NURSING ARTS

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UNIT- I

COMPREHENSIVE NURSING CARE

It is an individual plan of care based upon scientific principles and concepts in the form of understanding on the part of the nurses and the utilization of specialized skill and techniques for the care of the whole patient that is to meeting the physical, psychological, spiritual , social ,economical and intellectual needs of the patient.

UNIT-II

INTRODUCTION TO SICK AND WELL

The who has defined health but not disease, this is because disease has many shades (spectrum of disease) ranging from in apparent cases to severe manifest illness. Some diseases commence acutely e.g food poisoning and some insidiously e.g mental illness. In some diseases, a carrier state occurs in which the individual remains out weirdly healthy, and is able to infect others .The clinicians sees people who are ill rather than the diseases which he must diagnose and treat. However, it is possible to be victim of disease without feeling well without signs of physical impairment. In short, an adequate definition of disease is yet to be found a definition

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that is satisfactory and acceptable to the epidemiologist, clinician, sociologist and the statistician.

The WHO definition of health introduces the education of well –being .The question then arises: what is meant by well – being?

Recently psychologist have pointed out that the well-being of an individual or group of individuals have objective and subjective components .The objective components relate to such concerns as are generally known by the term standard of living or level of living. The subjective components of well - being is referred to as quality of life. Standard of living, the term standard of living refers to the usual scale of our expenditure, the goods we consume and the services we enjoy. It includes level of education, employment, food, dress etc. Quality of life: It is a composite measure of physical, mental and social well- being as perceived by each individual or by a group of individual.

UNIT-III

BASIC NURSING CARE AND NEEDS OF A PATIENT.

HYGIENIC NEEDS AND PHYSICAL NEEDS

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The word "hygiene is derived from Hygeia "The goddess of health in Greek mythology. Hygiene is the science of health and embraces all factors which contribute to healthful living.

The concept of nursing is changing fast. Nursing is not only caring for the sick, but takes care of prevention of illness, promotion and maintenance enables individuals, families and communities to develop their full health potentials. Its scope goes beyond the prevention and treatment of disease.

A healthy environment –personal and environmental hygiene is crucial for the health and well-being of individuals and communities. Several diseases are due to poor personal hygiene. E,g skin diseases , trachoma , leprosy and conjunctivitis and many more are due to poor environmental hygiene e,g; viral hepatitis , polio , cholera, typhoid etc. These diseases are easily spread in areas without community water supplies .In short much of the ill- health in India and many other developing countries is due to poor sanitation, lack of portable water supplies, sub –standard living conditions. Thus, the key to mans health lies in his personal hygiene and environmental hygiene.

Bathing is an important intervention to promote hygiene. Choice of method depends on the nurse's judgment as well as the medical plan of care.

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TYPES

I. Bed Bath

Ii. Bathroom Bath

Iii. Partial Bath

Bed Bath:-

The client can have complete bed bath or partial bed bath. In complete bed bath, the whole body is bathed out, but in partial bed bath only the areas where the secretions accumulate are cleansed .e.g face, hands, axillas, back and perineum.

Bed bath means bathing a client who is confined to bed and who does not have physical and mental capability to self-bath.

Purposes

1. To clean body off dirt and bacteria.

2. To increase elimination through skin.

3. To prevent bed sores.

4. To stimulate secretions.

5. To induce sleep.

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General instructions for giving bed bath

1. Maintain privacy.

2. Explain the procedure to the client to win confidence.

3. Wash hands before and after the procedure.

4. Use clean articles.

5. Clients unit should be at hand.

6. All needed articles should be at hand.

7. A thorough inspection should be done especially at the back to find out early signs of bed sore.

8. Special attention to be given at axilla and groin.

9. The temperature of water should be adjusted for the comfort of the client. The temperature for sponge both should be 110 - 115F.For tub bath the temperature should be 90-100F.

10. Avoid bathing immediately after meals.

NUURSES RESPONSIBILITY IN GIVING BED BATH

Preliminary assessment

Check the physician orders to see the specific precautions if any.

Assess the clients need for bath.

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Assess the clients' ability for self-care.

Check vital signs.

Assess clients' mental status to follow directions.

PREPARATION OF ARTICALES

Bath basin

Small bowel

Soap with soap dish

Wash clothes

Bath towels

Face towel

Bath blanket

Nail cutter

Nail file

PROCEDURE

1. Wash hands to prevent cross infection.

Mix hot and cold water in the basin and check the temperature on the back of the hand.

3. Place the towel under chin .Wash rinse and dry the areas in sequence- face, neck, arm, chest, abdomen, back, leg and pubic region.

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4.Take wash cloth , wet it , squeeze the excess water make a mitten , apply a soap on it and clean the face , ears and neck.

5. Take the other wash cloth, rinse it in water, squeeze soap is applied.

6. Turn the client to a prone position. Wash, rinse, and dry the back from shoulder to the buttock with brisk circular motion. Pay particular attention to the pressure areas.

7. Put on the upper garments and cover the client with bath blanket.

8. Replace the client's personal belongings.

9. Change bed linen to the necessary.

10. Take all articles to the utility room.

11. Wash hands Record the procedure with time and date.

12. Take opportunity to teach the client or his relatives about personal hygiene.

CARE OF HAIR

Cleanliness of hair is essential for good hygiene. An unclean scalp containing dirt, dandruff, excessive sebum and sweat will allow the growth of micro-organism and parasites on the scalp.

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PURPOSES

1. To keep hair clean and healthy.

2. To promote the growth of hair.

3. To prevent the loss of hair.

4. To prevent tangles.

5. To stimulate circulation.

NURSES RESPONSIBILITY IN DAILY CARE OF HAIR

Hair needs to be brushed in order to be healthy.

The hair can be combed in the morning so that the clients can feel refreshed.

ARTICALES

Clean towels.

. Clean comb.

Kidney tray.

Oil.

Paper bag.

PROCEDURE

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Check the physicians order.

Assess the general condition of the clients.

Assess the condition of scalp.

Check article.

Separate the hair in small strands.

Hold the strands above the part being combed to prevent pulling.

Comb the tangles out from the ends first and then go up gradually.

Application of oil may help to remove tangles.

Discard the loose hair.

10. After combing braid the hair into two to make the client comfortable.

11. Remove the towels and kidney tray.

12. Take articles to utility room.

13. Wash hands.

14. Record observations made.

CARE OF EYES, NOSE AND EARS

The eyes, nose and ears are important organs which require no special care in daily life. Hygienic care of the eyes, ears

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and nose prevents infection and helps to maintain the functions.

CARE OF EYES:

PRELIMINARY ASSESSMENT:

Check the diagnosis of the client.

Check the physicians order to see the special precautions.

Assess the general condition.

Check the articles available.

PREPARATION OF THE ARTICLES

ARTICLES:

1. Mackintosh and towel.

2. Sterile bowl with cotton swabs.

3. Sterile normal saline.

4. Kidney tray and paper bag.

5. Clean face towel.

PREPARATION OF CLIENT:

Explain the procedure to the client.

Adjust the bed to the comfortable working of the nurse.

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Arrange the articles.

Protect the pill one and bed with a mackintosh.

PROCEDURE:

Wash hands.

Pour sterile saline into the bowel.

Stand in front of the client, clean the eyes with the sterile swabs.

Discard the swabs into paper bag.

For crusted secretions place a wet warm gauze piece or cotton swab over the closed eye.

When the eyes are clean, stop the procedure. Wipe the face with face towel.

Instill medication if prescribed.

Remove mackintosh.

Take all articles to the utility room.

10. Wash hands thoroughly.

11. Record the treatment with date and time.

CARE OF NOSE AND EARS:

Excessive accumulation of secretions make the client sniff or blow the nose .The secretions can become crusted and abstract the airway.

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For clients who cannot remove the secretions, assistance is necessary to clear the congestion and protect the nasal mucosa. External crusted secretions can be removed with a wet wash cloth or a cotton applicator moistened with oil, normal saline or water.

When there is poor hygiene of ears , debris may accumulate behind the ear . This can lead to ulceration of the skin.

Warm liquid paraffin or a vegetable oil instilled into the ear can soften the wan which sometimes get accumulated and can be remove easily.

CARE OF PERINEUM:

PRELIMINARY ASSESSMENT:

Assess the condition of the perineal- skin any itching, irritation, ulcers etc.

Assess whether the perineal care should be done under an `aseptic technique.

Check physician's orders.

Assess the client's ability for self – care.

Check articles available.

ARTICLES:

Mackintosh

Jug with warm water.

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Wet cotton balls.

Gauze or rag pieces.

Long artery forceps in the kidney tray.

Paper bag.

Clean linen.

PROCEDURE:

Explain the procedure to the client.

Provide privacy by screens and drapes.

Remove all the articles that may interfere in the procedure.

Wash hands.

Pour water over the perineum.

Clean the perineum using wet swabs.

Clean from midline outward in the order:

_the vulvae

-labia minora

-labia majora

8. Turn the client to one side and dry the buttocks with a dry rag piece.

9. Change the linen if necessary.

10. Make client comfortable.

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11. Clean all articles.

12. Remove screen.

13. Wash hands

14 record the procedure with date and time.

ORAL HYGIENE

Oral hygiene means brushing the clients teeth or cleaning the dentures . Oral hygiene is provided to maintain the integrity of the clients teeth , gums , mucus membrane and lips .

