

132 EXAM REVISION

Semester 2 2018

WEEKS 1 TO 9

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Clinical Reasoning Cycle

Consider the person and the context		Head to Toe Assessment - Observe/ visual Ask Qs Context
Collect Cues and Information		Asking relevant questions- Objective and Subjective questions ❖ Do the cues match what they are saying
Process information		Processing → Making connections between data Documentation
Identify Problems/ Issues		Nursing problems Assessing data ABCD Priority- Always look for pain
Establish Goals		Goal set- SMART Goals Short term- what we can do <u>now</u>
Take Action/ Intervene		Interventions depend on context
Evaluate Outcomes		Did it work or not Best Practice
Reflect on Process and New Learning		Reflect on what has happened- what can be done better next time

Week 1 Infection Control

CPS

PPE → Gown, mask glasses, gloves.... Remove gown and gloves. Wash Hands. Remove glasses and mask. Wash Hands.

Moments of Hand Hygiene

Week 2 Safe Administration of Medications

Index book- Drug (active ingredient & common trade names), use, contraindications, and precautions.

S8- 2 Nurses check out drug together and both go to bedside

Storage of medications

- Within recommended reconditions (does it need to be in a fridge?)
- Labelled
- Expiry date

Safe Administration

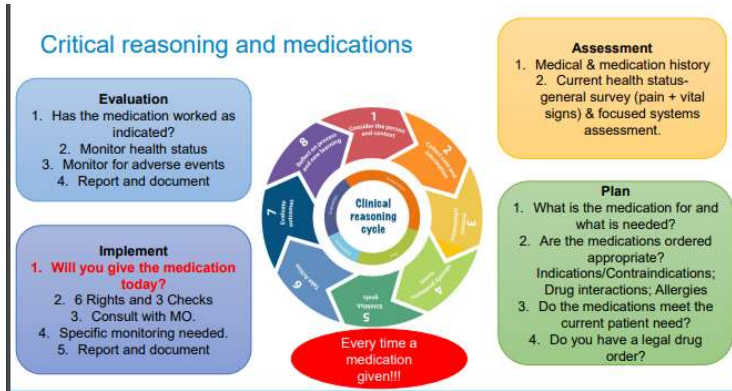
Route of Administration

6 Rights of Medication safety- patient, drug, dose, route, time, refuse. 7th Right Documentation

3 checks- 1. Removing medication from cupboard/trolley 2. Before dispensing into reciprocal 3. After dispensing and before administering

Identifying Patients

- ID Band- Full Name, DOB, hospital No.
 - Ask Pt. these details
- ID Band + what the patient tells you
- RAC- Photo ID
- Take care with cognitive impairment



Blood Glucose

4-6 = Normal 6-7= Moderate 7+= High blood glucose

Type 1 diabetes ¹	
Target levels	4–6mmol/L before meals 4–8mmol/L two hours after starting meals
Type 2 diabetes ²	
Target levels	6–8mmol/L before meals 6–10mmol/L two hours after starting meals

Week 3 Patient Mobility

What is a fall? A fall is an event which results in a person coming to rest inadvertently on the ground or floor or other lower level.

- Nervous system injury/disease - central or peripheral e.g. CVA.
- Delirium/ dementia/ altered level of consciousness.
- Musculoskeletal deficits
 - surgery
 - injury
 - Disease
- Need a thorough history of disease/issues. Musculoskeletal impairment - pain, weakness, deformity, limitation of movement, stiffness, crepitation

Data on Falls Risk Assessment from Tute

- ❖ Sensation- Feet, skin
- ❖ ? Pain
- ❖ Hx- Medications

- ❖ Vision? Hearing?
- ❖ Range of movement. Is there any osteo issues
- ❖ Any Recent Falls? Particularly unexplained

Week 4 Enteral Feeding

Nasogastric Tube – enteral feeding, decompression, lavage, diagnosis

Complications of enteral feeding:

- Vomiting and aspiration of feeds
- Diarrhoea
- Constipation
- Skin Integrity

Nursing considerations- Tube flushing & Placement, Patient Positioning, Protocol & regime, infection risk, weight & fluid monitoring, signs of fluid overload, FBC & food chart, biochemistry

Dietician prescribes regime of feeds and feed type

Treat Like Medication Complete Patient Checks

Week 5 Hydration and Nutrition

What measurable outcomes that indicate nutritional and hydration status

- Weight loss/ gain
- Waist, calf, upper arm circumference
- Vital signs
- Skin turgor
- Skin Integrity- dry/moist
- Urine output/ Bowel Motions

