

CJSim - Justin Smoake

Before answering this question, review the client's health information in the EHR. **Complete the sentence using the dropdown choices.**

The nurse's priority is to assess the

wheezing

✖ because of the risk of

respiratory distress

✖ .

Your answer is incorrect.

Debriefing: This client should be initially assessed for any overt hemorrhaging occurring. The amount of bleeding will indicate this and if it can be controlled with pressure. The client has a history of asthma and vaping, and it would be expected for the client to have wheezing. While vaccination status is essential to assess, it is not the highest priority for this client.

Consider:

1. What assessment finding is most concerning for this client?
2. What should the nurse prioritize when considering the complications of wound healing?
3. Why is the client's vaccination status a concern?

The correct answer is:

The nurse's priority is to assess the [amount of blood] because of the risk of [hemorrhaging].

Before answering this question, review the client's health information in the EHR. The nurse is performing wound care on this client. In what order should the steps be completed? **Select one answer in each row.**

✔ Complete hand hygiene.

✔ Apply clean gloves.

✔ Cleanse the skin.

✔ Pat dry with sterile gauze.

✔ Apply non-adherent dressing.

✔ Apply gauze wrap.

Your answer is correct.

Debriefing: Appropriate order of completing wound care includes hand hygiene and application of clean gloves. As this was a "dirty wound," it is unnecessary to apply sterile gloves. Cleansing the site with warm, soapy water is done using a patting method, not a scrubbing method. Scrubbing vigorously can further damage skin and cause rebleeding. After cleansing, it is important to pat the site dry. Moisture is a host environment for bacteria. Applying a non-adherent dressing protects the area during the first 24 hours of wound closure and prevents injury when removal of the dressing takes place. Wrapping the site with gauze will reinforce the non-adherent dressing.

Consider:

1. What discharge instructions would the nurse want to give to this client?
2. What assessment findings would the nurse be concerned with that would indicate a complication?
3. Discuss with a classmate which types of wounds require sterile dressing changes and which ones don't.