PRELIMINARY ASSESSMENT :

Check the condition of the oral cavity.

Check the ability of the client for self-care .

Doctors order.

Articles available.

ARTICLES :

Small mackintosh

Face towel

Small jugs

Feeding cup

Artery forceps

Dissecting forceps

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Rag piece

Kidney tray

Paper bag

10.Solutions for mouth wash

11. Tangue depressor

12. bowel of clean water

PROCEDURE:

Explain the procedure to the client.

Provide privacy .

Maintain a safe comfortable position.

Place mackintosh across the chest.

Remove dentures if any.

Arrange articles.

Wash hands.

Prepare mouth wash.

Help client to rinse his mouth .

10.Pick up the tooth brush , wet it with mater , spread a small quantity of toothpaste on it .

11.Instruct the client to brush all sides if the teeth outer side , inner side and chewing surface .

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12. Help the client to massage the gums. Place the thumb and index finger over the ridge of the gum using a press and release motion.

13. Apply glycerin or other emollient on the cracked lips and tongue to keep them soft.

14.Take all articles to the utility room.

15 .Wash hands.

16. Record the time and nature of the treatment.

NUTRITIONAL NEEDS:

Importance of diet I n health and disease

Nutrition is a basic human need that changes throughout the life-cycle and along the wellness illness continuum. Eating is not only a necessity in life, but it may also be a source of pleasure ,a pass time , medical treatment . Because nutrition is vital for life and health and a poor nutrition can seriously decrease ones level of wellness.

Nutrition is the science of food and nutrients and of the process by which an organism takes them in and uses them for producing energy to grow , maintain function and reneue itself . A client nutritional status may be good fair or poor depending on the intake of die…….. essential for normal growth , development and functions of the organs or normal reproduction , for optimal activity and working efficiency , for resistance to infection and for repair of injury or damage.

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FACTORS AFFECTING NORMAL NUTRITION IN SICKNESS

A persons dietary pattern is usually slow to change because food habits are deeply rooted in the past.

PHYSIOLOGIC AND PHYSICAK FACTORS :

Throughout the life cycle , the nutrients needs keep changing in relation to growth , development , activity and age-related change in metabolism and body composition . Periods of intense growth such as infancy , adolescence , pregnancy and location cause increased nutrient needs .

SOCIOCULTURAL AND PSYCHOLOGICAL FACTORS:

Dietary choices or restrictions are also influenced by culture, religion, and personal feelings.

Emotional states such as boredom. Anger, depression or loneliness, stress can influence the quantity and quality of the food eaten.

RELIGION: Dietary restrictions associated with religion might affect client's nutritional requirements.

ECONOMICS: The adequacy of a person's food budget affects dietary choices and patterns.

FACTORS AFFECTING NUTRITIONAL INTAKE

DECREASED FOOD INTAKE;

There are various reasons for a decreased food intake.

Anorexia.

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Psychosocial causes such as fear, anxiety.

Impaired inability to smell and taste.

Clients who have difficulty in chewing.

Clients on inadequate food budget.

INCREASED FOOD INTAKE

This may lead to obesity. Obesity increases the risk for numerous medical problems.

DIET IN SICKNESS:

Diet is as important as medicine in the treatment of diseases. A modification in the diet or in the nutrients can cure certain diseases. When the person is ill, the food intake becomes a problem.

The nurse's responsibility in the care of the sick in regard to nutrition can be analyzed into four major areas

1 .Assisting the clients to obtain needed nourishment either through feeding or assisting with eating e.g. tube feeding.

2. Motuiating client to eat.

3. Assisting clients to obtain needed nourishment by proper planning of the diet.

4. Assisting clients with special problems about therapeutic diets e.g helping a client to accept a salt free diet.

General instructions for a nurse in food service:

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The diet of every client in the hospital should be planned according to his need metabolic changes .

Nurse should report the quantity of food that is left in the tray .

Create a pleasant environment for the client .

Meals should be served in clean and covered containers.

The client should be encouraged to take a variety of food.

FEEDING HELPLESS CLIENT

NURSRS ROLE

PRELIMINARY ASSESSMENT

Check the physicians orders for any specific precautions .

Plan the diet according to the need of the client his likes and dislikes.

Ensure that the ordered diet is prepared properly and safely .

ARTICLES:

Mackintosh and towel.

Full plate , quarter plate , cup saucer.

Feeding cup .

Spoon , fork.

A glass of water .

Napkin.

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Feeding cup with water and kidney tray.

PROCEDURE:

1.Wash hands .

2. sit by the bedside , usually at the right side of the client , facing his head so that the nurse and the client can see each other.

3.Feed the client slowly , in small amounts , waiting for him to chew and swallow one mouthful before giving the next.

4.Give the food in the order in which they would normally be eaten by the client.

5.Take pleasantly to the client .

6. When the client has eaten the food in sufficient amount and to his satisfaction than stop feeding and offer a glass of water .

7. Help the client to wash his mouth , face and hands .

8.Take all articles and the food tray to the utility room .

9.Wash hands .

10. Record in the nurses record the amount of the food , if vomiting has taken place .

ELIMINATION NEEDS

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The elimination of waste from the bowl and bladder is an essential body function .The major nursing responsibilities associated with bowel and bladder elimination include , assessing the bowel and bladder function , promoting normal bowel and bladder health and management of altered bowel and bladder functions .

***CONSTIPATION**:*

Constipation occurs when stool anodes through the large intestines too slowly or remains in the large intestines for too long. Constipation is referred to the person's normal defecation pattern and involves a change in stool consistency and a change in defecation frequency.

CAUSES:

Inadequate, irregular diet.

Insufficient fluid intake.

Insufficient intake of roughage.

4. Lack of exercise and prolonged rest.

5. Emotional upset.

6. Surgery involving the intestines and rectum.

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Active exercise

Active exercise is the type physical activity accomplished by the clients without assistance .These exercises helps the clients to attain normal physiological functions of the body. Some of the active forms of exercises that can be done by the clients on bed are:

1. *Deep breathing and coughing exercise for lung expansion.*
2. *Exercise of limbs through full ranges of motion which include flexion, extension, adduction, abduction and rotation.*
3. *Moving in bed to change the position.*
4. *Foot exercise to prevent foot drop and toe deformities. The ambulatory clients can have both indoor and outdoor exercises. Some of the points to be kept in mind during the exercises are:*

- *Exercise should be planned according to the age, sex and physical condition.*
- *Check for the doctor's orders for any specific precautions.*
- *Avoid over fatigue.*
- *Exercise should not be done after a meal.*
- *The room should be well ventilated.*

Passive exercise

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In passive exercise the movement or activity is carried out by another person and the client and the client makes no voluntary effort to assist or resist the action.

The passive exercises are usually carried out by the physiotherapist or the nurse. The performance of certain nursing procedures such as bathing the client, giving back care and changing the position .Provides some passive exercise for the client. Passive exercise is usually useful for clients with restricted movements, deformities and unconsciousness.

Comfort measures

Meaning:-Comfort is a state of freedom from pain, and discomfort, tension, anxiety. Comfort is concerned with rest, with exercise with the relation of one part of the body to another ,with the bed and the whole environment, with relationship to other human beings, and with the attitude toward oneself and one's own condition and with the state of one's soul.

Comfort is a phase of every procedure it is an aspect of the total care of the patient.

Therapeutic positions are used to promote comfort of the client. Popper tuning and positioning allows the health care procedure to make clients as comfortable as possible

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prevent contractures and pressure sores and facilitates diagnostic tests.

***Comfort deuces**:-*

- *Pillows:-pillows are used to give comfortable position.*
- *Bed blocks:-Bed blocks of made up are wood. Size is 9 "to 12".It is used to raise foot and or head end of the bed. These are also used to prevent shock, to arrest hemorrhage to retain enema, after giving spinal anesthesia and after tonsillectomy.*
- *Foot rest: - It is used to give rest to the feet. It helps to maintain the normal position of the feet I,e at right angles to the leg.*
- *Bed cradles: Bed cradles are of wooden. Metal are electric .The bed cradles support and take off the weight of the top bedding. It is used to prevent top cloth coming in contact with the patient, in burn cases, drying plaster.*
- *Sand bags:- Sand bags are used to immobilize the part as in fracture cases and to relieve to discomfort . It is also used to give support to any part of the body.*
- *Rubber & cotton rings:- These are used to relieve pressure on certain parts of the body e,g , elbow.*
- *Air cushion:- Air cushions are round in shape and made up of rubber . It can be inflated with air. It is used to relieve pressure on certain part of the body.*

Body mechanics

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Body mechanics is defined as using alignment posture and balance in a coordinated effort to perform activities such as lifting, bending, and moving.

Body mechanics is using the body in an efficient and careful way it involves use of good posture, balance among the strongest and largest muscles of the body to perform work.

Body mechanics is the term used when referring to lifting techniques. It involves pushing, stooping, carrying and lifting correctly.

Correct body mechanics are essential and help to avoid work – related musculosketol injuries – diminished excessive strain and fatigue.

Posture or body alignment is the way in which the body part are alignment with one another posture is defined as the position in which the various parts of the body are held when sitting , principles of body mechanics .

