the ongoing assessments conducted by the nurse when caring for the client. The nurse obtains the blood pressure, pulse and respiratory rate, and pain rating in 5 to 10 minutes if the drug is given intravenously (IV). Respiratory depression occurs in clients who do not use opioids routinely and are being given an opioid drug for acute pain relief or surgical procedures. When an opiate is used as an antidiarrheal drug, the nurse records each bowel movement, as well as its appearance, color, and consistency.

    Question Format: Multiple Choice
    Chapter: 15
    Learning Objective: 1, 3
    Cognitive Level: Apply
    Client Needs: Physiological Integrity: Reduction of Risk Potential
    Integrated Process: Clinical Problem-solving Process (Nursing Process)
    Reference: p. 195, Preadministration Assessment

13. The nurse is caring for a client who is receiving an opioid. Which actions by the nurse will help decrease the risk of injury to this client? Select all that apply.
    A) Keep the lights in the client's room turned down.
    B) Assist the client from the bed to the toilet.
    C) Assist the client with rising from a lying position.
    D) Assist the client with hall-walking activities.
    E) Advise the client to stay in bed all night.

    Answer: B, C, D

    Rationale: To decrease the risk of injury to a client taking an opioid, the nurse should assist the client with ambulatory activities and with rising from a sitting or lying position. The nurse should also keep the client's room well lit during daytime hours, keep the client's room free of clutter, and advise the client to seek assistance when getting out of bed at night.
    Question Format: Multiple Select
    Chapter: 15

Learning Objective: 5
Cognitive Level: Apply
Client Needs: Physiological Integrity: Reduction of Risk Potential
Integrated Process: Clinical Problem-solving Process (Nursing Process)
Reference: p. 199, Injury Risk

14. A nurse is caring for the newborn of a suspected opioid-dependent mother. Which assessment findings would the nurse prioritize in the newborn? Select all that apply.
    A) Jaundice
    B) Increased respiratory rate
    C) Decreased respiratory rate
    D) Sneezing
    E) Fever

    Answer: B, D, E

    Rationale: Opiate withdrawal symptoms in a newborn usually appear during the first few days of life and include irritability, excessive crying, yawning, sneezing, increased respiratory rate, tremors, fever, vomiting, and diarrhea.
    Question Format: Multiple Select
    Chapter: 15
    Learning Objective: 5
    Cognitive Level: Apply
    Client Needs: Physiological Integrity: Physiological Adaptation
    Integrated Process: Clinical Problem-solving Process (Nursing Process)
    Reference: p. 200, Opioid Physical Dependence in Acute Pain Management
15. The nurse is assessing a client who recently received oxycodone and notes respiratory rate 10 breaths per minute, SaO_2 90%, shallow breaths, and lethargy. The nurse anticipates the client will be administered which medication?
    A) Naloxone
    B) Nalbuphine
    C) Naltrexone
    D) Naproxen

    Answer: A

    Rationale: Naloxone is an opioid antagonist specifically developed to reverse respiratory depression associated with opioids. Naltrexone may also be used, but its primary use is in the treatment of alcohol dependence. Nalbuphine is an agonist-antagonist used for severe chronic pain. Naproxen is an NSAID.
    Question Format: Multiple Choice
    Chapter: 15
    Learning Objective: 5
    Cognitive Level: Apply
    Client Needs: Physiological Integrity: Pharmacological Therapies

Integrated Process: Clinical Problem-solving Process (Nursing Process)
Reference: p. 194, Opiate Antagonists

16. A nurse is caring for a client who is receiving naloxone intravenously. The client develops acute pain while the drug is being administered. Which factor should the nurse investigate first?
    A) The drug was administered as too rapid a dose.
    B) The client's pain wasn't controlled before the administration of naloxone.
    C) The change in respiratory status has caused the increase in pain.
    D) The dosage of the naloxone was too small.

