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| HLTENN011 Implement and monitor care for a person with acute health problems  [Name]  [Institution]  [Date]  HLTENN011 Implement and monitor care for a person with acute health problems |
| |  | | --- | | **Attention Students: This is an editable word document. This word copy of assessment is for student to work offline. Please DO NOT upload this document in Student Hub. You can copy and paste answers from this word document to your online assessment.** | | **Assessments** | | |  |  |  | | --- | --- | --- | | **Student** | : | Mariama Kamara - S1711554 | | **Course** | : | Diploma of Nursing | | **Course Offer** | : | 17NDONB11 | | **Course Unit** | : | HLTENN011 Implement and monitor care for a person with acute health problems | | **Assessment type** | : | Theory Assessment | | | |  | | --- | | 1. **List 5(five) sign or symptoms of an Acute Renal disorder**   Acute kidney failure occurred when the kidneys are unable to filter the unwanted product from the blood vessels (Albright Jr, 2001). The common sign and symptoms are:   * Fluid retention results in the swelling in the ankles or feet * Decreased output of urine * Fatigue * Shortness of breath * Nausea (Meroney, Lawson, Rubini, & Carbone, 1956). | |  |  |  | | --- | | 1. **List 5(five) nursing interventions for the management of acute diarrhea**   Nursing intervention for the management of acute diarrhea includes:   * Assessment of abdominal discomfort, liquid stools, urgency, cramping, and hyperactive bowel sensations. * Nurses have to evaluate the defecation patterns in order to have direct treatment. The stool will be tested by the nurse to find out potential etiologic organisms. * Nurse should be investigating about the tolerance of the patient to dairy products as diarrhea is a sign of lactose intolerance. * Nursing intervention also includes the check-up for food intolerance of the patient, as some foot increases the osmotic pressure of the intestine. * Recommendation of medication such as antibiotic can also be included in nursing intervention for the management of acute diarrhea (Wayne, BSN, & R.N., 2017). | |  |  |  | | --- | | **3.  Myocardial Infarction** | | 3.1  List **3(three)** signs or symptoms for a suspected Myocardial Infarction   * Acute myocardial Infraction is a medical term for heart attack and the common symptoms for suspected myocardial infarctions are * Pain in the chest, jaw, back and other areas of the upper body that goes away and come back or lasts for more than a few minutes. * Sweating * shortness of breath (Barefoot & Schroll, 1996).   3.2  List **3(three)** nursing interventions for a suspected Myocardial Infarction  Nursing Intervention:   * Treatment of acute coronary syndrome by the help of morphine, oxygen, nitroglycerine, and aspirin (MONA). * Assessing a 12 lead ECG on the chest of someone having chest pain to find out whether an ST elevated MI is happening or not. The ECG results are normal then, the patient should be assessed through cardiac monitoring. * Nursing intervention can also include the cardiac catheterization and monitoring of blood pressure (“Nursing Care Plan for Myocardial Infarction (MI),” n.d.). |  |  | | --- | | **4.  Mr John has been admitted to the Emergency Department with chronic Pneumonia and severe dehydration** | | 4.1  Define pneumonia (25-50 words)  Pneumonia is an infection that affects one or both lungs. It intensifies the air sacs in the lungs and in sometimes the air sac is filled with pus or fluid causing cough, chills, fever, and difficulty in breathing. Pneumonia is caused by microorganisms like viruses, fungi, and bacteria. It can vary in seriousness from mild to acute life-threating illness (Van Der Sluis et al., 2014).  4.2  List **4(four)** nursing diagnosis according to priority  **Nursing diagnosis according to priority:**   * Problem-focused diagnosis is about the clinical judgment that concerns the response of a human to a health condition * Health promotion diagnosis focuses on the desire and motivation to improve the well-being of the patient. The health promotion diagnoses include risk-prone behavior, sedentary lifestyle, and readiness for the status of enhanced immunization. * Risk nursing diagnosis is the third one and it looks at the vulnerability of the patient for developing a reaction to some specific health condition. It requires some finding regarding the risk factors like obesity, smoking, and advanced age. * Syndrome is the final nursing diagnosis and identifies the special group of diagnosis that makes a pattern and can be addressed with the help of similar nursing interventions. For example, a risk of ineffective cerebral or cardiac tissue perfusion (Carpenito-Moyet, 2006).   4.3  List **3(three)** possible Nursing Diagnosis for severe dehydration  **Possible Nursing Diagnosis for severe dehydration**   * + Report of no urine for max 4 hours.   + Report of vomiting   + Lethargy, fussiness, and irritability(Gulanick et al., 1986).   