

Senior General Nursing Exam.

No. 4.

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1. Post-operative care for 3 days of a cholecystectomy patient.

The patient is returned to the ward from theatre into comfortable bed already prepared. The mattress has been covered with a sheet, a mackintosh sheet and draw-sheet. The ~~top~~^{first} two feet of the head of the mattress has been covered with a small waterproof and folded draw sheet. The bed contains an electric blanket, which is removed when the patient is brought in. By the bed, is an oxygen cylinder, previously tested, and on the adjacent locker are the post-operative instruments. These are a receiver, a bowl of cold linens, tongue forceps, tongue depressor, mouth gag and sponge holding forceps.

The patient is transferred gently from the trolley to the bed, and covered with a warmed blanket, the bed made up after placing him in a left lateral position. A half hourly pulse, respiration rate and blood pressure chart is commenced. This is continued for four hours and if there are no abnormalities it is decreased to four hourly ^{until awake} for twenty four hours and thereafter ^{day} daily. He should be watched until completely conscious.

As soon as the patient is conscious, he is fully groomed, dressed in his own night attire, and supported in a semi-Fowler's position by five or six pillows to facilitate drainage. If a rubber drainage tube has been inserted, care must be taken to see that there is no discharge through the dressing.

A light fat free diet is given, commencing with some light food such as jelly, and gradually increased.

Four hourly ~~at~~ treatment is given to the back by washing all pressure areas with soap and water, drying well then massaging with methylated spirits. Any excess is dried before finishing. An air cushion under the buttocks will probably relieve any symptoms of pressure.

care should also be taken of the patient's mouth. Mouth towels should be given as frequently as necessary, but

infection
 & ~~control~~ is
 glaucous
 response
 all too
 vague
 somewhat
 friends

Geek.
Paw

at least four hourly, if the patient cannot clean his own teeth. ^{Removes food} ~~These~~ ^{false} teeth should be replaced as soon as possible after the operation.

The patient's bowels are opened with an aperient on the evening of the second day or an enema given on the third day. Care is taken to see that the patient voids normally.

The dressings to the wound should be done daily, unless discharging copiously, when it is done more frequently. The surgeon will probably order the any drainage tube inserted to be shortened a certain length, usually an inch, each day.

This is done by gently ^{pulling} ~~removing~~ the tube one inch from the site, and cutting off an inch from the external end, then the ~~cut~~ area repacked with wool. The tube will be completely removed after the fourth day. If any ~~in~~ sutures are present they will be removed, by doctor's orders, about the ~~eleventh~~ ^{third} day. Ethical clips are removed half on the fifth day and half on the sixth.

The day after the sutures are removed the patient is allowed to sit out of bed and is allowed to go home after fourteen days.

Wrevelan
Master Question
3/1/19

2.

(a) Artificial feeding may be necessary for a patient who is either unconscious, refusing to eat, constantly vomiting, and as part of post operative treatment for a patient who has had a major operation - eg. a partial gastrectomy.

(b) The articles necessary for administering a nasal feeding are sterile. They are: 1. Tray with 2. 'Reflux' tubes.

2 receivers containing two pairs of forceps.

1. bowl for glycerine to lubricate if necessary.

1. bowl of swabs.

1. bowl of saline.

1. 10 c.c. syringe.

jug of fluid to be given.

lamp or spigot.

Artificial feeding apparatus used via
nasal
oesophagus.

Esophagus.

Esophagus insertion

Esophagus insertion

and give a condition
for each one also, at hand. strapping and scissors.

glass, connection
small funnel

20) A mackintosh cape and draw sheet are draped around the patient. He is (asked to) supported under the head by only two or three pillows if he is conscious. The tube is tested to make sure it is not blocked by syringing a few milliliters of saline through. The nose is cleaned before the procedure commences.

The tube is inserted and introduced into the nose, then guided along the nasal cavity. ~~(with the)~~ The tube is inserted for 12-14 inches, the length being measured by a black band on the tube. If the tube is in the wrong position a hissing sound occurs, or the patient ~~is unable to breathe~~ will ~~stop~~ ^{choke} to breathe. In the case of the latter the tube has not been inserted far enough and should be inserted for another few inches. If this is unsuccessful it should be removed and another tube inserted.

The liquid is syringed gently into the ^{tube's} external orifice only four to five ounces at a time. They should gradually increase in amount, and should be inserted every four to six hours.

The tube is sealed by a clamp or spigot, fastened to the face with strapping and the loose end tucked behind the patient's ear.

4. (a) Retrograde Pyelogram: is done to discover any abnormalities of the kidneys. The patient is first catheterized and any surplus urine withdrawn. Atept. Ureteric catheters ~~are~~ then inserted up to the pelvis of the kidney and a radio-opaque substance, such as lipiodol, inserted. This is disseminated throughout the kidney and, after being X-Rayed, any abnormalities are shown on the negative.

(b) Test meal: After an open-ended oesophageal tube has been passed into the patient's stomach, the "resting juice" is drawn ^{with a sterile syringe} off and placed in a labelled, sterile test-tube. The patient is then given 8 ounces of gruel to drink. This amount may be increased or reduced according to the size of the patient. For the following two hours, at half-hourly intervals, 4 samples

are withdrawn and placed in test tubes labelled "first specimen" and so on.

This is an investigation carried out to determine the function of the gastric juices on a test meal, and is done to help the doctor in his diagnosis. For example, a gastric ulcer may be discovered by the effect on the gravel.

4.

