Traumatized patient care

Definition

Trauma

- Being in an accident, such as a road traffic accident, or an accident at work.
- Being the victim of violence, such as being physically or sexually assaulted, imprisoned or tortured.
- Being in a life-threatening situation, such as a war, a natural disaster, or a health emergency.

Types

- Acute
- Chronic
- Complex

Primary survey

Airway

Head tilt chin left

oropharyngeal airway

Nasopharyngeal airway

Breathing

Cardiac monitor

O2 therapy

Endotracheal tube

Circulation

Capillary refill

Peripheral pulse

Skin temperature

Fluid resuscitation

Disability

Assessment of neurological status

Glasgow Coma Scale

EYE OPENING		VERBAL RESPONSE		MOTOR RESPONSE	
Spontaneous	4	Oriented	5	Obeys commands	6
To sound	3	Confused	4	Localising	5
To pressure	2	Words	3	Withdrawal	4
None	1	Sounds	2	Abnormal flexion	3
		None	1	Extension	2
				None	1

Glasgow coma scale scoring

Mild	Moderate	Severe
13-15	9-12	3-8

Adjuncts

Vital Signs

ECG

ABGs

Urinary/ gastric catheters

pulse oximeter and co2

CT scan

- **A** LLERGIES
- **M** EDICATION
- **P** AST MEDICAL HISTORY including vaccinations (especially tetanus status)
- **L** AST ATE (TIME)
- **E** VENTS LEADING UP TO INCIDENT

secondary survey

Prepared by
Group B
Supervised by
Dr. Sara Hegazy
2022 - 2023

Renal system Assessment

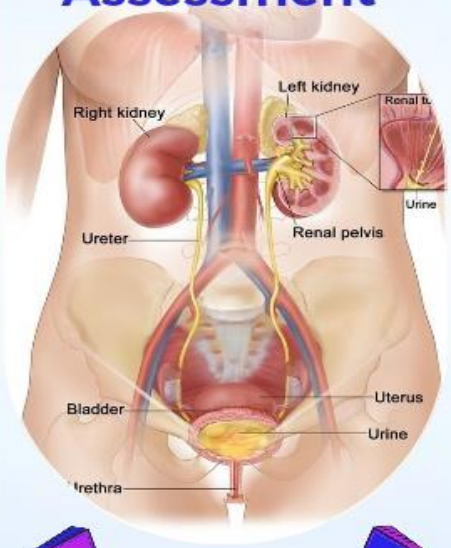
1.Inspection

- Assess skin on the extremities and trunk for color, presence of bruising or bleeding.
- Inspect the tongue and mucus membranes to assess hydration status.
- Inspect flank region while sitting and supine .

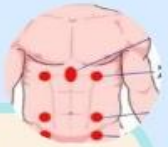
Inspect urethral meatus for :

- Deviation from the normal central location(congenital defect).
- Inflammation and discharge(urethral infection).
- Ulceration(a sexually transmitted disease).

Assessment



2.Auscultation



Auscultate the renal arteries:

- pressing the stethoscope above the umbilicus,then to left and right of it.
- presence of renal artery stenosis which may be come from diminished blood flow the kidney .

Note :

- a bruit an abnormal sound that resembles a blowing or swishing noise similar to the sound of a cardiac murmur.

3.Percussion

Percussing the patient's kidneys

- to check costovertebral angle tenderness that occurs with inflammation.

Percuss the bladder :

- Place the patient in supine position.
- Begin the percussion at the symphysis pubis and moves upward and outward to estimate the bladder size.
- Hear tympany sound normally.

Note :

- Dull sound signals of retained urine.

4.Palpation

Palpate the kidney :

- The kidney are normally not palpable unless they are enlarged.
- If the kidney feels enlarged the patient may have cysts or tumors.

Palpate the urinary bladder :

- palpate for distended bladder when the patient's history warrant (e.g., dull percussion noted over the symphysis pubis).
- Begin at symphysis pubis and move upward and outward to estimate bladder borders.

