NGN NCLEX 2026 · VISUAL REFERENCE

PHARMACOLOGY | PAIN MANAGEMENT | HIGH-ALERT

RX

Opioid Analgesics + *Trazodone*

Pain control · respiratory & CNS depression risk · overdose reversal · adjunct sleep agent

MORPHINE · HYDROMORPHONE · OXYCODONE · HYDROCODONE · TRAZODONE

⚠ SOURCE TRANSPARENCY

This topic was *not* present in the uploaded reference notes. Content compiled from standard NGN NCLEX 2026 references: **Saunders Comprehensive Review (Silvestri, 9th ed.)**, **ATI RN Pharmacology Made Easy / Adult Med-Surg**, **Lippincott Illustrated Reviews: Pharmacology (8th ed.)**, **Lehne's Pharmacology for Nursing Care (11th ed.)**, and the **CDC Clinical Practice Guideline for Prescribing Opioids for Pain (2022)**.

01 · OVERVIEW

What these drugs are — and why they matter

Opioids are first-line agents for moderate-to-severe pain, but they are **high-alert medications** with narrow safety margins. Trazodone is grouped here only because it's a frequently co-prescribed CNS depressant — it is *not* an opioid.

- **Opioid agonists** (morphine, hydromorphone, oxycodone, hydrocodone) bind to **mu (μ) receptors** in the CNS to block ascending pain signals and alter pain perception in the limbic system.
- All four opioids share the same core toxicity profile: **respiratory depression, sedation, constipation, miosis, hypotension**. Death from overdose is almost always from respiratory failure.
- All four are **Schedule II controlled substances** (US) — require written/electronic prescription, no refills without new Rx, and chart documentation per facility policy.
- **Trazodone is a SARI antidepressant** (Serotonin Antagonist & Reuptake Inhibitor). Most commonly used *off-label for insomnia* at low doses; treats depression at higher doses. Major adverse effect = **priapism (medical emergency)**.

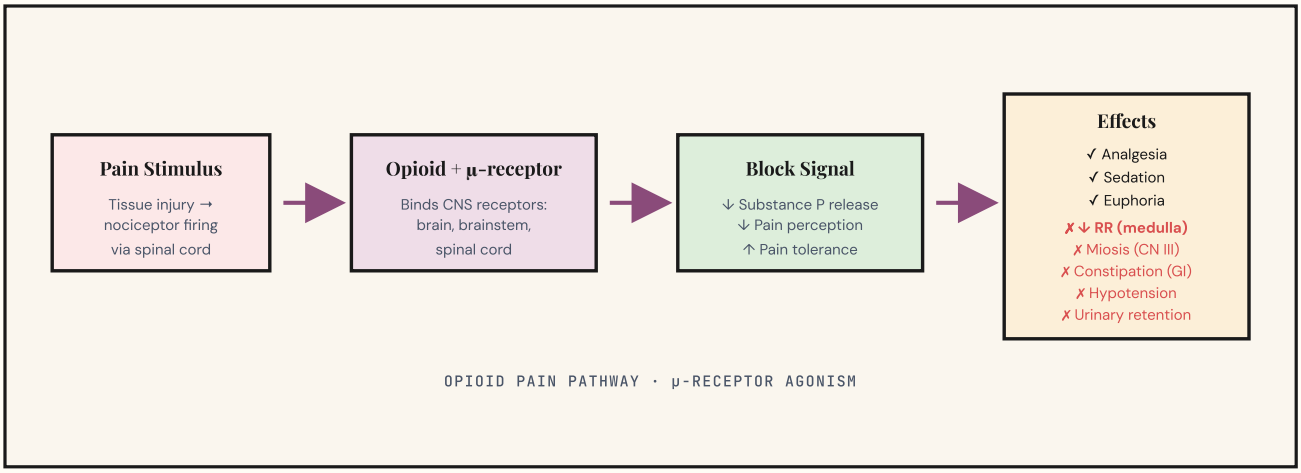
PRIORITY RULE

Hold any opioid and notify HCP if respiratory rate < 12/min in an adult (< 10/min in some opioid-tolerant protocols — follow facility policy). RR is the single most important assessment before and after every dose.

