

# Disaster mitigation in naga city

[Environment](#), [Natural Disaster](#)



This paper will critically examine the care needs and management of Mr Braun. An appropriate framework will be used, namely the ABCDE.

Alternative treatment will be analysed using the 5 WHs critical decision making tool (Jasper, 2006). His care will be based upon the nursing process ensuring that patient outcomes are agreed, implemented and evaluated. The assessment framework to be used in this assessment is the ABCDE assessment framework. The ABCDE framework looks at Airway, Breathing, Circulation, Disability, and Exposure/Elimination.

The reason for choosing this framework is that it uses a systematic method of assessing, it aids with elimination of post op complications. In addition, it is a commonly accepted framework which is widely used and can be used in critical care situations, pre & post-operative care and emergency situations. Furthermore, it allows the nurse to use her skills in accessing the patient's needs. The disadvantages of the framework are that it is a medical model in the sense that it looks specifically at the biological aspects of care and lumps emotional/psychological/cultural/social care under the exposure/elimination category.

Therefore it does not promote exploring these issues in great detail (Yunker, 2008 & Hargan 2012) Cancer Physiology Bowel cancer normally starts in the rectum or sigmoid colon. It starts as adenomatous polyps and then progresses to adenomatous carcinomas. It spreads by direct extension via the bowel circumference, submucosa and outer bowel wall layers. It can also spread to other areas by direct extension, for example, to the liver, pancreas and spleen. Metastasis is normally by way of the surrounding lymph nodes.

Primary cancerous cells can also travel into the lymphatic and circulatory system causing secondary cancer in other organs such as liver and pancreas (LeMone & Burke, 2003). Mr Braun is undergoing an operation for his sigmoid colon cancer. One route to take would be the traditional method. This consists of open bowel surgery. This entails making a large opening. A bowel prep is given prior to surgery, there is a longer starvation process, which can cause dehydration and electrolyte imbalance. Furthermore, it causes stress on the body, insulin resistance in the body is longer and the recovery period is longer.

In addition it causes longer paralytic ileus (Siddiqui et al. , 2012). The alternative treatment to the traditional method would be the laparoscopic method. Mr Braun would have a smaller incision, therefore making a quicker recovery. He would be in less pain and would be able to mobilise quicker. He would have a quicker return of GI function and a lesser period of paralytic ileus. He would be able to deep breath better as he would not be experiencing a lot of pain, therefore he would be at less risk of contracting a chest infection.

This would all work towards him having an earlier discharge, for example, 3-5 days post op compared to anywhere between 8-12 days on the traditional method. Research has also shown that community rehabilitation is much quicker, 2-3 weeks rather than 6-8 weeks on the traditional method (Jenson 2011). Further research shows that patients undergoing laparoscopic surgery have fewer complications post discharge (Hargan 2012). It appears then the laparoscopic route has better outcomes for the patient and in addition, the NHS.

Being able to discharge a patient between 3-5 days who experience fewer complications post operatively not only frees up beds but costs less to treat the patient. Therefore, after weighing up the pros and the cons of both the traditional and the laparoscopic it would seem that Mr Braun would be better off having the laparoscopic route. It appears from research that the laparoscopic route is the route which is used in almost 90% of colorectal surgery. However, the route that is taken ultimately depends on the surgeon's choice. Prior to collecting the patient from the recovery room

Before collecting Mr Braun from the recovery room I will need to check the bed area. This includes checking that the oxygen is working. I will need to ensure that there is a nasal tube and a venturi mask. I will also need to check the suction is working and ensure that a new tube is present by the bedside. I will also need to make there is a yonker. I will put a dynamap beside the bed which will allow me to take Mr Braun's clinical observations on return to the ward. I will also ensure that a drip stand is next to the bed as he may be on fluids or have a PCA on his return to the ward (Nicol et al. 2012).

