Discipline of Nursing
July 11, 2001

- Hygiene
- Skin Integrity
- Activity
- Medication Administration Part I and II

SKIN

- Largest organ in the body
- Functions of skin:
  - Protection from pathogenic organisms
  - Body temperature regulation
  - Sense organ
  - Excretory organ
  - Fluid and electrolyte balance
  - Vitamin D production (precursor in the skin)
  - Identity: provides shape and form to the body

Hygiene

- Elements which will influence hygiene practices:
  - Culture
  - Socio-economic status
  - Spiritual practices
  - Developmental level (age)
  - Health state
  - Personal preferences
Hygiene State tells you a lot about the patient

- Self care deficits
- Psychiatric state
- Neglect / abuse
- Resources

SKIN CONDITION: tells you a lot about the patient's state

- Health state:
  - Hydration status
  - Presence of diseases
  - Nutritional status
  - Age
  - Temperature
  - Psych

SKIN SIGNS

- Yellow/jaundice: Liver/ gallbladder
- Pale: anemia
- Dry, poor turgor: dehydration
- Frost: renal failure
- Grey: poor perfusion
- Warm, dry, pink: healthy
Hygiene

- Not every patient needs a head to toe bath every day.
- **Must have oral care every shift**
- Most have care to axilla, groin minimum 1X day, maybe more frequent
- Do not use too much soap
- During a bed bath, excellent time to inspect skin, do ROJM, talk to patient about health, assess mental functioning

Property and Valuables

- Must be safeguarded.
- Label everything!! (eyeglasses, wheelchairs, canes, walkers, etc.)
- Remove all jewelry from unconscious patient.
- Document chain of custody

Lice

- **Kwell and Ritz are neurotoxic**.
  - Use caution, wear gloves
  - Minimum dwell time if patient has lesions / sores on skin
  - Be professional: do not make the patient feel uncomfortable
  - Wear protective garb: gown, gloves, cap. Do not need a mask.
  - Get permission to cut hair or shave beard.
What to do when...

- The patient is really soiled
- There are a lot of body fluids to be cleaned
- The patient weighs 300 lbs.
- The patient has diarrhea or is oozing exudate.

Wounds

- Types
  - Contusion
  - Abrasion
  - Laceration
  - Incision
  - Avulsion
  - Clean vs. dirty

Basic care for wounds

- Control bleeding & Look for other injuries
- Assess for presence or absence of infection
- Clean: as per organization protocol
- Purpose of dressing: protect the wound
**Wound Assessment**

- Location
- Size cm x cm for irregular shape
- Drainage: serous, sero-sanguenous, blood, purulent, other
- Odor
- Pain
- Function of part: sensory and motor

**Dressings**

Purpose is to:
- Protect the wound from contamination
- Splint body part: decreases pain and promotes healing

**Dressings**

- Usually layers:
  - Wick layer: gauze or telfa
  - Absorption layer: topper sponge, absorbent pad
  - Outer layer: kling, kerlex, abdominal pad.
**Special dressings**

- Spandex
- Petroleum gauze
- Medicated petroleum gauze
- Occlusive dressings: duoderm
- Transparent dressings

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**TAPE**

- Types:
  - Adhesive: for heavy duty holding: abdominal dressings
  - Silk: for medium holding: minimum tension on the tape
  - Micropore: Lightweight
  - Paper: lightweight, used for person with allergies to adhesive

Use benzoin or skin tack to create a barrier between the adhesive and the skin. When pull off the tape, will be pulling off the skin tack. Makes the tape stick better. Always use to apply tape for endotracheal tubes.

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**Application of Heat and Cold**

- Must use caution
- Usually cold for 24 – 48hrs. Then heat
- Moist heat: works great: wet towel, apply to area, wrap with large plastic bag and tape shut.
- Most cold: clean wet cotton sock with ice cubes. Place a layer of protective cloth on skin before ice pack (or will burn the skin)
- Heat lamps: check the patient q 5 minutes (high risk)
Sponge baths

- Now only with tepid water.
- Do NOT use alcohol
- Do NOT use ice cold water

- As long as the water is less than 98 degrees, will loose heat
- Water, removes heat 30 x faster than air alone.