02 · MECHANISM

How they work in the body

Pain pathway → receptor binding → analgesia + classic side-effect profile.



OPIOID PAIN PATHWAY · μ-RECEPTOR AGONISM

- **μ (mu) receptors** mediate analgesia, euphoria, respiratory depression, and physical dependence — the primary target of every opioid in this set.
- **κ (kappa) receptors** contribute to spinal analgesia and miosis with less respiratory depression.
- **Trazodone is different:** it blocks 5-HT_2 receptors, inhibits serotonin reuptake, and antagonizes α_1 and H_1 receptors → strong sedation + orthostatic hypotension. No analgesic effect on its own.

03 · DRUG PROFILES

The five drugs at a glance

Indications · routes · onset & peak · nursing care · side/adverse effects · teaching — for each agent.

PROTOTYPE OPIOID

Morphine Sulfate

MS Contin · Roxanol · Duramorph · Astramorph PF

Pure μ-opioid agonist · natural opioid (from opium poppy) SCHEDULE II

INDICATIONS

Severe acute pain (post-op, trauma, kidney stones), **MI pain** (also ↓ preload via venodilation → useful in acute pulmonary edema), **cancer pain**, sickle cell crisis, dyspnea in palliative care, labor analgesia (epidural).

ROUTES

PO (IR tabs/liquid, ER tabs/caps), IV, IM, SubQ, **epidural**, **intrathecal**, rectal suppository

PHARMACOKINETICS

ONSET	PEAK	DURATION
IV: 5–10 min PO: 30 min	IV: 20 min PO IR: 60 min	IR: 3–5 hr ER: 8–24 hr

SIDE EFFECTS → ADVERSE EFFECTS

Common: Constipation (does not tolerate), N/V, sedation, miosis, pruritus (histamine release), urinary retention, dry mouth.

Adverse / red flag: **Respiratory depression, hypotension, paralytic ileus, anaphylactoid reaction, addiction/dependence, neonatal abstinence syndrome.**

NURSING CARE

- **Assess RR, BP, pain score, sedation level (Pasero scale) before AND 15–30 min after each dose**
- Hold and notify HCP if **RR < 12/min** or sedation level >3
- **Naloxone available at bedside** for opioid-naïve and IV/epidural pts
- Continuous pulse oximetry + capnography for high-dose/IV/PCA
- Start **bowel regimen day 1**: stool softener (docusate) + stimulant laxative (senna)
- Fall precautions; assist with ambulation
- Monitor I&O; assess for distended bladder
- PCA pump: only patient pushes the button — never family

PATIENT & FAMILY TEACHING

- No alcohol or other CNS depressants (benzos, sleep aids, antihistamines)
- Don't drive or operate machinery
- Increase fluids, fiber, and ambulation to prevent constipation
- **Never crush, chew, or split ER tablets** — risk of fatal dose dumping
- Store in locked container away from children/visitors; dispose of unused doses at drug take-back site
- Don't stop abruptly — taper to avoid withdrawal (sweating, cramps, yawning, anxiety, diarrhea)

HIGH-POTENCY OPIOID

Hydromorphone

Dilaudid · Exalgo (ER) · Palladone

Semi-synthetic μ-opioid agonist · ~5–10× more potent than morphine mg-for-mg **SCHEDULE II**

INDICATIONS

Moderate-to-severe pain when morphine inadequate or contraindicated; **opioid-tolerant patients**; breakthrough cancer pain; post-op pain; preferred in renal impairment (no active morphine metabolites like M6G).

ROUTES

PO (IR tabs, oral solution, ER caps), IV, IM, SubQ, rectal suppository

PHARMACOKINETICS

ONSET	PEAK	DURATION
IV: 5 min PO: 15–30 min	IV: 8–20 min PO: 30–60 min	IR: 3–4 hr ER: 13 hr

SIDE EFFECTS → ADVERSE EFFECTS

Common: Same opioid profile as morphine — sedation, constipation, N/V, miosis, pruritus.
Adverse / red flag: **Profound respiratory depression (highest risk in this group), hypotension, apnea, fatal overdose with mg-for-mg substitution errors.**