Principles of body mechanics:

1. *Proper balancing of all body parts helps to conserve energy*
2. *Stability of the body is maintained by having a greater base of support.*
3. *Injury and strain on the lower back can be avoided by performing pelvic till before activity.*
4. *Facing the direction of work will help to avoid the chance of injury.*

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5. *Initiating movement requires more energy than maintaining the movement of an object.*
6. *Moving an object on a level surface requires less effort.*

Nurses responsibility in moving client

Preliminary assessment:-

a. *Check the diagnosis and the specific precautions regarding the movement of the client.*
b. *Check the level of consciousness.*
c. *Check the ability for self-care.*
d. *Abilities and limitations such as paralysis.*
e. *Provide privacy.*
f. *Explain procure to the client.*
g. *Clamp the catheter to prevent back flow of urine during the transfer.*
h. *Three nurses position themselves at the beside along the same side .*
i. *The nurses place their arms on bed sliding them under the clients head, chest, shoulders, hips and legs.*
j. *Leader gives the signal by counting 1,2,3. At the count of '3'move the client to the side of the bed using a right angle 90^{o} pull maneuver.*

Moving a helpless client up in bed

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- *Fallow the steps of the procedure as above.*
- *At the cont of ,3, move client to the side of the bed put towards the head end of the bed using a diagonal pull maneuver.*
- *Raise the side rail next to the client and go the opposite side. Repeat the diagonal pull of the body as described above.*
- *Pull the client to the edge of the bed on alternate sides of the bed until the desired height in bed is reached.*
- *Slide client to the centre of the bed and put the body in correct alignment.*

Turning a client to one side of the bed

❖ *Before turning the client the nurse should move him to the same side of the bed so that he is slightly of the centre of the mattress. To move the client to the side of the bed, fallow the procedure as described above.*

❖ *Keep the farthest arm along the side of head and face , the near arm across the chest and the near leg flexed over the farthest leg.*

❖ *Place the arms under the shoulders and hips and roll him gently away from her.*

❖ *Make the client comfortable by placing pillows as in aside lying position.*

Transferring a helpless client from bed to shelter

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- *Position the stretcher at right angle to head or foot of the bed.*
- *Call helpers and position them at the beside along the same side of the bed.*
- *Move the client to the edge of the bed.*
- *At the cont of '1' the nurses slide their arms under the client to support the body sections of the client.*
- *At the count of '2' the nurses stand with the back erect, holding the client near to body as their possible.*
- *On the count of '3'the nurses take one step backward and pivot on their heels to3wards the stretcher.*
- *At the count of '4' move to the side of the stretcher and stand with a wide base and flexed knees ready to lower the client into the stretcher.*
- *At the cont of '5' the nurses lower the client to the to the stretcher in a back –lying position.*

Decubitus ulcer Or Pressure sore

Decubitus ulcers, also known as pressure sores or decubiti, are ulcerated or sloughed area of tissue subjected to pressure from lying on mattress on sitting on a chair for a prolonged period of time resulting in the showing of circulation and finally death (necrosis) of tissue.

Common sites

Pressure points are those that bear weight, so that the skin over them is subject to pressure. This may happen over the

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more frequently over the bony prominences of the body where there is no rich blood supply or nourishment and also there is a thin layer of skin.

The pressure points in the supine position are back of the head (occiput) scapula, sacral region, elbow, heels.

Causes

Direct causes

- ❖ *Pressure is considered to be primary cause of the pressure sore.*
- ❖ *Friction : of the skin with a rough or hard surface can cause tissue damage.*
- ❖ *Wrinkles on the bed clothes, hard surfaces of the plaster casts and splints, on the bed.*
- ❖ *Moisture: The skin contact with moisture for a period of time can lead to maceration of the skin.*
- ❖ *Presence of pathogenic organism*
  Lack of cleanliness harbors pathogens on the skin.

Client susceptible to pressure sores

- *Identification of clients who are particularly prone to the development of ulcer.*
- *Daily examination of the Decubitus-prone clients for redness, discoloration on 6the pressure points.*
- *Keep the clients clean and dry.*

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- *Change the position of client every 2 hours so that the another body surface bears weight.*
- *Keep the clients skin well lubricated to prevent by using powder.*
- *Provide clients adequate fluids and with a nourishing diet.*
- *Call assistance and lift the client before giving and taking bedpans.*
- *Provide a smooth, firm and wrinkle free bd on wich the client can take rest.*
- *Use special mattresses and beds to decrease the pressure on body parts.*
- *Teach the client the hygienic care of skin*

Signs and symptoms

The early symptoms of pressure sore are redness, tenderness, discomfort and smarting. The area become cold to touch & insensitive . There is local edema.

***Treatment of pressure sore**:*

- *Report to the sister in charge and the physician the early symptoms of a bed sore so that steps may be taken as early as possible to prevent further damage.*
- *Prevent the ulcerated area from becoming infected .*
- *A cleansing agent is used to clean the ulcerated area e,g normal saline.*

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- *Application of a few drops of insulin dropped from a syringe has a healing effect on the wound.*
- *Application of waterproof ointment e,g Zinc oxide on the surface of the wound will prevent infection of the underlying tissues.*
- *If slough is present lean the area thoroughly twice a day with hydrogen peroxide diluted with distilled water .*
- *If infection is settled , it may be necessary to give some of the antibodies prescribed by the physician.*

Enema

An enema (plural-enemas) is an introduction of fluid in to the lower-bowel through the rectum for the purpose of cleansing or to introduce medication or nourishment.

Purpose

- *To stimulate defecation and to treat constipation*
- *To soften hard faucal matter e,g oil enema .*
- *To administer medications e,g sedative enema.*
- *To protect and soothe the mucus membrane of the intestine e,g emollient enema.*
- *To destroy intestinal parasites e,g anthelmintic enema.*
- *To relieve inflammation e,g astringent enema.*
- *To relieve gaseous distension e,g carminative enema.*
- *To reduce temperature e,g cold enema*
- *To make diagnosis e,g Barium enema.*
- *To induce anesthesia e,g anesthetic enema.*

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Retained enema

- *Stimulant enema*
- *Nutrient enema*
- *Emollient enema*
- *Sedative enema*
- *Anesthetic enema*

Simple evacuant enema

Purpose:-

- *To stimulate defecation and to treat constipation.*
- *To relieve gaseous distension by stimulating the peristalsis.*
- *To stimulate uterine contractions and to hasten the child birth.*

Solution used

- *Soap & water: soap jelly 50ml to 1ml of water.*
- *Normal saline: sodium chloride 1 teaspoon to half liter of water.*
- *Tap water*

Amount of solution to be used

Adult: 500 to 1000 ml

Children: 250 to 500ml

Infant: 250ml or less.

Temperature of the solution

Adult:105 to 110^{o}f

Children:100^{0}f

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Oil Enema

These are given to soften fecal matter in case of scnere constipation , before the first bowel movement after operation on the rectum and perineum, to avoid straining and injury to the sutures and wounds. It should be retained for half an hour to 1hour to soften the faces.

Retention Enema

Stimulant enema: A stimulant enema is given in the treatment of shock and collapse. E,g coffee enema is given in cases of opium poisoning.

Solution Used

Black coffee: one tablespoon coffee powder to 300ml of water.

Brandy: 15 ml of brandy added to 120-180ml of glucose saline.

Amount of solution:180-240ml

Temperature of solution: 108 to 110f

Sedative Enema:- *It is a retention enema containing a sedative dreg given to induce sleep.*

Drugs used

Paraldehyde

Chloral hydrate

Potassium bromide

- *Anesthetic Enema: It is a retention enema containing an anesthetic drug to produce anesthesia in the client.*

  Drugs used: Averting 150 to300mg/kg

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- *Emollient Enema: This is the introduction of bland solution into the rectum for the purpose of checking diarrhea or soothing and relieving irritation on an inflamed mucus membrane.*

  Solution used:

  Starch and opium

  Nutrient Enema:-*It is a retention enema to supply food and fluids of the body. It is used in conditions like hemophilia which makes I.V infusion difficult or undesirable.*

  Solution Used:

  Normal Saline

  Glucose Saline2-5%

  Peptonized milk -120ml

  Temperature (100^{o}F)

  Procedure

- *Check the diagnosis*
- *Check the data of surgery*
- *Check the consciousness*
- *Check the nature of enema ordered*
- *Articles available in the unit*

Articles:

Tray containing

Enema can

Tubing

Screw clamp

RECTAL TUBE

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Mackintosh hand towel
Water soluble jelly
Rag pieces
Hot and cold water
Soap jelly
Quince glass
Paper bag
Specimen battle
Bed pan
Clean linen
Toilet tray
I.V stand

Process:

- *Explain the procedure to the client to win his/her confidence.*
- *Provide privacy with curtains.*
- *Place client in left lateral position with buttocks close to the edge of the bed.*
- *Keep all articles arranged.*
- *Adjust I.V pole to hold the enema can wash hands.*
- *Attach tubing to the enema can and clamp the tube.*
- *Prepare the solution at the required temperature add 30 ml of soap jelly to 600ml of water. Test the temperature of the solution.*
- *Hang the can with the solution on the stand and adjust the height at 45 cm from anus.*

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- *Attach rectal tube to the tubing .Loosen the screw clamp and let a small amount of fluid to run in to the kidney tray.*
- *Lubricate the tip of the rectal tube about 2-4 inches from the tip.*
- *Separate the clients buttock to visualize the anus clearly and insert 8 – 10cm gently.*
- *Hold the enema tube in place while realizing the pressure on the tube and let the fluid run in.*
- *Continue the fluid administration to give about 500 to 1000ml of solution. Stop the procedure if the client develops discomfort.*
- *Clamp the tubing. Gently remove the rectal tube by pulling it through 3-4 layers of rag pieces.*
- *Discard the rag pieces in the paper bag. Detach the rectal tube and place it in the kidney tray.*
- *Encourage the client to retain the fluid for 10-15 minutes.*
- *Turn the client on the back and assist him/her onto toilet.*
- *Observe enema results .*
- *Take all articles to utility room.*
- *Wash hands .*
- *Record the type of enema, the result etc.*

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SUPPOSITORIES

Suppositories are solid ,cone shaped or oval shaped masses that melt at body temperature. There are several varieties of suppositories available e.g; glycerin suppositories, dulcolax suppositories.