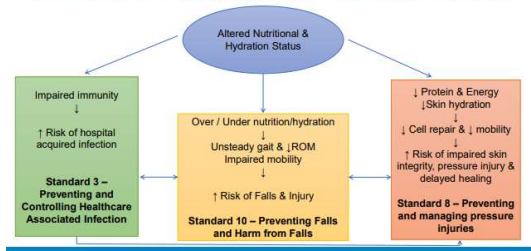
Nutritional requirements for older people

is of an older
ned by life long
ercise choices



Changes associated with ageing	Interventions/Outcomes
↓ Ability to store, use and absorb Vitamin A, D & C	
↓ Metabolic rate and general activity level	
↑ Debilitating chronic illness and medication use	
↑ Risk of constipation	
↓ Dentition	
↑ Dry mouth – decreased saliva	

Impact of nutrition and hydration on maintaining health status



Nutrition

Malnutrition is an excess, deficit or imbalance in the essential components of balanced diet.

Under = poor state of nourishment as result of inadequate diet or diseases that interfere with appetite or digestion of food

Over= ingestion of more food than that required- obesity

Factors impacting nutrition status

1. Ability to purchase ingredients and prepare meals
2. Ability to consume food
3. Ability to digest food

Nutritional concerns for elderly

- Functional ability- ability to purchase and prepare meals, ability to chew and swallow
- Social Isolation- may not eat as it is no longer a pleasurable event
- Financial hardship- cheaper to eat fast food or one meal a day. May consume adequate calories but be malnourished
- Lack of motivation- may have a lack of motivation to prepare nourishing meals

Nurses role in supporting nutrition

- Risk factors- able to chew food (dentition), safety swallow, medications impact appetite or absorption, access food independently (what level of assistance is needed), Aids to maintain independence
- Monitor for altered nutrition status
- Report significant changes
- Implement interventions- follow dieticians orders daily, monitor & document intake (food Chart), be aware of other food sources (e.g. family snacks)

Hydration

- Dehydration or overload
- Fluid Balance Chart

Nursing & Hydration

- Encourage fluids
- Try to not give too much caffeine (elderly often prefer to have tea but encourage hydrating fluids)
- Dehydration-
- Fluid Overload-
- Fluid can be lost through
 - 💧 Urine
 - 💧 Vomit

- 💧 Faeces
- 💧 Respiration

- 💧 Sweat
- 💧 Blood

Nurses role in hydration

Actions / Interventions

- 💧 Explain so pt cooperates
- 💧 Treat cause as appropriate (medications etc)
- 💧 Dehydration: offer frequent small amounts of water or rehydration solution, keep going even if recent vomiting. IV fluids
- 💧 Overload: restrict fluid input until balance regained i.e. 1000ml/day.

Evaluation/Monitoring ++

- 💧 Fluid Balance Chart – record all input and output and calculate progress at least 4th hourly. Notify
- 💧 Include everything: oral, IV, vomit, diarrhoea. Estimate if you can't measure
- 💧 Urine output expectation if well hydrated: 1ml/kg/hr accurate
- 💧 Accurate weight - daily

Malnutrition Screening Tool (MST)

Malnutrition
Is your patient at risk?

Malnutrition Screening Tool¹ (MST)

1. Have you/the patient lost weight recently without trying?	Applies to the last six months
No	0
Uncsure	2
Yes, how much (kg)?	
1 – 5	1
6 – 10	2
5 – 11	3
>15	4
Uncsure	2
2. Have you/the patient been eating poorly because of a decreased appetite?	Of weight loss and appetite questions
No	0
Yes	1
Total Score	

Score 2 or more

Action

- Refer to Malnutrition Action Flowchart and/or refer to Dietitian for full assessment and intervention
- Document
- Weigh patient's on admission and:
 - weekly (acute)
 - monthly (long-term care)
- Re-screen patients:
 - weekly (acute)
 - monthly (long-term care)

Small weight loss (weight added up for significant weight loss and malnutrition)
Note: Overweight/obese residents who have unexplained weight loss and others can become protein depleted/malnourished too.