NURSING CARE

- **HIGH-ALERT MEDICATION** — independent double-check of dose, concentration, and pump settings by 2 RNs
- Doses are small (often 0.2–1 mg IV) — never confuse with morphine doses
- Same monitoring as morphine but with **extra vigilance for respiratory depression**
- Naloxone at bedside; pulse ox/capnography
- Use lowest effective dose, especially in elderly, opioid-naïve, sleep apnea

PATIENT & FAMILY TEACHING

- Emphasize this drug is **much stronger than morphine or oxycodone** — never share, never adjust dose
- Same constipation, sedation, alcohol, and ER-tablet teaching as morphine
- Lock storage essential; report any accidental ingestion to poison control immediately

MEDICATION SAFETY ALERT

Hydromorphone and morphine are **look-alike, sound-alike (LASA)** drugs. Wrong-drug substitution at equivalent mg doses has caused fatal overdoses. **1 mg IV hydromorphone ≈ 7 mg IV morphine.**

ORAL OPIOID · ER FORM

Oxycodone

OxyContin (ER) · Roxicodone (IR) · Percocet (+APAP) · Percodan (+ASA)

Semi-synthetic μ-opioid agonist · oral only · ER form has highest diversion/abuse profile **SCHEDULE II**

INDICATIONS

Moderate-to-severe pain; **chronic pain requiring around-the-clock analgesia** (ER form); post-op step-down from IV opioids; cancer pain.

ROUTES

PO ONLY — IR tablets, oral solution/concentrate, ER tablets. No IV/IM/SubQ form in the US.

PHARMACOKINETICS

ONSET	PEAK	DURATION
IR: 10–30 min ER: ~1 hr	IR: 1–2 hr ER: 3–4 hr	IR: 3–6 hr ER: 12 hr

SIDE EFFECTS → ADVERSE EFFECTS

Common: Constipation, sedation, dizziness, N/V, pruritus, headache.
Adverse / red flag: **Respiratory depression, addiction/diversion (highest in this group), APAP hepatotoxicity (combo products), ASA bleeding risk (Percodan).**

NURSING CARE

- **Verify total daily APAP dose < 4 g/day** (≤ 3 g/day chronic alcohol use or liver disease) when giving combo products (Percocet, Roxicet)
- **NEVER crush, chew, or break ER tablets** — releases full dose at once → fatal dose dumping
- Same opioid monitoring (RR, sedation, pain, BP, bowel function)
- Screen for substance use history before starting; document baseline pain
- Use abuse-deterrent formulations when available

PATIENT & FAMILY TEACHING

- Read OTC labels: **don't double up on acetaminophen** (Tylenol, NyQuil, Excedrin all contain APAP)
- Swallow ER tablet whole with water — do not crush, split, chew, dissolve, or pre-soak
- Take with food if GI upset
- Lock storage; never share; safe disposal of unused doses (DEA take-back)
- Report signs of liver toxicity (RUQ pain, jaundice, dark urine) if on combo product

ORAL OPIOID · COMBO

Hydrocodone

Vicodin · Norco · Lortab (all with APAP) · Hysingla ER · Tussionex (antitussive)

Semi-synthetic μ-opioid agonist · oral only · almost always combined with acetaminophen **SCHEDULE II** (rescheduled from III in 2014)

INDICATIONS

Moderate pain (combo products with APAP); intractable chronic pain (Hysingla ER, single-entity); **antitussive** (Tussionex pennkinetic syrup) for non-productive cough.

ROUTES

PO ONLY — combo tablets/capsules, ER capsules/tablets, antitussive syrup. No injectable form.

PHARMACOKINETICS

ONSET	PEAK	DURATION
IR: 10–30 min ER: ~1 hr	IR: 30–60 min ER: 6–14 hr	IR: 4–6 hr ER: ~12–24 hr

SIDE EFFECTS → ADVERSE EFFECTS

Common: Drowsiness, dizziness, constipation, N/V, dry mouth.
Adverse / red flag: **Respiratory depression, hepatotoxicity from APAP component, addiction/dependence, accidental pediatric ingestion of cough syrup.**

NURSING CARE

- **Watch APAP ceiling: < 4 g/day adult** (≤ 3 g if chronic alcohol or liver disease); FDA capped combo products at 325 mg APAP/tablet
- Monitor LFTs (AST, ALT) for long-term combo use
- Same opioid monitoring: RR, sedation, pain, bowels
- For Tussionex (cough syrup): use only as antitussive, not analgesic; not for children < 6
- No IV form — never piggyback; route conversion needed if NPO

