MATRIC NO: 16/MHS02/027

COURSE TITLE: ADVANCED MEDICAL SURGICAL NURSING

COURSE CODE: NSC 408

CARDIAC ARREST

This is a sudden, unexpected loss of heart function, breathing and consciousness. This usually results from electrical disturbance in the heart. It is not the same as heart attack

* Perform CPR and monitor cardiac rhythm.
* Give 1mg epinephrine with an IV or an endotrachial tube and repeat every 3-5 minutes.
* Continue CPR and medication until cardiac rhythm is normal
* Take proper patient history
* Continue to monitor patient vital signs
* Position patient in a fowlers position
* Ensure adequate diet

CARBON MONOXIDE POISONING

Carbon monoxide is sometimes called the silent killer, and aptly so. It is a gas that is produced by incomplete combustion of carbon- containing material, it is colorless, odorless, and tasteless, and carbon monoxide (CO) can be lethal. Despite large-scale public education and prevention programs, CO exposure is still a serious public health problem. The pathophysiology, clinical effects, and the best methods for treating CO poisoning have been intensively studied, but there are still areas of uncertainty and controversy.

Carbon monoxide is produced when carbon-containing materials such as coal, oil, tobacco, or wood are burned. Common sources of CO exposures that can cause poisoning are automobile exhaust fumes, fumes from any gasoline powered engine, natural gas, and wood fires. It is important to remember that CO poisonings happen because of the production of CO that occurs when the source material is burned and when these combustion fumes are not properly ventilated.

MANAGEMENT

* 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. Pulse oximetry, although not useful in detecting carboxyhemoglobin HbCO) is still important because a low saturation causes even greater apprehension in this setting.
* 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 measurements from the 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
* Avaoid exertion to limit tissue oxygen demand.

EPISTAXIS

Epistaxis is relatively common but rarely fatal. Anterior bleeding is usually managed by digital pressure, gentle chemical cauterization, or nasal packing. Posterior bleeding, which is less common, is characterized by massive bleeding that is initially bilateral. This bleeding may be difficult to control.

MANAGEMENT

• Put on protective gear, including gown, gloves, and face 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 patient to apply direct external digital pressure to the nares with index finger and thumb. Tell patient to breathe through her mouth while they hold firm pressure on the soft flesh of their 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 patient 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 patient’s 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 patient about any prescribed antibiotics. If patient has posterior packing, they’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 self, forcefully blowing nose, or bending over. Patient should also avoid NSAIDs, alcoholic beverages, and smoking for 5 to 7 days. Tell patient to apply water-soluble ointment to their lips and nostrils while packing is in place and to use a cool-mist room humidifier. Advise patient to take steps to prevent constipation and straining, which increases the risk of bleeding.
* Do not leave the patient unattended during epistaxis.

FOREIGN BODY IN THE EYE

A foreign body in the eye is something that enters the eye from outside the body.it can be anything that does not naturally belong there, from a particle of dust to a metal shard. When a foreign body enters the eye, it will most likely affect the cornea or the conjunctiva.

Sysmptoms of foreign bodu in the eye include: a feeling of pressure or discomfort, sensation that something is in the eye, eye pain, extreme tearing, pain when on looks at light, excessive blinking, redness or bloodshot eye.

MANAGEMENT

* Restrict patient eye movement. Reassure patient
* An anesthetic drop will be use to numb the eye’s surface
* Fluorescein dye will be applied o reveals surface objects and abrasions.
* Locate object using magnifier and remove.
* If foreign object has caused corneal abrasion, antibiotic ointment may be prescribed to prevent infection.
* Pain medication like acetamoniphen can be prescribed
* CT scan or any other imaging may be required for further investigations.