Sample Nursing Process to assess and determine treatment of injury

**Overview of Situation:** Student comes in from recess crying and bleeding from right knee.

**Assessment:** Observe an emotionally upset student. Ask student (and any staff present) what happened.

Considerations: did they slip on a wet floor (that is a safety issue, address right away, call custodian), was student pushed, (disciplinary issue, address right away by informing principal/counselor if it’s a friend or sibling dispute), did they trip over their own two feet, (consider factors of quick movement versus improper footwear, vision, ambulation or muscle function issue if this is a frequent occurrence). Simultaneously assessing the knee, considerations include:

* Volume of blood
* Observe for wound smell or other material oozing from it
* Observe for other debris that needs to be removed
* Assess range of motion
* Check circulation above and below affected area
* Observe wound size and depth
* Visualization of wound tissue- is muscle, tendon, or bone visible
* Will it need sutures or healthcare provider evaluation?
* Did student hit any other part of their body when they fell?
* Observe student’s head, the palms of their hands and the other knee

The nurse must always be cognizant of and have a level of competence to recognize and address signs and symptoms of other safety concern areas (i.e. child abuse)

**Nursing Diagnosis:** Alteration in skin integrity and increased risk of infection due to impaired skin integrity

**Planning and Implementation of Treatment:**

* Clean the area by applying cool water that will wash out the wound, apply soap and gently clean the wound. Then rinse the wound. Apply a clean bandage and provide an ice pack to ease any discomfort.Have student wash hands with soap and water and give her a drink of water.
* Send student back to class, inform her teacher that she was in the health office and why.
* Call the parents/guardians and inform them of what happened and what treatment was provided, along with information on observing the wound for complications (i.e. redness, swelling, drainage from wound site, low grade fever, decreased weight bearing on affected limb) and educate parent that these are indications to follow up with the primary care provider.
* Follow that up with written note in student’s backpack with same information and directions.Complete incident report per district policy.
* Document the entire event in the student’s cumulative health record (CHR). This includes student’s or staff member’s description of event, nursing assessment and treatment, student’s reaction to the assessment and treatment, communication with school staff and the parent/guardian, provision of follow up instructions.

**Evaluation:** Depending on size and depth of wound, have the student return in an hour or two to reassess the wound and the bandage.Considerations include:

* Has anything about this wound changed?
* Is there increased redness, swelling or bruising evident near the wound?
* Is drainage (amount and type) evident on the bandage?
* Does the bandage need to be changed?
* How is her pain level, movement of affected limb or area, circulation in the area, and emotional status?
* This reassessment, care provided, informing and educating staff and parent/guardian is also documented in the student’s CHR.