PATIENT & FAMILY TEACHING

- Same APAP ceiling teaching as oxycodone — read all OTC labels
- Tussionex syrup: **do not mix or dilute**, measure with provided oral syringe (not kitchen spoons)
- Refrigerate liquid forms if instructed; shake well
- Avoid alcohol absolutely (compound hepatotoxicity + sedation)
- Safe storage in locked container; keep away from children — flavored syrup is a poisoning hazard

NOT AN OPIOID · SARI

Trazodone

Desyrel · Oleptro (ER) · Trialodine

Serotonin Antagonist & Reuptake Inhibitor (SARI) · atypical antidepressant · also α_1 and H_1 blockade NOT CONTROLLED

⚠ Important distinction

Trazodone is **not an opioid**. It has no analgesic effect of its own. It's included here because it is frequently co-prescribed with opioids for sleep, anxiety, and depression in chronic pain patients — and the combined CNS depressant effect matters clinically.

INDICATIONS

FDA-approved: Major Depressive Disorder (MDD). **Most common real-world use is OFF-LABEL for insomnia** (low-dose 25–100 mg at bedtime). Also used off-label for anxiety, PTSD-related nightmares, and as an adjunct in fibromyalgia.

ROUTES

PO ONLY — IR tablets, ER tablets. No injectable form.

PHARMACOKINETICS

ONSET	PEAK	HALF-LIFE
Sedation: 30 min Antidep: 1–3 wk	1–2 hr	7–10 hr

SIDE EFFECTS → ADVERSE EFFECTS

Common: Sedation (#1 — used therapeutically), orthostatic hypotension, dizziness, dry mouth, blurred vision, headache, N/V, weight gain.

Adverse / red flag: Priapism (painful sustained erection > 4 hr — medical emergency), serotonin syndrome (with SSRIs, SNRIs, MAOIs, triptans, St. John's wort), QT prolongation/torsades, suicidal ideation in patients < 25 (BLACK BOX), hyponatremia (SIADH-like).

NURSING CARE

- **Give at bedtime** with a light snack (sedative effect + food slows absorption to reduce dizziness)
- **Orthostatic BP checks** on initiation and titration; fall precautions (especially in elderly)
- Screen mood and ask about suicidal ideation, especially < 25 years old (black box)
- Ask male patients about prolonged/painful erections — instruct to seek ER if > 4 hr
- Hold MAOIs ≥ 14 days before/after trazodone (serotonin syndrome)
- Monitor sodium in elderly (hyponatremia risk)
- Avoid in active suicidality with means restriction concerns; baseline ECG if cardiac history

PATIENT & FAMILY TEACHING

- Take at **bedtime with a light snack**; expect drowsiness within 30 min
- Change positions slowly (sit → stand) to prevent dizziness/falls
- Avoid alcohol and other CNS depressants (including opioids — compounded sedation)
- **Seek emergency care immediately for any erection lasting > 4 hours or that is painful — risk of permanent impotence**
- Antidepressant effect takes 1–3 weeks — don't stop early; don't stop abruptly (discontinuation syndrome)
- Report new agitation, suicidal thoughts, or worsening mood — especially first weeks and in those < 25
- Report fever, sweating, tremor, agitation, fast heart rate, confusion (serotonin syndrome warning signs)

