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MATRIC NUMBER: 16/MHS01/162

COURSE CODE: NSC 408 (ADVANCED MEDICAL/ SURGICAL NURSING 2)

ASSIGNMENT TITLE: EMERGENCY NURSING MANAGEMENT

QUESTIONS

1. Management of cardiac arrest
2. Management of carbon monoxide poisoning
3. Management of Epistaxis
4. Management of foreign body in the eye

Management of cardiac arrest

* Position patient in a recumbent state, on a flat hard surface and tilt the hand backwards
* Remove tight clothes
* Strike a precordial bow with the fist, on the patient’s sternum
* Start resuscitation (mouth to mouth) and chest compression
* Observe carotid pulse rate, skin colour and return to normal respiration. If not in a hospital, arrange for medical aid.
* Maintain airway.
* Oxygen support should initially be in high concentration to achieve rapid restoration; as breathing improves aim at achieving Sa02 (arterial oxygen saturation) >94% or 88–92% if the patient has Chronic Obstructive pulmonary disease.
* Maintain neurological monitoring (if Glasgow comma scale score <8, patient needs intubation).
* Observe for any seizures as this may indicate cerebral hypoxia and possible raised Intracranial pressure (an indication for intubation).
* Monitor rhythm/BP/pulse/respiration rate/oxygen saturations, capnography, blood glucose, and temperature (haemodynamic instability may indicate need for inotropic support).
* Repeat Electrocardiogram (changes to ECG must be immediately reported).
* Initial ECG may be undiagnostic. Cardiopulmonary resuscitation (CPR) is not a contraindication for thrombolysis.
* Chest X-ray
* Check urea and electrolytes (to include Mg2+), full blood count, and clotting.
* Arterial blood gas
* Maintain accurate fluid balance and observe urine output.
* Cool the patient according to local guidelines. Research into post-arrest cooling is ongoing.
* Confirm admission area/bed.
* Debrief the resuscitation team.
* Keep family informed and involved.

Management of carbon monoxide poisoning

* ensure removal of the patient from the carbon monoxide (CO) source.
* ensure the airway is patent, and administer high-flow oxygen (100%).
* The half-life of CO is 75h on breathing air, 1h on 100% oxygen, and 40min with hyperbaric therapy. If hyperbaric therapy is not locally available, its value is debatable, as Carboxyhaemoglobin levels may already be significantly d with high-flow 100% oxygen by the time a transfer is arranged. those most likely to benefit from hyperbaric treatment include patients with a history of unconsciousness, a Carboxyhaemoglobin level of >20%, pregnancy (due to fetal Hb levels), and cardiac complications such as MI and arrhythmias.
* Managing the critically ill patient in a hyperbaric chamber presents its own problems and may not, in fact, be practicable.
* Patients who present with CO poisoning will feel confused and unwell, and need support and reassurance.

Management of Epistaxis

* Ask the patient to sit upright and forward, and to squeeze the nostrils. Offer constant reassurance, as patients find this very distressing.
* Give the patient a bowl, and encourage them to breathe through the mouth.
* Monitor pulse and BP.
* Monitor for signs of hypovolaemia.
* Establish iv access, and collect blood for full blood count, group and save, and clotting if the patient is on anticoagulants.
* If bleeding continues, prepare for packing.
* Use a nasal tampon. These are easy to insert and comfortable for the patient. use Naseptin cream to lubricate the tampon.
* Pack both sides. Packs are usually left in place for 24h. use BiPP (bismuth sub-nitrate and iodoform paraffin paste) or 1cm of ribbon gauze impregnated with petroleum jelly if nasal tampons are not available. Posterior bleeds, which are much less common (75%), require packing and a balloon catheter to arrest bleeding.
* Patients with posterior packs require admission and are usually commenced on antibiotics.
* Psychological support. A calm, reassuring manner will help to reduce the patient’s anxiety.

Management of foreign body in the eye

Conjunctival foreign body

These are usually superficial.

* Instill topical anesthetic.
* Remove from the conjunctiva by wiping with a dampened cotton bud
* (any swab/cotton bud used on the eye should be pre-moistened with Saline Minims or the residue of an anesthetic Minims—otherwise, epithelial tissue sticks to the swab, rather than the eye, and significant injury can result).
* Stain after the foreign bodies has been removed to identify the extent of damage.
  + If there is minimal stain, a single application of chloramphenicol ointment may be instilled.
  + If there is significant stain, chloramphenicol ointment should be prescribed until the eye feels back to normal.

Deeper foreign bodies on the conjunctiva may be removed using a 21G hypodermic needle, often mounted on the end of a cotton bud to form a longer and more easily manipulated tool.

Corneal foreign body

Assess depth using a slit lamp. The depth of the cornea may be seen within the slit lamp beam. If the foreign body is anything other than superficial, it should be referred to the local eye unit for further assessment and removal. Foreign body removal should always take place at a slit lamp to provide magnification and stability for the patient’s head. If this is not possible, consideration should be given to referral to a more appropriate setting.

* Instill topical anesthetic.
* Use a 21G needle; bore upwards to gently lift off the foreign body from the cornea.
* Metallic foreign bodies may need slightly more forceful removal.
* rust must be removed at some point. This can be facilitated by giving the patient chloramphenicol ointment or drops to use for 2 or 3 days, and then reviewing in the ed or in the eye unit. rust is much easier to remove at this stage. Again, an antibiotic or ointment should be prescribed until the eye feels back to normal.

Once an foreign body is removed, treatment is the same as for a corneal abrasion and should be focused on preventing infection, relieving pain, and optimizing healing