Before introducing suppositories, explain the procedure to client. The client is placed in a comfortable position, usually left lateral. Suppository is removed from its package and held in the right hand between the two fingers. Separating the buttocks with the left hand insert the suppositories into the anus. Once it has passed the external sphincter, advance it beyond the internal sphincter, pushing it with the index finger, otherwise the suppository will be expelled from the anal canal. The nurse should make sure that the suppository is positioned to the side of the rectum against the mucosa, rather than in the faecal matter, because the intended action of the medication is on the intestinal wall.

INSERTION OF FLATUS TUBE

A rectal tube inserted into the rectum relieves the flatulence and gaseous distension of the abdomen. Prepare the client as far an enema. Place the client in a comfortable position. Lubricate the flatus tube and introduce 4 to 6 inches into the anal canal while the free end of the tube being kept under the water in the kidney tray. Watch for the expulsion of the gas which is seen bubbling through the water. The tube is left in

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place for not more than 20 minutes, longer periods of insertion can lead to permanent Sphincter damage.

CARE OF PERINEUM

Perineal hygiene involves cleaning the external genitatia and surrounding area. The most pertinent principle for the perineal care is to clean the perineum from the cleanest to the les clean area.

NURSING RESPONSIBILITY IN THE PERINEAL CARE

Preliminary assessment :-

1. *Assess the condition of the perineal skin any itching, irritation, ulcers.*
2. *Assess the need and frequency.*
3. *Check the articles available.*
4. *Articles required*

A tray containing

- *Mackintosh*
- *A jug with warm water*
- *Wet cotton balls*
- *Gauze*
- *Long artery forceps*
- *Paper bag*
- *Clean linen*
- *Bedpan*

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Procedure

1. *Explain the procedure to the client .*
2. *Provide privacy by screens.*
3. *Remove all articles that may interfere with the procedure*
4. *Wash hands.*
5. *Pour water over the perineum.*
6. *Clean the perineum using wet swabs.*

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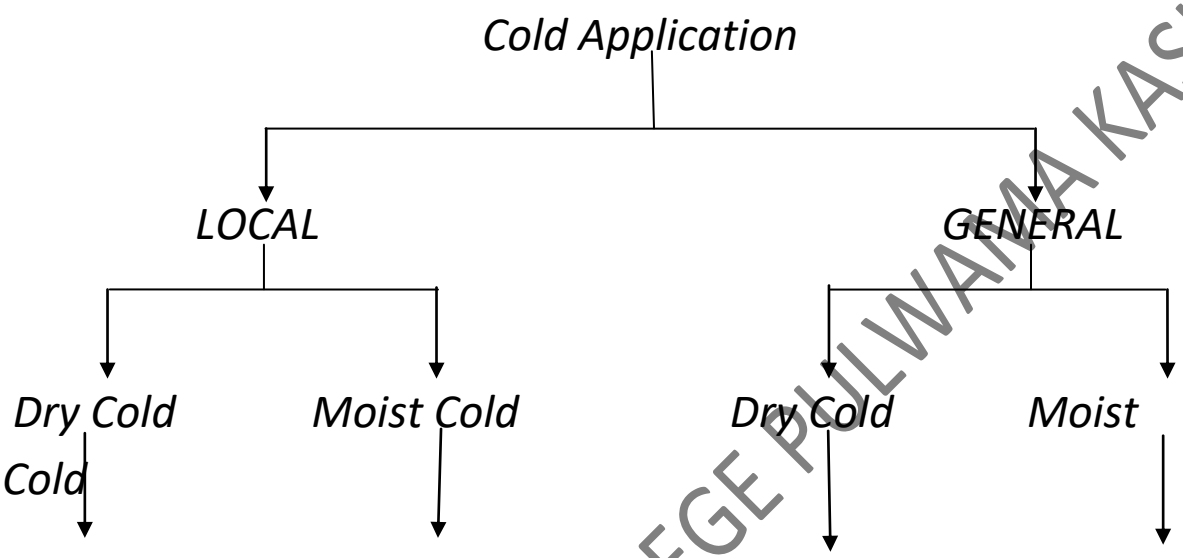
COLD APPLICATION

Cold application is the application of a cold agent cooler than skin either in a moist or dry form, on the surface of the skin,

to reduce pain and body temperature, to anaesthetize an area, to check hemorrhage, to control the growth of bacteria, to prevent gangrene, to prevent edema and reduce inflammation.



Ice bag	*Ice to suck*	*Hypothermia*	*Cold Sponge*
Ice pack	*Cold compress*		*Cold bath*
Ice cradle	*Evaporating lotion*		*Cold Packs*

Therapeutic uses of Local Cold Applications

1. *Cold relieves pain.*
2. *Prevents edema.*
3. *Controls hemorrhage.*
4. *Checks the growth of bacteria*

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ICE BAG

An ice bag is a dry cold application. The bag is filled with crushed ice or ice chips and sprinkled sodium chloride. The salt lowers the melting point and prevents the ice from melting.

Articles required

- *Ice bag*
- *Crushed ice*
- *Flannel cover*
- *Sodium chloride*
- *Paper travels*

Procedure :

1) *Explain the procedure to the client .*
2) *Fill the ice with water, put the stopper, turn the bag upside down for leakage.*
3) *Empty the bag.*
4) *Fill the bag half to two-third with crushed ice.*
5) *Sprinkle sodium chloride.*
6) *Keep the bag on a flat surface and squeeze the air.*
7) *Screw the cap tightly.*
8) *Place the bag in the flannel corner.*
9) *Apply it on the ordered area.*
10) *The bag is applied on 30 minutes.*
11) *Make sure client is comfortable.*

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12) Wash hands.

13) Document the care given-time, sits, skin area.

COLD PACKS

Commercially prepared ice packs are available. These bags are sealed containers filled with chemical or non-toxic substance. Depending on the type, the bags are frozen in the freezer or squeezed to activate the chemical that produce the cold. These packs have the advantages that frozen solution remains pliable and can be easily molded to fit the body part.

Non-commercially, the pack can be a wash cloth towel, flannel or a piece of old line depending on the size of the body part receiving the application. A basin of cold water is prepared and the packs are immersed into it.

HOT APPLICATIONS

Hot application is the application of a hot agent, warmer than skin either in a moist or dry form on the surface of the body to relieve pain and congestion, to provide warmth, to promote suppration, to promote healing, to decrease muscle tone and to soften the exudates.

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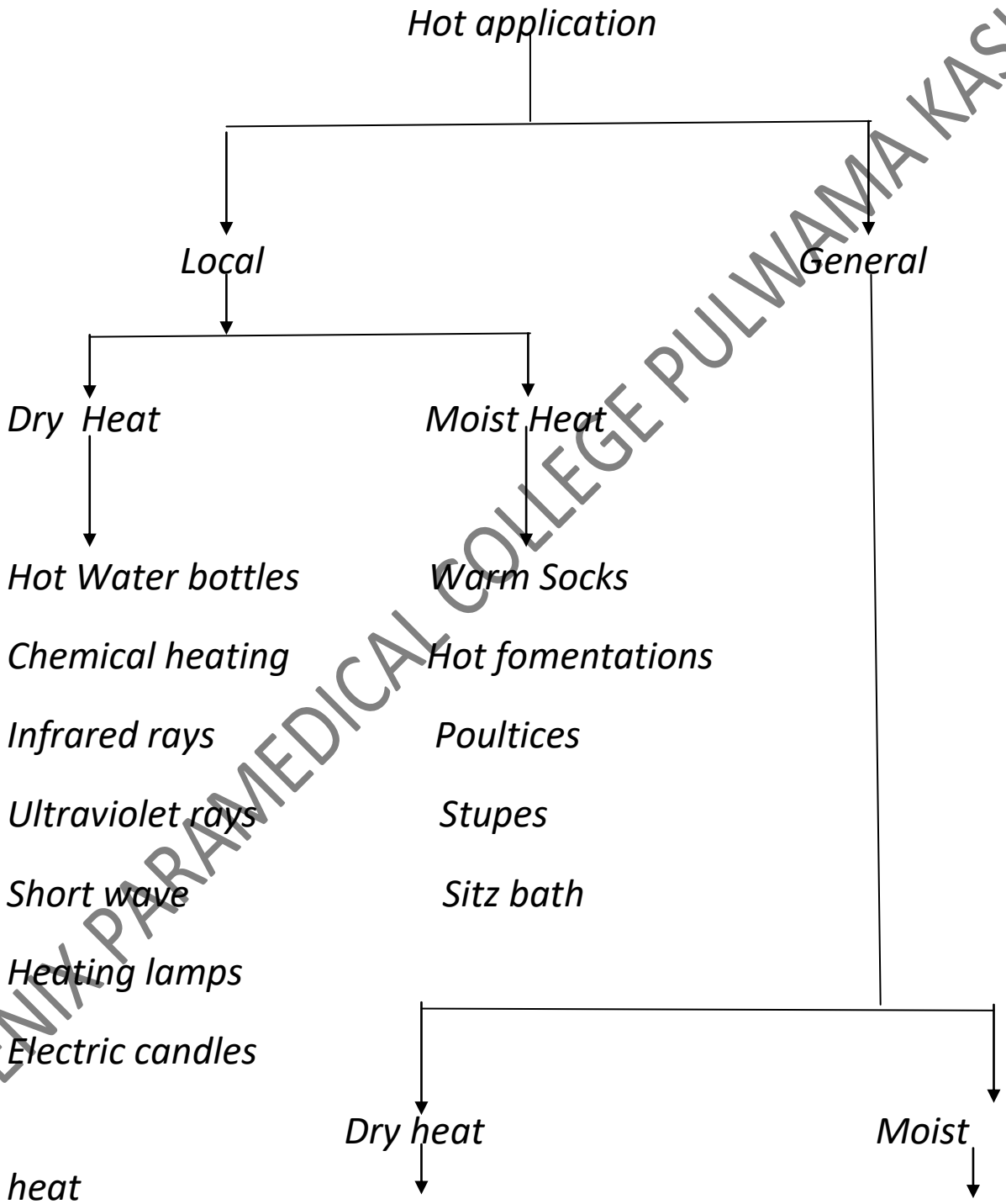