04 · QUICK-COMPARE TABLE

Side-by-side recap

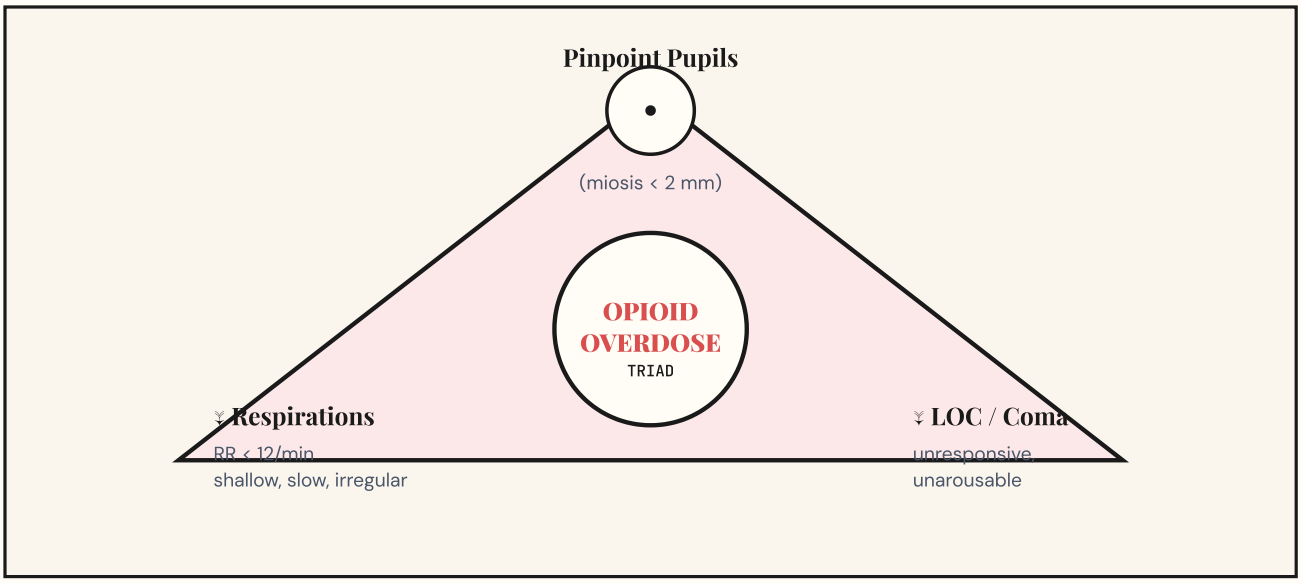
Use this for fast last-minute review.

DRUG	PRIMARY USE	ROUTES	ONSET / PEAK	TOP ADVERSE EFFECT	#1 TEACHING POINT
Morphine	Severe pain, MI, pulmonary edema	PO, IV, IM, SubQ, epidural, intrathecal, PR	IV: 5–10 min / 20 min	Respiratory depression, hypotension, histamine itch	Hold if RR < 12; start bowel regimen day 1
Hydromorphone	Severe pain when morphine inadequate; renal impairment	PO, IV, IM, SubQ, PR	IV: 5 min / 8–20 min	Profound respiratory depression (5–10× morphine potency)	High-alert; never substitute mg-for-mg with morphine
Oxycodone	Moderate-severe acute & chronic pain	PO only (IR, ER, oral solution)	IR: 10–30 min / 1–2 hr	Respiratory depression; APAP hepatotoxicity (combo); abuse	Never crush ER — fatal dose dumping; APAP < 4 g/day
Hydrocodone	Moderate pain; antitussive (Tussionex)	PO only (combo tabs, ER caps, syrup)	IR: 10–30 min / 30–60 min	Respiratory depression; APAP hepatotoxicity	Watch for double-dosing APAP from OTC products
Trazodone	Depression; off-label insomnia (most common)	PO only (IR, ER)	Sedation: 30 min / 1–2 hr	Priapism, orthostatic hypotension, serotonin syndrome	Take at bedtime; seek ER for erection > 4 hr

05 · TOXICITY: OPIOID OVERDOSE

The classic opioid overdose triad

Recognize early. Reverse immediately. Documents everything.



EARLY / MILD

- Drowsiness, sedation (Pasero level 2–3)
- Slurred speech, confusion
- RR 10–12/min, shallow
- Pinpoint pupils
- Constipation, urinary retention
- Itching, flushing (histamine — morphine)

LATE / SEVERE

- **RR < 8/min or apnea**
- **Unresponsive / coma**
- Cyanosis, SpO_2 < 90%
- Hypotension, bradycardia
- Pulmonary edema (non-cardiogenic)
- Cardiac arrest

06 · PRIORITY INTERVENTIONS

The ABC framework in opioid overdose

When in doubt, prioritize the airway. Naloxone reverses the drug — but oxygenation reverses the death.

