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Assignment Title: Emergency Nursing 2

Course Title: Advanced Medical/ Surgical Nursing II

Course Code: NSC 408

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

**SEIZURES**

A seizure occurs as a result of a sudden surplus of electrical activity in the brain producing an abnormal neuronal discharge within cerebral tissue. The type of seizure that a person has depends on the area of the brain where this activity occurs. Grand mal seizures hthat produce repetitive tonic– clonic movements are those most frequently seen in the emergency set- ting. Epileptic seizures are classed as partial or generalized. Partial seizures involve part of the brain, whereas generalized seizures involve the whole brain. It is possible for partial seizures to become generalized if the epileptic activity spreads to the whole brain. After a seizure, a post-ictal state ensues, characterized by muscle relaxation and deep respiration. This may last from a few minutes to several hours.

In ‘status epilepticus’, there are multiple seizures without respite or recovery between seizures. This is an emergency condition, and it can result in respiratory difficulties or irreversible cerebral damage if it is not treated immediately. Nurses must remember that seizures are a manifestation of an underlying condition.

Disorders that give rise to seizures include:

* epilepsy
* stroke
* metabolic disorders
* pregnancy-induced hypertension
* alcohol withdrawal
* overdose of barbiturates, cocaine, or benzodiazepines
* previous neurological trauma.

Symptoms

* aura—taste, smell, or sounds preceding the seizure
* Fever and/or tremors.
* active seizure—tonic–clonic seizure
* Deep respiration.
* Possible cyanosis.
* raised temperature.
* Incontinence.

Nursing assessment and interventions

The immediate aim of treatment is to stop the seizure and to protect the patient during the seizure. Some of the nursing assessments and interventions are;

* Position the patient in the recovery position.
* Check airway, breathing, and circulation, and give high-flow oxygen. use suction, if necessary.
* Keep the cot sides up on the trolley.
* Obtain IV access; check CBG levels, and administer anticonvulsant medication as prescribed (IV, or per rectum (Pr) if there is no IV access) or according to local policy.
* Record vital signs as soon as the seizure ceases, and maintain frequent observations, whilst the patient is post-ictal.
* Continually reassure the patient, who may feel very confused and frightened after a fit.
* Other investigations that may be indicated if this is the patient’s first fit include full blood count, urea and electrolytes, blood glucose levels, electrocardiogram, and chest X-ray.

Nurses must remember that any disorder of the CNS is very frightening for the patient, so, when caring for the patient, they must be calm and reassuring.

**UNSTABLE ANGINA**

Any condition that affects myocardial oxygen demand can worsen existing stable angina, leading to unstable angina.

Unstable angina and myocardial infarction may be hard to differentiate initially, so the assessment and early management are similar. Unstable angina is a medical emergency with a high 30-day mortality.

Symptoms

* Pain at rest.
* Pain lasting >15min.
* Pain greater than patient’s normal angina.
* Pain i in frequency/severity/duration.
* Associated shortness of breath, nausea and vomiting, or other new symptoms
* Arrhythmia or left ventricular failure (LVF).

Conditions that can cause stable angina to worsen to form unstable angina

* Anaemia. Hemoglobin affects oxygen delivery. Obtain FBC.
* Tachycardia, e.g. Atrial fibrillation. i myocardial oxygen demand.
* Hypoxia. oxygen delivery.
* Hypotension. Significant hypotension d coronary artery perfusion.
* Pyrexia. i myocardial OXYGEN demand—typically by i vasodilatation and thus hR.
* Valve disease. Aortic stenosis i myocardial OXYGEN demand/workload. All valve disease i the risk of AF.
* Multiple pathologies. A combination of systemic illness (e.g.pneumonia), pyrexia, d oxygenation, and i hR can combine to produce unstable angina.

Management and nursing interventions

**Immediate management**

* Rapid assessment
* ABCDE airway, breathing, circulation, disability, exposure/AMPLE/PQRST.
* Attach the patient to a cardiac monitor.
* Record BP and heart rate every 15min in the first hour; then reduce to hourly if stable.
* After repeating every 15min in the first hour, if the patient develops additional pain, this is an indication of potential instability.
* Review electrocardiograms in their correct sequence.
* Summon help if ST segment deviation is detected.

