

Medical/Surgical Nursing Assessments

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Assessment 1

After The night handover, the RN will begin her duty by conducting a mini-assessment of John Doe. The assessment will be based on a quick visual and physical assessment. The nurse will use a stethoscope to listen to various parts of the body. This includes listening to the lungs to note any abnormalities in the lung sounds. The heart sound is listened to for abnormal sounds. The heart is further evaluated for valve functions and rhythm. Percussion is done to discover fluids in the unwanted areas and locate the borders and size of the organs. Other things to be checked are height, weight, and pulse. The blood pressure and circulation will also be measured. The nurse will then assess the mental well-being, the patient's overall appearance, consciousness level, and vital signs before dwelling on the primary problem the patient has. New vital signs for blood pressure, heart rate, respiratory rate, and temperature (Duplantier & van, 2013).

Renal assessment; this assessment deals with any aspects of urinary elimination; the patient's hydration status, diet and fluid restrictions, urine output, urinalysis, and blood chemistry are tested.

Skin assessment: John has an open wound, and he would need his skin to be assessed. The skin around the wound should be observed for any color changes, fluid buildup in the wound, itchiness, and inflammation. The nurse should obtain the history of the wound from the patient.

The framework for conducting assessments on the patient is to generate appropriate information for the patient-sensitive results and give the patient the right treatment and plan of care (Phoenix, Das & Joshi, 2012). Conducting the assessments inaccurately may lead to wrong treatment and patient care.

Assessment 2

In the nursing care plan for John Doe, the treatments should bring desired outcomes. The patient will be expected to display timely wound healing without any complication, maintain their nutrition and well-being, verbalize feelings to increase his self-esteem, participate in a psychiatric treatment program, adopt a skincare routine, treat other arising infections and develop home-based care for the patient (Brölmann et al., 2012).

1. Wound Healing

- The goal is to ensure the timely healing of the wound with no further complications.

Nursing Interventions

- Patients with gram-positive wound infections base their care on the antibiotic regime.
- Obtain a secure specimen from John's wound to indicate the right therapy.
- Complications will be monitored daily to note any complications and monitor the wound healing process.
- Cleaning the wound area; keeping the wound area clean and dry, dress it carefully daily to assist the body in the natural process of healing and repair (Lillis, et al., 2010).
- The wound will be cared for by using the right coverings.
- Consult with a wound specialist who can develop a plan for serious wounds.

Rationale

- Monitoring of the patient's wound infection.

Evaluation

- Timely wound healing with no complication
- Patient participation in preventive measures

2. Laboratory Tests

- To determine specific complications through laboratory diagnoses and giving the right medication.

Rationale/ intervention

- Monitoring of the laboratory tests to determine the urea level, gentamicin creatinine level, blood protein, white blood cell count, and hemoglobin level (Brölmann et al., 2012).
- The laboratory tests will determine heart, liver, and renal function.
- The urine culture test will determine if the patient has any infections due to urine incontinence (Brölmann et al., 2012).

Evaluation

- Elimination of other diseases that may contribute to the slow healing of the wound.
- Treating any infections noted immediately with the right medication.

3. Nutrition

- Nutrition is essential in patients as it contributes to their healing

Goal

- Boost the patient's immunity through the intake of healthy foods that contribute to cell regeneration and the addition of vitamins and minerals.

Nursing Intervention

- Encourage the patient to consume foods that are rich in protein, vitamins, minerals, and calories (Harris et al., 2010).

Rationale

- Healthy feeds help to support the immune system response. Patients with poor nutritional status are anergic, making them highly susceptible to infections (Brölmann et al., 2012).

Evaluations

- The patient had little appetite and was on a pure fluid diet. Further consultation with the nutritionist is to be conducted before his discharge.

4. Fluid intake

- Taking fluids will prevent the patient from being dehydrated.
- It is administered both orally and intravenously.

Goal of Care

- Increase body intracellular water to promote the excretion of waste; this will reduce infections.

