Falls and risk assessment nursing essay

Health & Medicine, Nursing

Due: April Friday 26th 2013Lecturer: Kerry Reid-SearlRachel BishopS0243151

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Introduction

This assignment allows a Student Nurse (SN) to critically think and implement nursing strategies and address patient care in order to gain a touch of experience in preparation for practical clinical placement in term two. This assignment is based on the care of an 83 year old patient named Mr Cyril Smith who has the following underlying conditions; chronic obstructive pulmonary disease (COPD), prostatic hypertrophy, hypertension and diabetes (mature onset). The task of the SN is to examine and address the importance of hand hygiene, pressure injuries and falls prevention. In addition, this assignment will discuss the SN's approach to assessing and managing Mr Smith's clinical presentation, utilizing the ISBAR (Identification, Situation, Background, Assessment and Recommendations) method. Evaluating relevant literature through researching up-to-date journal articles and textbooks allows the SN to implement critical thinking and link theory to practice. As a result, this will effectively prepare the SN for similar clinical presentations that may occur during placement. Chronic obstructive pulmonary disease (COPD) is described in Mosby's Dictionary as being " a

progressive and irreversible condition characterized by diminished inspiratory and expiratory capacity of the lungs" (Harris, Naggy & Vardaxis, 2010, p. 364). Clinical signs COPD can produce are chronic coughing with sputum production and shortness of breath (SOB) (Kennedy, 2011). Mosby's dictionary defines prostatic hypertrophy as an increase in growth of the prostate caused by an excessive multiplication of cells (Harris et al., 2010, p. 1424). People who suffer from Hypertension have an elevated blood pressure and it is usually more difficult to treat in individuals with existing renal disease, coronary heart disease or diabetes (Harris et al., 2010, p. 852). Diabetes (mature onset), also known as Diabetes Mellitus, is the resistance of insulin in the muscles which requires the pancreas to secrete excess glucose from the blood and store it elsewhere in the body (Miller, 2005). According to Diabetes Australia (2011), type two diabetes is a process by which the pancreas still produces an amount of insulin, however it is not a sufficient amount required by the body. This disease can take place through genetics or the onset of lifestyle factors including poor nutrition, minimal physical activity, high blood pressure and obesity (Diabetes Australia, 2011).

Hand Hygiene

Hand hygiene plays an important role in the management of infection prevention and control. Hand hygiene is described as a basic infection-control method that reduces the risk of cross contamination (Tollefson, 2012, p. 2). As Mr Smith is a patient in a health care facility, adhering to hand hygiene allows the prevention of spread and transmission of infection to him. The five moments for hand hygiene would be considered by the SN when providing care for Mr Smith. These include before touching a patient, before

a procedure, after a procedure or body fluid exposure risk, after touching a patient and after touching a patient’s surroundings (Tollefson, 2012, p. 2). Routine hand washing involves cleansing the hands with warm water and soap which is a simple and most regularly used technique to adhere to hand hygiene (Tollefson, 2012, p. 2). Similarly, hand sanitizers are used as an effective hand hygiene tool, as they are suitable for minimally contaminated hands as they increase compliance and reduce skin irritation (Tollefson, 2012, p. 4). Hand hygiene is one of the many vital factors to comply with in any nursing facility to minimize and reduce the risk of cross contamination.

Pressure Injuries

In addition to hand hygiene, the SN has a responsibility to minimize the risk for Mr Smith from experiencing a fall or a pressure injury. A pressure injury is defined as a " localized injury pertaining to the skin or underlying tissues, as a result of pressure or including with, a combination of shear force and/or friction." (Australian Wound Management Association, 2012, p. 15). A pressure injury can be created within just one hour when tissue is compressed between two areas, for example skeletal bone and the bed, which restricts blood flow to the affected area and can cause the cells to have reduced oxygen and nutrient supply (Berman et al., 2008). The risk factors that are associated with pressure injuries include confinement to the bed or a chair, immobility, incontinence, poor nutrition, advanced age and lowered mental awareness (Berman et al., 2008). As per the risk factors noted, it is necessary that the SN undertakes a risk assessment tool for all patients admitted to a ward, to determine the potential of the patient developing a pressure injury during their stay at the medical facility.