A
AIRWAY

- Position head-tilt/chin-lift
- Suction secretions
- Oral/nasal airway if needed
- Prepare for intubation if RR < 6 or apneic

B
BREATHING

- BVM ventilation with 100% O_2
- Continuous SpO_2 + capnography
- **Naloxone IV/IM/intranasal**
- Repeat naloxone q 2–3 min PRN

C
CIRCULATION

- Cardiac monitor; assess BP, pulse
- IV access, fluid bolus for hypotension
- Vasopressors PRN per protocol
- 12-lead ECG (especially with trazodone — QT)

1. **Stop the opioid** — discontinue infusion, remove fentanyl patch, hold all PO opioids.
2. **Call for help** — rapid response or code per facility protocol.
3. **Open airway, support breathing** with BVM + 100% O_2.
4. **Administer naloxone** per orders or standing protocol.
5. **Establish IV access; monitor** continuously.
6. **Reassess** RR, SpO_2, LOC, and pain every 2–5 minutes — naloxone is short-acting and overdose may recur ("renarcotization").
7. **Document & report**: event, response, interventions, vitals. Complete medication error/event report per facility policy.

07 · ANTIDOTE

Naloxone — opioid reversal

Pure opioid antagonist that competitively displaces opioids from μ-receptors. Works in seconds. Does *not* reverse trazodone or benzodiazepines.

Naloxone (Narcan, Evzio)

PURE OPIOID ANTAGONIST · PREGNANCY CATEGORY C

DOSE & ROUTE

- IV: 0.04–0.4 mg, may repeat q 2–3 min up to 10 mg
- IM/SubQ: 0.4–2 mg
- Intranasal: 4 mg (one spray, one nostril) — community/home use
- Onset: IV 1–2 min; IN 2–5 min
- Duration: 30–90 min — SHORTER than most opioids

NURSING CONSIDERATIONS

- Titrate to RR ≥ 12, not to full alertness — sudden reversal in chronic users → acute withdrawal (HTN, tachycardia, sweating, agitation, vomiting, seizures)
- **Monitor for renarcotization** — opioid outlasts naloxone; may need repeat dosing or naloxone drip
- Have resuscitation equipment ready
- Continuous monitoring 2–24 hr depending on opioid (longer for methadone, ER formulations, fentanyl patches)

KEY DISTINCTION

Naloxone reverses opioids only. If overdose involves trazodone or benzodiazepines, naloxone will not help. Flumazenil reverses benzodiazepines (but is rarely used due to seizure risk). No specific antidote exists for trazodone — treatment is supportive (airway, IV fluids, monitor QT).

08 · NCLEX TEST TRAPS

What students get wrong

Wrong-thinking vs. right-thinking on the most commonly missed NGN items.

✗ "The patient is groggy and sedated — I'll hold the next opioid dose."

✓ Sedation alone is not the trigger. Hold for RR < 12/min OR sedation level > 3 on the Pasero scale. A drowsy but easily arousable patient with RR 16 is expected after a dose. Reassess in 15–30 min.

✗ "Naloxone is given — patient is fine, I'll go chart."

✓ Naloxone wears off in 30–90 min; most opioids last 3–24 hr. Renarcotization is common. Stay with the patient, monitor RR/SpO_2/LOC continuously, anticipate repeat naloxone doses.

✗ "Trazodone is a sedative — let me give it with the hydrocodone."

✓ Compounded CNS depression and serotonin effects. Trazodone is not an opioid, naloxone won't reverse it, and combined with opioids it can deepen respiratory depression. Coordinate timing with the prescriber and monitor closely.

✗ "Patient with chronic back pain says erection lasted 5 hours — sounds like a side effect, document and move on."

✓ Priapism is a medical emergency. Erection > 4 hr can cause permanent ischemic damage and impotence. Hold trazodone, notify HCP STAT, prepare patient for ER evaluation.

✗ "I'll crush this OxyContin ER tab and put it down the NG tube."

✓ Never crush extended-release tablets — releases full 12-hr dose at once → fatal dose dumping. Switch to immediate-release oral solution or a different opioid via NG. Consult pharmacy.

✗ "The Percocet is fine — the patient also took 2 Tylenol Extra Strength for fever, just to be safe."