Note :

- normally, an empty bladder is neither palpable nor tender.

Prepared by
Group D1_D5
supervised by
Dr/ Manar Ayoub

Gastrointestinal System Assessment

1.Inspection

shape:
- Normal shape of the abdomen is described as flat to rounded and thy be should symmetric bilateral .

Skin :
- The surface is smooth and even with homogeneous color.

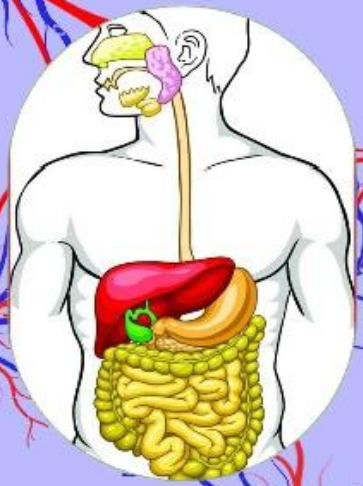
Movement :
- Normal move of the abdomen expand with inspiration and retract with expiration

Umbilicus :
- Normal in medline, shape rounded and inverted, color the same color of the skin and normally with no discharge

Peristaltic waves
- Normal peristalsis are not seen

3.Percussion

- Tympanyis heard over the surface of the skin.
- Dullness is heard over the liver and spleen .
- Percussion the liver it is usually at fifth to seventh intercostal space.
- In an adult anormal liver span is 4to8 at the mid midsternal line and 6to12 at the right midclavicular line
- Percussion the spleen it is usually at 9th to 11th
- Normally tympany or resonance is heard at the last left interspace



PREPARED BY
GROUP C6_C10
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DR/MANAR AYOUB

2.Auscultation

Auscultation for bowel sound :
- Begin in the right lower quadrant in quadrant in clockwise.
- Listen for at least 5 minutes before determining that no mowel sounds are present .
- Normally high pitched gurgling anywhere from 5to30 times per minute .