Nursing Intervention

- Encourage the patient to take 2 to 3 liters of water daily unless contraindicated.

Rationale

- Fluids increase intracellular water levels, leading to effective biochemical processes that result in wound healing.

- Fluids make the urine diluted reducing urine stasis, in turn, bladder infections in the urinary tract are eliminated (Brown, et al., 2017).

Evaluation

- The patient remained hydrated, and the urine test confirmed there were no urinary tract infections.

5. Pain management

- Managing pain effectively reduces trauma to the patient.
- In this case, John is a chronic anxiety patient who should be effectively monitored by a psychologist to see the response in PCA.

Goal of Care

- To reduce unnecessary pain when the patient is ambulating and to make the patient feel comfortable with his condition.

Nursing Intervention

- Monitor the wound site at least once a day for any signs of infection.
- Determine pain changes and sensations by interviewing the patient.
- Pay attention to the patient's skin folds and bony prominences (Harris et al., 2010).

Rationale

- Pain may develop if the pain-relieving drug is not acting effectively.
- Pain can be managed by a change to another effective drug.
- Secondary pain develops most especially during movement and dressing (Rippon, Davies & White, 2012).
- The dressing pain can be managed by interventions that focus on reducing trauma and other things that contribute to wound pain.

Evaluation

- The wound did not display signs of infection.

6. Respiratory Tract Infection

- Cellulitis wounds can contribute to upper respiratory tract infections like pneumonia (Bailey &

Kroshinsky, 2011).

Goal of Care

- Reduce the risk of getting an upper respiratory tract infection

Nursing Intervention

- Encourage the patient to engage in cough and deep breathing exercises in different positions.

Rationale

- Deep coughs and breathing exercises help reduce the stasis of exudations in the lungs and bronchial tree.
- The occurrence of stasis leads to pneumonia; in addition, the patient may be highly susceptible to pathogens that cause upper respiratory tract infections (Bailey & Kroshinsky, 2011).

Evaluation

- The patient shows no signs of struggles in breathing, sounds in the lungs or interrupted sleep.

7. Limiting the number of daily visitors

- The goal of care is to prevent wound reinfection, most probably from the outside pathogens carried by the visitors.

Nursing Intervention

- Limit the patient's visitors.

Rationale

- Visitation restriction reduces the risk of pathogen transmission.
- In case any visitor comes to see the patient, they are provided with a surgical mask, especially for those sneezing and coughing.
- Instruct the visitors to cover their noses and mouths while sneezing (Rippon, Davies & White, 2012).
- They should sanitize their hands.

- The visitors should be educated on how they should eliminate pathogen infection in the patient, thus lowering the chances for the patient to heal.

Evaluation

- The patient fully recovered within 3 weeks of continued therapy.

Assessment 3

Gentamicin 300mg TDS, IV

Gentamicin was administered to John because he had a life-threatening infection (cellulitis). In the earlier therapy, it was administered in doses of higher concentrations because of the increase in extracellular water (Bailey & Kroshinsky, 2011). It was used to treat urinary infections; blood was seen in John's blood, indicating that he had upper urinary tract bleeding. The drug was used for synergy. The high-dose therapy should be extended in patients with renal impairment and adjusted on the serum levels (Tadesse et al., 2012).

Ibuprofen 400mg TDS, oral

Ibuprofen is an NSAID that blocks prostaglandin synthesis, thus inhibiting inflammation. It modulates the T-cell function, inhibits the inflammatory cells' chemotaxis and decreases the release of superoxide chemicals. In general, ibuprofen is a pain reliever and decreases wound inflammation (Rainsford, 2013).

Registered nurses should ensure they have the right knowledge that would enable them to handle drug administration. They are legally responsible for giving accurate drugs to the right patient, giving the right dosage with the right administration route, and also at the right time. Another responsibility delegated to the nurses is to monitor the effects that the drugs administered would have on the patient (Freund et al., 2015). The drugs administered may have the required effect, adverse reactions, and little or no effect.