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Sun bath *Steam Baths*

Electric Cradles *Hot Packs*

Blanket Bed

THERAPEUTIC USES OF HOT APPLICATIONS

1) Heat decreases pain.
2) Heat decreases muscle tone.
3) Heat promotes healing.
4) Heat relieves deep congestion.
5) Heat provides warmth.

APPLICATION OF HOT WATER BOTTLE

1) Check the diagnosis .
2) Assess the type of application to be used.
3) Inspect the body part that is to receive the treatment for any lesions.
4) Check the articles available
5) Articles required.

A tray contained
Hot water contained
Jug
Duster

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Towel

Vaseline

Lotion thermometer

6) Provide privacy

7) Wash hands

8) Take hot water in the jug. Pour some water into the hot water bottle and empty it.

9) Check the temperature of water.

10)Fill one-third to half of the bottle with the hot water.

11) Place the bag over a flat surface and expel the air.

12) Apply the hot water bottle over the area and cover it with the towel or sheet.

13) Keep the bottle in place for about 26-30 min changing the position of the bag.

14) Remove the hot water when completed.

15) Dry the area.

16) Position the client comfortably.

17) Take all articles to the utility room.

18) Wash hands.

19) Record the procedure with date and time.

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FOMENTATIONS (MOIST HEAT)

Fomentations are moist applications of heat over an area by means of double thickness of flannel or other soft material using out from hot water, protected by a waterproof covering, wool and bandage.

TYPES

1) *Simple fomentation.*
2) *Medical fomentation.*
3) *Surgical fomentation.*

PURPOSE

1) *To relieve pain and congestion.*
2) *To relieve inflammation.*
3) *To relieve retention of urine.*
4) *To promote suppuration.*
5) *To stimulate peristalsis.*
6) *To relieve muscular spasm.*
7) *To relieve congestion.*

PROCEDURE

1) *Identify the client.*
2) *Check the diagnosis.*
3) *Check the articles.*
4) *Kettle with boiling water is required.*
5) *Articles required:*

Tray contained :

- *Cotton balls*
- *Forceps*
- *Olive oil*
- *Paper bag*

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- *Kidney trap*
- *Lint or flannel pieces.*

6) *Provide privacy .*
7) *Wash hands.*
8) *Prepare the hot compresses either at the bedside or in the treatment room from where it can be taken to the client without any delay.*
9) *Place the fomentation pads in the wringer and keep it inside the basin with the free ends outside.*

10)Pour boiling water over the pad and wring out the pad as dry as possible.

11) Keep it in the heated plates.

12) Open the wringer, take out the pad, shake it well for the steam to escape from the compress.

13) Test the temperature try applying it on the back of your hand.

14) Apply the compress over the area.

15) Secure the dressing with a many tailed bandage or abdominal binder.

16) Place the hot water bag just above the bandages.

MEDICAL FOMENTATIONS

Stupes are moist heat applications , in which a medicine (e.g; turpentine) is applied locally to augment the effects of the hot compresses used. Stupes are commonly used to relieve tympanites by increasing the peristalsis and releasing the muscle spasm.

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Articles needed will be same as that of hot fomentations. After the application of Stupes, it will be necessary to insert a flates tube to expel the flatus. The drugs used are : Turpentine, well minded with olive oil (6 parts).

To apply the turpentine stupe: Take the turpentine and the olive oil is=n the correct proportion, mix them well and warm it by keeping the container in a bowl of hot water. Apply the warm oil mixture over the part, apply the hot compresses and follow the procedure as in hot compresses and follow the procedure as in hot compresses and follow the insert the flatus tube and water for expulsion of the flatus .

Basic needs and care

Care of patient with fever:-

Regulation of body temperature:

Care of clients in fevers focuses on reducing the elevated body temperature. When a clients temperature is moderately elevated, various methods of reducing the temperature may be started. The room should be maintain at comfortable temperature. The room should be a well ventilated. The blankets and excess clothes should be removed but prevent the client from getting draughts. The various methods used for cooling the body are:

- *Exposure to cool by an electric fan.*
- *Administration of cool drinks*
- *Application of cold compress.*
- *Cold bath.*

When surface cooling is used, treatment is directed at not only cooling the body but also for preventing shivering . shivering must be

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prevented because it increases metabolic activity, produces *heat, increases the oxygen usage markedly increases circulation, may cause hyperventilation.*

2. Meeting the nutritional need

The cellular metabolism is greatly increased during fever therefore, a high caloric diet is indicated in fevers.

3. Providing rest and sleep

All clients have fever should be asked to take complete bed rest. To ensure rest and sleep, provide a unit, which is calm, quiet.

4.Maintenance of personal hygiene

Care of mouth is very essential for clients having fever for many days. Sponge bath is given daily to keep the client clean.

5. Safety factors

Never leave a client with fever alone.

Surface cooling should be done gradually.

Sudden cooling can lead to serious side effects such as cardiac arrhythmias.

Care of unconscious patient

Introduction :consciousness is a state of being wakeful and aware of self, environment, and time.

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Unconsciousness can be brief lasting for few seconds to an hour or so, or sustained, lasting or few hours to longer. Unconsciousness can be produced by a disorder that disrupts the ascending reticular activating system(RAS).

Coma is a state of sustained unconsciousness in which the client does not respond to verbal stimuli, does not move voluntarily, does not blink , may have altered respiratory patterns.

Nursing diagnosis according to priority:

- *Ineffective airway clearance related to upper airway obstruction by tongue and soft tissues, in ability to clear respiratory secretions as evidenced by unclear lung sounds, unequal lung expansion.*
- *Ineffective cerebral tissue perfusion related to effects of increased ICP (intra cranial pressure) as evidenced by papilledema, vomiting.*
- *Risk for injury related to unconscious state.*

Nursing care plan

1.Diagnosis –I (a) assess respiratory rate pattern, lung sounds, lung expansion, signs of tissue hypoxia, cyanosis.

(b) Renate head of bed to 30^{o}

Or place client in lateral or semi-prone position.

(c) insert oral airway if tongue to paralyzed or is obstruct the airways.

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2. Diagnosis –ii (a) assess signs of increased intra – cranial ` Pressure, cerebral edema.

(b) Maintained head of the head elevated to 30$^{o.}$

***(c) A**dminister low flow oxygen.*

(d)Maintain a patent airway.

(e) Administer osmotic diuretics e,g maintop, corticosteroids.

Diagnosis 3:

Assess risk factors for injury- lack of side rails, seizures loss of corneal blink reflect.

(b) keep side rails up and bed in lowest position whenever client is not receiving direct care.

(c) keep clients nails short.

(d) Administer prescribed seizure drugs.

(e) Always turn the client to nurse to prevent fall.

<u>Care of terminary ill or dying person</u>

Psychological support: There are five psychological stages that dying person pass through. These are denial, anger, bargaining, depression and acceptance .In all these stages, the nurse needs to be truthful but prudent in all her dealings with the client. Maintain a genuine, honest attitude of interest. The client may ask many questions and may want to clarify many of his doubts.

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*2. **Symptomatic Management**:*

Problems associated with breathing:

The dying person who is restless, apprehensive and short of breath may be given the oxygen inhalation to ease his discomfort. Elevation of the clients head and shoulder may make breathing easier.

3. Problems associated with eating and drinking

Anorexia nausea and vomiting are commonly seen in the dying persons. Most of them require I.V fluids. if they can tolerate the oral

fluid sips fluids may be given with teaspoons. That will help the client to keep the mouth moist.

