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# Nursing Management of Patients with Emergency and Critical Conditions

**Adult Health Nursing**

Shock, multiple organ dysfunction syndrome, respiratory failure, cardiac emergencies, sepsis, poisoning, trauma, burns, emergency assessment and critical care nursing.

**For educational purposes only.**

## CHAPTER 18 / ADULT HEALTH NURSING 18. Nursing Management of Patients with Emergency and Critical Conditions

## 1. ABCDE and triage

A: identify airway obstruction and protect cervical spine when indicated. B: assess respiratory effort, oxygenation and ventilation. C: assess pulse, perfusion, bleeding and obtain access as indicated. D: check consciousness, pupils and glucose. E: expose to identify injury while maintaining warmth/privacy. Treat life threats as found, call for help and reassess. Triage prioritizes urgency, not arrival order.

### Shock

Definition and pathophysiology: Inadequate tissue perfusion; hypovolaemic (loss), distributive (sepsis/anaphylaxis), cardiogenic (pump failure), obstructive (e.g. tension pneumothorax).

Clinical features and investigations: Tachycardia, altered mentation, delayed refill, oliguria, hypotension (may be late); lactate and cause-specific evaluation.

Management and nursing care: Immediate help, oxygen/ventilatory support as needed, control bleeding, IV access and cause-specific resuscitation; fluids carefully in cardiogenic/obstructive shock, reassess perfusion and overload; prepare vasopressors as ordered.

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### Sepsis and septic shock

Definition and pathophysiology: Life-threatening organ dysfunction from dysregulated host response to infection; septic shock involves profound circulatory/metabolic abnormalities.

Clinical features and investigations: Suspected infection with new organ dysfunction; monitor BP, consciousness, respiratory rate, output, lactate and appropriate investigations.

Management and nursing care: Activate sepsis pathway; timely antimicrobials based on likelihood/urgency, cultures if no harmful delay, source control, individualized crystalloid resuscitation and vasopressor support when required. Reassess frequently. Use current 2026 SSC/local guidance.

### Multiple organ dysfunction syndrome (MODS)

Definition and pathophysiology: Progressive dysfunction of multiple organs after severe infection, trauma or other critical illness.

Clinical features and investigations: Respiratory failure, renal injury, coagulation disturbance, hypotension,

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altered consciousness.

Management and nursing care: Treat cause, organ support, monitor trends, prevention of infection and pressure injury, nutrition, communication and goal-of-care discussions.

### Respiratory failure

Definition and pathophysiology: Failure of gas exchange or ventilation.

Clinical features and investigations: Hypoxaemia, hypercapnia, fatigue, altered mental status; ABG and assessment.

Management and nursing care: Airway support, individualized oxygen and ventilation, treat cause. Monitor response and avoid delaying intubation if failing non-invasive support.

### Cardiac arrest and cardiac emergencies

Definition and pathophysiology: Loss of effective circulation; also unstable arrhythmia, ACS and acute pulmonary oedema.

Clinical features and investigations: Unresponsive and absent normal breathing; trained providers check pulse no longer than 10 seconds.

Management and nursing care: Activate emergency response, CPR 100-120/min, adult depth 5-6 cm, full recoil/minimize pauses; 30:2 without advanced airway; AED/defibrillator promptly as indicated. Follow certified BLS/ALS algorithms (AHA 2025).

### Poisoning

Definition and pathophysiology: Toxic exposure by ingestion, inhalation, injection or skin contact.

Clinical features and investigations: Variable toxidromes; history, substance/time, glucose, ECG, organ tests; ensure staff safety.

Management and nursing care: ABCDE, poison-centre/specialist guidance, remove exposure safely, selected antidotes (e.g., naloxone for opioid respiratory depression). Do not induce vomiting. Monitor delayed toxicity and psychosocial risk.

### Trauma and burns

Definition and pathophysiology: Physical injury with potential haemorrhage, airway damage or occult internal injury.

Clinical features and investigations: Mechanism, bleeding, deformity, neuro status, breathing and perfusion; trauma imaging as indicated.

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Management and nursing care: Control major bleeding (direct pressure/tourniquet if indicated and trained), immobilize appropriately, prevent hypothermia, activate trauma team. Cool limited thermal burns with running water, avoid ice; major burns need specialist resuscitation.

## 2. Critical care nursing

Continuous or appropriate monitoring, line/device infection prevention, ventilator care, sedation and delirium assessment, skin and VTE prevention, nutrition, early mobilization when safe and family communication. Track

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fluid balance and urine output. A change in trends can precede critical events. Document times, actions and response.

## 3. Important Examination Questions

### Long Answer Questions

1. 1. Explain types of shock and emergency nursing management
2. 2. describe sepsis and MODS.

### Short Answer Questions

1. 1. Write ABCDE
2. 2. state adult CPR principles
3. 3. explain initial poisoning care.

### Very Short Answer Questions (with answers)

1. 1. What is AED? - Automated external defibrillator.
2. 2. Is hypotension always early in shock? - No.

## 4. Quick Revision

- Treat life threats immediately.
- Sepsis requires time-sensitive assessment.
- Reassess after every intervention.

## 5. Conclusion

Treat life threats immediately. Sepsis requires time-sensitive assessment. Reassess after every intervention.

## Practice questions

Choose one best answer. The answer key and explanations follow the questions.

**1. Which principle determines triage priority?**

A. Order of arrival alone
B. Patient age alone
C. The time required to complete registration
D. Clinical urgency

**2. Which shock category results primarily from failure of the heart as a pump?**

A. Cardiogenic shock
B. Hypovolaemic shock
C. Distributive shock
D. Obstructive shock

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**3. During the disability component of ABCDE, which observations are assessed?**

A. Pulse, perfusion and bleeding

B. Consciousness, pupils and glucose

C. Respiratory effort and oxygenation

D. Skin exposure and warmth alone

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## Answer key and explanations

**1. D - Clinical urgency**

Triage prioritizes the urgency of the patient's condition.

**2. A - Cardiogenic shock**

Cardiogenic shock is caused by pump failure.

**3. B - Consciousness, pupils and glucose**

The D component checks neurological status and glucose.

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