The American Pain Society (APS) defines pain as an unpleasant sensory and emotional experience associated with actual or potential tissue damage. Pain is one of the most common reasons that individuals seek medical attention and it may be acute or chronic. Because of its potentially debilitating impact on a person's livelihood and quality of life, pain assessment and treatment are complex. Pain is both physical and emotional. Nurses must recognize that a person's pain response is often a result of his/her culture and past experiences with pain and pain management. Pain is subjective, and the nurse needs to treat the individual based on his or her perceived pain response.

Next Gen Clinical Judgment:
> How does discomfort impact a person's health and well-being?
> Besides pain, what are other ways a person is uncomfortable?
> How can a nurse determine discomfort in a person who is not verbal?
Go To Clinical Case

While caring for this client, be sure to review the concept maps in chapters 3 and 4.

Case 1: Impaired Tissue Integrity and Pain

Related Concepts: Circulation, Protection, Emotion, Nutrition
Threaded Topics: Skin Integrity, Wound Care, Infection, Pain
Management, Safety

Mattie Smith is an 88-year-old who has lived alone in Florida since the death of her husband three years ago. They were married for 60 years. Mattie has had failing health over the past months, and her son John, who lives out of state, has been concerned about her and asked that she moves out of her home and come to live with him in Tennessee. Mattie and her son have never been close, and she refused his offer. He is visiting her for the holidays and finds her home untidy, with dirty dishes and clothes strewn everywhere. She looks disheveled, lacks proper hygiene, and says there is a lot of pain near her “buttock” area. He recalls that his mother always kept a clean house and had a lot of pride when it came to her appearance. He coaxes her to let him take her to the emergency department, but she refuses.

1. What information in the case cues John that something is not quite right with his mother?

John is on the second day of his 4-day visit and notices that his mother rarely moves from one location on the couch where she sits to watch television. Occasionally she will briefly get up to go to the bathroom, get something to eat, or go to bed at night. When she walks, he notices a limp. He questions her about the limp, but Mattie minimizes it, saying “I’m just a little uncomfortable from a sore spot on my right heel.” She refuses to let him see her heel. John also observes that her meals consist of cakes, pies, coffee, and soda. He is concerned about Mattie and brings up going to the hospital again. This time, she reluctantly agrees.
NURSING NOTE

June 6 1200
Older adult female brought to the emergency department (ED) accompanied by her son. The client is unkempt, frail, and emaciated. There is a strong smell of urine—pressure ulcer on the sacrum and both heels.

2. Along with the pressure ulcers, what information is vital for the emergency department nurse to convey to the floor nurse in the report? Select all that apply.
   1. Mattie's smell of urine.
   3. Loss of her spouse.
   4. Mattie's behavior at home.
   5. Mattie's refusal to live with her son.

Mattie is admitted to the medical unit. The floor nurse determines that Mattie is not incontinent but that she has not had a proper bath in a while. The unlicensed assistive personnel (UAP) bathes Mattie and settles her in bed. The nurse transcribes the admission prescriptions in the electronic record.

ADMISSION PRESCRIPTIONS

June 6 1530

1. Admit to the medical unit.
2. Activity: with assistance as tolerated.
5. Consult physical therapy.
6. Consult psychiatrist.
7. Consult dietitian.
8. Normal saline at 100 mL/hour.
9. Morning labs: Complete blood cell count (CBC), total protein, electrolytes.
10. Continue home medication: metoprolol 100 mg by mouth daily.
11. Acetaminophen 500 mg PO every 4 hours as needed, and 30 minutes before dressing changes, not to exceed 3,000 mg in 24 hours.
3. How should the nurse respond when the client's son asks, "Why does the doctor want a psychiatrist to come see my mom?"


4. The nurse reviews the results of the morning blood work in Mattie's chart. Highlight the lab result that is the highest priority.