4.Problems associated with elimination constipation, retention of urine and incontinence of urine and stools are some of the problems faced by the client. Through skin and perineal care are necessary to keep the client clean and to prevent skin breakdown.

5. Problems associated with rest and sleep

Pain may be a distressing symptom in these clients .All the possible care should be given to alleviate pain and to ensure rest and sleep. Client should not be disturbed when he is sleeping. The

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visitors should be instructed not to disturb the client during his rest hours.

Care of body after death

1. *It is the function of the physician to declare the death of the client. Clients are not legally death until the physician has certified death and nothing should be done that would interfere with life, as there is possibility of life remaining in the body.*
2. *Nurse preparing the body after death should know whether there is to be an autopsy or an inquest. She should get written permission for autopsy.*
3. *When death occurs fallowing certain communicable diseases such as smallpox, the body requires special attention to prevent the spread of the disease.*
4. *After the dead body is removed from the room, the room should be treated as in case of 'discharge of client'.*

Leaving against medical advice

A client can decided to leave the hospital against medical advice. For this a client must sign a form that release the physician and the healthcare institutions from any legal responsibility for his/her health status.

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Signs of approaching death

a. *Facial appearance*

   Facial muscles relax; cheeks become flaccid, moving in an out with each breath.

   Facial structure may change, so that dentures cannot be worn with the dentures removed, mouth structure may collapse lip pucker and skin in.

b. *Changes in the sight, speech and hearing sight gradually fails. The pupils fail to react light. Eyes are sunken and half closed. Speech becomes increasingly difficult, confused, and finally impossible.*

c. *Changes in respiratory system*

d. *Respiratory becomes irregular, rapid or slow.*

e. *Circulatory system:*

   Circulatory changes cause alterations in the temperature, pulse and respiration.

f. *Gastrointestinal system*

   Hiccoughs, nausea, vomiting, abdominal distension are seen. The gag reflex disappears.

g. *Genitourinary system*

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Retention of urine, distension of the bladder.

h. Skin

The skin may become pale, cool and sweat profusely. Ears and nose are cold to touch.

i. Central nervous system

Reflexes and pain are gradually lost.

Client may be restless due to lack of oxygen.

Signs of clinical death

The signs of clinical death are,

Absence of pulse, heart beat and respiration red blood cells rolling to stop.

Pupils of the eye becoming fixed and non-reactive to light, absence of all reflexes.

Mouth care

Infection of mouth can spread to neighboring structures leading to the fallowing :

Parotitis – Inflammation of parotid gland.

Sinusitis- Inflammation of sinus cavity.

Otitis media- Inflammation of middle ear.

Good oral hygiene makes a person feel socially acceptable and to have self-respect. All the persons who are unable to

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attend the mouth should be assisted to clean the mouth. Nurses responsibility in attending the mouth of a client in illness.

Preliminary assessment

1. *Check the condition of the oral cavity.*
2. *Check the ability of the client for self care.*
3. *Articles available in clients unit.*
4. *Articles required:*

A tray containing

Small mackintosh

Face towel

Small jugs

Feeding cup

Artery forceps

Dissecting forceps

Gauze piece

Kidney tray

Paper bag

Choose one of the solutions.

Choose one of the emollients.

- *Tongue depressor*

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- *Bowel of clean water*
- *Solution commonly used*

  Potassium permanganate ($KMNO_4$) 1:5000 solution (one crystal to a glass of water to give a pink colour and it should be freshly prepared each time).
  - *Hydrogen peroxide(H_2o_2)1:8.*
  - *Sodium chloride ,1 teaspoon to a pint of water.*
- *Emollient used*

  Cream or butter

  Liquid paraffin

  Olive oil

Procedure

1. *Explain the procedure to the client.*
2. *Provide privacy.*
3. *Maintain a safe comfortable position.*
4. *Wash hands.*
5. *Prepare the mouthwash by adding hot and cold water and drop one crystal of potassium permanganate into it.*
6. *Help the client to rinse his mouth.*
7. *Pick up the toothbrush, wet it with water, spread a small quantity of toothpaste on it and hand it over to the client.*
8. *Instruct the client to brush all side of the teeth, outer side, inner side and chewing surface.*
9. *Help the client to rinse his mouth thoroughly.*
10. *Ask client to massage the gums.*

Tube Feeding or Gastric gavages

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Gastric feeding is an artificial method of giving fluids and nutrients through a tube, that has passed into the esophagus and stomach through the nose, mouth or through the opening made on the abdominal wall, when oral intake is inadequate or impossible.

Indications

- *When the client is unable to take food by mouth. For example, unconscious, semiconscious.*
- *For a client who refuses food e,g psychotic.*
- *When a clients mouth or esophagus is not able to swallow e,g fracture of jaw, repair of the cleft palate and cleft lips.*
- *When the client is too weak to swallow food or when the conditions make it difficult to take a large amount of food orally. E,g acute and chronic infections, malnutrition etc.*
- *When the client is unable to retain the food, e,g anorexia nervosa, vomiting etc.*

Advantages of tube feeding

1. *An adequate amount of all types of nutrients including distasteful foods, and medications can be supplied.*
2. *Large amount of fluids can be given with safety.*
3. *Dangers of parental feeding are avoided.*

Articles required

A tray containing

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Feeding cup with water
Kindly tray
Mackintosh and towel
Catton tipped applicators
Saline
Ryle's tube in a bowl of ice
Lubricant
Adhesive plaster
Paper bag
Glass of feed
Quinces glass
Bowl with water
Clamp

Procedure

- *Explain the procedure to the client*
- *Identify doctors orders*
- *Check the ability for self care*
- *Provide privacy*
- *Place the mackintosh across the chest*
- *Wash hands*
- *Take the tube and check whether it is in good order*
- *Measure distance on the tube from bridge of the nose to the ear lobe plus the distance from the ear lobe to the tip of the xiphiod process of the sternum. Mark the distance of the tube.*
- *Lubricate the tube for about 6-8 inches with the lubricant*
- *Hold the tube coiled in right hand and introduce the tip into the left nostril.*

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- *Pass the tube gentaly but quickly backwards and downwards.*
- *When the tube reaches the pharynx the client may gag.*
- *Have the client take sips of water and swallow on command.*
- *Check the placement of the tube in the stomach.*
    - *Aspirate for gastric contents with syringe.*
    - *Place the end of the tube with a syringe barrel or funnel into a bowl of water and note the rhythm of escaping bubbles.*
    - *Ask the client to hum or speak.*
- *Before giving the feed, pour semi water through the funnel to expel the air.*
  Then give the feed and medicines kept ready for the client.

<u>Catheterization</u>

Urinary catheterization is the introduction of a tube through the urethra into the urinary bladder to drain the bladder.

Purpose

1. *To get a sterile urine specimen for diagnostic purpose.*
2. *To empty the bladder when a condition of retention is thought to exist.*
3. *To determine whether the failure to void is due to retention or suppression.*
4. *To empty bladder prior to surgery involving rectum, vagina and pelvic organs.*

ARTICLES REQUIRED :

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A tray containing:

- *Sterile catheter – straight or an indwelling catheter (Foleys)*
- *A small bowel containing dettol 2% .*
- *Cotton swabs .*
- *Gauze piece .*
- *A pair of glucose*
- *Sponge holding forceps*
- *Kidney tray*
- *Specimen bottles*
- *Syringe with distilled water*
- *Drainage tubing and collection bag*
- *An unsterile tray containing:*
- *Mackintosh*
- *Towel*
- *Kidney tray*
- *Spot light*
- *Clean linen*
- *Pint measure.*

Preparation if the client

1. *Explain the procedure of the client*
2. *Adjust the position of the bed*
3. *Place the client in dorsal recumbent position*
4. *Place the mackintosh under the client.*
5. *Arrange the articles*

Procedure

1. *Scrub the hands as for a surgical procedure.*

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2. Lift the draping sheek back to expose only perineum

3. Open the sterile tray with aseptic techniques.
Put on the gloves.

4. Place the sterile towel and the slit in position.

5. Lubricate the catheter and place it in the sterile tray.

6. Clean the perineum with the cotton balls dipped in the antiseptic lotion using the forceps.

7. Keep the labia separated and pulled upwards from the time the vulwa is cleaned until the catheter is introduced.

8.Pick up the catheter with the gloved hand , holding it about 7.5cm from the tip and place the distal end in the sterile kidney tray .

9. Gently insert the catheter about 5-7 .5cm . the urine will flow into the kidney tray .

10. Release the labia minora and hold the catheter with same fingers. Maintain this position until the catheterization is completed, or balloon on indwelling catheter is inflated.

11. Collect the urine specimen if required.

Attach the drainage tubing if an indwelling catheter

Is put in.

12. Take all articles to utility room.

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13. *Send urine specimen, if any to lab .*
14. *Wash hands.*
15. *Record the procedure*.

STORING OF MEDICINES

Care of medicine cabinet and drugs.

