



มหาวิทยาลัยราชภัฏนครปฐม



Adult and Geriatric Nursing Practicum 2

Napat rattanahongsa
Faculty of Nursing, Nakhon Pathom Rajabhat University

Nursing care for Anaphylaxis

Anaphylaxis is an acute hypersensitivity reaction with potentially life-threatening consequences. It is often a sudden, multi-system, widespread allergic reaction. Anaphylaxis frequently results in death if untreated because it quickly progresses to respiratory failure.

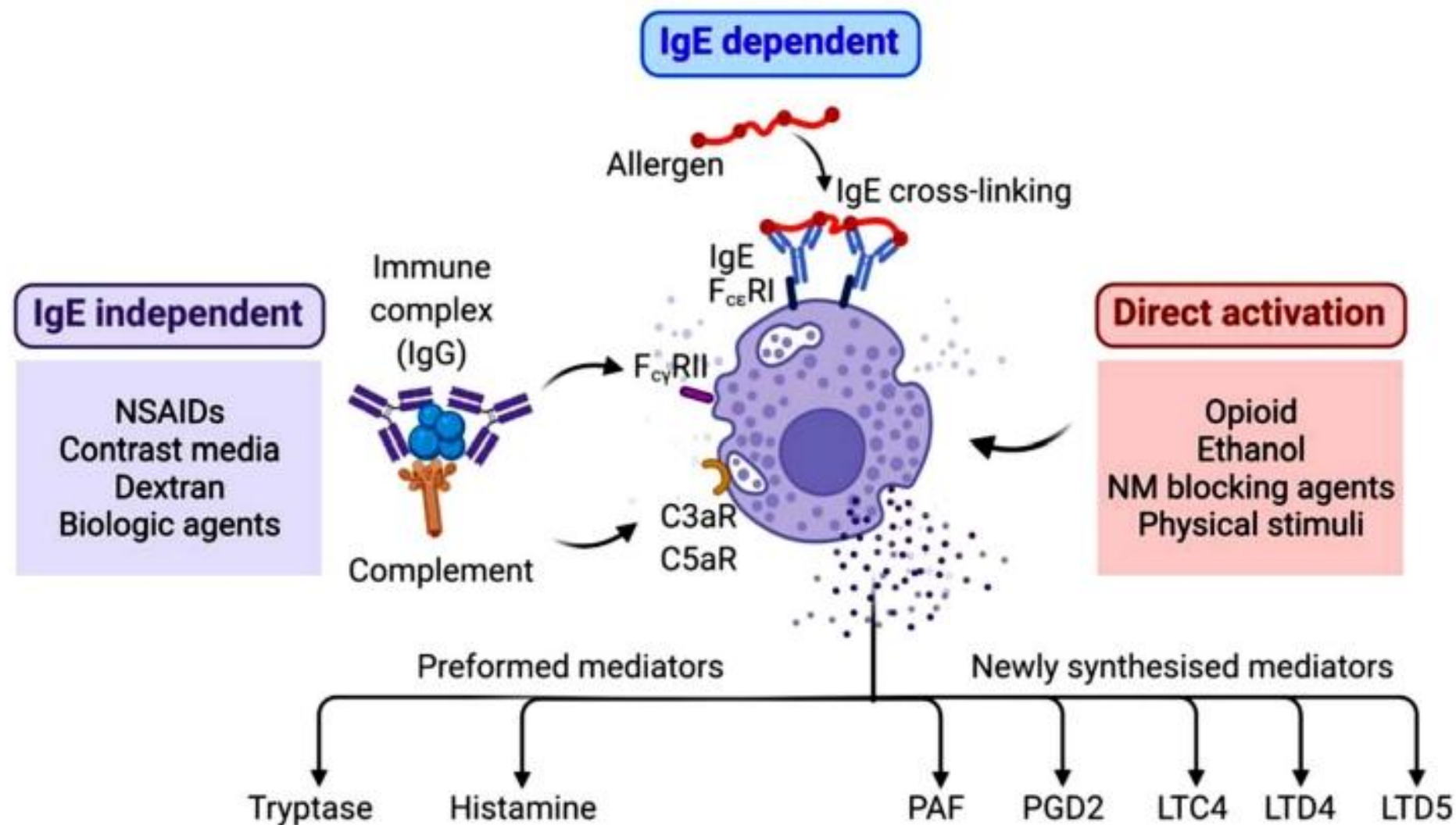
What causes anaphylaxis?