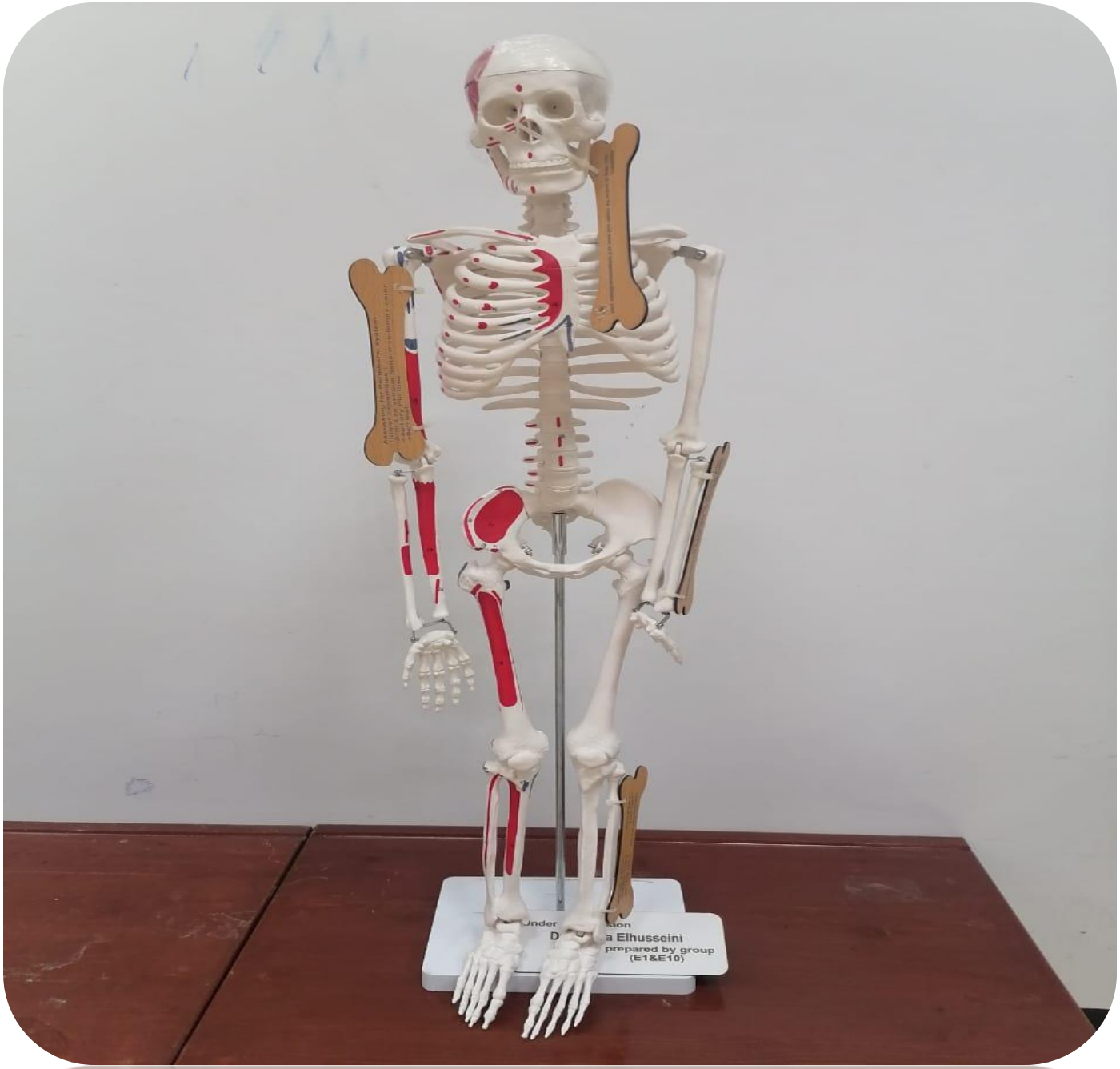
Auscultation for vascular sound:
- Listen to abdominal aorta renal iliac and femoral arteries .
- Note the presence of any vascular sound or Bruits.
- Bruits is a vascular sound similar a heart murmur.

4.Palpation

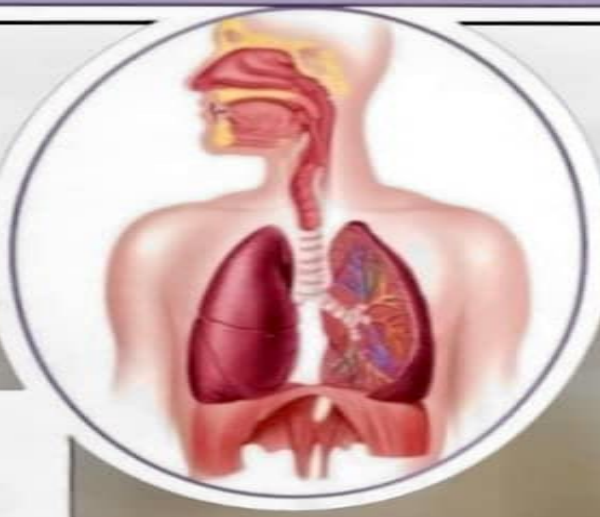
- Don't palpated a rigid abdomen peritoneal inflammation maybe casess pain, The abdomen should be soft and non tender.

Palpation of the liver :
- Palpate the liver to check for enlargement and tenderness.
- They should be smooth, firm and somewhat round.

Palpation of the spleen :
- Palpate the spleen to detect tenderness and enlargement .
- Normally spleen isn't palpable if the spleen is enlarged you'll feel it's rigid border if you do fell the spleen stop palpating immediately.