Collecting the patient from the recovery room On collecting the patient from recovery, I will take with me a kidney bowl in case the patient needs to be sick on his return journey, a pair of gloves, a oropharyngeal (geudel) airway in case his airway becomes compromised in anyway and a pocket mask for mouth to mouth. My first priority is to ensure that Mr Braun is safe to return to the ward. I will check his level of consciousness using the AVPU tool. This tool looks at whether he is Alert, whether he responds to Voice or whether he

only responds to Pain and whether he is Unconscious. I will then take a handover from the recovery nurse.

This should include informing me of the procedure Mr Braun has had, how well he has responded to the surgery and his current responsiveness/consciousness level. I would need to check with the recovery nurse whether his vital signs are within the normal range. This is for patient safety which is paramount and is at the centre of nursing care. This would need to be checked against the Early Warning Score (EWS) system which includes level of consciousness, the physiological parameters, for example, temperature, blood pressure, Oxygen saturation (SATS), respiratory rate, pulse and urine output.

The EWS gives an overall score which informs me whether or not it is safe to take Mr Braun back to the ward. The recovery nurse would also inform me which medications he has had, information regarding IV fluids, how long they should run for and whether more are needed when it finishes and check they are written up on the drug chart. In addition, I would need to see the wound bed. This would help with later assessment on the ward where I would be able to compare whether there has been any further bleeding or leakage. I would need to see the stoma site.

The recovery nurse would inform me whether Mr Braun had a urinary catheter and whether there had been any urine output. After handover I would say hello to the patient and manually take his pulse so that I can get an indication of his heart rate (Nicol et al. 2012). On the ward On returning to the ward I will orientate the patient. I will inform him of every procedure that I do so that I can gain informed consent (NMC 2012). I will immediately carry

out a set of clinical observations. This is so I can make a comparison with his perioperative baseline.

Although doing the clinical observations with the dynamap, I will manually take his pulse as it is vital that I know whether it is regular/irregular, strong or weak. ABCDE Assessment Airway The best way to check the airway is to speak to ask the patient and get him to respond to you. If he is able to talk in normally, this will be indicative of his airway being patent. I would need to listen to whether there are any sounds, like barking or gurgling as this could indicate that there is partial obstruction.

I would also need to check whether Mr Braun is experiencing any nausea or vomiting. If Mr Braun is experiencing this I would need to immediately administer an anti-emetic as per drug chart instruction. This would help prevent the risk of pulmonary aspiration. I would also need to check whether Mr Braun has any allergies. I would ensure that he is wearing two red wrist bands with the allergies clearly written on them so that other staff members are aware. His allergies would be documented in his nursing notes and on his drug chart with information on what sort of reaction he experiences.

Assessing whether Mr Braun has any allergies is extremely important as allergic reactions can cause swelling of the tongue and in the throat which would compromise his airway and leave him with difficulties breathing (Resuscitation Council UK, 2012). Breathing I would now assess breathing by checking Mr Braun's respiratory rate (RR). The normal range is between 12-20 breaths per minute. In PAC, his RR was slightly raised. This could have been due to anxiety but was more than likely due to his anaemia (this will be

looked at further under circulation). I will be able to gain a comparison and start looking for a trend.

It is important that the RR is counted for a full minute. His breathing may be irregular and therefore not counting the full minute would give an inaccurate measurement. I would also check Mr Braun's SATS. The normal range should be  $> 95\%$ . Checking his SATS will inform me whether he is getting enough oxygen and whether his tissues are being perfused adequately. Lack of oxygen can cause hypoxia which if not managed will lead to multiple organ dysfunction and ultimately death. I will also therefore check for cyanosis as this will also inform me whether he is lacking oxygen. It is important to look at how Mr Braun is breathing.

For example, is he struggling to breath, is he breathing deeply or is it shallow. Does he have to use his accessory muscles to help him breath. I would check whether his chest is rising equally on both sides. I would also speak as him a question to ascertain whether he is able to speak in full sentences because someone who is struggling to breathe is unable to speak in full sentences. I would look at whether he is breathing fast or slow. Furthermore, I would look at how he is sitting, for example, is he leaning to one side. Also when you are assessing breathing it is important to listen for any wheeze or stridor.