Pressure risk assessment prediction tools are essential in the nursing profession in order to identify individuals that are at risk, determine the factors that place them at risk and recognize who requires pressure area prevention guidance (Berman et al., 2008). If any patient is at risk of acquiring a pressure injury during their length of stay in the health care facility, it is vital for the SN to consider the intrinsic and extrinsic factors that place them at risk. Extrinsic factors include pressure, sheer and moisture whereas intrinsic factors include age, nutrition, increased body temperature, COPD and diabetes mellitus (Niezgoda & Mendez-Eastman, 2006). There are several tools which can assess extrinsic and intrinsic factors, including Norton, Braden and Waterlow (Berman et al., 2008). However, for the purpose of this assignment, Mr Smith was assessed using the Waterlow Pressure Ulcer Risk Assessment Tool and received a score of twenty-two. This score places Mr Smith at a very high risk of developing a pressure injury due to his restricted mobility, single organ failure, 81+ age and diabetes (see appendix 1). Identifying a patient who is at risk requires the SN to implement strategies to prevent a pressure injury, considering each patient is different but all strategies follow a certain protocol. Mr Smith is at very high risk of pressure injuries which requires appropriate strategies to be implemented in order to control and prevent pressure injuries from developing. It is essential that the SN performs regular daily inspection for any pressure injuries in order to ensure early detection, as all pressure injuries can be preventable (Carville, 2005). A strategy the SN can apply for Mr Smith to prevent a pressure injury is by ensuring the use of appropriate surface support in bed. Pillows will provide maximal comfort and a foam mattress with ensure

support for the skeletal bones (Mayo Clinic Staff, 1998). The SN must educate Mr Smith to change positions regularly in the bed and ensure that he lets them know if any burning or pain in any bony prominence is occurring. A bony prominence is an area in the body where the bone (without any fat padding) is close to the surface of the skin (London Health Sciences Centre, 2007). The SN should assist in turning and re-positioning Mr Smith at least every two hours whether he is in bed or in a wheel chair (Berman et al., 2008). However if able to do so, he should be educated to re-position himself every 15 minutes (Mayo Clinic Staff, 1998). The promotion of mobility is a fundamental requirement for all patients at risk of pressure injuries. As Mr Smith has restricted mobility the SN must educate him to walk to the bathroom or around the ward every few hours to improve his blood circulation but must also assist him in the process (Mayo Clinic Staff, 1998). In addition, as Mr Smith has prostate problems and " dribbling" sometimes occurs, the SN needs to educate and ensure that he makes regular trips to the toilet so that he can attempt to empty his bladder. Due to the dry skin Mr Smith has, the SN must educate him to treat his skin by applying moisturizers on the affected areas whilst the skin is moist after showering (Berman et al., 2008). In addition, his skin should be reassessed by the SN on a regular basis to take note of any skin changes. The implementation of prevention strategies for not only Mr Smith but for every patient in the ward is essential to avoid a pressure injury.

Falls and Risk Assessment

A fall is described as " an event which results in a person coming to rest inadvertently on the ground or floor or other lower level" (Safety and Quality

Council, 2005). The risk of falls has a substantial impact on the patient themselves and also associated costs to the health industry. Consequently it is vital for the implementation of falls and risk assessment for prevention of falls. Examining Mr Smith's falls assessment and management plan, there are many intrinsic factors which place him at risk (see appendix 2). Mr Smith's age, gender, cognitive impairment, existing incontinence, requirement of assistance with mobility and medications influence his increased risk of him having a fall (Safety and Quality Council, 2005). As a result it is because of these factors that Mr Smith requires the necessity for prevention strategies to be applied. The rule of the five B's provides simple strategies to prevent falls. These include that the bed is low which allows the patient to have the ability to be mobile and continent, the brakes of the bed are on in order to make sure the bed doesn't move, the bed rails are only used if recommended and needed and the nurse contact buzzer and belongings are well within reach in case of an emergency (Qld Health, 2007). As well as the five B's, Mr Smith also requires appropriate footwear, regular toileting with assistance and supervision as well as education by the SN to communicate falls prevention and equipment use. Implementation of identifying a patient at risk of falls and then applying appropriate prevention strategies will enhance the safety of everyone in a health care facility.

