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**LEVEL: 400.**

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**QUESTION**

Still on Emergency Nursing: Four emergency nursing conditions were identified in our last assignment (cardiac arrest, carbon monoxide poisoning, epistaxis and foreign body in the eye), read more and **identify/explain 4 more emergency nursing conditions and their management**

1**)** Bleeding

2) Breathing difficulties

3) Someone collapses

4) Severe pain

**1) BLEEDING:** Cuts and wounds cause bleeding, but severe injury can also cause internal bleeding that you cannot see.

* **NURSING MANAGEMENT**
* Ensure that it is safe to approach the casualty;
* If possible, wash your hands using soap and water to minimise the risk of cross-infection
* If they are available, don gloves
* Carefully remove any clothing that is covering the casualty’s wound
* If an object is embedded in the wound, do not remove it;
* Place a sterile dressing pad over the wound. If this is not available, improvise by using a clean piece of non-fluffy material to cover the wound
* Apply firm pressure to the pad using the fingers or palm of the hand. In some situations, it may be reasonable and practical to ask the casualty to maintain this pressure. Ensure no pressure is applied to an embedded object
* Handle the injured part as carefully as possible, as there may be an associated injury such as a limb fracture;
* If appropriate, raise the injured limb so it is higher than the level of the heart. Gravity will help to reduce the flow of blood to the wound;
* Encourage the casualty to lie down – this will reduce blood flow to the wound and help to minimise the effects of shock
* Ensure that the emergency services have been alerted
* Reassure the casualty and stay with them until more help comes;
* Make sure to keep the patient warm, for example by placing a blanket or coat over them;
* If you are able to do so, regularly monitor the casualty’s vital signs including respiratory rate, pulse rate and level of consciousness. If possible record the casualty’s blood pressure (if a sphygmomanometer is available at the moment);
* If the casualty’s level of consciousness deteriorates, place them in the recovery position and continue to monitor their vital signs. If the casualty stops breathing, send someone to alert the emergency services again and start resuscitation;
* Where wounds are extensive, effective haemorrhage control may only be achieved by applying indirect pressure over a proximal artery such as the femoral or brachial artery.

**2) BREATHING DIFFICULTIES:** There can be a number of reasons why someone may have difficulties in breathing. For example, asthma attacks, allergic reaction ([anaphylaxis](https://www.nhs.uk/conditions/anaphylaxis/)), and coughs or colds.

* **NURSING MANAGEMENT**
* Check the person's airway, breathing, and pulse. If necessary, begin [CPR](https://medlineplus.gov/ency/article/000010.htm).
* Loosen any tight clothing.
* Help the person use any prescribed medicine (such as an asthma inhaler or home oxygen).
* Continue to monitor the person's breathing and pulse until medical help arrives. DO NOT assume that the person's condition is improving if you can no longer hear abnormal breath sounds, such as wheezing.
* If there are open wounds in the neck or chest, they must be closed immediately, especially if air bubbles appear in the wound. Bandage such wounds at once.
* A "sucking" chest wound allows air to enter the person's chest cavity with each breath. This can cause a [collapsed lung](https://medlineplus.gov/ency/article/000087.htm). Bandage the wound with plastic wrap, a plastic bag, or gauze pads covered with petroleum jelly, sealing it on three sides, leaving one side unsealed. This creates a valve to prevent air from entering the chest through the wound, while allowing trapped air to escape from the chest through the unsealed side.
* DO NOT:
* Give the person food or drink.
* Move the person if there has been a head, neck, chest or airway injury, unless it is absolutely necessary. Protect and stabilize the neck if the person must be moved.
* Place a pillow under the person's head. This can close the airway.
* Wait to see if the person's condition improves before getting more help.

**3) SOMEONE COLLAPSES:** If someone has collapsed, they are likely to need medical attention. This is because their levels of consciousness or breathing could be affected. There can be a number of different medical reasons which can cause someone to collapse.