RR is one of the first things to alter when a patient is deteriorating. It is vital that if Mr Braun is experiencing any of the above, the nurse responds quickly. The first thing would be to check whether he is written up for any more oxygen and if so to increase it. The nurse would then have to check in RR and SATS again after 15 minutes to ascertain whether there was any

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improvement or further deterioration even. If the patient was deteriorating further the nurse would need to involve the doctor who would be able to review Mr Braun immediately and give further instructions on his care (Queen Mary University & City University, 2006).

**Circulation** An assessment of Mr Braun's pulse needs to be undertaken. This will allow the nurse to ascertain his heart rate. In addition, it would allow me to feel whether his pulse is strong or weak and whether it is regular or irregular. The normal resting pulse should be between 60-80 beats per minute (bpm). In the PAC, Mr Braun was slightly tachycardic, which could be due to anxiety of his diagnosis, hearing about the treatment he would receive or his prognosis. By taking his pulse it will allow for a baseline, pre-operative and peri-operative comparison.

His blood pressure (BP) would also be assessed. The normal ranges are 90/60-140/90. Mr Braun's BP in PAC was 135/80. Although this is still within the normal range, it is slightly high. However, this would be an appropriate BP given his age. It is vital that clinical observations are carried out every 15 minutes for the first two hours post-op as there is a higher risk of complications occurring and clinical signs are the physiological parameters which tell you whether a patient is deteriorating or improving.

For example, if a patient is tachycardic and hypotensive this could be indicative of hypovolaemic shock which would need to be managed immediately as this can lead to potential death. It is vital when taking clinical observations that the nurse is aware that she should not only rely on the measurements. This is because a patient can be in hypovolaemic shock and still have a normal BP. This is because in hypovolaemic shock, the

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compensatory mechanisms take over and the body will do everything it can to keep the BP at normal level.

Therefore, it is vital that the nurse also observes what the patient looks like, for example, does he look palor, he is sweaty or clammy. These are all important factors when carry out clinical observations. When a patient undergoes surgery he has enforced reduced mobility. Mr Braun will be in bed for a while and due to these factors is therefore at risk of Deep Vein Thrombosis (DVT), which is one of the highest cause of PE leading to hospital deaths. The nurse should check whether he still has his TED stockings on and check that they are not rolled down or creased as this may prevent them from achieving good prophylaxis.

Furthermore it could compromise his skin integrity. Mr Braun will probably also be prescribed oral or subcutaneous anticoagulants as a further prevention of DVT. Mr Braun's Hb levels should be checked to ensure that his anaemia is improving. If Mr Braun was assessed in PAC as having met the criteria, which is expected to make a good recovery, for the ERP, his anaemia would have been dealt with prior to him being admitted. He would have been assessed for any co-morbidities and his GP would have been involved to treat his anaemia.

If his anaemia had not been treated, prior to his admission, it is likely that Mr Braun would have undergone a blood transfusion during surgery. This would mean that he would have a cannula in situ which would need to be assessed to check for phlebitis. This would need to be documented on the VIP chart (Hargan 2012). The cannula needs to be checked to ascertain whether it is patent. The date of insertion should also be noted on the VIP chart as it is not

allowed to stay in for longer than 72 hours. Mr Braun will also have a catheter in situ. Therefore it is important to check for urine output.

Mr Braun should have a urine output of 0.5ml/kg/hr, in other words half his body weight per hour. Therefore if Mr Braun weighs 80kg, he should have a urine output of 40mls per hour. If going through the traditional method, Mr Braun would have to have a low residue diet approx. 2 days prior to the operation. He would only be allowed clear fluids approximately 12-18 hours before surgery and would then be starved from the midnight before the day of surgery to prevent aspiration. Research has shown that prolonged starvation causes dehydration and electrolyte imbalance.

It causes the body to experience insulin resistance for longer and cause the body more stress (Burch & Slater 2012). In contrast, he would have been given carbohydrate loading prior to surgery in the form of iso-osmolarity which 90% passes through the stomach within 90 minutes therefore he would have been able to have it one and a half hours prior to surgery. This would cause less insulin resistance and put his body through less stress. He would be able to come off any IV fluids as he would be encouraged to eat and drink at will post operatively.