✓ Hidden APAP! Each Tylenol ES = 500 mg APAP × 2 = 1 g, plus 325 mg × multiple Percocet doses. Total daily APAP must be < 4 g (3 g chronic alcohol/liver disease). Hepatotoxicity risk is the trap.

✗ "I'll substitute 4 mg hydromorphone for the 4 mg of morphine that's out of stock."

✓ Hydromorphone is ~5–10× more potent than morphine. 4 mg hydromorphone IV ≈ 20–40 mg morphine IV — likely fatal in opioid-naïve patient. Always use an equianalgesic conversion table and verify with pharmacy.

09 · PATIENT & FAMILY EDUCATION

Key talking points for discharge

Universal opioid teaching, plus drug-specific reminders.

Universal Opioid Teaching

- Take exactly as prescribed — never share, sell, or "save" pills
- No alcohol, marijuana, benzos, sleep aids, or other CNS depressants
- Don't drive or operate machinery until you know your response
- Increase fluids, fiber, and walking to prevent constipation; use ordered laxatives
- Store in locked container; keep away from children, teens, visitors
- Dispose of unused medication at a DEA take-back site, not toilet (unless flush-listed)
- Don't stop suddenly after > 1 wk of use — taper per HCP
- Know overdose signs: snoring, blue lips, can't be awakened
- Household naloxone kit if available; teach family how to use
- Call 911 for unresponsive person — naloxone first, then CPR

Trazodone-Specific Teaching

- Take at bedtime with a light snack (improves absorption, reduces dizziness)
- Change positions slowly — orthostatic hypotension is common, especially in elderly
- **Seek emergency care for any erection lasting > 4 hours** — risk of permanent damage
- Watch for serotonin syndrome: fever, sweating, tremor, agitation, fast heart rate, confusion — go to ER
- Antidepressant effect takes 1–3 weeks — don't quit early
- Report new agitation, suicidal thoughts, or worsening mood (especially first weeks; < 25 yr)
- Tell all providers you take trazodone — interacts with MAOIs, SSRIs, triptans, lithium, tramadol
- Don't stop abruptly — taper to avoid discontinuation syndrome

10 · MEMORY BOOSTERS

Mnemonics, patterns, and quick associations

Pattern recognition is everything on NGN. Anchor each drug to one image.

M·O·R·P·H·I·N·E

M	**Miosis** — pinpoint pupils
O	**Out of it** — sedation, ↓ LOC
R	**Respiratory depression** — #1 killer
P	**Pruritus & hyPotension** (histamine release)
H	**Hypotension** & bradycardia
I	**Increased ICP** — caution in head injury
N	**N/V & constipation** (no tolerance to constipation)
E	**Emesis** + euphoria (addiction risk)

3 P's of Opioid OD

P	**Pinpoint pupils**
P	**↓ resPirations** (RR < 12)
P	**uPon trying — unresponsive** (coma)

TRAZ Triggers

T	**Tired** — sedation #1
R	**Rises slowly** — orthostatic BP
A	**Always at bedtime**
Z	**Zero is goal** for erection > 4 hr → ER!

QUICK ASSOCIATIONS

- **"-one" or "-ine" + scheduled = opioid.** Morphine, hydromorphone, oxycodone, hydrocodone, codeine. Trazodone ends in "-one" but is NOT an opioid — it's an antidepressant.
- **RR < 12 = hold the opioid.** Always. No exceptions without prescriber order.
- **Naloxone bedside** = every patient receiving an opioid, especially PCA, IV, epidural, or opioid-naïve.
- **Bowel regimen day 1** — tolerance never develops to opioid-induced constipation.
- **Crush an ER tablet = kill the patient.** Use IR oral solution instead.

11 · NCJMM CLINICAL JUDGMENT

Next-Gen Case: post-op hydromorphone

A 6-step walkthrough of the NCSBN Clinical Judgment Measurement Model — apply it on test day.

CLIENT SCENARIO

A 68-year-old female is 8 hours post-op from a total hip arthroplasty. She has a PCA pump delivering hydromorphone 0.2 mg IV q 8 min lockout. She also takes trazodone 50 mg PO HS for sleep. At 0200, the nurse notes: RR 8/min, SpO_2 86% on room air, BP 92/54, HR 52, sedation level 4 (asleep, difficult to arouse), pinpoint pupils. Last PCA bolus 12 minutes ago. Daughter at bedside reports she pressed the button "to help mom sleep better."