* **NURSING MANAGEMENT**

### A) Ensure personal safety

* There are very few reports of harm to rescuers during resuscitation.
* Your personal safety and that of resuscitation team members is the first priority during any resuscitation attempt.
* Check that the patient’s surroundings are safe.
* Put on gloves as soon as possible. Other personal protective equipment (PPE) (eye protection, face masks, aprons, and gowns) may be necessary especially when the patient has a serious infection such as tuberculosis.
* Be careful with sharps; a sharps box must be available. Use safe handling techniques for moving victims during resuscitation.

### B) Check the patient for a response

* If you see a patient collapse or find a patient apparently unconscious, assess if he is responsive (shake and shout). Gently shake his shoulders and ask patient questions
* If other members of staff are nearby it will be possible to undertake several actions simultaneously.

### C) If the patient responds

* Urgent medical assessment is required. Call for help .This may include calling a resuscitation team (e.g. medical emergency team (MET)).
* While waiting for the team, assess the patient using the ABCDE (Airway, Breathing, Circulation, Disability, and Exposure) approach.
* Give the patient oxygen. Use a pulse oximeter to guide oxygen therapy.
* Attach monitoring: a minimum of pulse oximetry, ECG and blood pressure.
* Record vital signs observations and calculate the early warning score.
* Obtain venous access, and take blood samples for investigation.
* Prepare for handover using SBAR (Situation, Background, Assessment, Recommendation) or RSVP (Reason, Story, Vital signs, Plan).

### D) If the patient does not respond

* Shout for help (if not done already).
* Turn the patient on to his/her back.
* Open the airway using head tilt and chin lift.
* If there is a risk of cervical spine injury, establish a clear upper airway by using jaw thrust or chin lift in combination with manual in-line stabilisation (MILS) of the head and neck by an assistant (if enough people are available). If life-threatening airway obstruction persists despite effective application of jaw thrust or chin lift, add head tilt a small amount at a time until the airway is open; establishing a patent airway, oxygenation and ventilation takes priority over concerns about a potential cervical spine injury.
* Keeping the airway open, look, listen, and feel to determine if the victim is breathing normally. This is a rapid check and should take less than 10 seconds:
  + Look for chest movement (breathing or coughing)
  + Look for any other movement or signs of life
  + Listen at the victim’s mouth for breath sounds
  + Feel for air on your cheek
* Check for breathing and assess the carotid pulse at the same time. The assessment should take less than 10 seconds whether you do a pulse check or not.
* Agonal breathing (occasional, irregular gasps) is common in the early stages of cardiac arrest and is a sign of cardiac arrest and should not be mistaken for a sign of life. Agonal breathing and limb movement can also occur during chest compressions as cerebral perfusion improves, but is not indicative of a return of spontaneous circulation (ROSC).
* Changes in skin colour (e.g. pallor, cyanosis) in isolation are not diagnostic of cardiac arrest.8
* If the patient is already attached to monitoring in a critical care area this will add to rather than replace the assessment for signs of life.
* Monitor patient every 10-20 minutes after resuscitation in case of any complications.

**4) SEVERE PAIN:** Everyone experiences pain in different ways, depending on their pain threshold, we all experience aches and pains from time to time. Pain can occur suddenly or increase over a period of time. Pain can be caused due to illness or injury. Severe pain tends to be more intense and, in some cases, will stop people from being able to carry out normal daily activities.

* **NURSING MANAGEMENT OF SEVERE PAIN**
* Determining the nature of the pain and its impact on the resident
* Identifying factors that affect the patient’s perception and expression of pain
* Determining when to administer analgesics
* Deciding which analgesic to administer, if more than one is ordered
* Determining the dose of the analgesic medication to administer, if a range is prescribed
* Evaluating the effectiveness of the analgesic
* Assessing for and managing side effects of the medication
* Determining why the analgesic was ineffective, if applicable
* Determining the need to change the dose, timing, or medication and reporting this information to the healthcare provider
* Using nursing interventions to promote comfort and relieve pain
* Making sure the plan of care describes pain assessment and management
* Documenting pain assessment and intervention noted herein to reflect use of the nursing process