

# The history of impaired skin integrity nursing essay

[Health & Medicine](#), [Nursing](#)



\n[[toc title="Table of Contents"](#)]\n

\n \t

1. [Introduction](#) \n \t

2. [Main body](#) \n \t

3. [Conclusion](#) \n

\n[/toc]\n \nCase Study

## **Introduction**

To the medical ward was admitted 73 years old lady through the A&E. She was windowed, lived alone but had big family of 7 children. Twice a day patient was visited by home help, to help with ADL'S and meals. Patient came in with complains of poor appetite, hypoglycaemia, jaundice, diarrhoea, nausea, vomiting and fever. She had a history of CVA (Cerebral Vascular Accident) , left leg 5th toe ulcer, cholecystectomy and hypertension. First diagnosis: hypoglycaemia induced by DVT (deep vein thrombosis) and dehydration. On admission to the ward patient seemed slightly confused due to dehydration and hypoglycaemia, she was orientated to the time and place. Vital signs were measured; patient was hypotensive due to dehydration. Patient was asked about her allergies. Intravenous fluids were given at: 125 mills/hr as charted. Urinary catheter inserted due to impaired renal function and urine sample taken. Patient was on strict intake and output chart. She had pressure ulcer on the right small toe, wound chart started and MRSA swab sent.

## **Main body**

Assessment: On the patient's arrival to the ward I assessed her needs using the model of Roper, Logan and Tierney based on the twelve activities of daily living: Maintaining safe environment, breathing, communication, controlling body temperature, eating and drinking, working and playing, personal cleansing, elimination, mobility, sleeping, expressing sexuality and psychological and spiritual needs. Based on these needs a generic nursing care plan was set out. (N1) Maintaining safe environment: Patient was assessed using Glasgow Coma Scale to determine conscious state of the patient. (N4) Controlling body temperature: patient presented with pyrexia on admission. (N5) eating and drinking: patient was non-insulin dependent diabetic, she was not aware of it before entering the hospital, that's why she presented with hypoglycaemia. (N7) personal cleansing and dressing: assistance by one required as patient presented with left side hemiplegia due to CVA. Medley score was completed to assess the risk of developing pressure ulcers (Kozier et. al 2008) (N8) elimination: urinary catheter in situ and incontinence wear in situ as per request of the patient. (N9) Mobilisation: patient was assessed using falls risk assessment scale. All needs were discussed and agreed with the patient and her family, they were given a chance to ask questions and express any concerns. Patient was prescribed Aspirin 75mg, Bisoprolol 1.25mg (beta blocker), Regurin 20 mg (incontinent), Centrum, Clexane 20 mg. Few tests were made in order to find the cause of her condition. Blood test was done, MRCP, ERCP and Colonoscopy. MRCP (Magnetic Resonance Cholangiopancreatography) is a type of magnetic imaging that shows detailed images of liver, gallbladder, bile

ducts, pancreas and pancreatic duct (Rosch et. al 2002 ). Pre-test patient was explained what is going to happen and what to expect during the procedure. Aspirin was on hold and patient was NPO 6 hours before the test. After a test patient was continued on normal diet and IV fluids to clean up contrast from the body. MRCP showed biliary obstruction and focal lesion of the left side of liver. Examination results found left hepatic lobe lesion which are suspected for malignancy. Afterward patient was sent to Mater hospital for ERCP. ERCP (Endoscopic Retrograde Cholangiopancreatography) is type of the procedure used to diagnose problems in bile and pancreatic ducts (White 1990). Pre procedure patient was NPO from the 12 midnight all medication was kept on hold. I assisted patient with washing and dressing and patient was escorted to the procedure. ERCP procedure found common bile duct stones, which were removed. Colonoscopy is a procedure used to detect any abnormalities, inflammations or ulcers of the colon and rectum (Waye, Rex and Williams 2003). The quality of test depends from the good bowel preparation. 4 sachets of Klean Prep were given to patient a day before procedure as prescribed by the doctor. Patient was kept on clear fluids only and NPO from 12 midnight (Dykes and Cash 2008). Patient and her family were informed about the nature of the procedure and expectations after, they were provided with opportunity to ask questions and prepare. When patient was back to the ward, I checked her vital signs every 15 min for an hour, then every 30 min for two hours and then every hour, Including airway and breathing to make sure for adequate ventilation after sedation. Observed for signs of bowel perforation, as well as for any signs of bleeding, abdominal pain and fever. Observe and document any signs of