Malnutrition occurs in approximately 30% of patients in Australian hospitals²

1. Bergman, M., Cook, G., & Fisher, R. (2010). Development of a valid and reliable malnutrition screening tool for acute care hospital patients. *Malnutrition*, 10(1), 1-6.
2. Australian Government, Department of Health, & Australian Government, Department of Social Services. (2013). *Malnutrition in Australian hospitals: A national action plan*. Canberra: Australian Government.

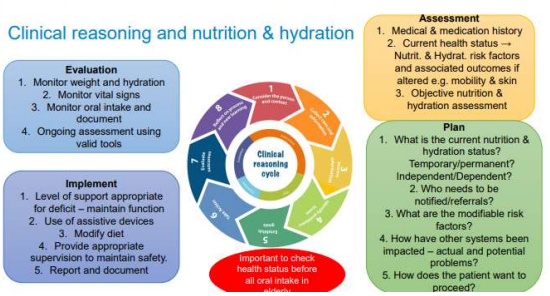
Feeding Patient- Know the diet they need, check it's the right meal, patient is alert, take time, monitor patient

Nursing Patients with Dysphagia

Dysphagia- A difficulty in swallowing, commonly associated with obstructive or motor disorders of the oesophagus.

Nurses responsibility

- Follow care plan
- Check correct meal/fluids provided
- Ensure all kitchen staff aware- including kitchen staff
- Trial swallow before all oral intake
- Ensure pt is in high fowlers and alert
- Educate pt and family/friends



Week 6 Care Of Children And Elderly

Stage	Psychosocial Crisis	Basic Virtue	Age
1.	Trust vs. Mistrust	Hope	0 - 1½
2.	Autonomy vs. Shame	Will	1½ - 3
3.	Initiative vs. Guilt	Purpose	3 - 5
4.	Industry vs. Inferiority	Competency	5 - 12
5.	Identity vs. Role Confusion	Fidelity	12 - 18
6.	Intimacy vs. Isolation	Love	18 - 40
7.	Generativity vs. Stagnation	Care	40 - 65
8.	Ego Integrity vs. Despair	Wisdom	65+

Erickson's Psychosocial Development

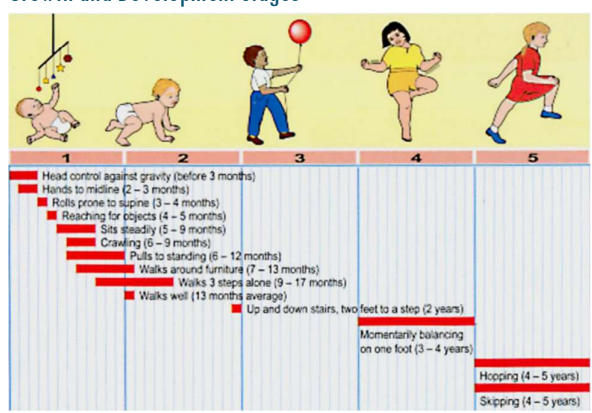
This model is important to consider when making interventions or caring out nursing care

Paediatric Nursing Care

Atraumatic Care

- ♥ Avoid using procedure in bed space
- ♥ Give a sense of control. When possible
- ♥ Child friendly environment

Growth and Development stages



Social Aspects can play a large part on treatment compliance

Treatment for children

In children treatment is based on age and weight

- Hydration is important- Fluid balance and equations are used as children get dehydrated easier

Nutrition

- Recommended breast fed till 2
- Solids not till 6 months
- Obesity is a major issue
- Food allergies, religion, obesity → all important to consider in a hospital setting

Pain Assessment

- Very Young/ Babies- FLACC Pain Scale
- Young Child- Wong- Baker Faces Rating Scale
- Older child- Numerical

Geriatric Nursing

Summary of Normal Age related changes

Cardiovascular System – great variability; changes in heart sounds; thickening of walls and leaking heart valves; reduced contractility

Respiratory system – chest walls stiffens and muscles weaken; decreased lung mass, cough efficacy and response to hypoxia & hypercarbia

Skin – decreased elasticity, turgor, vascularity, fat; thickened nails; hair loss (head and body) and greying

Musculoskeletal system – spine discs compresses and increased curvature; decreased muscle contractility and strength; increased bone reabsorption

Gastrointestinal system – poor dentition; decreased appetite, saliva, taste buds, swallow response; decreased peristalsis and sphincter strength; altered fat distribution around abdomen

Renal system – decreased bladder elasticity and bladder volume; decreased sphincter control; decrease renal function; weakened pelvic floor

Sensory system – atrophy of eyes causing decreased acuity; hearing loss; reduced peripheral sensation