<table>
<thead>
<tr>
<th>Lab</th>
<th>Normal</th>
<th>June 6</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potassium</td>
<td>3.5 - 5.0 mEq/L</td>
<td>3.3 mEq/L</td>
<td></td>
</tr>
<tr>
<td>Sodium</td>
<td>136 - 145 mEq/L</td>
<td>140 mEq/L</td>
<td></td>
</tr>
<tr>
<td>Glucose</td>
<td>70 - 100 mg/dL</td>
<td>90 mg/dL</td>
<td></td>
</tr>
<tr>
<td>Total protein</td>
<td>6 - 7.8 g/dL</td>
<td>4.8 g/dL</td>
<td></td>
</tr>
<tr>
<td>WBC</td>
<td>4,000 - 10,000 µL</td>
<td>6,000 µL</td>
<td></td>
</tr>
<tr>
<td>RBC</td>
<td>4.2 - 5.9 cells/L</td>
<td>4.0 cells/L</td>
<td></td>
</tr>
<tr>
<td>Hemoglobin</td>
<td>12 - 17 g/dL</td>
<td>14 g/dL</td>
<td></td>
</tr>
<tr>
<td>Hematocrit</td>
<td>36 - 51%</td>
<td>40%</td>
<td></td>
</tr>
</tbody>
</table>
WOUND CARE PRESCRIPTIONS

June 7
1000

Sacrum - Clean wound to sacrum with normal saline. Dry around the wound with 4X4 gauze pads. Pack the wound loosely with saline impregnated 4X4 gauze dressing until the wound space is filled. Cover with an absorbent dressing and change daily, and as needed.

Right heel - Clean wound to right heel with normal saline. Dry around the wound with 4X4 gauze pads. Apply a transparent adhesive to the heel. Change dressing every 3 days or as needed.

Left heel - Clean wound to left heel with normal saline. Dry around the wound with 4X4 gauze pads. Apply a foam dressing to the heel. Change dressing every 3 days or as needed.

1. Keep off sacrum. Turn and reposition every 2 hours from side to side.
2. Position head of bed low to reduce shearing force.
3. Place heel protectors on and float heels.
4. Place a pressure relief mattress on client's bed.

5. The WOCN examines Mattie's wounds and writes the prescriptions shown in the chart. Which factors are used to explain the differences in wound care prescriptions? Select all that apply.
   1. Wound size.
   2. Wound depth.
   3. Wound smell.
   4. Wound severity.
   5. Wound location.

6. What action must the nurse take to prevent possible cross-contamination of the wounds when performing dressing changes?
   1. The nurse ensures glove changes between all three sites.
   2. The nurse utilizes sterile supplies for dressing changes.
   3. The nurse does not cross the sterile field once set up.
   4. The nurse 'lips' the bottle before pouring.

Mattie moans in pain when the nurse performs the dressing changes, especially the dressing to her sacrum. She rates her pain at 5/10 despite pre-medication.

7. The nurse prepares an SBAR hand-off report for the accepting hospital. Complete each section of the communication form.

   S -
   B -
   A -
   R -

   Clinical Hint:
   S - Situation
   B - Background
   A - Assessment
   R - Recommendation
8. The nurse enters Mattie’s room to re-assess her pain and finds her in bed as shown in the image. What is most concerning to the nurse?
   1. Her appearance of boredom.
   2. That she is on her back.
   3. That she is propped up on two pillows.
   4. That her side rails are down.

9. The dietitian completes the consultation and determines that Mattie needs a high protein diet with adequate hydration. Which foods should the nurse recommend?
   1. Pasta, vegetables, and eggs.
   2. Meats, eggs, and cheese.
   3. Tofu, rice, and fruits.
   4. Breads, cereals, and vegetables.

Mattie loves sweet foods and asks her son to bring her cakes and other fresh pastries. She does not like to drink water, favoring coffee and diet sodas instead.

10. The nurse receives a hand-off report on her assigned patients and is starting to make rounds when she observes that Mattie’s son has brought her the breakfast, shown in the image. What teaching points need to be reinforced?
    1. She should not consume that much sugar in one meal.
    2. No caffeine is allowed on her diet.
    3. These items don’t have protein needed for healing.
    4. She should not have anything to eat or drink until later.

Physical therapy is working with Mattie, and though she is resistant to work with them, she is starting to be more cooperative. The psychiatrist has also completed the consultation and concluded that Mattie is suffering from depression, triggered by the loss of her husband and living alone.

11. The psychiatrist prescribes sertraline 200 mg taken orally once daily. The nurse reviews the drug guide before delivering the medication and decides to call the psychiatrist before administering the drug to Mattie. Highlight the cues within the drug guide that caused the nurse to question this prescription.

