

N202 Unit VI Part 2

Class Preparation Assignment - Trauma Case Study

Patient Profile:

J.B. is a 78-year-old male who was found by his neighbor laying on the ground in his garden. It is unknown how long he has been lying there. It appears he has fallen off the roof while fixing the shingles on his house. His left femur is protruding through the skin. The paramedics report that he was found in a large pool of blood. Additional visible wounds include scattered bruising to head and abdomen.

Subjective Data:

- N/A - unresponsive, no family at bedside

Objective Data:

- Unresponsive
- BP 60/42, HR 168, RR 14, SpO2 88% on RA, Temperature 94.7 F
- Left femur protruding through skin
- Scattered bruising to abdomen and head
- Scattered abrasions

Questions:

1. What potentially life-threatening injuries does J.B. have? Why did you come to this conclusion?

Hemorrhage- decreased BP, amount of blood at the scene, open femur fx, bruising to the abdomen

Head bleed- scattered bruising on head, unwitnessed fall

Air way complications- unresponsive (unable to protect airway), Spo2; 88% on RA

Open fx of left femur- femur protruding from the skin

2. What is the priority of care for this patient?

Control bleeding, Airway (unable to protect if unresponsive), breathing,

3. What diagnostic studies (images & labs) do you anticipate being ordered for this client?

X ray/CT/MRI/ FAST ultrasound at bedside, H&H, PT/aPTT/ INR, CBC, CMP, ABG

4. Once the client is initially stabilized, the nurse begins to consider additional injuries. What other potential complications/syndromes/injuries may this client be experiencing?

- Compromised circulation/compartment syndrome - open femur fx outside of the skin
- Infection/osteomyelitis - open femur fx outside of the skin

5. For the identified injury/illness above, what clinical manifestations should the nurse assess for?

- Hemorrhage/ hypovolemic shock- decreased BP, bradycardia, decreased LOC, Cullens sign, abdominal tenderness, pain, weakness, Kehr's sign, abdominal distention
- Head bleed: decreased LOC, pupil changes, signs of increased ICP, changes in mental status (agitation, restlessness)
- Airway compromise: decreased RR, absent or diminished breath sounds, adventitious
- Infection (later): increased (WBC), erythema, drainage, hot to touch around the site, fever, tachycardia, tachypnea, fatigue

6. What treatment measures and nursing interventions does the nurse anticipate for this client?

Tourniquet, blood transfusion (maybe mass transfusion protocol), 100% O₂ via nonrebreather, rapid fluid resuscitation, sx for ORIF, abx, c spine - CT to clear spine