

Principle of wearing gloves nursing essay



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Gloves are mainly used for protection of hand from the contamination with organic matter and microorganisms and also wear to reduce the risk of transmission of microorganisms to both patients and staff. However, a decision to wear gloves including its types should be based on an assessment of the risk associated with the care activity, specific nature of the task to be undertaken and the potential for contamination with microorganisms and hazardous chemicals. Perhaps, sterile gloves are used especially for the following practices . The rationale for wearing gloves will indicate the choice of glove required. . Major indication of wearing gloves are:

The choice between sterile and non-sterile gloves is based on contact with susceptible sites or clinical devices. Sterile gloves have been recommended to be worn in the following circumstances some of the reason behind wearing gloves includes:

During the procedure of Surgery.

Surgical wound dressings

Invasive procedures, for example lumbar puncture, for immune compromised patients.

Procedures requiring an aseptic technique.

Insertion of invasive devices, for example urinary catheters. Sterile pharmaceutical preparations.

Warm saline or water

Removing dressing and cleaning wound is the most painful wound care interventions. The application of cold cleaning solutions to wounds can be unpleasant and harmful to wound healing. Different techniques and solution are being used for dressing and irrigation in practice. The use of saline or water as cleansing solutions or leaving out the cleansing step resulted in similar infection and healing rates. However, the decision to use tap water to cleanse wounds should take into account the quality of water, nature of wounds and the patient's general condition.

Steps of wound Assessment

Assessing wound via palpation mainly for

Swelling

Separation of edges

Lightly palpate for localized area of tenderness or drainage

May need to culture drainage if present

Assess for pain.

The initial wound assessment takes in the big picture location, shape, and size.

Location

Location of the wound can give clues to the cause. For example, a sacral wound may be the result of sitting long time in the same position specially

the elderly patient or patients has a weakness musculoskeletal system applying pressure on sacrum.

Used anatomic land marks and language while documenting location of wound. For example, right medial malleolus is preferred to right inner ankle. Trochanter is preferred to left hip.

Body diagram is useful to document wound location

Shape

Shape of wound also can shed light on the cause of the wound. For example, a linear wound on the posterior mid thigh of patients who uses a wheel chair could be caused by pressure from the edge of the seat. A triangular sacral or coccygeal wound could be due to shearing and pressure forces caused by movement in bed.

Tracing is useful to document size for irregular shape. Follow the facility policies and procedure for tracing.

Always be sure to written consent and adhere to facility's policies and procedures if wound is photographed. Use wound film with size markings included or place a ruler in the photograph for perspective.

Size

Measure the wound in 3 dimension length, width and depth. Measurement should be always in centimeters. To measure length place the measuring guide at greatest length (head to toe) likely to measure the width place measuring guide at greatest width (side to side) never the less to measure depth gently insert a cotton-tipped applicator into the deepest part of the

wound. Place a mark on the applicator at the level of the skin (may be the clinician's thumb and index finger or an actual ink mark on the applicator) then hold the applicator against a centimeter measuring device to determine the depth of the wound. if possible measuring the wound by the same nurse for each subsequent assessment.

While measuring the wound depth, moisten sterile, cotton- tipped applicator with sodium chloride solution. (Don't use a dry one, which could injure newly formed granulation tissue.) Place the applicator tip in the deepest aspect of the wound and measure the distance to the skin level. If the depth is uneven, measure several areas; document the range and which part of the wound is the deepest.

Types of tissue

identify the types of tissue for example viable tissue i. e. granulation, clean non-granulating, epithelial non viable (necrotic) may also visualize muscle tendon subcutaneous in the wound bed, estimate how much of each is present, such as 60% granulation, 20% slough, and 20% Escher. Document the percentages on a flow sheet to allow for assessment of wound healing or deterioration.

Wound integrity

If your patient has a full thickness wound, assess for undermining, a hollow between the skin surface and the wound bed that occurs when necrosis destroys the underlying tissue. On the other hand, it is a passageway within and beyond the wound walls or base.

Examine the wound for the presence of supporting structures, such as tendons or bones. Note any orthopaedic hardware and be alert for foreign bodies, such as sutures and staples, all of which increase infection risk. Wounds with tunnelling or undermining are especially vulnerable for retained dressings. Lastly, assess for foreign bodies, such as a forgotten suture or lint.

Exudate

Follow your facility's guidelines for defining "None", "light", "moderate" and "high" amounts. Describe the exudates types as serous, serosanguineous, sanguinous or purulent. Infection can affect the color, consistency, and amount of exudate as well as cause an odour.

Examine wound edges

Check for the characteristics like attached, unattached, fibrotic or scarred (closed) and rolled edges (epibole). In full-thickness wounds, particularly when undermining (tissue destruction that occurs underneath intact skin around the perimeter of the wound) is present, the edges may curl under and delay healing. A white, shiny appearance at the wound edges may be the result of epidermal cells migrating across the wound to resurface it, which signals healing.

Peri wound skin

Assess the skin around the wound for color, moisture, intactness, in duration, edema, pain, and presence of a rash, tropic skin changes, and infection. For example, the color can be pink, red, blue, pale white, or gray; in darker skin, you may note deeper skin tones. Pink usually indicates healthy skin; red may

indicate friction, pressure, or beginning infection; blue or pale white is often a sign of compromised circulation.

The skin surrounding a wound may have too much moisture (maceration), which could increase the patient's risk of fungal or yeast infection. Assess the peri wound skin for primary skin lesions.

Documentation

Documentation is a very crucial tool for nurses to evaluate & provide proper nursing care plan, support mutual relation between the health professionals or colleague, it facilitate to meet and maintain professional and legal standards. Documentation of complete wound assessment includes pertinent history related to the wound. Depending on nature of wound assessments flow sheet can be used as alternative to reduce the documentation time . A wound assessment will be performed and result in documented evidence of a type of wound and a etiology of wounding Location of wound Dimensions of wound Clinical appearance of the wound Amount and type of exudate Presence of infection, pain, odor or foreign bodies State of surrounding skin and alterations in sensation Physiological implications of wounding to the individual Psychosocial implications of wounding to the individual and significant other.. Some of the examples of documentation are like

Patients care plan

Observation chart

Wound assessment chart

FBC and Daily drain chart

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GCS Chart

Progress notes, etc.

Risk and Complications

Sometimes, a large amount of fluid may leak from around the drain site, making the gauze dressing completely wet. If this happens, use soap and water to clean the area. Pain may accompany drain removal and persist after removal. Impaired wound healing may be a complication if fluid accumulates beneath the skin. Infection and injury to adjacent tissues may also occur. Occlusion of the tubing by fibrin, clots, or other particles can reduce or obstruct drainage. Infection may develop at the tubing exit site. Other complications may include breakage of the drain, difficulty in removal, inadvertent removal, pain, puckering scar, and visceral perforation. The patient may develop allergic reaction. .