Neurological system – neuron atrophy; brain shrinks; decreased cerebral blood flow; slower motor responses; slower recall

Immunity – decreased lymphoid tissue, antibody production, T and B cells – altered acute pathogen response

Examination sequence in Older Adults

Subjective Data

- Presenting problem
- Medical history (past/present) including current medications
- Family & social history (including support network)

Objective Assessment

- Function- ADLs, mobility, Aids eg hearing aids, glasses, mobility aids, prosthesis
- Body systems review- baseline (compare with old data)
- Physical examination- may require some changes
- Cognitive assessment- may impact history taking
- Biochemistry

Polypharmacy risk is increased for elderly esp. those with chronic illness

Transitions in Care

Home → Emergency department → Acute Care Unit → Home

Nursing Home → Acute Care → Nursing Home

Increased risk of Medication errors, falls, pressure injury, malnourishment and other hospital acquired adverse outcomes (HAAO).

RAC → No longer able to care for self.

Two types: Permanent Care 24/7 ongoing care in facility or Respite Care – temporary

Signs of Dying

- May not be able to predict exact time of death
- May make numerous recoveries

- Common signs prior to death (retrospective data)
 - Increased fatigue
 - Increased pain – people with cancer
 - Dyspnoea
 - Confusion
 - Anxiety
 - Depression
 - Nausea and Vomiting

Week 7 Skin Integrity & Hygiene Needs

Pressure Injuries

Skin tears

Moisture-associated skin damage (MASD)

Pressure Injury (PI) *Standard 8- preventing and managing pressure injuries*

Risk factors

- Impaired mobility
- Environmental factors- shear, friction forces on the skin
- Individual factors- nutrition status, oxygen delivery, skin temperature, age and gender, chronic disease, use of some meds eg NSAIDs

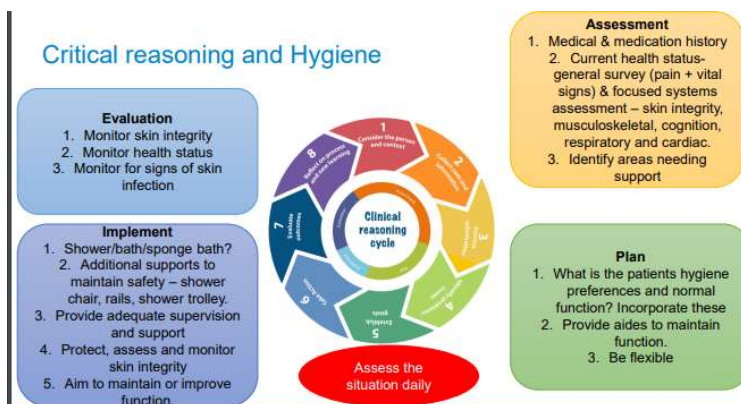
Hygiene

Assess skin when performing hygiene cares

DVT Prevention

TED Stockings

Sequential Compression Devices – Used with TEDs, commonly used post surgery



Week 8 Elimination Needs

Urinary/renal system

Objective assessment Data

- Inspection of external organs- inflammation, abnormal discharge, lesions, deformity
- Inspection of urine sample- volume, clarity, colour, presence of sediment, consistency, smell
- Assess fluid balance
- Palpate/percuss bladder
- Urine analysis- protein, glucose, ketones, haemoglobin, bilirubin, urobilogen, acetone, leukocytes → Dip stick test

Factors impacting bladder elimination

- Mobility
- Neuro-cognitive function
- Medications- anticholinergics, sedatives, diuretics
- Faecal impaction
- Fluid intake

Fluid Balance Chart

- 24 hr
- Accuracy is vital
- Record input and output
- Patient cooperation is needed

Urinary Incontinence








- Impacts all ages
- Usually an underlying treatable medical condition
- Women 2x more likely than men to experience
- 35% total pop over 60 are incontinent

Gastrointestinal System- Faecal Elimination

Gastrointestinal System

- 👤 Function – supply the body cells with nutrients
- 👤 Accomplished by:
 - 👤 Ingestion – food/fluids enter via the mouth
 - 👤 Digestion – starts at the mouth with mastication and continues as it moves to the stomach and bowel
 - 👤 Absorption – nutrients extracted from food
 - 👤 Elimination – waste is eliminated as faeces

Bristol Stool Chart

Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on its surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges (passed easily)
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces. Entirely Liquid

Bristol Stool Chart

- Aim type 3 or 4

“Have you opened your bowels today?”