Nutrition

Mosby's Dictionary defines malnutrition as a disorder of nutrition where the diet is unbalanced, insufficient or excessive (Harris et al., 2010 p. 1053). It is of vital importance that SN completes and is aware of a Malnutrition Screening Tool in order to understand their critical role (see appendix 1).

This role involves applying holistic care procedures and encouragement of healthy eating habits through the ‘ EAT’ approach – Encouraging, Assistance and Time to eat (Reid-Searl, 2013, April 9). To provide Mr. Smith with a meal, Berman et al., (2008, p. 1324) suggests that the SN considers the environmental factors such as odors, sights and sounds and adjust these to the patient’s requirements. Adding to this, providing and offering patient hygiene will enhance appetite and enthusiasm to eat (Berman et al., 2008, p. 1324). To assist with a comfortable eating setting, the use of pillows for support and surfaces for the food to rest on will benefit the patient’s needs (Berman et al., 2008, p. 1324). Implementation of suitable mealtimes is essential so that the patient has assistance to eat meals when needed and enough time as well (Hungry to be Heard Campaign Program, n. d.). A dietician can provide a service for Mr Smith’s ideal nutritional intake which is vital to maintain healthy eating whilst still focusing on his food preferences (Berman et al., 2008, p. 1324). SN’s have the responsibility to enhance and promote the nutritional holistic care to Mr Smith throughout his stay in the ward.

Vital Signs

As seen in the video when Mr Smith starts to have shortness of breath and feels unwell, the SN performs a skill set of vital signs (see appendix 3). These include the patient’s respiratory rate, O2 saturation, O2 flow rate, blood pressure, heart rate, temperature and consciousness. Anomalies in these vital signs are often indications to a disease or an illness. Any alterations made to the progress notes are used to assess a patient’s progress (Harris et al., 2010 p. 1824). As presented in the Vital Signs Chart, also known as ADDS

(Adult Deterioration Detection System), Mr Smith scores a six which requires the SN to inform the registered nurse immediately to review him and to request a review and note on the back of the vital signs form. Considering Mr Smith’s situation, the SN can use the ISBAR approach in order to effectively communicate to her registered nurse or the doctor.

ISBAR

ISBAR stands for Identification, Situation, Background, Assessment and Recommendations. The elements that should be applied by the SN when contacting Doctor James concerning Mr Smith’s state includes:

Identification & Situation

" Hi Doctor James, my name is Rachel Bishop and I am a student nurse at CQUniversity Hospital in the medical ward. I am concerned with the situation regarding patient, Mr Cyril Smith. He is short of breath with a respiratory rate of thirty, an elevated temperature of 39. 5 degrees and heart rate of one hundred. He stated that he feels worse and so I have notified my Registered Nurse who is assisting Mr Smith now".

Background

" Mr Smith currently has chronic obstructive pulmonary disease, prostatic hypertrophy, hypertension and type two diabetes."

Assessment

" Just to clarify Mr Smith’s observations, he is alert however is short of breath with his respiratory rate increased to thirty. His O2 saturation is ninety-five and flow rate at two. His blood pressure is stable at 140/90 but his heart rate

is increased to one hundred and his temperature is high at 39. 5 degrees Celsius. His ADDs score is six. I am not sure what the problem might be therefore I have notified my registered nurse who is assisting Mr Smith at the moment."

Recommendations

" Doctor James, may I please request you to attend to Mr. Cyril Smith who is in the medical ward, room 9, as soon as possible as I am very concerned with his state?" By implementing the ISBAR approach, Mr Smith's current condition, medical history and future recommendations can be effectively communicated. As well as this, an assessment strategy acronym SOAP; Situation, Observation, Assessment and Plan can help to determine final recommendations (Berman et al., 2010). All in all, applying these strategy tools in a clinical environment can provide the SN the ability to critically think, communicate effectively and apply holistic care.

Conclusion

By examining patient Mr Cyril Smith, he was a helpful asset in putting practical theories into a critical thinking written assessment. This assignment related to three dominant areas of health care practice. These included the importance of hand hygiene, pressure injuries and falls prevention. These areas were discussed and strategies were implemented to keep Mr Smith safe whilst his stay on the ward. Observing Mr Smith allowed the use of vital signs and the response a Student Nurse should give using the strategy tool ISBAR. Identifying, researching and putting theory into practice will assist

student nursing to critically make decisions and provide holistic care within a health care facility.