1. *To stock the medicines, each ward should be provided with a medicine cabinet.*
2. *Adequate lighting should be provided within the cabinet to read the labels clearly.*
3. *There should be separate compartments for different categories of drugs – for mixtures, tablets, powers etc.*
4. *A register should be maintained to keep the account of the poisonous drugs.*
5. *All the poisonous drugs should be marked poison in red ink,*
6. *No drug should be stored without labels.*
7. *The drugs that are unusual in color, odor and consistency should be returned to the pharmacy and replaced with fresh ones.*
8. *Emergency drugs should be kept bin in a place where they are readily obtainable for emergency use.*

SAFETY MEASURES

The rights ensure safety in giving drugs.

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1. *Right client: Read the physicians orders to make a sure for whom the medicine is ordered call the client by name and ask him to repeat, his name.*
2. *Right drug: Read the physicians orders to study the correct name of the drug.*

- *Be careful of drugs whose names sound alike.*
- *Look for the color, odor of the drug.*

3. Right dose: Read the physicians orders to know the correct dose.

- *Know the minimum and maximum dose of the medicine administered.*

4. Right time: Read the physicians orders.

- *Give medicine as ordered in relation to the food intake e.g , before food or after food .*
- *Give medicines according to the action expected e.g , sleeping pills are given at bedtime .*

5. Right method: Read the physicians orders

- *Know the method of giving drug e.g , orally , rectally etc .*
- *Know the abbreviations used to designate the route of administration e.g , IV, IM .*

<u>COLLECTION OF SPECIMEN</u>

Blood may be collected by pricking the finger tips or ear

lobes and by vex puncture. The blood may be collected

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as' whole blood or clotted blood'.

The fallowing precautions are kept in mind when the 'Whole blood' is collected.

- *Whole blood is collected only by vex puncture. Vex puncture is done under strict aseptic technique.*
- *To collect blood by vex puncture, a syringe of proper size is selected and sterilized.*
- *The syringes and needles should be dried well before use, to prevent haemolysis of blood.*
- *To collect whole blood, the blood is collected in a test-tube or a penicillin bottle in which is placed on optimum quantity of suitable anticoagulant.*

Commonly used anti- coagulant is E.D.T.A (ethylene Demine tetra-acetic acid).

Gastric Lavage or stomach wash

Stomach wash means to wash out or irrigate the stomach with a solution. It is used most frequently as an emergency treatment in gastric dilatation and poisoning .

Purpose

1. *To remove the injested poisons are any irritating matter from the stomach.*
2. *To relieve nausea and vomiting.*
3. *To cleanse to stomach as a preparation for surgery.*

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4. *To obtain casts of apothecial cells for bacteriological studies.*

Solution used

- *Plain water (plain water is particularly useful when the poison is un identified)*
- *Normal saline*
- *Weak solution of sodium bicarbonate*
- *Specific antidotes: If the poison is identified there are three types of anti-dots*

a. *Physical antidotes: It is the one that mines with the poison and dilutes the poison or prevents its absorption.*
b. *Chemical antidotes: These react with the poison and neutralize it.*
c. *Physiologic antidotes: These have a systematic effect opposite to that of a poison.*

***Amount of fluid**:*

Gastric lavage is carried until the return flow is clear .About 500ml of fluid is to be introduced at a time to reach all parts of the mucous membranes of the stomach.

General Instructions

1. *Explain the procedure to the patient (if the patient is conscious) to win his confidence and cooperation.*
2. *Ask the help of the doctor to insert the gastric tube in patients with depression of the central nervous system.*
3. *Insert the tube slowly and gently to prevent trauma to the tissues.*

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Lubricate the tube with a water soluble jelly to make the insertion easy and to prevent friction.

4. *Ensure proper placement of the tube (in stomach).*
5. *Introduce about 500ml of liquid (irrigating solution in stomach and observe the patients response to the in flow). Stop inflow if any signs of intolerance occur.*

The tube is introduced either orally or through the nose often making sure that tube is in the stomach, laboratory examinations, in case of poisoning.

Attach the funnel to the tube and fill it with the irrigating fluid. Expel out air from the tube and raise the funnel to allow the fluid to run in to the stomach . When two or three funnels of liquid have run into the stomach and before the funnel is completely empty , pinch the tube and insert the funnel over a receptacle and allow the fluid to siphon back .Continue the treatment by alternately introducing fluid into the stomach and permitting it to run back until the return flow is clear are until the desired effect is achieved.

To discontinue the treatment, pinch the tube and pull it quickly. Record the treatment with time and date, on the nurses' record.

Bandages

Binders and bandages are applied over are around the dressings to provide extra protection and therapeutic benefits by:

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- *Creating pressure over the body part*
- *Immobilizing the body part*
- *Supporting a wound Securing splint*
- *Securing dressings*

Bandages are makeup of different materials such as gauze, elasticized knit, muslin, crepe, inexpensive, mold easily around the contours of the body.

According to the size and shape of the bandages they are classified as:

Roller bandages.

Tailed bandages.

T- Bandages.

Tubular bandages

<u>Principle</u>

Correctly applied bandages and binders do not cause injury to underlying and nearby body parts or create discomfort to the client.

1. Before a bandage is applied the nurses responsibility include:

a. Inspection of the skin for abrasions, edema, discoloration.

b. Exposed wounds or open abrasions should be covered with sterile dressings.

c. Inspect the underlying dressing.

2. Triangular bandages are used mainly as sling to support limbs. They may also be used to cover dressings over a large area.

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a. Tailed bandages (scultetus) is a rectangular piece of strong cloth with many tails to attached to either sides of it. It is commonly used as abdominal binder for the support of the abdominal musculature to prevent wound dehiscence fallowing abdominal surgery.

b. T-binders: is used to secure rectal or perineal dressings. The double T-binder is used for the males and the single for the females.

c. Tubular gauze: is a bandage in the shape of a tube, designed to cover cylindrical parts of the body and to secure dressings.

Blood transfusion

It is the transfusion of whole blood or its components such as blood cells and plasma one person (donor) to another person (recipient) This involves two procedures- The collection of blood from the donor and the administration of blood to the recipient.

Process

a. To restore the blood volume when there is sudden loss of blood due to hemorrhage.
b. To raise the hemoglobin level in cases of severe anemia which are not corrected by the administration of vitamins and iron therapy.

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c. To treat deficiencies of plasma proteins, clothing factors and hemophilic globulin. Etc.
d. To provide antibodies.
e. To replace the blood with hemolytic agents.

Grouping and cross matching: *The individual from whom the blood is transferred is called the donor. The individual to whom the blood is transferred is known as the recipient.*

Indiscriminate transfusion may lead to serious conditions and even death. This consequence is due to the process of climbing or agglutination or breaking up of red blood corpuscles .Agglutinogens and those in the plasma called agglutinatinius. Types of blood which gets agglutinated in the transfusion. Is said to be incompatible.

RH factor

85% of the world population is having the antigen 'D' of the 'Rh' blood group system. Those persons who possess this antigens is called 'Rh positive' and those who don't inherit this antigen, is called 'Rh negative'. The name Rh- factor comes from the 'Rhesus monkeys' whose blood contains these antigens .This antigen was discovered in 1940 by Landsteiner and Weiner.

The Rh – groups are of equal importance as the ABO group because of their relations to hemolytic diseases of the new born and their significance in blood transfusions. As in case of ABO blood groups persons who are Rh-positive do not have

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anti D in their serum. However, in contrast, to the ABO blood type, persons who are Rh-negative develop Anti-Rh antibodies only after exposure to Rh- positive blood, either by transfusions or by transplacental passage of red cells from a Rh-positive fetus.

General instructions for giving blood transfusion

- *Donor shall be free of diseases of heart, kidneys, lungs etc.*
- *There should not be any history of cancer, jaundice, hepatitis, tuberculosis etc.*
- *Donors must have a normal temperature pulse and blood pressure.*
- *Explain the procedure to the donor and reassure him/her to win his/her confidence.*
- *Before the blood is transfused, the donors blood must be cross-matched with the recipient blood.*

Collection, storage and transportation of blood

i. *Collection of blood from the donor is done in the laboratory. The donors blood is collected into a sterile container containing anticoagulant solution.*
ii. *All the articles used for the collection of blood should be sterile. They should be pyrogen free.*
iii. *Each donor unit must be labeled in clear, readable letters.*

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iv. *Stored blood shall be inspected daily and before use for evidence of haemolysis.*

v. *Freezing and heating of the blood will destroy the blood cells.*

Regarding administration of blood to recipient

- *When sending the recipients blood sample for grouping and cross matching, it must be carefully labeled at the beside of the recipient.*
- *Whole blood and blood products should be administered through an appropriate, sterile, pyrogen free transfusion set containing a filter which will remove clots and larger aggregates of leucocytes.*
- *No medication-antibiotics, vitamins, calcium should be added to the unit of blood or administered through the same intravenous system as they may cause damage to the red cells.*
  Blood may be allowed to stand at the room temperature for 30-45 minutes before it is administered to the patient.
- *The fallowing observations are made throughout the procedure:*
  a. Rate of flow.
  b. Signs of circulatory overload urinary output.
  c. Reaction to the blood transfusion.

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- *Keep the patient warm and comfortable with blankets, if necessary.*

Vaginal Douche

The term 'douche' is applied to a stream of fluid directed to a body cavity to flush that cavity. A vaginal irrigation is the washing of the by a liquid at low pressure. It is similar to the irrigation of external auditory canal, in which the fluid immediately returns after being installed in.