When ibuprofen is administered, the nurse should monitor the patient from time to time. The nurse should question the patient if he is receiving the desired effect, if not, then the nurse should switch the patient to another alternative. This may include the use of topical pain medications; they come in gel, cream, and liquid form. Excessive use of ibuprofen may expose the patient to the risk of getting cardiovascular complications such as stroke, hypertension, and cardiovascular complications. Ibuprofen also increases systolic blood pressure.

When gentamicin is administered, the registered nurse should monitor the patient regularly because

of the potential toxicity the drug has. The renal function should be closely monitored by examining the urine for increased protein excretion, cell presence and a decrease in the specific gravity. Serum creatinine and blood urea nitrogen should be examined periodically (Prayle et al., 2010). The gentamicin serum concentration should be closely checked to ensure accurate levels, thus preventing toxicity. Any evidence of ototoxicity will require a dosage adjustment or discontinuation.

Assessment 4

Auscultation will be conducted to note any abnormal sounds in the lungs. The respiration rate should be measured; usually, it involves recording the depth and pattern of the patient's breathing. An irregularity was noted in John's breathing which might be an indication that he has an upper respiratory infection. During the observation of the respiratory rate, the patient's lip color should be noted. The oxygen saturation should be measured using an oximeter. Observe if the breathing is through the mouth, use of abdominal muscles, or flared nostrils. The respiration will be recorded along with other vital signs.

The abdomen will be examined to determine what is causing nausea. Auscultation will be conducted for bowel sounds and palpation of the abdominal masses. The mouth will be examined to look for any ulceration. For the head, a neurological test will be undertaken to examine John's vestibular function and a CT scan of the brain in case there is an increase in intracranial pressure. The serum creatinine level will be measured through a blood test to determine its level. A urine culture is conducted to rule out any infections. Finally, check if the patient is managing well with the PCA.

The patient may have a severe biochemical disturbance, thus causing the symptoms (Harris et al., 2010). John has a history of chronic anxiety, which might have contributed to headaches, nausea, and vomiting. Much fluid had accumulated in his body, thus leading to infection of the lungs and the eyes.

The serum creatinine in John's blood was high, indicating that the gentamicin was overdosed and needed to be stopped. The level of creatinine in the blood also contributed to some symptoms, such as nausea, headache, and renal failure. The kidney failed to excrete the water, which led to infections (tachypnea).

The RN will have to immediately stop the patient's administration of gentamicin and use another antibiotic to eliminate infections. Another drug will be needed to eliminate pain, and the chronic anxiety of the patient will be checked by a psychologist. The mentioned measures will eliminate biochemical disturbances, thus contributing to the timely healing of John's wound (Jemec et al., 2011).

Assessment 5

Taking good care of the wound after discharge will contribute to faster healing. The registered nurse will show the patient different habits that he should be involved in to help in the wound healing

process. First, the patient will be encouraged to use the medications that he has been given correctly. The ibuprofen will help in the reduction of pain and inflammation and the Gentamicin will help in the elimination of the bacteria. John should contact the hospital if he feels the medicine is not working or has side effects.

The second thing that the patient will do is take care of the wound. A family member can help him in doing this. The caretaker should ensure that the wound is always clean and dry. The wound should be covered when bathing to keep it dry. The wound should be cleaned with a wound cleaner and bandaged with clean bandages on a daily basis.

Their lifestyle of John will contribute to the recovery process of his wound; he should eat healthy foods like fruits and vegetables, fish, low-fat products, and cereals. These foods are healthy, and they will make him heal faster (Brown et al., 2017). Other health conditions that John has should be followed up on and managed by his healthcare provider because they may cause slow wound healing (mental well-being, blood pressure, and diabetes). The patient should also not get involved in using other illegal drugs as they too slow wound healing.

John may want more information on wound care, and this may be accessed by his community social workers, who would be making weekly visits, educating him on wound care, and also doing the dressing and rehabilitation...

Terminologies

- Stasis
- Exudation
- Ambulate
- Anergic

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