Pressure Ulcers

- LTC: 3.5 to 29 % incidence
- Approx 5 % for hospitals
- Can form in 1-2 hours, depending upon patients physical condition
- Prevention is the KEY. This is a NURSING CARE issue.
- Causes: pressure, friction, shearing forces

Risks for Pressure Ulcer Development

- Immobility
- Nutrition and hydration
- Underlying pathology and physical state
- Incontinence (urine and or feces)
- Mental status
- Age
Risk assessment of prevention strategies

- Need a thorough assessment upon admission or first encounter.
- Nsg dx: Potential for skin breakdown r/t (immobility), urinary incontinence, ...
- Plan: strategies to address the risk factor (turn q 2 hr), (perineal care q 1 hr, frequent toileting, ....
- Patients who are really high risk must be assessed every SHIFT.

Pressure Ulcer Staging

- I Reddened area, skin intact
- II Superficial, abrasion, blister, shallow crater
- III Full thickness of skin, into subcutaneous tissue
- IV Full thickness of skin, through subcutaneous tissue into muscle

Wound care for pressure ulcers

- I Turn, position, relieve pressure
- II Moist dressing
- III Debridement
- IV Debridement and skin grafting
- For all: address risk factors (mobility, incontinence), increase nutritional status.
Mobility

- Terms: Know the terms in the book
  - Abduction
  - Adduction
  - Circumduction
  - Flexion
  - Extension
  - Hyperextension
  - Dorsiflexion
  - Plantar flexion
  - Rotation
  - Internal rotation
  - External rotation

Hazards of Immobility

- CV: Pulse rate will go up, Orthostatic hypotension develops
- Resp: pooling of secretions: pneumonia
- GI: alteration in metabolism, decrease in peristalsis
- Urinary system: stasis of urine in renal pelvis: renal stones
- M/S: muscle wasting, loss of strength, bone demineralization
- Skin: skin breakdown
- Psychological: decreased sensory stimulation: hallucination

Body Mechanics

- Wide base of support (spread feet apart)
- Use stronger thigh muscles (not abdominals, as the pressure will go to your spine)
- Get help of a co-worker
- Use a hydraulic lift where necessary
- Work in concert: move on three, 1,2,3
Medication Administration

- Five rights:
  - Patient
  - Medication
  - Dose
  - Route
  - Time

Medication Errors

- Common in hospitals
- If you rush, you will make an error. TAKE YOUR TIME. Very few meds need to be given within one second!!
- Know what you are giving he patient. If you don’t look it up, before you give it so that you are aware of usual dosing, contraindications, drug incompatibilities, unwanted side effects, and expected therapeutic actions.
- Where applicable, document effect of medication: pain relief, temperature, respiratory status, etc.

Medication assessment

- Current meds
- Reason for taking
- Dose, frequency
- Compliance?
- Last dose
- ALLERGIES to foods or medications
Drug Preparations

- Generic name
- Trade name
- Official name

- Drug preparations for routes:
  - Oral:
    - Capsule or Eventab
    - Elixir/syrup/suspension
    - Lozenge
    - Tablet

- Injection: IV, IM, SQ, intradermal
- Transdermal: patch, ointment
- Suppository: rectal, vaginal

Times (must know all abbreviations)

- AC before meals
- PC after meals
- QD every day
- QOD every other day
- QW every week
- BID twice a day (different from Q 12h)
- TID three times a day (different form Q8 h)
- QID four times a day
- Q __ H every __ hours
- HS bedtime
- STAT immediately
- PRN as needed (Q __ hrs, prn)
Medication Cart Safety

- Pour meds as close to the patient bedside as possible
- When not in use, keep med cart locked
- Do not give meds that someone else poured
- When through with chart, close it when in the patient room
- Do not leave meds at the patient bedside, unless specific arrangements have been made.
- Chart meds as close as possible to time given
- Keep meds organized
- Figure out at the beginning of the shift what has to be given when, and order up if not in cart, before it is needed.
- Check medication orders at beginning of the shift.

Narcotic Safety

- Do not give narcotics that someone else took out of tubex
- Sign out your own narcotics
- If given the keys to hold, do a narcotic count
- Be sure that you have wasting witnessed
- Narcotic count at beginning and end of each shift.
- Sign out narcotics at the time they are used, and chart in medical record as well.
- Whenever possible, nurses should administer narcotics which they take out of the narcotic cabinet.

P.O. Medications

- Some meds on full stomach
- Some meds on an empty stomach
- Be sure that the patient swallows the medication, especially psych patients and pediatrics
Parenteral Medications

- Sterile technique
- IM, SQ: make skin taunt, puncture skin quickly to minimize pain.
- Be sure that patient is appropriately immobilized if agitated
- Use the smallest lumen needle that will do the job.
- Certain meds can be mixed in a syringe, and others can’t: refer to med compatibility chart.

Organizing your day

Pt. Name: ________________

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