1

RECOGNIZE CUES

What data is significant?

- **Classic opioid overdose triad:** RR 8, sedation level 4, pinpoint pupils
- SpO_2 86% (severe hypoxemia), hypotension, bradycardia
- **PCA-by-proxy** — family member pushing button = patient safety event
- Concurrent trazodone (compounds CNS depression)
- Age 68 — increased opioid sensitivity

2

ANALYZE CUES

What's happening clinically?

Opioid-induced respiratory depression and oversedation, exacerbated by PCA-by-proxy administration and additive CNS depression from trazodone. Without immediate intervention, the patient will progress to apnea, hypoxic cardiac arrest, and death. Hydromorphone potency (5–10× morphine) makes even small extra doses dangerous in an opioid-naïve elder.

3

PRIORITIZE HYPOTHESES

Which problem first?

- **#1 Airway/breathing failure** from opioid overdose → highest priority (ABC)
- #2 Hemodynamic instability (hypotension, bradycardia)
- #3 Medication safety event (PCA-by-proxy education)
- Patient teaching, fall risk, and trazodone review = later priorities

4

GENERATE SOLUTIONS

What interventions are indicated?

- Stop the PCA pump immediately; document last dose time
- Call rapid response / notify HCP
- Open airway, apply 100% O_2 via non-rebreather; BVM if RR < 8 or apneic
- Administer naloxone 0.04–0.4 mg IV; titrate to RR ≥ 12 (avoid full reversal in chronic users)
- Continuous cardiac, SpO_2, and capnography monitoring
- IV fluid bolus for hypotension; reassess BP/HR
- Remove daughter from button access; educate on PCA-by-proxy danger
- Anticipate repeat naloxone — opioid half-life exceeds naloxone duration

5

TAKE ACTION

Implement priority interventions now

- 0202 — Stop PCA; call rapid response; apply 100% O_2 via non-rebreather; begin BVM with bag valve
- 0203 — Naloxone 0.04 mg IV push; reassess in 2 min
- 0205 — RR now 14, SpO_2 94%, sedation level 2; patient arousable
- 0205 — Educate daughter at bedside: only the patient may push the PCA button; resume PCA only after HCP order
- 0210 — Hold trazodone for the night; notify prescriber
- 0215 — Document event; complete medication safety event report

6

EVALUATE OUTCOMES

Did it work? What's next?

- **Effective:** RR ≥ 12, SpO_2 ≥ 92%, sedation level ≤ 2, BP > 100 systolic, patient oriented
- **Continue:** q 15 min monitoring × 2 hr, then q 30 min × 4 hr; watch for renarcotization
- **Reassess pain:** may need non-opioid adjuncts (acetaminophen scheduled, ice, repositioning) or lower-dose PCA settings
- **Family education:** PCA-by-proxy is a sentinel event — reinforce written and verbal instructions; document understanding
- **Medication reconciliation:** trazodone-opioid combination requires prescriber review

REFERENCES

Silvestri, L. A. (2024). *Saunders Comprehensive Review for the NCLEX-RN Examination* (9th ed.). Elsevier.

ATI Nursing Education. (2023). *RN Pharmacology Made Easy 4.0 — Pain Management*.

Whalen, K., et al. (2023). *Lippincott Illustrated Reviews: Pharmacology* (8th ed.). Wolters Kluwer.

Lehne, R. A. (2022). *Pharmacology for Nursing Care* (11th ed.). Elsevier.

CDC. (2022). *Clinical Practice Guideline for Prescribing Opioids for Pain — United States*. MMWR 71(3).

ISMP. (2023). *List of High-Alert Medications in Acute Care Settings*. Institute for Safe Medication Practices.

FDA. (2024). *Opioid Analgesic REMS Education Blueprint*.

NCSBN. (2023). *Clinical Judgment Measurement Model (NCJMM)*.

FOR NGN NCLEX 2026 EXAM PREP · NOT A CLINICAL DECISION TOOL · VERIFY ALL DOSES WITH CURRENT INSTITUTIONAL POLICY & PHARMACY