<https://images.app.goo.gl/7qvhBjwPpaV78g4r5>

Nursing care for Anaphylaxis

Pathology



Signs of anaphylaxis



Airway

- Shortness of breath.
- Breathing difficulties.
- Being unable to swallow.



Skin

- Hives.
- Redness.
- Itchy rash.
- Swelling.



Stomach

- Cramps.
- Diarrhea.
- Nausea and vomiting.



Heart

- Drop in blood pressure.
- Increased heart rate.
- Weak pulse.
- Feeling faint.



<https://images.app.goo.gl/Tnzktu2fdcNMvbL3A>



Nursing care for Anaphylaxis

Diagnosis

Consists of having 1 of the following 2 symptoms:

1. Acute (within minutes or hours) symptoms of the skin or mucosal tissue, or both, such as generalized hives, itching, rash, or swelling of the mouth, tongue, or soft palate, along with at least one of the following symptoms:

1.1 **Respiratory symptoms:** Stuffy nose, runny nose, hoarseness, shortness of breath, Wheezing, stridor, decrease peak expiratory flow (PEF), Hypoxia

1.2 **Hypotension**

1.3 **Severe gastrointestinal symptoms**

2. **decrease blood pressure, bronchospasm, tachycardia**

Nursing care for Anaphylaxis

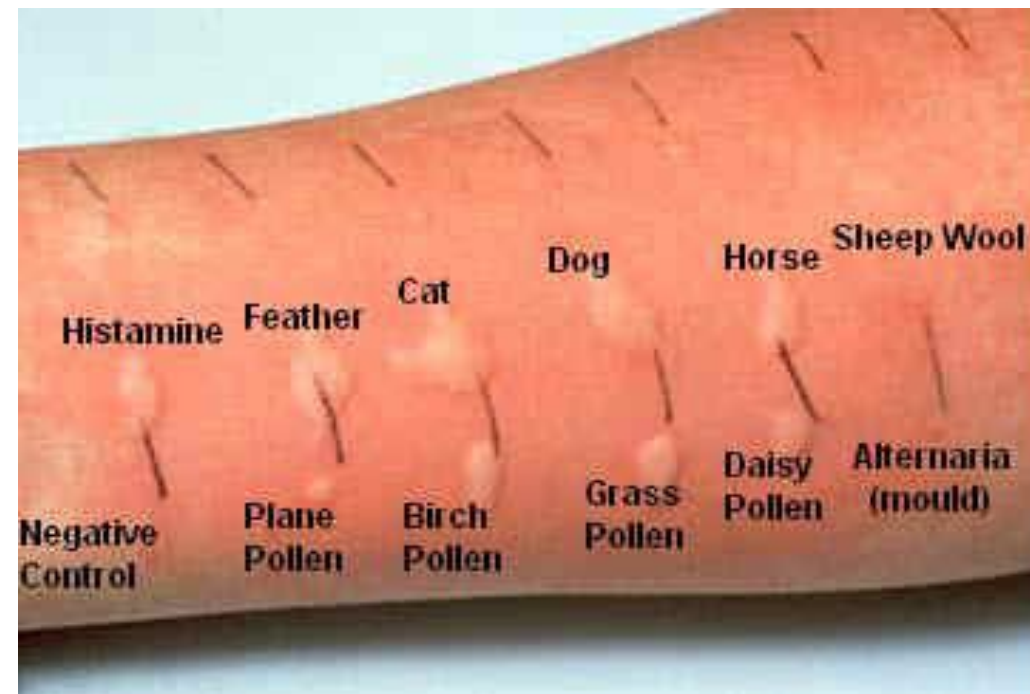
Laboratory

1. serum total tryptase : alpha-tryptase, beta-tryptase
2. Measurement of histamine and metabolite levels in urine

