

Medical/Surgical Nursing Assessments

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Introduction

Medical-surgical nursing assessment is a continuous process of observing, measuring, interpreting, prioritizing, and reassessing rather than a one-time checklist. In the John Doe case, the nurse must integrate the patient's wound or cellulitis, pain, respiratory status, renal function, hydration, nutrition, mobility, medications, laboratory trends, and discharge needs into one clinical picture. The most important responsibility is detecting change early and escalating findings that suggest deterioration. Baseline observations should include respiratory rate, oxygen saturation, heart rate, blood pressure, temperature, and level of consciousness, with additional assessment guided by the patient's condition. NICE recommends systematic physiological monitoring and an escalation response when abnormalities or clinical concern indicate that an acutely ill adult may be worsening (NICE, 2024). Nursing judgment is therefore not simply the completion of ordered tasks. It includes recognizing when an assumption is unsafe, when an order requires clarification, and when several apparently separate findings may share a common cause. A patient with infection, changing renal function, medication exposure, and new symptoms requires integrated reassessment rather than automatic continuation of the existing plan.

Wound and Cellulitis Assessment

For cellulitis or a wound, assessment should document the location and extent of redness, warmth, swelling, tenderness, drainage, odor, tissue appearance, wound edges, and any progression from prior findings. Marking the boundary of cellulitis can help monitor spread, while reassessment is required if symptoms worsen rapidly, the patient becomes systemically unwell, or improvement does not begin as expected (NICE, 2019). Microbiological swabbing should not be treated as an automatic requirement for uncomplicated cellulitis. NICE advises considering a swab when the skin is broken and circumstances such as penetrating injury, water exposure, or acquisition outside the United Kingdom make an unusual organism more plausible. The nurse should also consider underlying contributors such as edema, venous disease, diabetes, impaired mobility, or skin damage and communicate them to the medical team. Pain out of proportion to visible findings, rapidly spreading inflammation, systemic instability, or concern for sepsis or necrotizing infection requires urgent review. Wound management should be matched to tissue condition, drainage, and the prescribed plan rather than assuming every dressing must be changed at the same interval.

Medication Safety and Renal Monitoring

Medication safety is especially important when an aminoglycoside such as gentamicin appears in the case. A fixed regimen should not be presented as a universal adult dose because aminoglycoside dosing depends on the indication, body size, renal function, dosing strategy, serum concentrations, and local antimicrobial protocol. The nurse's role is to verify the prescription, review allergies and relevant laboratory values, document administration accurately, and recognize changes that require escalation. Renal assessment should include urine output, fluid balance, creatinine trends, hydration status, and concurrent medicines that can affect kidney function. If renal function worsens or serum monitoring is due, the next dose may require review under local policy before administration; the nurse should contact the prescriber or pharmacy team rather than independently designing a replacement regimen. Symptoms such as hearing change, tinnitus, dizziness, or balance disturbance may also be clinically relevant because aminoglycosides can cause ototoxicity. Medication administration is therefore an active safety process. An order that was appropriate yesterday can become unsafe when the patient's physiology changes, making reassessment and timely communication essential.

Whole-Patient Care Priorities

Nutrition, hydration, pain control, mobility, and respiratory assessment should be individualized rather than handled through generic instructions. Wound healing requires adequate energy, protein, micronutrients, and fluid, but a universal recommendation to drink a fixed number of liters is inappropriate when renal, cardiac, hepatic, or other conditions may require a different target. The nurse should review appetite, weight change, oral intake, swallowing, nausea, urine output, ongoing losses, and prescribed fluid goals, seeking dietetic input when nutritional risk is significant. Pain assessment should identify severity, quality, timing, triggers, functional effect, and response to treatment. Mobility should be encouraged safely because prolonged immobility can contribute to deconditioning, pressure injury, constipation, venous thromboembolism, and respiratory complications. New tachypnea, hypoxemia, abnormal breath sounds, confusion, or increasing work of breathing should not automatically be attributed to anxiety. Respiratory infection, sepsis, fluid imbalance, medication effects, pain, and other causes may coexist. A structured reassessment of vital-sign trends and the whole clinical picture reduces anchoring on one diagnosis and supports earlier escalation when the patient's condition changes.

Recognizing and Escalating Deterioration

When deterioration is suspected, nursing assessment should move from routine monitoring to structured escalation. A patient who develops reduced urine output, worsening vital signs, confusion, new respiratory difficulty, severe pain, or rapidly spreading infection requires prompt review

according to local track-and-trigger and rapid-response procedures. NICE guidance emphasizes that physiological abnormalities and professional concern should produce a graded response, ranging from increased monitoring to urgent medical and critical-care review depending on severity (NICE, 2024). Repeating observations is useful only when the results lead to action. The nurse should communicate the trend, relevant medications, fluid balance, recent interventions, and the specific concern rather than reporting isolated numbers without context. Diagnostic testing and treatment decisions belong to the responsible clinical team, but nurses contribute essential longitudinal information because they often observe change between medical reviews. The case should also avoid assuming that one symptom proves a particular diagnosis. Headache and nausea do not automatically require brain imaging, just as tachypnea does not automatically prove anxiety. Assessment should first identify urgent physiological threats, then support targeted investigation based on the complete presentation.

Discharge Planning and Safety-Netting

Discharge planning should begin before the final day and should test whether John can manage safely outside the hospital. Clinical stability is necessary, but so are medication reconciliation, wound-care competence, follow-up arrangements, mobility, nutrition, and understanding of warning signs. If home dressing is required, the patient or caregiver should receive specific instructions about hand hygiene, supplies, dressing changes, and when to seek help. Advice should explain that skin appearance may take time to normalize even after infection begins to improve, while rapidly spreading redness, increasing pain, fever, systemic illness, new drainage, reduced urine output, or significant medication adverse effects require review (NICE, 2019). Any antimicrobial plan should clearly state the drug, duration, monitoring requirements, and who will review results. Community nursing, wound-clinic follow-up, primary care, pharmacy, or other services may be appropriate depending on complexity and social circumstances. Discharge education should use teach-back rather than assuming that handing the patient written instructions proves understanding. A safe transition reduces the risk that improvement achieved in hospital is lost through confusion, inaccessible care, or an unrecognized recurrence.

Conclusion

Medical-surgical nursing assessment is most effective when it connects observations rather than treating wound care, medication administration, renal monitoring, respiratory assessment, pain, nutrition, mobility, and discharge as unrelated tasks. In John Doe's case, the priorities are to establish a reliable physiological baseline, monitor the cellulitis or wound for progression, recognize the conditions under which microbiological testing is useful, and maintain medication safety when renal function or aminoglycoside exposure creates additional risk. No generic gentamicin dose should be copied into the care plan without patient-specific prescribing and monitoring, and no new symptom should be explained by anxiety before serious physiological causes have been considered. Current guidance supports systematic recognition of deterioration, appropriate escalation, and safety-netting

when cellulitis fails to improve or worsens (NICE, 2019; NICE, 2024). The nurse's distinctive contribution is continuous clinical surveillance combined with communication: noticing meaningful change, relating it to treatment and physiology, and ensuring that the responsible team acts before preventable harm develops. That approach makes assessment a dynamic patient-safety process rather than a list of boxes completed once per shift.

References

National Institute for Health and Care Excellence. (2019). *Cellulitis and Erysipelas: Antimicrobial Prescribing* (NG141).

National Institute for Health and Care Excellence. (2024). *Acutely Ill Adults in Hospital: Recognising and Responding to Deterioration* (CG50, current recommendations).