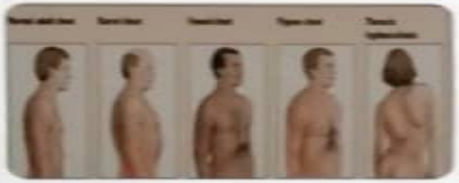

a Elhusseini
prepared by group
(E1&E10)

RESPIRATORY SYSTEM ASSESSMENT



Inspection

"CRAMPS"



Chest wall symmetry

Respiratory rate and pattern

Accessory muscle using

Masses or scars

Paradoxical movement

Inspecking related **S**tructure

Palpation

Palpation for tenderness

Palpation for tactile vocal fremitus

Evaluation the chest expansion

Prepared by group: -

B 1 - B2 - B3 - B4 - B 5

Under supervision: -

A.L. Nagwa Yehya Ahmed

Percussion

Auscultation

Integumentary System Assessment

A

Inspect general skin coloration & Spotty record

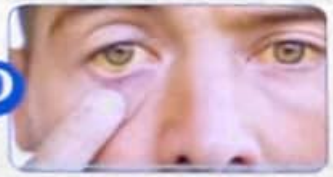
B

Assess for cyanosis

C

Assess for Erythema

D

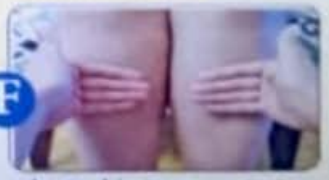


Assess for jaundice

E

Assess for Rashes

F



palpate skin to assess texture

G

Palpate skin turgor

H

Inspect for Lesion

I

palpate to assess temperature

J

Assessing the Hair

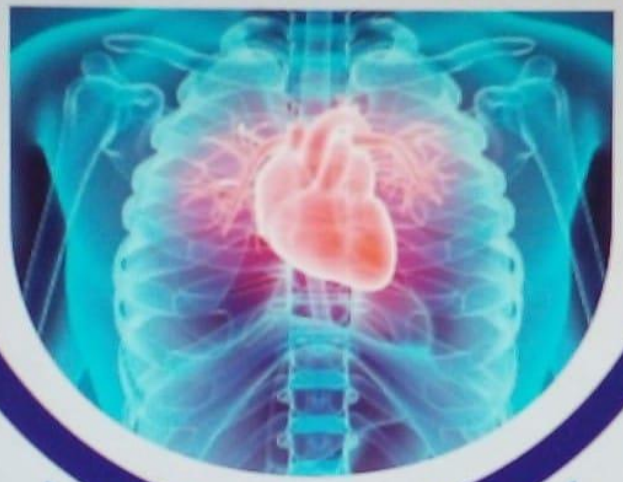
Under Supervision
Dr: Aya Ali

Prepared By
Group : C1 . C5

Critical and Emergency Nursing Department
2022- 2023

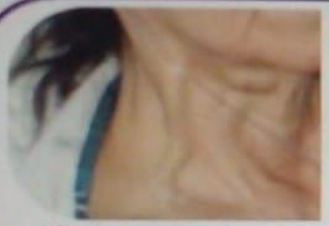
Mansoura University
Faculty of Nursing

Cardiovascular System Assessment

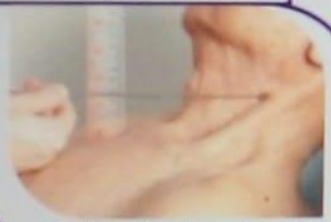


Inspection of the patient

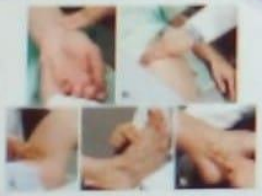
Palpated the carotid



Neek and jugular veins

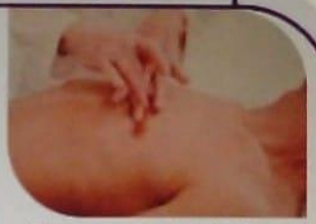


Evaluating jugular vein

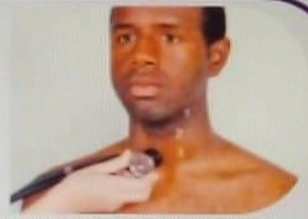


Palpation of puls

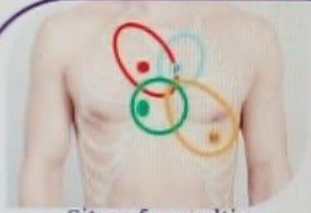
Palpating precordium



Percussion of the heart