specific IgE antibody

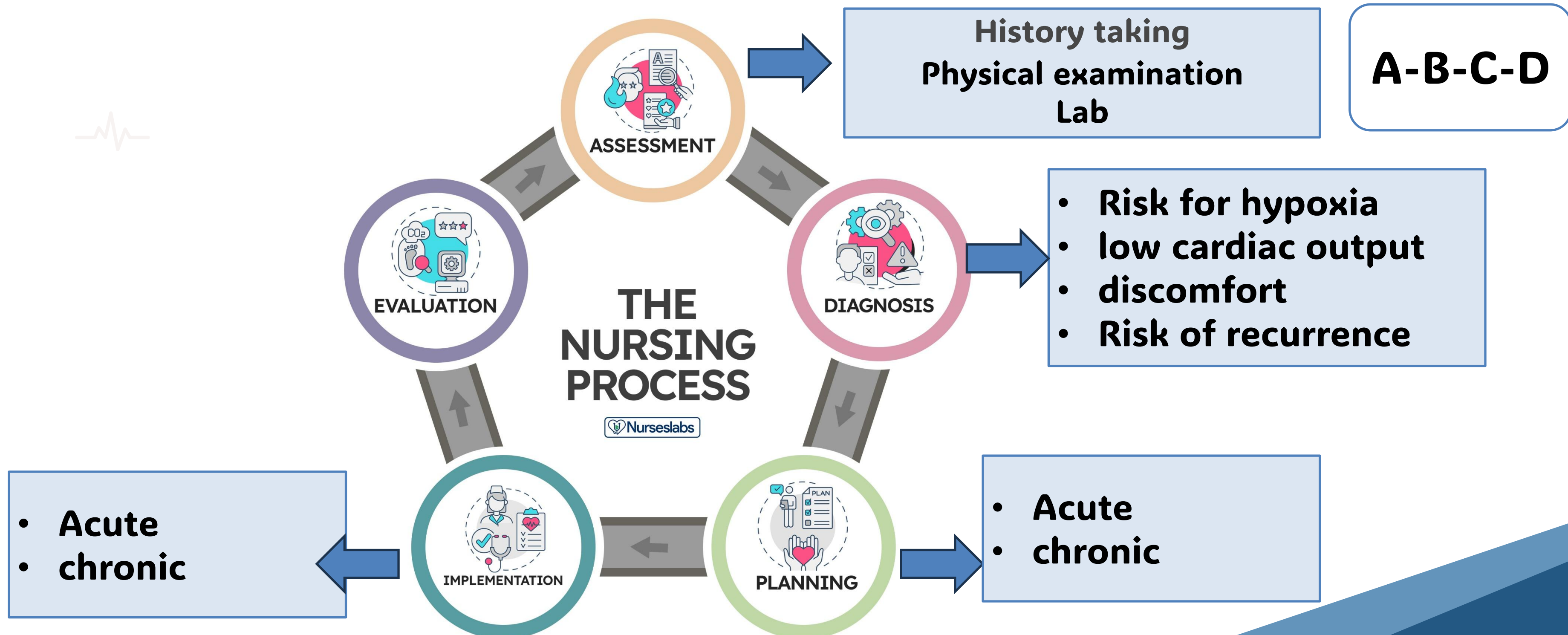
cause

skin prick test, SPT / intradermal test, IDT



<https://images.app.goo.gl/dhvukYApfihpHYzk6>

Nursing care for Anaphylaxis



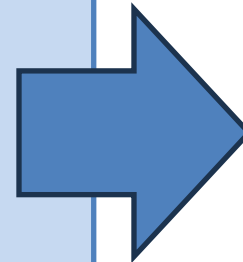


Nursing Care Plans

Impaired Spontaneous Ventilation

Related to:

- Angioedema
- Narrowing of the airways
- Respiratory failure
- Airway obstruction
- Bronchospasm



As evidenced by:

- Dyspnea
- Adventitious lung sounds (wheezes or stridor)
- Hypoxia
- Cough
- Tachycardia
- Cyanosis
- Restlessness

Expected outcomes:

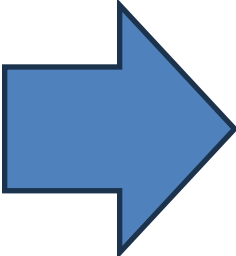
- Patient will demonstrate respiratory rate and oxygen saturation within normal limits.
- Patient will demonstrate clear lung sounds upon auscultation.