4.4  List **3(three)** nursing interventions  Nursing intervention   * + Asses Vitals like taking notes of the presence of fever, elevated breathing or heartbeat or dehydration   + Examination of skin for the symptoms of dehydration.   + Monition the output and intake of the patient to find out the fluid balance in the body (Gulanick et al., 1986). | |  |  |  | | --- | | **5.  Burns** | | 5.1  Using the Rule of Nines, estimate the percentage of burns for a person with second degree burns to both arms and chest.  **Rule of nine:**  The rule of nine estimates the percentage of burns in a human body and is useful to make treatment decisions. If both the arms and chest are burned then the percentage of burn according to the rule of nine would be 81 per cent. As both arms have a percentage of 4.5 each and chest’s percentage is 9 (Wachtel, Berry, Wachtel, & Frank, 2000).  5.2  List the three phases of psychological intervention planning you would implement in a burn case  **Critical stage:**  The characteristic of this face includes the stress, struggle for survival and uncertainty about the result of the treatment. The primary goal of this face is physical survival through various defense mechanism applied by the care center.  **Acute stage:**  That focusses on the restorative care, but the patient will continue to have painful treatment.  **Long term rehabilitation face:**  Begins after discharge from hospital and include patient’s physical rehabilitation, surgery or dressing element for a patient recovering from severe burns (Wiechman & Patterson, 2004). |  |  | | --- | | **6.  List three nursing interventions for the following Nursing Diagnosis related to burn management** | | |  |  |  | | --- | --- | --- | |  | **Nursing Diagnosis** | **Nursing Management** |   6.1   * **Promoting Gas Exchange and Airway Clearance** Nursing intervention could be encouraging patients to take a deep breath * Monitor that rate, effort, depth, and rhythm and of respiration * Nursing intervention could be the monitor the cough and respiratory secretion (Greenfield, 2010a).   6.2  Restoring fluid and Electrolyte Balance   * Nurse can be responsible for the complete blood count of the patient and will be checking the increasing and decreasing hematocrit value. * Screening test should be done to check the plasma level of an electrolyte like potassium, sodium, chloride, and bicarbonate. * The pH of urine and be checked and should be between4.6 and 8.2(Rogenes & Moylan, 1976).   6.3  **Maintaining Normal Body Temperature:**   * Covering up the head of the patient will help to minimize the loss of heat from the body * Room temperature should be kept elevated by the nurse to increase the patient’s body temperature. * Nurse intervention should also be included avoiding wet dressing and the usage of lukewarm water to maintain body temperature (Burns, Wojnakowski, Piotrowski, & Caraffa, 2009).   6.4  **Minimizing Pain and Anxiety**   * Detailed pain assessment can be done, and should be continued in a regular interval. * Nurses need to concentrate on stress-free pain management and psychological assessment of the patient and the family can be done. * Patient response to the pain management plan is checked and actions are taken accordingly (Greenfield, 2010b). |  |  | | --- | | **7.  Outline 2(two) examples of post-operative education for a client who has had a Total Hip Replacement and will soon be discharged** | | |  |  |  | | --- | --- | --- | |  | **Problem** | **Post-operative discharge education** |   7.1  **Pain management**  For the management of pain, the patient pain assessment should be done and the list of pain medication should be reconciled. Post-operative education for the patient could be to take the timely anti-inflammatory drug and not to sit in a position that can increase the pain (de Leon, 2016).  7.2  **Wound care**  Post-operative discharge education to patient regarding wound manage could be continuously changing the dressing of the wound to keep it safe from getting the infection by taking medication on time (de Leon, 2016).  7.3  **Potential complications**  Physical therapy is important to minimize the potential complication after hip replacement and antibiotic should be taken during, after or before any invasive procedure (de Leon, 2016). |  |  | | --- | | **8.  A client returned from theatre 20 minutes ago post bowel surgery with a GCS of 15. On examination of this client you find that their GCS has dropped to 10.** | | 8.1  What will you do?  If the patient is having a GCS of 10 then it means that the patient is in severe dysfunction. In that situation, I would try to manage his or safety. I would try to wake the patient up with the help of clear and loud vocal voice to check the patient response to that stimuli. I would also elicit a pain response by pushing behind the era (Basauhra Singh et al., 2016).  8.2  What are the possible causes?  