Auscultation of carotid Artery



Sites of auscultion
Of heart sounds

Prepared By

B6 - B10

Under Supervision

Dr : Aya Elhusseini

Course Coordinator

Dr : Marwa Mehrez

Head of the Department

Assist.Prof Dr : Asmaa Ibrahim


Critical Care and Emergency Nursing Department
Splint Maket
1
2
3
4
5
Prepared by- C4
Under supervision of Dr. Asmaa Mohamed

Chocking For Infants

1. Check the mouth

2. Give firm back blows

3. Give chest thrust

Call the emergency services

- Repeat steps 1-3 until baby stops choking, help arrives or start CPR if your baby loses consciousness

1. Check for a response
Tap him/her

2.Check for normal breathing

Unresponsive breathing / not breathing

- Unresponsive and breathing - recovery position

- Unresponsive and not breathing normally - CPR

GROUB
C 5 - C6 - C7

UNDER SUPERVISION
DR . ASMAA MOHAMED

Epistaxis

Instruct the victim to sit down lean the head slightly forward breath through mouth and apply pressure by pinching the nostril up to 10 minutes.

Remove any tight clothes around the neck.

Encourage the victim to spit out any blood accumulated in his mouth.

Instruct the victim not to blow his nose.

Repeat the pressure for further 10 m, if bleeding doesn't stop.

Use ice bag or compresses on the nose bridge, if bleeding doesn't stop.

Advise the victim to rest for 2 hours at least after bleeding stoppage.

Tell the victim to seek medical facility if bleeding doesn't stop for more than 30 minutes

Prepared by
Group E

Under Supervision
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Course coordinator
Dr/ Asmaa Mohamed

