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**COURSE: NSC 408 ASSIGNMENTS.**

**LEVEL: 400.**

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Read about Emergency Nursing and answer the following questions. Your submission must be typed (maximum of 4 pages) and uploaded as an attachment.

1. Management of cardiac arrest

2. Management of carbon monoxide poisoning

3. Management of epistaxis

4. Management of foreign body in the eye

**1). MANAGEMENT OF CARDIAC ARREST**

* MEDICAL MANAGEMENT OF CARDIAC ARREST
* Anti-platelet medicines
* Nitro-glycerine
* ACE ( Angiotensin converting enzymes) inhibitors
* Beta- blocking agents
* Coronary Angioplasty
* Coronary Artery Bypass Grafting
* NURSING MANAGEMENT OF CARDIAC ARREST
* Perform CPR (cardiopulmonary resuscitation) and monitor cardiac rhythm.
* Give 1 mg epinephrine with an IV or an endotrachial tube (breathing tube), and repeat every 3 - 5 minutes. You can also give vasopressin 40U, but one time only.
* Continue CPR and medication until the cardiac rhythm returns to normal or the patient expires.

**2). MANAGEMENT OF CARBON MONOXIDE POISONING**

Move patient into fresh air immediately. Symptoms include headache, dizziness, nausea, shortness of breath, weakness and confusion.

Treatment may involve:

* **Breathing pure oxygen:** In the emergency room, patient may breathe pure oxygen through a mask placed over the nose and mouth. This helps oxygen reach their organs and tissues. If they cannot breathe on their own, a machine (ventilator) may do the breathing for them.
* **Spending time in a pressurized oxygen chamber.** In many cases, hyperbaric oxygen therapy is recommended. This therapy involves breathing pure oxygen in a chamber in which the air pressure is about two to three times higher than normal. This speeds the replacement of carbon monoxide with oxygen in your blood.
* **Hyperbaric oxygen therapy** may be used in cases of severe carbon monoxide poisoning. It helps protect heart and brain tissue, which are particularly vulnerable to injury from carbon monoxide poisoning. Hyperbaric oxygen therapy may also be recommended for pregnant women because unborn babies are more susceptible to damage from carbon monoxide poisoning.

**3). MANAGEMENT OF EPISTAXIS**

* 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 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 anaesthetic 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 non-steroidal anti-inflammatory drugs (NSAIDs), anti-platelet 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.

**4) MANAGEMENT OF FOREIGN BODY IN THE EYE**

1. Provide analgesia as required as per pain scale.
2. Clean external area of any wound/s with sterile water or 0.9% sodium chloride
3. Attempt to remove small, superficial foreign bodies with a sterile needle and / or sterile fine forceps – if removal is unsuccessful discontinue NDEC and escalate to medical officer.
4. Apply dressing/s where appropriate
5. Consider administration of Tetanus Toxoid as per immunisation history and [Tetanus Toxoid Standing Order](https://aci.health.nsw.gov.au/__data/assets/pdf_file/0009/286776/Tetanus_Toxoid_NDEC_Standing_Order.pdf)
6. Document assessment findings, interventions, investigations and outcomes.

Management objectives include relieving pain, avoiding infection, and preventing permanent loss of function. Topical antibiotic drops (e.g, polymyxin B sulfate-trimethoprim [Polytrim], ofloxacin [Ocuflox], tobramycin [Tobrex] qid) or ointment (e.g, bacitracin [AK-Tracin], ciprofloxacin [Ciloxan] qid) should be prescribed until the epithelial defect heals to prevent infection. Topical cycloplegic (cyclopentolate 1% qd/bid) can be considered for pain and photophobia, although a review of the literature shows that they are not effective. Pressure patch or bandage contact lens is best avoided (unless the epithelial defect is >10 mm2 and then bandage contact lens may be the better option).The following scenarios represent high risk for the patient to develop permanent vision loss. Do not patch if any of the following are present:

* A chance of a perforation of the globe exists.
* A corneal infiltrate is present.
* A chance of a retained intraocular foreign body is possible.