MATRIC NUMBER: 16/MHS02/029

1. MANAGEMENT OF CARDIAC ARREST

* Loosen tight clothing
* Place the patient in a flat surface
* Wipe of secretions from the upper respiratory tracts
* If ambu bag is available, oxygen should be delivered 4-6litres per minutes
* Start CPR immediately
* If an automated external defibrillator(AED) is available deliver one shock before carrying out CPR
* Other treatment includes chemotherapy: Beta blockers ACE inhibitors and calcium channel blockers, coronary angioplasty, coronary bypass surgery, corrective heart surgery

NURSING MANAGEMENT

* Observation of vital signs
* Check input and output regularly
* Assess for signs of cyanosis
* If conditions improve help in self care and activities of daily living, passive and active exercises, adequate rest and psychological support to reassure patients

1. MANAGEMENT OF CARBON MONOXIDE POISONING

* Promptly remove the patient from continued exposure and immediately institute oxygen therapy with a nonrebreather mask.
* Perform intubation for the comatose patient or, if necessary for airway protection, and provide 100% oxygen therapy.
* Institute cardiac monitoring.
* Give notification to the emergency department for comatose or unstable patients because rapid or direct transfer to a hyperbaric center may be indicated.
* If possible, obtain ambient carbon monoxide (CO) measurements from fire department or utility company personnel, when present.
* Early blood samples may provide much more accurate correlation between HbCO and clinical status; however, do not delay oxygen administration to acquire them.
* Obtain an estimate of exposure time, if possible.
* Avoid exertion to limit tissue oxygen demand.

1. MANAGEMENT OF EPISTAXIS

* Put on protective gear, including gown, gloves, and faces shields. Quickly assess the ABCs (airway, breathing, and circulation) and support them as indicated. Reassure the patient.
* Have the patient sit upright with her head tilted forward, and instruct her to apply direct external digital pressure to the nares with her index finger and thumb. Tell her to breathe through her mouth while she holds firm pressure on the soft flesh of her nose for at least 10 minutes. If bleeding persists, cotton pledgets soaked in a vasoconstrictor and anesthetic will be placed in the anterior nasal cavity, and direct pressure should be applied at both sides of the nose.
* Ensure bedside suction is functioning properly. Provide an emesis basin and tissues. Tell her to spit blood into the basin if necessary. This helps prevent nausea and vomiting and lets you estimate the amount of bleeding.
* Obtain vital signs and SpO2 level, and assess her breath sounds. Administer supplemental oxygen via facemask if needed. Continue to monitor vital signs closely.
* Assess for signs and symptoms of hemodynamic instability, including change in mental status, pallor, diaphoresis, hypotension, tachycardia, and tachypnea.
* If bleeding is significant, establish vascular access, place the patient on a cardiac monitor, and begin fluid resuscitation with a crystalloid solution, as prescribed. Obtain specimens for blood work, including complete blood cell count and coagulation profile, as prescribed.
* Obtain a focused health history, including previous nosebleeds, other bleeding episodes, easy bruising, and medication use, especially use of aspirin and other nonsteroidal anti-inflammatory drugs (NSAIDs), antiplatelet agents, warfarin, and herbal products.
* If bleeding persists, assist in preparing the epistaxis tray and a headlamp. Make sure lighting is adequate. Once the bleeding site is identified, the definitive treatment is cautery (silver nitrate or electrical). If cautery is unsuccessful, nasal packing will be used to apply direct pressure to the bleeding site. During the procedure, reassure the patient, monitor vital signs, and assess for hypoxia.
* After bleeding is controlled, reassess the patient and provide oral care. Keep the patient's mouth moist while the packing is in place.
* If packing is used, especially posterior packing, monitor for respiratory compromise. Tell the patient to report signs and symptoms of infection and teach her about any prescribed antibiotics. If she has posterior packing, she'll be admitted to the hospital. A patient with anterior packing will follow up with an ear, nose, and throat specialist as an outpatient.
* The nasal packing will be left in place for 3 to 5 days. Instruct the patient to avoid exerting herself, forcefully blowing her nose, or bending over. She should also avoid NSAIDs, alcoholic beverages, and smoking for 5 to 7 days. Tell her to apply water-soluble ointment to her lips and nostrils while packing is in place and to use a cool-mist room humidifier. Advise her to take steps to prevent constipation and straining, which increases the risk of bleeding.
* Don't leave the patient unattended during epistaxis.

1. MANAGEMENT OF FOREIGN BODY IN THE EYE

* The doctor or nurse checks your vision.
* Once they find the foreign body, they gently remove it after numbing the eye with anaesthetic eye drops. If it is central or deep, they will arrange for you to see an ophthalmologist (specialist eye doctor) to have it removed.
* Your eye may be washed with saline (sterile salt water) to flush out any dust and dirt.
* X-rays may be done to check whether an object has entered your eyeball or orbit.
* Your eye may be patched to allow it to rest and any scratches to heal.
* You will be advised not drive until the eye patch is removed and your vision has returned to normal.
* Your doctor will want to see you again to check that your eye is healing and that your vision is all right. You should not miss this appointment. Even though you may feel better, your eye may not have fully healed. The follow-up is needed to make sure the treatment is working.
* If there are any serious problems, or a residual rust ring, you will be sent to an ophthalmologist.