Maintaining Normal Function

- 👤 Diet- fibre and hydration
- 👤 Review of medications
- 👤 Provide adequate privacy
- 👤 Dignity
- 👤 Safety
- 👤 Position

“the four Fs: fibre, fluids, fitness, feet”

Potential Problems

Constipation associated with: age related changes, dietary imbalance, mobility.

Faecal incontinence associated with: mobility/function impairment, constipation/obstruction

Nursing Considerations

- 👤 Provide adequate privacy
- 👤 Remember position of patient to aid evacuation
- 👤 Allow adequate time- don't rush pt.
- 👤 Can be painful and life threatening (constipation/ bowel obstruction)
- 👤 Can be cause of Delirium (constipation/ bowel obstruction)

Stoma

Stoma- Greek word meaning mouth or opening

Ostomy- Surgical opening that has been made to divert the direction and flow of contents

Colostomy- Normally formed on left abdomen and is larger than ileostomy. Any part of the colon: ascending, transverse or descending colon. Output Formed or softer depending on location.

Ileostomy- right side of abdomen. Made on small bowel. Output liquid to paste
Alkaline, can damage skin if leaks.

Diet for patients with ileostomy- add salt to meals, electrolyte drinks (prevent dehydration), fibrous foods can cause obstruction, avoid nuts, chew foods well, foods to thicken output: white starchy foods, applesauce, peanut paste, marshmallows, ripe bananas. *Liaise with dietician*

What we teach our patients....

- Always use warm water to clean around the stoma and their skin
- Avoid soaps and creams (due to PH of soaps)
- Cut the appliance so as little peri-stomal skin is showing as possible
- Change immediately if the appliance/bag leaks
- The stomal mucosa should always be pink and moist
- The peri-stomal skin should remain healthy and intact
- Empty or change the stoma bag when 1/-1/3 full.
- Minimise the use of "extra" products such as skin barrier.
- Provide photo pictorials on "how to change your stoma bag"
- Discuss hernia prevention, support garments

Urostomy- formed when cystectomy is performed (bladder cancer or trauma), permanent. Connected to drainage tube.

Week 9 Dementia

Dementia is the term used to describe a collection of symptoms caused by damage to the brain resulting in changes to the functioning of the brain. Causes Alzheimer's disease (70%), vascular dementia (2nd Leading), Dementia with lewy bodies (26%), fronto-temporal lobar degeneration (1-5%) and others.

Dementia is a progressive disease.

Cognitive testing:

- * Modified Mini Mental Exam (MMSE)*
- * The Alzheimer's Disease Assessment Scale – Cognition (ADAS-Cog)
- * General Practitioner Assessment of Cognition (GPCOG)
- * Psychogeriatric Assessment Scale (PAS)
- * Rowland Universal Dementia Assessment Scale (RUDAS)

Psychological symptoms:

- * Psychotic symptoms –
 - o Hallucinations – 15-49% of people with dementia
 - o Delusions – 10-73%
 - o Misidentification – 6.5-49.1%
- * Affective symptoms – mood (depression most common)
- * Anxiety
- * Sleep disturbance – 22%

Behavioural symptoms of dementia:

- * 90% of persons with dementia will experience these
- * Effected by type and stage of dementia
- * Common examples: aggression, wandering, resistance to care, inappropriate sexual behaviour, vocalisation
- * Causes high carer burden, disturbing to person with dementia
- * Precipitates admission to permanent care

Assessments delirium vs dementia:

- Confusion Assessment Method (CAM)
- Assessment test for delirium and cognitive impairment: 4AT

Principles of Effective Communication (NSB103 Revision)

From NSB132 lecture communicating with dementia patients-

- Call them by name
- Be patient and allow time for response
- Use simple words and short sentences
- Remember non-verbal communication
- Don't reason choose action
- Limit background noise
- It's OK to repeat but don't repeat too many times

Oxygen Administration

Nurse initiated oxygen if stats under 93% or signs of shock

2-4L use nasal prongs

4L+ - 10L use simple face mask

Other areas

Progress notes should include variations to care. Abnormal Observations, normal observations don't typically need to be charted.