pain. As patient to describe pain and rate it on the scale from one to ten. If patient complained of pain I administer analgesia with the supervision of a nurse as prescribed and recorded effectiveness (Turk and Melzack 2011). I provided patient with privacy by closing curtains around the bed, to let her rest after a procedure. When patient came of sedation she could resume to normal diet. Colonoscopy results showed that patient had mid left sided diverticulosis. Implementation: Patient presented with hypoglycaemia due to dehydration. It is defined as a state when body has a low plasma glucose level (Toth and Pacaud 2002). Diabetes is a metabolic disease which is categorised in to two ways, Type 1 and Type 2. Type 2 is when pancreas partially loses ability to make insulin (Guthrie and Guthrie 2002). Patient and her family were educated about management of diabetes. Being provided with information contributed to patient's faster recovery and reduced stress. She was put on Gliclazide 30 mg OD. She was explained the importance of right diet and normal level of glucose which are at level of 4-7 millimols. Blood glucose was monitored 3 times a day before food and recorded in diabetic chart. Patient also was put on the list for review of diabetic nurse. To ensure the accuracy of the results, every morning control check was done. Before the procedure she was explained what's going to happen, for the better cooperation. Patient was asked to wash hands before the test, for accurate results. I washed hands and used gloves, to minimise the risk of cross infections. I took the blood sample from the side of the finger as it is less painful. After a test I disposed strips and lancet to the sharps bin, to reduce risk of needle stick injury. Wash hands after a procedure (Kozier et. al 2008) Strict diabetic diet maintained, patient was encourage to take fluids

for dehydration. Diabetic patients may have weekend immune system, narrow arteries and neuropathy. Due to nerve damage patient developed toe ulcer. Impaired skin integrity: Skin ulcer is when epidermis or dermis is impaired (Shai and Mailbach 2005). Before changing the dressing I washed my hands and prepared sterile trolley. Explained patient what I am going to do and received verbal consent. First loosened old dressing and placed in yellow bag. Assed wound, for colour, width, depth and any signs of infection (O'Meara et al 2000). Putted my sterile gloves on, and cleaned the wound with normal saline, inside out to reduce risk of infection. Applied sterile dressing and cleaned hands after. Referral was sent for the review of tissue viability nurse. Wound care plan was started and swab was sent to lab for investigations. Team requested X-ray on the toe. Infection was present so patient was put on IV antibiotics for seven days.

## **Conclusion**

By monitoring blood glucose levels before every meal, providing diabetic diet and administering oral anti diabetics, patient's sugar levels stabilised.

Increased fluid intake solved dehydration which was the cause of hypoglycaemia, IV fluids were stopped . Cleaning and changing wound as per care plan improved wound. Infection cleared up, eventually skin started to close, redness and pain went. When bile stones were removed jaundice gone. Urinary catheter was removed to prevent urinary tract infection. While caring for this patient I encountered few challenges. The most difficult part for me was moral support for the patient and family when they were informed about malignancy. This news choked family and depressed my patient. However patient had very supportive family who provided comfort

and care, it helped to relieve stress felt by patient, which helped patient to  
Although I found it very challenging, it helped me to improve my  
interpersonal and communication skills. While caring for this patient I  
improved my knowledge on CVA, diabetes, different procedures and tests.  
Also I developed and improved medication knowledge and basic nursing  
care. This experience will help me in future nursing practice as these  
conditions are very common in aging population.