    Answer: A

    Rationale: When naloxone is given IV and the bolus is given too rapidly, withdrawal symptoms and the return of intense pain occur as the level of opioid is reduced. There is no indication that the client's pain hadn't been controlled previously. A change in the respiratory status does not lead to increased pain. If the dose was too small, the client would still be experiencing some of the effects of the opioid that is being reversed.
    Question Format: Multiple Choice
    Chapter: 15
    Learning Objective: 5
    Cognitive Level: Analyze
    Client Needs: Physiological Integrity: Pharmacological Therapies
    Integrated Process: Clinical Problem-solving Process (Nursing Process)
    Reference: p. 200, Acute Pain

17. A client with respiratory depression is administered an opioid antagonist by the nurse. What ongoing assessment should the nurse perform when prioritize?
    A) Monitor vital signs every 5 to 15 minutes.
    B) Review allergy history and other treatment modalities.
    C) Teach different breathing patterns to the client.
    D) Monitor the blood pH level of the client.

    Answer: A

    Rationale: The ongoing assessment performed by the nurse when administering an opioid antagonist to the client involves monitoring the vital signs of the client every 5 to 15 minutes. Monitoring the blood pH level of the client is not part of the ongoing assessment. Reviewing the allergy history and other treatment modalities and teaching different breathing patterns to the client are preadministration assessments that are performed before the administration of the drug; they are not ongoing assessments.
    Question Format: Multiple Choice
    Chapter: 15

Learning Objective: 5
Cognitive Level: Apply
Client Needs: Physiological Integrity: Reduction of Risk Potential
Integrated Process: Clinical Problem-solving Process (Nursing Process)
Reference: p. 196, Fears of Respiratory Depression

18. An opioid-naïve client experiences acute pain after surgery and is prescribed opioid therapy. The nurse would be especially alert for the development of which reactions?
    A) Pruritus
    B) Severe headache
    C) Respiratory depression
    D) Urticaria

    Answer: C

    Rationale: The nurse should monitor for symptoms of respiratory depression developing in the client as one of the severe adverse reactions of opioid treatment. Pruritus, urticaria, and headache are caused by opioids, but these conditions are not the most severe and common adverse reactions observed in opioid-naïve clients. Therefore, the nurse need not monitor for pruritus, severe headache, or severe urticaria in an opioid-naïve client undergoing opioid therapy.
    Question Format: Multiple Choice
    Chapter: 15
    Learning Objective: 3
    Cognitive Level: Apply
    Client Needs: Physiological Integrity: Reduction of Risk Potential
    Integrated Process: Clinical Problem-solving Process (Nursing Process)
    Reference: p. 195, Preadministration Assessment

19. A newly admitted client with chronic back pain is to receive naloxone secondary to an inadvertent overdose of tramadol with accompanying respiratory depression. Which action should the nurse perform when administering naloxone?
    A) Monitor the client's blood pressure every 20 minutes.
    B) Administer the medication by slow IV push.
    C) Assess pain during administration.
    D) Monitor the client’s temperature.

    Answer: B

Rationale: When naloxone is used to reverse respiratory depression and the resulting somnolence, the drug is given by slow IV push until the respiratory rate begins to increase and somnolence abates. Monitoring the client's blood pressure every 5 minutes until the client responds, monitoring vital signs every 5 to 15 minutes if the client is responsive, and monitoring the client's respiratory rate and rhythm (not temperature) are all interventions involved in the ongoing assessment of the client that the nurse performs while the client is undergoing the drug therapy. Pain levels should be monitored, but it is not necessary to do so during administration.
Question Format: Multiple Choice
Chapter: 15
Learning Objective: 5
Cognitive Level: Apply
Client Needs: Physiological Integrity: Reduction of Risk Potential
Integrated Process: Clinical Problem-solving Process (Nursing Process)
Reference: p. 200, Impaired Self-Ventilation

20. The nurse is monitoring the effects of naloxone after administering the drug to a client with respiratory depression due to an opioid overdose. The nurse may administer the drug how often, until symptoms resolve?
    A) Continuously, at no more than 0.2 mg/minute
    B) Every 2-3 minutes
    C) Every 5 minutes
    D) Every 10-12 minutes