Priority Problems

Need to work further on this and organise better rough draft/ compiling notes

Problem	Goal	Action	Evaluation
Gastroenteritis (Norovirus) - Infection control context	Prevent Further Spread of infection	Contact precautions- Appropriate use of PPE Separate room and bathroom from rest of ward to prevent spread Cohort nursing when many sick to prevent cross infection/ spread Education on appropriate hand hygiene	Patient improves and no further spread of infection Reflect on practice
Vomiting and Diarrhoea- Dehydration Tachi, dull mucus ,membranes, skin turgor	To rehydrate and fix symptoms	Encourage small sips Strict Fluid Balance Chart Use IV as directed by Dr (only if instructed- Collaborative Intervention)	Improvement in Vital signs Fluid Balance

Falls Risk Recent fall & Mobility Issues	To keep safe and prevent/ reduce risk of further falls	Identify that patient is a falls risk Physio referral to assess mobility Non- slip footwear Assist with Mobility and ADLs Encourage use of mobility devices- wheely walker, walking frame, rollator	No falls during admission
Swallowing Difficulties- Dysphagia Risk Aspiration Coughing when given fluids	Patient does not aspirate and is able to safely consume food and water Nurse in the appropriate position	Check swallow Give thickened fluids till speech review	Chest Sounds – Checking if aspirated
<i>Neurological Decline / Alerted Consciousness</i>	<i>Monitor consciousness level</i>	<i>GCS Assessment Pearl</i>	
Nasogastric Tube Aspiration Risk and unsure of management at home	To Educate on safely providing food and fluids via NG “ Patient demonstrates an improvement in confidence around proving self NG Feeds prior to discharge”	Check positioning Education around feeds- what is normal Explain process when providing feeds & hydration to pt.	Demonstrates confidence and ability with the safe use of NG Tube
Impaired Nutrition	To improve nutrition status and to ensure adequate nutrition is received	FBC + Food chart Dietetic Review Assistance with meals as Required	
Skin Integrity Pressure injury	Treat and prevent pressure areas worsening	Barrier Cream and Hydrocolloid dressing on affected area Reposition patient away from pressure area Waterlow assessment	
Body Image concerns with Medical Equipment Colostomy Bag	To increase patients confidence with management of bag Build confidence about self-image	Education	Ability to safely manage stoma

Priority Problems

Priority problem	Cues	Risks	Intervention

Email Revision Questions

What are the normal ranges for vital signs?

Assessment data	Normal range - child	Normal range – adult
Temperature	Newborn 1 year 3 years 6 years 10 years 14 years	< 65 36.2-37.5°c >65 year
Pulse	Newborn 100-150bpm 1 year 70-110 bpm 3 years 65-110 bpm 6 years 80-110 bpm 10 years 75-100bpm 14 years 60-90bpm	< 65 60-100bpm >65 year
Respirations	Newborn 30-60rpm 1 year 30-50rpm 3 years 25-32rpm 6 years 20-30rpm 10 years 20-30 14 years 16-19rpm	< 65 12-20 rpm >65 year
Blood Pressure	Newborn 40 (mean) 1 year 95/65 3 years 6 years 105/65 10 years 110/65 14 years 120/75	< 65 <120/80 >65 year
Oxygen saturation	Newborn 1 year 3 years 6 years	< 65 95%-100% >65 year

	10 years	
	14 years	
Pain	Newborn	< 65
<ul style="list-style-type: none"> ❖ PQRST ❖ Wong Baker Faces Pain Rating Scale ❖ Abbey Pain Scale 	1 year	
	3 years	
	6 years	>65 year
	10 years	
	14 years	
Urinalysis	<ul style="list-style-type: none"> ✓ Positive reading indicates: Leukocytes – white cells -> UTI ✓ Urobilinogen – liver failure ✓ Protein – albumin in urine -> injury, inflammation, kidney disease ✓ pH – normal range 4.5-8 (needs to be a fresh sample). High pH can be dietary or UTI; low pH dietary, diabetes, dehydration ✓ Blood – UTI, trauma, kidney stones, menstruation (female) ✓ SG – concentration (dehydration/overload), major organ failure ✓ Ascorbate – Vitamin C ✓ Ketones – starvation, diabetes ✓ Bilirubin – liver disease Glucose – diabetes, liver disease ✓ Miro Albumin – kidney damage ✓ Nitrite - UTI 	

Methods of Assessment

Body System	Subjective data	Objective data
	What we are told	What we can measure
Cardiovascular system (Week 4 lecture – Health Assessment)	Age, gender, ethnicity Chief complaint Diseases of the heart Medical hx Medications Social history- smoking, alcohol, caffeine, drugs, sexual issues, work, hobbies, stress	Pulse Rate Blood Pressure PQRST for Chest pain Inspection- acute distress, oedema etc Palpation Postural hypertension Heart Sounds ECG