Purpose

i. *To cleanse the vaginal canal, removing an offensive or irritating discharge.*
ii. *To relieve inflammation and congestion of the genital tract.*
iii. *To arrest hemorrhage.*
iv. *To stimulate circulation of pelvic organ.*

Solution used

a. Sterile water
b. Normal saline
c. sodium bicarbonate 2%
d. vinegar 1%
e. Baric acid 2%

Nurses responsibility

Preliminary assessment:

1.Check the name, bed no, of the patient.

2.Check the diagnosis and purpose of vaginal irrigation.

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3.Check the condition of the perineum.

Articles required:

- *Irrigating can with tubing and a clamp.*
- *Douche nozzle.*
- *Gloves 1 pair.*
- *Jug with extra fluid irrigation*
- *Bedpan.*
- *I.V pole.*
- *Kidney tray.*
- *Vaginal speculum*
- *extra sheets*
- *Dry Catton balls*
- *Mackintosh and towels.*

Procedure

i. *Explain the procedure to the patient*
ii. *Provide privacy with screens*
iii. *Ask the patient to void*
iv. *Place the mackintosh and towel under the patient*
v. *Assist the patient to a dorsal recumbent position on the bed pan*
vi. *Wash hands*
vii. *Pour the solution into the can and allow little solution to run through the tubing*
viii. *To put on gloves*
ix. *Clean the perineum with wet swabs.*

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x. *Gently insert the nozzle into the vagina about 2-3 inches*

xi. *Allow the fluid to run in a steady stream. Note the character of the return flow.*

xii. *Disconnect the douche nozzle and place it in the kidney tray.*

Urine examination

Urine is examined by two ways:

1. physical

2. Chemical

In physical examination, color appearance, volume, specific gravity , is examined

In chemical examination, urine is tested especially for sugar and protein.

Articles:

A tray containing:

I. *Test tubes 4-6 on a test tubes stand.*
II. *Test tube holder*
III. *Spirit lamp*
IV. *Conical glass*
V. *Filter paper*
VI. *Urinometer*
VII. *Kidney tray*
VIII. *Acetic acid 2%*
IX. *Nitric acid*
X. *Benedicts solution*

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XI. Sample of urine

Urinalysis

Color: Normally color of urine is pale yellow or amber color.

Appearance: Inspect the whole urine for the presence sediments.

Reaction: To test the reaction dips one end of a litmus paper into the urine. If urine is acidic blue litmus turns into blue. Normal urine is acidic in reaction.

Test for sugar:

Pour 5ml of benedicts solution into a test tube boil it over the spirit lamp. If there is no color change in the benedicts solution, add 7 to 8 drops of urine to it with a dropper. Boil it again. Allow the test tube to cool. Record the result as fallows-

- *Blue liquid with no deposits –sugar Nil.*
- *Greenish deposits in a greenish liquid- sugar 1%*
- *Yellow deposits- sugar 2%*
- *Orange-sugar 3%*
- *Brick red- sugar 5%.*

Interpersonal relationship in nurse

We have seen that the nurse is an important member of the health care team that must work in cooperation and harmony or the care of the client. This cooperation and harmony

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depends upon the interpersonal relationship that is maintained among the members of the health care team.

Principles of interpersonal relationship:

1. Learn everyone's individuality.

2. Respect everyone.

3. Keep emotions under control.

4. Team leader should not make an any excuse regarding his/ her responsibility.

5. Be impartial to others.

6. There should be team spirit or we feeling among the members.

7. There should be delegation of responsibility in a group.

8. Establish a god rapport among the members in order to achieve the aim.

9. Every member should be familiar with the organization plan and the policies.

10. Develop habit of listening.

Spirituality

Spirituality is defined as the experience and expressions of one's spirit in a unique and dynamic process reflecting faith in God or supreme being; connectedness with oneself, with

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others, universe and God and integration of the dimension, mind, body and spirit.

Religion is a belief system, including dogma, rituals and traditions.

Spiritual health refers to a state of wholeness of the spiritual dimensions.

Nursing recognizes the spiritual aspect of human nature as an integral component of a person's sense of wellness.

Nurses have an opportunity to contribute to or participate in the spiritual care of clients. The word spirituality is derived from the Latin word 'spiritus' which refers to breath of wind.

Spiritual needs

Just as everybody has a spiritual dimensions, all clients have needs that reflect their spirituality. These needs are often brought forward by any illness or any other health crises. Clients whoa a have well- defined spiritual belief may find that their beliefs are challenged by their health situation, clients who have no defined belief may suddenly come face to face with challenging questions related to the meaning and purpose of life.

Spiritual needs include the following:

Need for love

Need for hope.

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Need for trust.

Need for values

Need for creativity.

Sense of purpose.

Goals of spiritual care:

- *Help the client fulfill religious obligations.*
- *Help the client draw on and use inner resources more effectively to meet the present situations.*
- *Help the client find meaning of existence.*
- *Promote a sense of hope.*

<u>Assessment</u>

In the spiritual assessment of a client, four important areas are considered:

1. *Concept of God*
2. *Source of hope*
3. *Religious practices*
4. *Relation between sp[ritual beliefs and state of health.*

<u>Nursing Diagnosis</u>

- *Spiritual distress R/T*
  Loss of child
  Sense of guilt.
  Conflict about belief
  Sexual abuse

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2. Potential for enhancing spiritual well-being.

3. Risk for spiritual distress.

4. Ineffective coping.

5. Readiness to enhanced spiritual well-being related to terminal illness.

Interventions

1. Communicating about spiritual needs.

2. Nurse must use herself therapeutically

3. Nurse must accompany the client.

4. Nurse must provide therapeutic environment.

5. Nurse must provide access to spiritual advisors.

6. Nurse must support the clients' religious practice.

Preparation Of Clients Unit

There are few factors which are considered as essentials to well-being. There are:

- *Adequate lightening during the day.*
- *Provision of an atmospheric temperature and humidity that promotes normal body functions.*
- *Atmospheric pressure within mans tolerance.*
- *Provision for disposal of refuse and excreta.*
- *Removal of dust, injurious chemicals and pathogenic bacteria from the atmospheric air.*

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Influence of external environment

1. Atmospheric temperature: in an ideal temperature, the person should not feel chilly, but it should be sufficiently warm enough to cause perspiration.

2. Humidity: humidity is the amount of moisture in the air. It affects the evaporation of moisture from the skin. A humidity of 40-60% is considered comfortable.

3.Air movement: ventilation mans movement of air . The chief purpose of ventilation is to supply fresh air and to maintain a proper humidity.

4. Lightning: the amount of light is an important factor in comfort. It is provided by natural or artificial light. Avoid direct light on the face and eyes. Prevent glare. The amount of light depends upon the use of client and the time of the day. The client, if conscious, should have within his reach a light which he can control.

5. Noise: Noise produces irritability, restlessness, fatigue and exhaustion in an acutely ill client. Noise interferes with sleep. ON the contrary, melodious sounds induce pleasure. The degree of noise may be reduced by various measures. Noise caused by friction may be reduced by lubrication use of rubber tyres and estrous for trolleys and wheel chairs reduce the sound when moving furniture.

Made echo-proof rooms. Avoid objects dropping.

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6. *Purity of air: Dust cause significant hazards to clients. Dust in hospitals may be laden with micro – organisms which cause infection.*
7. *Aesthetic factors: the environment becomes attractive if it appeals to the senses. Whether we are conscious or not, the design on arrangement of the room contributes to its harmony.*

   Through skillful use of color, the room can be made attractive. Color preferences vary with age, sex and race. Aesthetic consideration should include freedom for unpleasant sights. Bedpans, urinals, soiled dressings and used linen etc should be removed from the sick room immediately .

Stool specimens

Characteristics of normal stool

Color:

Normally the color of stool is light to dark brown.

Odour:

Normally stool has a pungent smell. It is normally affected by the type of bacteria flora, by the food.

Frequency:

One to two per day

Composition: The feces contain 30% water. Remaining portion contains shed epithelium from the intestine, a quantity of bacteria, mucin, calcium etc.

***Method of collecting stool specimen**:-*

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Water proof disposable contains or wide- mouthed containers are provided with necessary instructions. The client passes stool in a clean bedpan. A small amount of stool is removed with a stick or spatula and is placed in the container. Discard the stick in the waste bin.

***Sputum specimen**:*

Quantity:

Normally no sputum is expectorated. The amount of sputum coughed up in 24 hours varies with the disease. The sputum may be classified into various types according to its consistency and appearance, e.g., serous, frothy, mucoid.

Odour:

Normally the sputum is odoueless. In acute diseases the sputum is odouless.In chronic infection when the sputum is retained inside the lung, odour becomes foul.

Colour:

When sputum consists largely of mucus it may be colourless and translucent.

Presence of pus may give rise to yellowish colour. Greenish color is seen in bronchiectasis.

Rusty color of the sputum is due to the altered hemoglobin as seen in pneumonia.

Method of collecting sputum specimen:

Waterproof disposable sputum cups are used to collect sputum specimen. A large container is required if the physician desires to have the total sputum expectorated in

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24 hours. If sterile glass bottle with a screw cap can be used.

The client is given the container and is instructed to raise the material from the lungs by coughing and not simply expectorating the saliva or discharges from the nose or throat. The sputum should be collected in the morning before brushing the teeth and taking the food.

To collect the sputum from a young child use a cotton applicator and a test tube.

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