    Answer: B

    Rationale: For a suspected opioid overdose, the client may receive 0.4-2.0 mg IV at 2- to 3-minute intervals
    Question Format: Multiple Choice
    Chapter: 15
    Learning Objective: 5
    Cognitive Level: Apply
    Client Needs: Physiological Integrity: Pharmacological Therapies
    Integrated Process: Clinical Problem-solving Process (Nursing Process)

    Reference: p. 204, Summary Drug Table

21. The nurse is assessing the medical history of a client before administering an opioid for pain. The nurse would question the order if which disorder was listed in the client's record? Select all that apply.
    A) Acute bronchial asthma
    B) Acute myocardial infarction
    C) Head injury
    D) Grand mal seizures

E) Mild renal impairment

Answer: A, C, D

Rationale: The use of opioids is contraindicated in clients with acute bronchial asthma, emphysema, upper airway obstruction, head injury, increased intracranial pressure, convulsive disorders, severe renal or hepatic dysfunction, and acute ulcerative colitis.
Question Format: Multiple Select
Chapter: 15
Learning Objective: 5
Cognitive Level: Apply
Client Needs: Physiological Integrity: Pharmacological Therapies
Integrated Process: Clinical Problem-solving Process (Nursing Process)
Reference: p. 192, Contraindications

22. The nurse is preparing to administer an opioid analgesic to a client reporting pain. The nurse will collect what information from the client first? Select all that apply.
A) Pain assessment
B) Respiratory rate
C) Heart rate
D) Past medication history
E) Current medication therapy

Answer: A, B, C, D, E

Rationale: Prior to the administration of an opioid analgesic, the nurse should perform a comprehensive assessment, considering the client's vital signs, pain assessment, and medications (recent and current).
Question Format: Multiple Select
Chapter: 15
Learning Objective: 3
Cognitive Level: Apply
Client Needs: Physiological Integrity: Pharmacological Therapies
Integrated Process: Clinical Problem-solving Process (Nursing Process)
Reference: p. 195, Preadministration Assessment

23. The nurse has administered oxymorphone and promethazine to a client. Which assessment will the nurse prioritize? Select all that apply.
A) Temperature
B) Blood pressure
C) Pulse
D) Respiratory rate
E) Blood glucose

Answer: B, C, D

Rationale: The nurse should take care to closely monitor a client's blood pressure, pulse, and respiratory rate when an opioid is administered with promethazine.
Question Format: Multiple Select
Chapter: 15
Learning Objective: 3
Cognitive Level: Apply
Client Needs: Physiological Integrity: Reduction of Risk Potential
Integrated Process: Clinical Problem-solving Process (Nursing Process)
Reference: p. 195, Preadministration Assessment

24. After teaching a group of nursing students about opioids, the instructor determines that additional teaching is needed when the students choose which drug as a natural opioid?
A) Meperidine
B) Morphine
C) Codeine
D) Opium

Answer: A

Rationale: Meperidine is a synthetic opioid. Natural opioids include morphine sulfate, codeine, opium alkaloids, and tincture of opium.
Question Format: Multiple Choice
Chapter: 15
Learning Objective: 2
Cognitive Level: Understand
Client Needs: Physiological Integrity: Pharmacological Therapies
Integrated Process: Clinical Problem-solving Process (Nursing Process)
Reference: p. 190, Opioid Analgesics

25. A client with a terminal illness is prescribed an opioid for pain management. The nurse should carefully monitor the client for development of which adverse reaction?
A) Emphysema
B) Alopecia
C) Dehydration
D) Severe anorexia

Answer: D

Rationale: The nurse should monitor the client for severe anorexia, which is one of the adverse reactions of opioid analgesics on the GI system. Other adverse effects on the GI system include constipation, nausea, and acute abdominal pain. The nurse does not need to monitor the client for emphysema, alopecia, or severe headache. Opioid analgesics do not cause emphysema, but their administration is contraindicated in clients who have this condition. Administration of opioid analgesics is not known to cause alopecia or dehydration in clients.
Question Format: Multiple Choice
Chapter: 15

Learning Objective: 3
Cognitive Level: Apply
Client Needs: Physiological Integrity: Reduction of Risk Potential
Integrated Process: Clinical Problem-solving Process (Nursing Process)
Reference: p. 199, Malnutrition