		Capillary Refill
Respiratory system (Week 4 lecture – Health Assessment)	Risk Factors: ❖ Smoking Hx ❖ Lifestyle ❖ Age ❖ Environmental exposure ❖ Obesity ❖ Fam Hx Cough Sputum Chest Pain SOB	Respiration Rate Oxygen Saturation Lung sounds (Auscultation) Blood Gases sputum Spirometry Chest X-ray
Musculoskeletal (Week 3 – Mobility)	Medical History: Acute & Chronic eg Arthritis Falls Hx Mobility History Medications	Vital signs (blood pressure and postural blood pressure) Mobility Assessment Weight Musculoskeletal Assessment- Weakness, stiffness, ability to mobilise Pain Assessment
Digestive system – (Week 5 lecture – Nutrition)	Medical History- disease, Allergies and intolerances, religion. Socioeconomic factors Medications Appetite Dysphagia	Input vs Output Vital signs FBC Food Chart Swallow Assessment MST- Malnutrition Screening Tool Pain
Gastrointestinal system – (Week 8 lecture – Elimination)	Hx of GI disease Unexplained Weight loss/gain Pain, blood loss Nausea and vomiting Meds surgery Elimination pattern / Bowel habits (regularity, appearance,	Inspection: abdominal distension, asymmetry, pulsations, herniation, scars, stomas Palpation: Pain, soft/hard, assess each quadrant Auscultation: Bowel Sounds (constant if normal peristalsis) Percussion: tympani drum or dull

	<p>recent changes, use of laxatives)</p> <p>Oral care</p> <p>Oral intake pattern (Food, fluids, daily habits, allergies, food preferences, special diets)</p>	<p>Inspection of Faeces (colour, odour, consistency, frequency, amount, shape, constitutes) <i>remember shape and constitutes</i></p> <p>Bristol Stool Chart</p> <p>Bowel Chart</p>
<p>Urinary system</p> <p>(Week 8 – Elimination)</p>	<p>Medical Hx</p>	<p>Inspection of external organs</p> <p>Urine sample appearance (clear? Colour, sediment?)</p> <p>Fluid balance</p> <p>Palpate/ percuss bladder</p> <p>Urine analysis</p> <p><i>Daily weighs</i> <i>Input vs Output (FBC)</i> <i>Vital Signs</i></p>
<p>Integumentary system</p> <p>(Week 7 – Skin Integrity)</p>	<p>Past medical history</p> <p>Medications</p>	<p>Inspection of skin-temperature, texture, colour, hair, nails, palpation</p> <p>Observe for wounds, dressings, drains or invasive lines</p> <p>STAR Classification System for skin tears</p> <p>Waterlow and Braden for Pressure injuries</p>
<p>Neurological system</p> <p>(Week 4 – Health Assessment; Week 9 – Dementia/Delerium)</p>	<p>Pain involving head or nerve related (burning)</p> <p>Altered sensation – numbness, tingling, paresthesia</p> <p>Altered function – mobility/gait/weakness/tremors/incoordination, speech/swallow, memory</p> <p>Dizziness, seizures</p> <p>Head injury/surgery</p>	<p>Inspection – symmetry, trauma, colour/texture, lesions/tumors/scars</p> <p>Mental status – level of consciousness, orientation</p> <p>Cranial nerves – symmetry of face, smile, poke out tongue, puff cheeks</p> <p>Motor system – strength, equal movement arms and legs</p>

	Medication/drug use	Sensory system – sensation Reflexes
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Risk Assessment Tools

Problem	Factors that are assessed	Underlying cause of the risk
Falls (pg 25) Week 3		
Impaired skin integrity (pg 49) Week 7		
Dysphagia (pg 43) Week 5		
Impaired mobility (pg 21) Week 3		

Safety Standards Covered This Semester

1. What actions can a nurse take to prevent the **spread of infection**? (Week 1)
2. What actions can a nurse take to **minimise falls risk**? (Week 3)
3. What actions can a nurse take to **reduce the risk of developing pressure injuries**? (Week 7)

4. How do these actions reduce risk (rationale)?

Care of the older person

In an older person, do you know the age related changes that occur and how care needs to be modified to ensure accurate assessment is completed?

