

# Nursing Pharmacology

Drug classes, prototypes, warnings, indications, administration & more

## PHARMACOLOGY & THE NURSING PROCESS

### Assessment

- Gather data necessary to evaluate therapeutic effects
- Gather data necessary to evaluate adverse reactions
- Judge if patient is capable of self-administration of treatment
- Assess any potential risk factors

### Analysis/Diagnosis

- Determine if prescribed therapeutic plan is appropriate
- Identify possible drug interactions, adverse reactions, and health problems

### Planning

- Compose a care plan, including nursing interventions and expected outcomes

### Implementation

- Administer the drug
- Educate the patient about the drug
- Enact measures that will enhance drug effectiveness and minimize adverse reactions

### Evaluation

- Determine the presence or absence of the desired therapeutic response or adverse reactions
- Identify if patient followed the regimen prescribed and is satisfied with treatment



## DRUG NAMES

### Chemical Name

Scientific name, describes the atomic and molecular structure of a drug

### Generic Name

Nonproprietary name, abbreviation of the chemical name

### Brand Name

Trade name, selected by the pharmaceutical company that made the drug

## EDUCATING PATIENTS

When instructing patients on a prescribed drug, share the following:

- Drug name/category
- Dosage size/schedule
- What to do in the event of skipped dose
- How to administer
- Expected response
- How the patient can enhance response
- Duration of treatment
- How to store the drug
  - Major and minor side effects
  - Important possible interactions
  - How to react to an emergency

## DRUG INTERACTIONS

**Additive:** Two drugs with similar therapeutic effect = combined potency

**Antagonistic:** Two drugs taken together = decreased effectiveness of both

**Potentialistic:** One drug's potency is enhanced when combined with another

**Absorption:** One drug affects absorption rate of another

**Metabolism:** One drug affects metabolism of another; if inhibited, can cause toxicity

### Adverse Reactions

#### Caused by Patient Sensitivity

Allergic/anaphylactic reaction  
Idiosyncratic response

#### Caused by Dose

Secondary/side effects  
Hypersensitivity  
Idiosyncratic effects  
Overdose

## ROUTES OF ADMINISTRATION

**Oral:** Capsule, tablet, liquid; absorbed in GI tract

**Intravenous (IV):** Injection into bloodstream via vein

**Intramuscular (IM):** Injection into muscle; can use large doses; fast systemic action

**Intrathecal:** Injection into spinal canal; affects spinal fluid

**Subcutaneous (sub-Q):** Injection into tissue below dermis

**Sublingual:** Absorbed under the tongue

**Rectal/vaginal:** Suppositories or creams; usually for local distribution

**Inhalation:** Absorbed in lungs; gaseous form; rapid absorption

## PHARMACOLOGY BASICS

**Pharmacokinetics:** Study of drugs' actions as they move through the body

**Absorption:** Affected by administration route, formulation, patient stress level or stomach contents, blood flow

**Distribution:** Affected by solubility, protein activity, blood flow

**Metabolism:** Affected by diseases, environment, age, genetics

**Excretion:** Through kidneys, skin, intestines, lungs, exocrine glands

**Pharmacodynamics:** Study of the mechanism of action of drugs within the body and how drugs produce their effects in the body

**Pharmacotherapeutics:** Study of drugs used to prevent, treat, or diagnose disease

## CONSIDERATIONS ACROSS THE LIFESPAN

### Pregnant/Breastfeeding Women

- Renal excretion rate and hepatic metabolism are accelerated = consider higher dosages
- Intestinal excretion rate decreased = longer absorption time = consider reduced dosages
- Assume all drugs can enter the fetus via placenta
- Consult FDA risk categories for every drug before considering administration
- Weeks 3-8 present greatest risk of drug-induced malformation of fetus
- After pregnancy, doses should be taken directly after breastfeeding to ensure minimal drug concentration in breast milk for next feeding

### Pediatric Patients

- Assume increased drug sensitivity due to immature organ system
- Infants have irregular gastric patterns = absorption rates may vary
- Infants/young children have thin skin = rapid topical drug absorption
- Infants' blood-brain barrier not fully developed = increased sensitivity to CNS drugs, risk of toxicity
- Neonates absorb IM drugs slower than adults; infants absorb IM drugs faster
- Infants have reduced protein-binding ability = high free concentrations of drugs
- Liver and kidneys not fully developed until after 1 year of life; assume reduced ability for hepatic and renal metabolism in infants
- In children over 1 year of age, drug metabolism rate is higher than adults
- Children may have unique side effects to certain drugs, including suppressed growth
- General rule for dosing adjustment:  
Body surface area of child x Adult dose = approx. dose for child  
1.73 m<sup>2</sup>
- Patient education should include instructions for how to account for spitting or spilling of medication, avoiding multiple dosing

### Geriatric Patients

- Assume increased drug sensitivity due to deteriorated organ system
- Reactions vary greatly based on individual patient condition
- Rate of absorption generally slowed = delayed therapeutic response
- Hepatic metabolism rate likely slowed = longer therapeutic response
- Renal excretion slowed = accumulation of drug, increased risk of adverse effects
- Determine creatinine clearance prior to drug administration to assess renal function
- Intentional failure to follow prescribed regimen a common problem; longer or more extensive patient education may be required
- Anticipate, assess, and/or manage drug interactions carefully



## SCHEDULES OF CONTROLLED SUBSTANCES

| Schedule Class    | Characteristics                                                                                                                                                                                      | Examples                                                                  |
|-------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|
| Schedule 1: C-I   | High abuse potential; not legal; no acceptable medical use; no prescriptions available                                                                                                               | Heroin, LSD, cocaine, marijuana, methaqualone                             |
| Schedule 2: C-II  | High abuse potential and severe dependence liability; current, accepted medical use; prescription drug signed, not stamped prescription; 30-day supply; no refills                                   | Opium, morphine, coca, methadone                                          |
| Schedule 3: C-III | Less abuse potential; low-moderate physical dependence; high psychological dependence; by prescription only; expires within 6 months; max. 5 refills on one script                                   | Amphetamines, codeine, barbiturates, Valium, Xanax, anabolic steroids     |
| Schedule 4: C-IV  | Less abuse potential than C-III drugs; accepted medical use; limited physical and psychological dependence; written or verbal prescription; expires within 6 months; max. 5 refills on one script    | Chloral hydrate, meperidine, paraldehyde, phenobarbital                   |
| Schedule 5: C-V   | Limited abuse potential; accepted medical use; small amounts of narcotics used as antitussives (cough medicine) or antidiarrheals; may not need a prescription but must be recorded as a transaction | Promethazine with codeine (cough medicine), diphenoxylate (antidiarrheal) |

# Study Guide For Nursing Pharmacology

**Bruce D. Clayton, Sandra  
Cooper, Yvonne N. Stock, Valerie Baker**

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