(c) Blood Urea: $\frac{1}{100}$ ^{of blood} millilitres are mixed with 4 millilitres of potassium oxalate and the specimen is sent to Pathology. It is then tested for the amount of urea it contains.

As the normal blood urea is from 20-40 milligrams of urea to every hundred millilitres any abnormality will be a sign of a disease. For example an excess in blood urea will be a sign that the kidneys are not excreting the correct amount. When the blood urea is high, the urea in the urine is relatively low, and vice versa.

(d) Glucose Tolerance Test: The patient is allowed nothing to drink or eat for twelve hours beforehand. At 6 a.m. he is asked to void into a sterile pan or urinal and the specimen is transferred into a sterile test tube and labelled. If he cannot void a catheter specimen is taken. ^{50gms} grams of glucose are then given to him to drink. This may be mixed with 300gms of water. The next specimen voided into a sterile urinal is placed in a sterile test tube, labelled, and the two test tubes sent to Pathology with the correct slip.

plus
specimen
blood and
liver
1/2 hour
for 2 hours in
Pathology
staff
house

5. Intramuscular injections.

When giving an intra-muscular injection the nurse should always wear a mask, and should scrub her hands well with soap and under running water before drying them under a sterile towel. She should also always have a second nurse to help her.

On the sterile tray there should be two receivers, one with

the syringe and needles, the other with two pairs of Spencer Wells' forceps, there should also be three bowls, one for swabs or for normal saline, and the other for ^{Zephiran} ether sulphate or some other skin preparation. The tray is covered with a sterile towel and the bottles or phials of the fluid to be injected, next to it.

After drying her hands the nurse syringes the syringe and needles with normal saline, taking care not to touch the piston or inside of the syringe barrel or the needles with her hands. Goggles are used.

The amount of the injection is drawn up into the syringe. (If it is obtained) with a large bore needle. If it is obtained from a subcutaneous bottle the cap is sterilized before inserting the needle. The amount is checked by the second nurse. If a dangerous drug is to be administered it must be checked by the doctor authorizing it, and must be signed for in the Drug book.

The syringe with short needle and a swab of which has been immersed in ether sulphate is taken to the patient's bedside. The second nurse uncovers the area to be injected, and, if the patient is a child or a coward he is firmly held.

The area is swabbed, the needle inserted ^{the patient is held firmly} three-quarters of its length at right angles to the skin, and the solution slowly injected. The needle is quickly withdrawn and the area lightly rubbed with a swab. The patient is then made comfortable.

Precautions to be observed are:

not to render any part of the injection unsterile.
to give only in correct places (eg. the gluteal, femoral and ~~triceps~~ muscles)
to avoid scaring young patients by not letting them see

the syringe

to avoid any blood vessels or nerves - these can be detected by drawing back the piston to ensure the needle is not in a vessel, for blood will appear in the syringe if it is, or the patient will complain of ardent pain if by any chance a nerve is struck.

It is also necessary to prevent children moving whilst having an injection as the needle may break.

Sharp needles
not given into
venous system

b.

(a) Embolism: is an obstruction, usually in a blood vessel. It may be a foreign body or a blood clot. If it occurs in the cerebrum it is usually fatal, but is often operable when occurring in other parts of the body. If operated on in time, the patient has a very good chance of complete recovery. The operation is known as an embolotomy. One of the most common sites for an embolus to lodge is in the aortic arch.

(b) Cerebral Irritation: is called 'contra-coup' or depressed fractures of the skull, and may also be caused by infection. It occurs frequently with fractures of the base of the skull. Meningitis.

The patient is usually unconscious and delirious for several days, depending on the severity. Sedatives such as Paraldehyde are given if the patient becomes violent. They must be watched continuously, and I.V. blood pressure and pulse recorded.

(c) Universal Donor: The blood group known as O₊ is generally regarded as being the universal donor, as it can be given to most people in emergencies. This is because it does not contain the proteins which are included in the groups A, B, and AB. People with Rh negative blood do not always tolerate group O.

(d) Haemostatic: is a fluid injected into the patient hypodermically to promote clotting of the blood. It is most frequently given in cases of haemophilia and severe haemorrhage. A common example is calcium gluconate. When applied locally to the site of bleeding it is known as a styptic. Adrenalin is often used for this purpose.

(e) Secondary Haemorrhage: may occur when the effects of shock, caused at an accident or operation, have worn off, from infection which breaks down blood vessels, etc., and from lesions of sutured sutures. 7-10 days. Haemorrhage may occur be withheld for a time by the symptoms of shock. This lowers blood pressure, slows the pulse, etc., but when the patient recovers from the shock his condition improves and the blood is free to flow. Immediate treatment is to stay with the patient, and

You are concerned with post-traumatic haemorrhage.

reassure him. If possible, and for medical assistance. ~~It is~~
 Firm dressings should be applied over the wound if
 indicated. Arterial pressure on one of the ^{nearest} artery pressure points
 will help stop the flow of blood. ~~The~~ The patient should be
 prevented from seeing the blood as it will only alarm
 him. ~~Any orders~~ The foot of the bed should be placed
 on blocks and any orders received from the Doctor
 carried out.

(c) Ascites: is a collection of fluid in the peritoneal cavity
 resulting in acute distention of the ~~stomach~~ abdomen.
 It may be caused by cancer, nephritis, or congestive cardiac
 failure. It is usually relieved by an abdominal paracentesis.
 This is done by inserting a trocar and cannula into the peritoneal
 cavity at the right or left iliac fossa and allowing the fluid
 to drain. The condition is usually chronic.