Do you know the difference between dementia and delirium? How do they differ?

Delirium v's Dementia

Delirium	Dementia
<ul style="list-style-type: none">• Disorientated to time, person and place• Functional and behaviour changes• Sudden onset• Treatable cause• Causes: infection, deoxygenation, pain• Older and very young most at risk	<ul style="list-style-type: none">• Disorientated to time, person and place• Functional and behaviour changes• Progresses over time• Cause is incurable• Causes: Alzheimer's disease, vascular dementia, dementia with Lewy Bodies, Parkinson's disease• Age is a risk factor

What assessment tools can be used to identify a cognitive impairment and delirium?

- ✓ Modified Mini Mental State Exam (MMSE)
- ✓ The Alzheimer's disease Assessment Scale- Cognition (ADAS-COG)
- ✓ General Practitioner Assessment of Cognition (GPCOG)
- ✓ Psychogeriatric Assessment Scale (PAS)
- ✓ Rowland Universal Dementia Assessment Scale (RUDAS)

- ✓ Confusion Assessment Method (CAM)

A person with dementia and a person experiencing delirium are at an increased risk of experiencing adverse outcomes while in care. What adverse outcomes could they experience?

Why is a person with dementia/delirium at greater risk of experiencing adverse outcomes while in care?

Behavioural Symptoms of Dementia (BSD) – Can cause aggression, wandering, resistance to care, inappropriate sexual behaviour, vocalisation.

What actions can you take to maintain safety for the person with cognitive impairment related to the following areas:

Falls risk

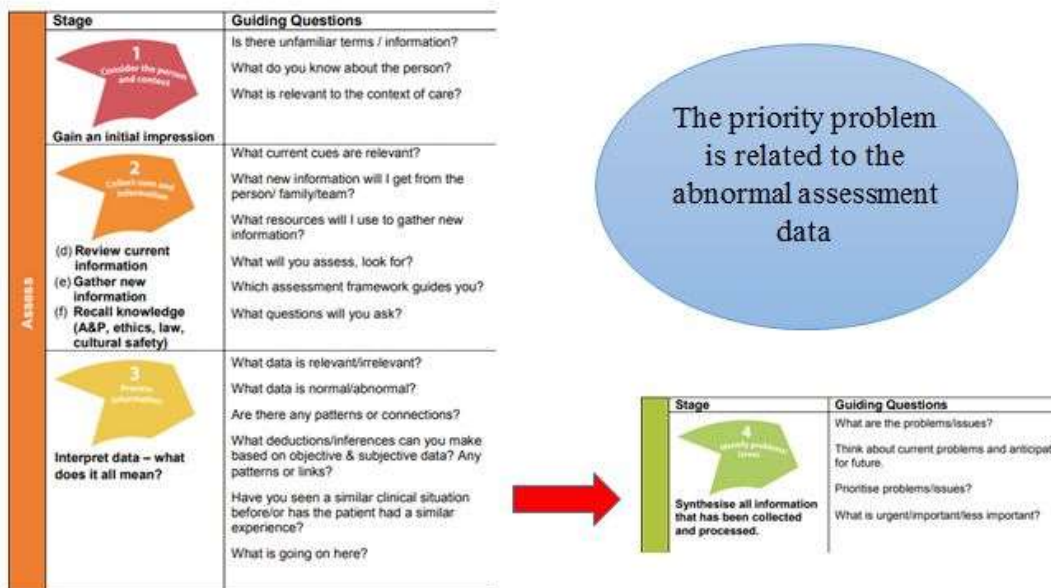
Medication error

Under treated pain

Look for nonverbal signs of pain

Entering other residents' bedrooms

Identifying and Addressing Priority Problems



Remember that a priority problem IS NOT a medical diagnosis.

For example: the patient falls and hits his/her head and as a result he/she is drowsy and is feeling dizzy.

In this example the underlying pathophysiology (cause) is the blow to the head causing an altered level of consciousness; the priority problem is *impaired safety (increased falls risk) due to the altered level of consciousness causing the person to be dizzy.*

Note: you are looking for problems that can be addressed by the nurse. A nurse cannot change the underlying pathophysiology of altered level of consciousness.

Goal for care

When setting a goal for care it would need to relate directly to the priority problem

Example: Through the implementation of evidence based safety measures (state what these are), the patient will not experience an injury related to a fall during the period of altered consciousness.

Planning Evidence Based Interventions