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**EMERGENCY MANAGEMENT OF FOREIGN BODY IN THE EYE**

What is a foreign body?

It is any particle such as dirt, metal or sawdust that lodges on the surface of the eye or inside the eye. The main causes are dust carried by wind, metal fragments from grinding, and wood particles from drilling or cutting.

Most foreign bodies are found under the eyelid or on the surface of your eye.

1. After examination, you should:
2. Protect the eye from further damage by using an eye shield.
3. Administer systemic analgesics.
4. Administer prophylactic broad-spectrum systemic antibiotics.
5. Administer anti-emetics if the patient has nausea or vomiting.
6. Update tetanus prophylaxis.
7. Recommend ‘nil by mouth’ status in preparation for surgery.
8. Carefully document all findings and actions taken.
9. Take note:
10. Defer Intra ocular pressure measurements in patients with lacerations
11. Avoid any pressure on the globe; for example, do not press on the sclera
12. Do not attempt to pull out any foreign material that may be sticking out of the eye.
13. A person may need to take antibiotic eye drops to treat corneal scrapes and protect against eye infections. Over-the-counter (OTC) pain relievers, such as ibuprofen and acetaminophen, can reduce any pain.

**EMERGENCY MANAGEMENT OF EPISTAXIS**

1. Epistaxis is defined as acute hemorrhage from the nostril, nasal cavity, or nasopharynx
2. Examine /Ensure secure airway
3. Attempt to visualize site of bleeding. Have patient gently blow nose to clear the clots. Obtain adequate lighting and use a nasal speculum, if available.
	1. In the treatment of “active” anterior epistaxis, merely spraying the anterior cavity with
	2. a combination vasoconstrictor and local anaesthetic is often not enough to stem the bleeding
	3. Using cotton wool, you can form a wick of about 5 cms long, and, after soaking it in a solution of constrictor/anaesthetic, apply it with a Tilley's forceps into the bleeding nasal cavity.
4. Ask the patient to apply digital pressure to the nose for about 10 minutes. The increased contact to the bleeding point in Little's area is more likely to stem the bleeding, and can then be localised and cauterised.
5. The digital pressure applied to the nose is better applied with the fingers in a flexed, fist like position and the dorsal aspect of the middle phalanx of the index finger resting on the maxilla. The pinch action is then completed by applying the palmar aspect of the interphalangeal joint area of the thumb to the lower part of the nose on the other side.
6. Apply ice compress to dostrum of the nose
7. Instruct client not to speak swallow or cough
8. Silver Nitrate/Cautery
9. If a bleeding anterior vessel is identified, an attempt at chemical or electrical cautery can be made. Silver nitrate sticks offer an easily accessible and efficacious.
10. Gently clean nostril to mop up dribble
11. Interventional Radiology or Surgery.
	1. ENT consultation should be obtained in a timely manner for severe, refractory bleeding that may require intravascular embolization or surgical ligation.

**EMERGENCY MANAGEMENT OF CARDIAC ARREST**

Medications and Interventions

1. Begin CPR using Basic Life Support interventions immediately. Compressions must be at least 100 per minute and consistently fast and depressed 2 - 2.4 inches.
2. Airway must be placed to deliver oxygen and to aid respiratory efforts.
3. Insert IV (intravenous) or IO (intraosseous) to give emergent access into the bone.
4. Epinephrine is the drug of choice for PEA and asystole. Use 1mg every 3-5 minutes.
5. Locate the cause of the event if possible.

**EMERGENCY MANAGEMENT OF CARBON MONOXIDE POISONING**

Carbon Monoxide poisoning is a type of inhalation poisoning through over exposure to carbon monoxide. It may occur at home or in industrial places. It may be in the form of accidental inhalation or intentionally inflicted like that of suicide. It primarily causes tissue anoxia, which later leads to more severe health problems, and worst, death.

ASSESSMENT

1. Assess immediately for airway. If it is due to carbon monoxide smoke inhalation, stridor may be assessed. This is due to the formation of laryngeal edema from thermal injury.
2. Check for airway obstruction if client is unconscious. Muscles around air passages may relax if the client turned unconscious due to prolonged exposure or massive poisoning.
3. Assess for breathing. Client may manifest respiratory depression (5-10 per minute).
4. Position to semi-Fowler’s if not contraindicated.
5. Secure safety through side rails.
6. Administer 100% via face mask. Make sure the mask fits the client’s face to deliver desired amount.
7. Monitor for signs on the necessity for intubation.

**FOLLOW-UP ASSESSMENT**

1. Gather incident history from the patient or any person, particularly the type and length of exposure.
2. Determine client’s underlying health status that would cause higher risk, especially for presence of anemia, pulmonary disease, and/or cardiac disease.
3. Monitor vital signs.
4. Expect for an elevated respiratory and pulse rates.
5. Be alert for altered breathing pattern and episodes of apnea.
6. Recheck for the level of consciousness. Monitor signs of cerebral hypoxia (confusion), for it has the possibility of rapid progression to coma.
7. Assess for other neurologic and other systemic signs like:
8. Dizziness
9. Headache
10. Muscular weakness
11. Palpitations
12. Assess for signs of acute respiratory distress syndrome (rales and/or wheezes).
13. Monitor Aterial Blood Gas (less than 12% is still considered normal)
14. Greater than 30% to 40% may be present for severe poisoning.
15. Monitor skin for signs of severity with the perfusion.