Nursing Care Plans

Impaired Spontaneous Ventilation Interventions:

Assessment:

1. **Monitor the respiratory rate and oxygen saturation.**
 2. **Auscultate lung sounds.**
 3. **Educate the patient and family on the necessity of intubation.**
- 

1. **Ensure patency of the airway.**

Suction any secretions if present to encourage spontaneous ventilation and prevent complications like aspiration.

2. **Administer medications as prescribed.**

*infusion of epinephrine 1:1,000 (1 mg./ml.) 0.01 mg./kg Max 0.3 mg. in Ped or 0.3-0.5 mg in Adulte IM at mid-anterolateral q 5-15 min * 2 dose*



Nursing Care Plans

Impaired Spontaneous Ventilation

Interventions:

2. Administer medications as prescribed.

- antihistamine
- corticosteroid
- β 2-adrenergic agonist : *Bronchodilators like albuterol, Salbutamol*NB

3. Collaborate with respiratory therapy.

4. Obtain ABGs.



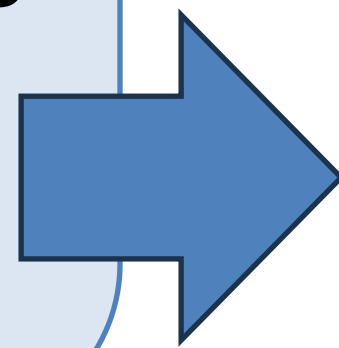


Nursing Care Plans

Decreased Cardiac Output

Related to:

- **Decreased preload**
- **Leak of histamine causing blood vessels to leak fluid into the tissues (third spacing)**
- **Vasodilation**



As evidenced by:

- **Tachycardia**
- **Palpitations**
- **Hypotension**
- **Anxiety**
- **Restlessness**

Expected outcomes:

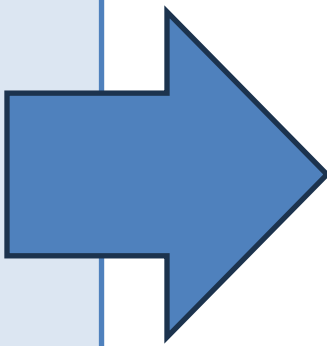
- Patient will maintain pulse rate and blood pressure within therapeutic limits.
- Patient will be able to verbalize relief from anxiety and restlessness.
- Patient will be able to manifest a calm and well-rested appearance.



Nursing Care Plans

Decreased Cardiac Output

Assessment:

1. Monitor the pulse rate and blood pressure.
 2. Assess cardiovascular status.
 3. Assess mental status changes.
 4. Urine Output
- 

Interventions:

1. Check for IV access.
2. Immediately discontinue a suspected IV medication or infusion.
3. Administer IV fluids.
4. Fluid resuscitation is a central intervention for hypotension. Isotonic crystalloid bolus is recommended. 10-20 mg./Kg. in 5-10 min
5. Administer vasopressors. Adrenaline 1-4 mcg/kg/min titrate Keep BP
6. Prepare the emergency or crash cart at the bedside.

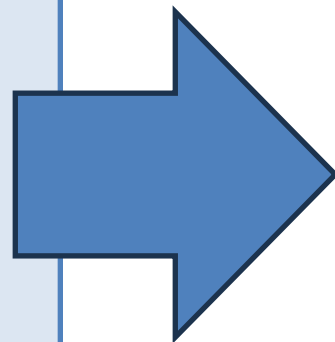


Nursing Care Plans

Deficient Knowledge

Related to:

- Insufficient knowledge about anaphylaxis
- Inadequate understanding of signs and symptoms of anaphylaxis
- Lack of information about emergency management of anaphylaxis
- Misconception of anaphylactic triggers



As evidenced by:

- Verbalization of concerns
- Questions about anaphylaxis
- Improper use of epinephrine auto-injector
- Development of preventable complications such as anaphylactic shock
- Nonadherence with prevention and management recommendations

Nursing Care Plans

Deficient Knowledge





มหาวิทยาลัยราชภัฏนครปฐม