Head of Department
prof.Dr/ Nahed Attia Kandeel

Basic Life Support

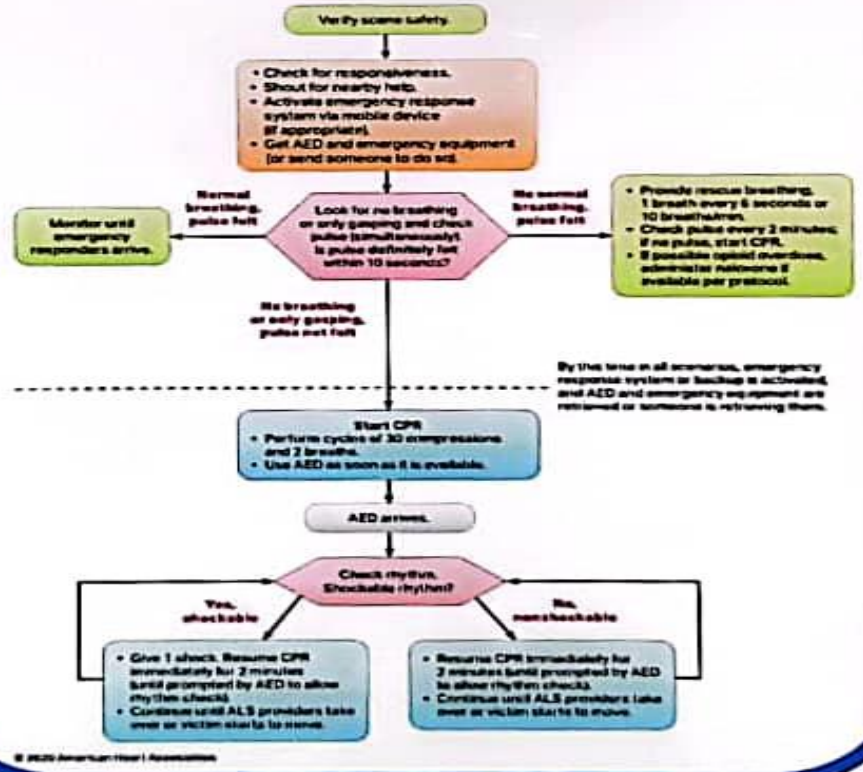
Check Scene Safety

Check Responsivness

Shout For Help And Get An AED

Check Pulse and Breathing

Chest compression



Return of Spontaneous Circulation

Automated External Defibrillator

Mouth to mouth breathing

Open Airway

Prepared by: Group D AL/ Mohamed H. Eid

Under Supervision: Dr/Asmaa Mohamed

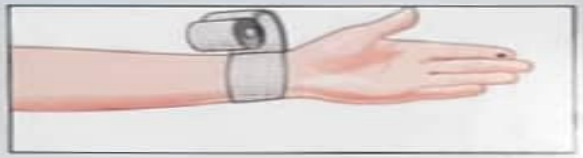
Course Coordinator: Prof.Dr/Nahed Kandeel

Head Of The Department:

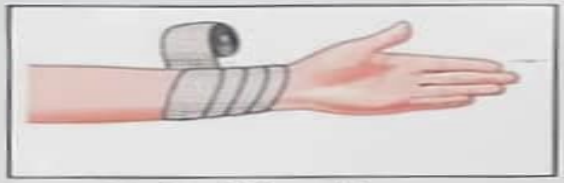
Bandage Macket

Critical Care and Emergency Nursing Department

Recurrent bandage



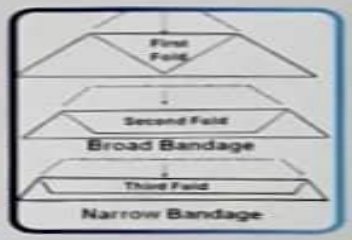
Circular bandage



Spiral bandage

spiral bandage

Tubular bandage



Triangular bandage

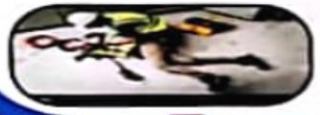
Under supervision
Dr/ Asmaa Mohamed

Critical Care and Emergancy Nursing Department
Faculty of Nursing- Mansoura University
2022-2023