**Nursing intervention**

* Supplementary, as indicated.
* Glyceryl trinitrate (according to local patient group direction) or as prescribed.
* Aspirin 300mg (unless known allergy) by patient group direction or as prescribed.
* Establish IV access, and collect blood for urea and electrolytes (including Mg2+), FBC, cardiac enzymes, appropriately timed troponin I/troponin T (early may be negative), blood glucose, clotting, lipids (for risk stratification). If tachycardia, request thyroid function.
* Request chest X-ray.
* Assist the doctor in examination and assessment of the patient.
* Reassure the patient, and keep the relatives informed.

**APPENDICITIS**

Appendicitis is a common emergency department presentation in children and young adults. It is less common in patients >40years. Appendicitis is the commonest surgical emergency and should be considered as a cause of an acute abdomen in all patients if it has not been removed. The presentation can range from mild/moderate right iliac fossa (RIF)

pain to generalized peritonitis with associated shock. Presentations are often atypical; symptoms vary, and up to 45% of appendices that are removed are normal. In sexually active women, acute salpingitis associated with sexually transmitted infections (STIs) is a common cause of right iliac fossa pain. Pain can be bilateral, and there is an associated vaginal discharge.

The diagnosis of appendicitis is a clinical one, unless a CT scan has been performed and excludes it. Therefore, do not allow the surgeon to delay assessment by insisting on waiting until blood results are available.

Signs and symptoms

* Nausea.
* Vomiting.
* Abdominal pain. Classically, pain begins vaguely centrally/periumbilical and then localizes to the right iliac fossa.
* Fever.
* Diarrhea occasionally occurs.

Nursing assessment

Accurate nursing assessment should enable differentiation between patients with localized pain in the

right iliac fossa and those with more serious pathology, e.g. generalized peritonitis and shock. Assessment should also include investigations that may point to another cause.

* Vital signs.
* Pain assessment and score.
* Urinalysis.
* Last menstrual period; risk of pregnancy.
* Full blood count. The white cell count may be raised, but not always.
* Urea and electrolytes, β-hCG.

Nursing interventions

* IV access.
* Analgesia.
* IV fluids if nil per oral or dehydrated.
* IV antibiotics reduce the risk of post-operative complications associated with infection.
* Prepare for admission.
* Preoperative preparation may be required if theatre is arranged imminently.

**ACUTE RETENTION OF URINE**

In men, complaints are of suprapubic pain and a reduced or incomplete ability to pass urine. This may be 2° to a tumor or urethral stricture, or as a post-operative complication. Other causes seen in men and women are post-trauma, burns/scalds, uterine fibroids, infection, e.g. painful herpetic lesions, and blockage of long-term catheters.

Nursing assessment

**History**

* Last micturition, amounts of urine passed. Previous history.
* Consider a deliberate foreign body or a blocked indwelling catheter (IDC).
* Again provide privacy and a room with a door.
* Bladder decompression with an in dwelling catheter is required if no contraindications, e.g. trauma or strictures.

**Observation/inspection**

* Obvious discomfort/distress. Exceptions are patients with chronic retention; this may be painless.
* Use a bladder scan to assess the size of the bladder.
* Abdominal percussion may reveal a distended bladder.
* Cloudy urine or pus with infection.
* Frank hematuria.
* Genital trauma, urethral bleeding in the unconscious patient.
* Palpation. Tender, enlarged bladder.
* Percussion: suprapubic and above may be dull;
* Reduced or absent bowel sounds with constipation.
* Pyrexia indicates infection.
* Tachycardia due to this, pain, or hemorrhage 2° to infection, tumor, accidental or deliberate trauma.

Management

* An in dwelling catheter will provide pain relief. Insert, using an aseptic technique.
* Observe the urinary output for amount and frank haematuria.
* Document the catheter gauge and residual urine amount.
* Clamp after 1litre has drained. Blood vessels previously compressed may now vasodilate with rebound hypotension.
* Remove the clamp after 30min.
* Confirm/exclude infection on urinary dipstick, and send an midstream urine specimen to the laboratory.