The level of lowering of GCS can drop du to any injury in brain and in this case the patient will not be given proper airway management.  8.3  List **4(four)** members of the Emergency Response Team.   * Doctors * Nurses * Respiratory therapist * Pharmacists (Basauhra Singh et al., 2016). |  |  | | --- | | **9.  Total Parenteral Nutrition (TPN)** | | 9.1  What is TPN? (15 -30 words)  Total parenteral nutrition full fill the requirements of all-day nutrients. It is a method of feeding through the gastrointestinal tract. A specific formula is followed to give the body enough nutrients that it wants.  9.2  When would it be used? (30-60 words)  The methods can be used by some who is unable to take food or fluid through the mouth. It can be used both at home and in hospital. The doctor will choose the right amount of TPN solutions and calories. The cathedral will also be checked whether. It can be used by the patient with GI tract (Goldstein, Braitman, & Levine, 2000).  9.3  How is it administered (30-60 words)?  TPN can be administrated by a doctor and the water required for the solution should BE kept between 30-40 milliliter. Critical ill patients need 45 kcal of energy and children will be needing a different concentration of a fluid. Normally 2L of the solution is needed daily and can be modified upon laboratory testing (Goldstein, Braitman, & Levine, 2000).  9.4  List **4(four)** signs and symptoms to watch for at the insertion site?   * Bloodstream infection related to catheter also called sepsis should be taken care of. Aseptic technique should be strictly followed with insertion * The localized infection could be experienced at the entry and exit site. * Pneumothorax can happen if the catheter touched the pleural space * Hyperglycemia should be checked after the insertion (Goldstein, Braitman, & Levine, 2000). |  |  | | --- | | **10.  Obstructive Sleep Apnoea/CPAP** | | 10.1  List **4(four)** nursing interventions for a client diagnosed with Sleep Apnoea and receiving CPAP   * Nurse can take care of the ventilation setting to check the Inspiratory and expiratory pressure. * Oxygen therapy should be applied to ease breathing * Humidification is also needed in case of Sleep Apnoea * Regular oral hygiene needs to be improved (Mansfield, Antic, & McEvoy, 2013)   10.2  When would it be necessary to consult with an RN regarding a client diagnosed with Sleep Apnoea and receiving CPAP?  The patient who would be in high risk of adverse health outcomes should be consulting with RN.  If the patient needs to improve life condition like the patient might want some advice on diet, weight loss or exercise, reduce alcohol intake or wants to quit smoking can consult RN (Mansfield, Antic, & McEvoy, 2013) |  |  | | --- | | **11.  Anesthesia List 3(three) complications of the following:** | | 11.1  **Complications of General Anesthesia**   * Dizziness * Temporary confusion * Memory loss (Galbraith, McGloughlin, & Cashman, 2018).   11.2  **Complications of Spinal Anesthesia**   * Urinary retention * Infectious co plications * Hematologic complications (Galbraith, McGloughlin, & Cashman, 2018).   11.3  **Local Anesthesia**   * Paresthesia * Infection * Complications that occur from the blockage of nerve in that area (Eke & Thompson, 2007).   11.4  **Epidural Anesthesia**   * Low blood pressure * Itchy skin * Loss of bladder control (Wulf, 1996).   11.5  **Peripheral nerve block**   * Bleeding * Nerve injury * LAST (Fredrickson & Kilfoyle, 2009). |  |  | | --- | | **12.  Pre and Post-operative Nursing  The following question relate to a 56 years old man with a History of Diabetes, HT and smoking. They are having a R) Below Knee Amputation (BKA).** | | 12.1  What psychological challenges are likely for a BKA? (15 -30 words)  Post-traumatic stress disorder is seen in a patient with BKA with a patient who had surgery due to burning, suicidal attempt or injury. A number of problems that re related to body image appears after BKA. Mutilation anxiety might also affect the patient (Bradway, Malone, Racy, Leal, & Poole, 1984).  12.2  List **4(four)** pre-operative nursing interventions  **Pre-operative nursing interventions**   * Communication with the patient and make them feel easy before the operation * The patient should be briefed on the routine they are going to expect. * Patient’s pre-operative question should be heard and noted down by the nurse. * Baseline pf the patient be recorder and general anesthesia will be given (Vera, BSN, & R.N., 2013).   12.3  List **4(four)** post-operative nursing interventions for a client with Below Knee Amputation  **Post-operative nursing interventions**   * Encourage the patient to perform the advised exercises * Stump care will be given by taking care of the wounds. * Measuring the process of the patient periodically * Nee extension should be maintained (Vera, BSN, & R.N., 2013).   **References**  Albright Jr, R. C. (2001). Acute renal failure: A practical update. 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