Basic Life Support

Check Scene Safety

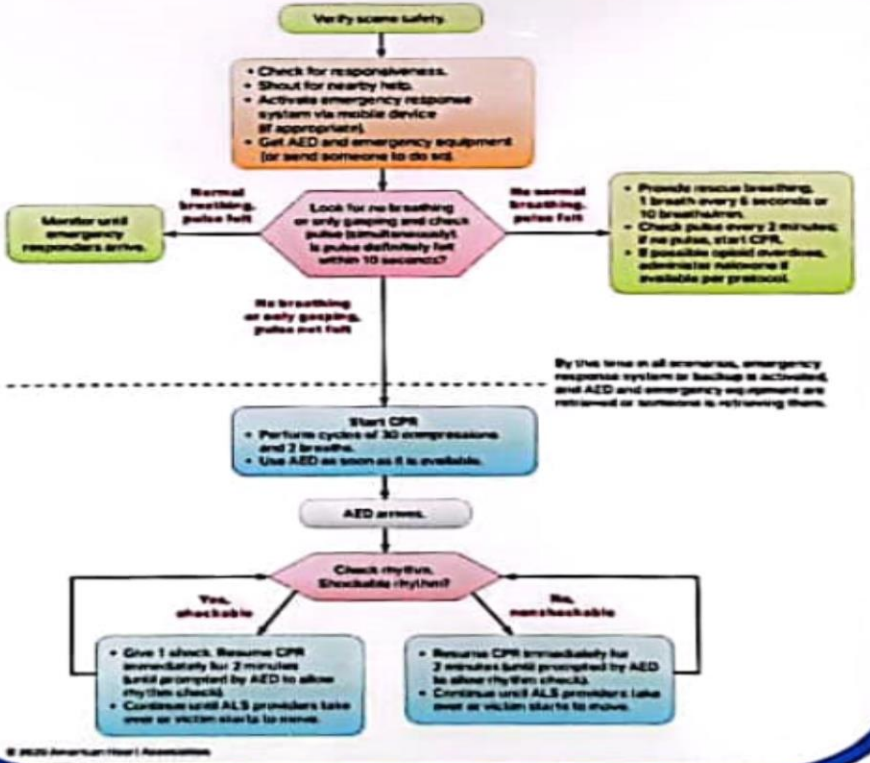
Check Responsivness



Shout For Help And Get An AED

Check Pulse and Breathing

Chest compression



Return of Spontaneous Circulation

Automated External Defibrillator

Mouth to mouth breathing

Open Airway

Prepared by: Group D

Under Supervision: AL/ Mohamed H. Eid

Course Coordinator: Dr/Asmaa Mohamed

Head Of The Department: Prof.Dr/Nahed Kandeel

Endocrine System Assessment

Inspection

* Inspect the thyroid region on the lower half of the neck for a visible enlargement.
*Normal thyroid gland is not visible or palpable.
*Observe for truncal obesity, supraclavicular fat pads and a buffalo hump that seen in (adrenocortical excess).

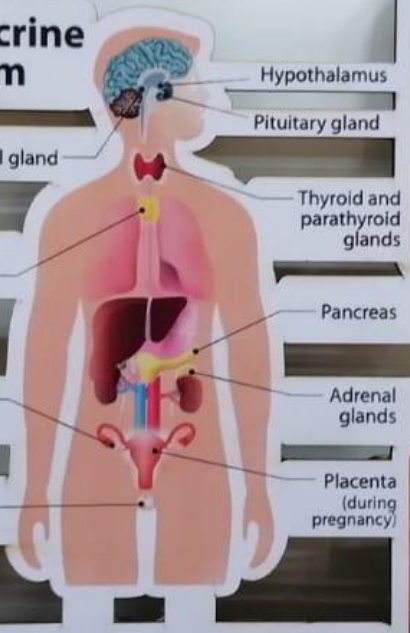
-Neck

Check for neck symmetry and midline positioning and for symmetry of the trachea.

-Chest

Assess size, shape, and symmetry of the patients chest, noting any deformities.
*In females, assess the breasts for size, shape, symmetry pigmentation (especially on the nipples and in skin creases), and nippledischarge (galactorrhea).
*In males, observe for bilateral or unilateral breast enlargement (gynecomastia) and nipple discharge.

Endocrine system



Palpation

* Palpate the thyroid gland to assess size, symmetry, general shape and presence of nodules or other irregularities.
* Stand in front of the patient and place index and middle fingers below the cricoid cartilage on both sides of the trachea.
* Palpate for the thyroid isthmus when the patient swallows.
* Ask the patient to flex his neck toward the side being examined to gently palpate eachlobe.

Auscultation

* If you palpate an enlarged thyroid, auscultate the gland for systolic bruits, a sign of hyperthyroidism.
* To auscultate for bruits:
* Place the bell of the stethoscope over one of the lateral lobes of the thyroid.
* Measure blood pressure with the patient lying, sitting, and standing
*Compare the findings with normal expected values and the patients baseline measurements.

Prepared by- D6- D10
Supervised By Dr. Manar Ayoub

MANSOURA UNIVERSITY
جامعة المنصورة

Critical Care and Emergency Nursing Department

Cranial Nerves Assessment

olfactory
smell

oculomotor
eye movement and pupil reflex

trigeminal
face sensation and chewing

facial
face movement and taste

glossopharyng
throat sensation, tast and swallowing

accessory
neck movement

optic
vision

trochlear
eye movement

abducens
eye movement

vestibulocochlear
hearing and balance

vagus
movement, sensation, and abdominal organs

hypoglossal
movement, sensation, and abdominal organs

Prepared by- A6-A10
Under supervision of A.L.Nagwa Yehya