<table>
<thead>
<tr>
<th>Sertraline</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Class:</strong> antidepressant</td>
</tr>
<tr>
<td><strong>Action:</strong> Inhibits serotonin reuptake in CNS.</td>
</tr>
<tr>
<td><strong>Uses:</strong> Major depressive disorder, obsessive-compulsive disorder, posttraumatic stress disorder, panic disorder, social anxiety disorder, premenstrual dysphoric disorder.</td>
</tr>
<tr>
<td><strong>Contraindications:</strong> Hypersensitivity to this product or SSRIs.</td>
</tr>
<tr>
<td><strong>Precautions:</strong> Pregnancy, breastfeeding, geriatric patients, renal/hepatic disease, epilepsy, recent MI, latex sensitivity.</td>
</tr>
<tr>
<td><strong>Interactions:</strong> Altered lithium levels, MAOIs, SSRIs.</td>
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<tr>
<td><strong>Dosage:</strong> Adult/geriatric PO 25-50 mg/day; may increase to a max of 200 mg/day; do not change dose at intervals of &lt; 1 week; administer daily in morning or night.</td>
</tr>
<tr>
<td><strong>Side effects:</strong> seizures, neuroleptic malignant syndrome-like reaction, serotonin syndrome, suicidal ideations, hepatitis, diarrhea, nausea, SIADH, palpitations.</td>
</tr>
<tr>
<td><strong>Black Box Warning:</strong> Mental status, mood. Sensorium, suicidal tendencies, depression, panic attacks.</td>
</tr>
</tbody>
</table>
12. Mattie’s wounds are healing very slowly. On day 10 of admission, she reports more pain to her sacrum and is refusing to get out of bed. When the nurse performs the dressing change, the nurse observes this. The wound has thick, purulent drainage and is malodorous. It is 10 cm x 5 cm in size. How should the nurse proceed?
1. Document the findings.
2. Dress as per WOCN prescriptions.
3. Contact the WOCN to re-evaluate the prescription.
4. Culture the wound.

13. Based on what is known about Mattie’s case and her course of hospitalization, place an X in the table to indicate assessment factors that contributed directly, indirectly, or did not contribute to Mattie’s poor wound healing.

<table>
<thead>
<tr>
<th>Factors</th>
<th>Contributed directly</th>
<th>Contributed indirectly</th>
<th>Did not contribute</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laying on her back</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating pies and cakes</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Resistant to mobility</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Keeping an untidy house</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor hydration</td>
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<td></td>
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</tbody>
</table>

14. **NurseThink® Prioritization Power!**
Based on Mattie’s wound what are the **Top 3 Priority** concerns?

1. 

2. 

3. 

The WOCN determines that Mattie’s sacral wound must be debrided since it is infected. The wound is debrided the next day, and new wound care prescriptions are received. Mattie is started on an intravenous antibiotic every 8 hours.
15. How will the nurse know that the antibiotic is effective? Select all that apply.
   1. The client no longer reports pain with dressing changes.
   2. The yellow and black slough is no longer present in the wound bed.
   3. The wound drainage changes from thick yellow to serous.
   4. The wound size decreases from 10 cm to 8 cm.
   5. The wound is no longer malodorous.

16. The night nurse is rounding on Mattie when her son complains about the nurse from the day shift, stating, "Mom is still hurting from today, that nurse is no good!" Review the documentation in Mattie's chart, written by the day shift nurse. What error in care may have contributed to Mattie's discomfort?

   **NURSING NOTE**

   June 11 1030
   Morning care provided. Sitting up in bed and eating breakfast. Refused to get out of bed and work with the physical therapist (PT). States, "My backside hurts. I'd rather not get up today." States pain is 6/10. Acetaminophen 500 mg given.

   1215
   Offered client assistance to get up to the chair for lunch. Client refused stating, "I'll get up for dinner later." Ate 30% of lunch. Son brought the client a large slice of cake; the client ate 100% of the cake. Reminded client and son of the need for the client to eat more nutritious and high protein foods to help with wound healing.

   1400
   The physical therapist tried to work with the client again. The client worked with PT for 15 minutes and asked to be assisted back to bed. Resting quietly in bed. Son at the bedside.

   1745
   Dressing change performed to stage IV wound on sacrum as prescribed. The wound has a copious amount of yellow, malodorous drainage. Wound bed pink with a small area of yellow slough to the center of the injury. Dressings changed to stage two wounds on bilateral heels. Both heels with scant serous drainage. New foam and a transparent dressing applied. Client states that there is a pain to sacrum during the dressing change, but she is resting comfortably in bed now. Son at the bedside.

   1. Spent too long up in the chair.
   2. Physical therapy sessions too aggressive.
   3. Wound care performed too aggressively.
   4. Failed to pre-medicate before wound care.

Mattie's wounds are showing signs of healing. Culture from the wound indicates that the infection is gone, and Mattie no longer needs antibiotics. The antidepressant is starting to be effective, and Mattie is in a more cooperative mood. She has been working with physical therapy and getting stronger. The health care provider tells Mattie and her son that she should not live at home alone again. John decides to move Mattie to Tennessee to live with him, his wife, and children. Though Mattie is saddened to leave her home, she agrees. John has many questions about Mattie's care.
17. Prioritize the discharge teaching by placing an X in the appropriate column and offer the rationale for your decision.

<table>
<thead>
<tr>
<th>Priority</th>
<th>Not a priority</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home health nurse to do Mattie's dressing changes.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mattie should not share a room with any family members.</td>
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<tr>
<td>Do not allow Mattie to take anymore acetaminophen to prevent her from being addicted.</td>
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<tr>
<td>Remove loose rugs from the home.</td>
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<tr>
<td>Place grab bars in Mattie's shower.</td>
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<tr>
<td>Shop for high protein foods.</td>
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<td></td>
</tr>
<tr>
<td>Transport Mattie back to see her home in Florida periodically.</td>
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<td></td>
</tr>
<tr>
<td>Monitor Mattie's antidepressant administration.</td>
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</tbody>
</table>

Mattie has been living with her son for the past two months, and things are not going well. Mattie is back to her old ways of eating poorly. She gets her granddaughter to buy her sweet treats and only picks at the high protein foods that John’s family cooks. The wounds to her heels have healed, but the home health nurse notes that the wound on Mattie’s sacrum has a quarter size black area in the center and Mattie still reports pain when the dressing change is done. Mattie is disagreeable and argumentative with John and his wife. She sits on the couch and refuses to get up and walk around, even though John got her a walker to assist her with staying safe when she walks. She says, “I’m not using it.” John has decided to place Mattie in a nursing home. Mattie is furious.

18. THIN Thinking Time!
The home health nurse ponders the information above about Mattie and applies the concept of THIN Thinking.

T -
H -
I -
N -

Scan to access the 10-Minute-Mentor on THIN Thinking.
NurseThink.com/THINThinking
19. The charge nurse at the nursing home is determining the best room placement for Mattie. Place an X in the room that is most appropriate for Mattie.

**Room 324**
- Bed A: 80-year-old female with dementia who wanders.
- Bed B: Open

**Room 325**
- Bed A: Open
- Bed B: 75-year-old female who is confused, bedbound and has multiple pressure ulcers.
- Bed C: 82-year-old female who is confused and yells all the time.

**Room 326**
- Bed A: 40-year-old female who was in a motor vehicle accident and is receiving short-term, skilled care.
- Bed B: Open

**Room 327**
- Bed A: 90-year-old male who is bedbound, has a tracheostomy and requires frequent suctioning.
- Bed B: Open

**Room 328**
- Bed A: 50-year-old female who has paraplegia.
- Bed C: 48-year-old female who is bedbound and non-verbal from injuries sustained in a violent home invasion.

**Room 329**
- Bed A: 90-year-old female who had a stroke, is quiet, pleasant, ambulates with a walker and likes to sit in the dayroom.
- Bed B: Open

**Room 330**
- Bed A: Open
- Bed B: 86-year-old female with MRSA infected wound to the lower extremity.

**Room 331**
- Bed A: 62-year-old male who is ambulatory.
- Bed B: Open

**Room 332**
- Bed A: Open
- Bed B: 94-year-old female who grumpy and not friendly.

20. Which actions of the admitting nurse in the nursing home will help to alleviate Mattie’s stress as she moves to her new home? Select all that apply.

1. Encourage Mattie to fill her room with familiar personal items.
2. Introduce her to some of the other residents.
3. Let her tour the facility.
4. Show her the schedule of meals and activities.
5. Let her know she will have the freedom to come and go as she pleases.