

MODULE 8

Throat Cultures

- The means of gathering other information about the patient's health status is identifying pathogens and analyzing urine, blood, sputum, and feces.
- As a practical nurse, you may be responsible for collecting and labeling specimens for analysis and ensuring their delivery to the lab.
- Washing your hands carefully also prevents the spread of disease.
- For self-protection and to prevent the spread of disease, wear gloves whenever you work with body fluids.

After completing this lesson, the learner will;

- Understand the principles, and procedures with the supplies and equipment used to obtain a sample for throat culture.
- Learn what supplies and equipment are required to perform a throat culture

The supplies and equipment required to obtain a sample for throat culture are as follows;

- Sterile cotton-tipped applicator specimen collection kit (cultrate).
- Tongue depressor
- Laboratory request form.
- Flashlight.

Throat cultures are done to isolate and identify any pathogens, which may be medium.

The slide or medium is incubated in the laboratory to determine which organisms causing a throat disorder.

A sample of mucus and secretions from the back of the throat is collected on a cotton-tipped applicator and applied to a slide or culture are present.

- Always wash your hands before the procedure.
- Explain to the patient what you are going to do.
- Have the patient sit comfortably on a bed or chair and tilt his head back.
- Use the Flashlight to illuminate the back of the throat.
- Check for inflamed areas using the tongue depressor.

A determination of which drug is most effective against a particular organism may be made.

A full culture and sensitivity test takes several days because the organisms must have time to grow.

If strep infection is suspected a quick strep test may be done so that antibiotic therapy can be started immediately.

- Ask the patient to say “Ahhh” as you swab the tonsillar areas from side to side. Be sure to include any inflamed or purulent sites.
- Avoid touching the tongue, cheeks, or teeth with the applicator, as this will contaminate it with oral bacteria.
- Place the cotton-tipped applicator into the culture tube immediately.
- Label the culture tube with the patient’s name, SSN, and ward number if applicable.

Complete the request form with the following information:

- Patient’s name.
- Patient’s rank or status.
- Family member prefix and sponsor’s social security number.
- Any antibiotics the patient is taking.
- Wards number if inpatient, or phone number if outpatient.
- Date and time the specimen was obtained.
- Name and the physician who ordered the culture.
- Source of the specimen (that is, throat).

Documentation to record Specimen collected:

- ✓ Patient's name.
- ✓ Patient's rank or status.
- ✓ Family member prefix and sponsor's social security number.
- ✓ Ward number if inpatient, or phone number if outpatient.
- ✓ Source of the specimen (that is, throat).
- ✓ Any antibiotics the patient is taking.
- ✓ Date and time the specimen was obtained.
- ✓ Name of the physician who ordered the culture.

Types of Specimen Collection

In addition to Throat culture, and again flowing on from the Physical Examination, the learner is introduced to other types of Specimens Collected to gather information about the patient's health status by identifying pathogens from the specimen samples collected as follows;

- Respiratory sputum specimen
- Stool specimens
- Urine Specimen
- Midstream Urine Specimen
- 24 Hour Urine Specimen
- Guaiac Test

Learning Outcomes

After completing this lesson, the learner should be able to:

- Cite the principles, supplies equipment, and procedures that apply to obtaining a sputum specimen.
- Cite the principles, supplies equipment, and procedures that apply to obtaining a stool specimen.
- Identify the steps of the procedure for correctly obtaining a midstream urine specimen, a 24-hour urine collection, and urine for pregnancy test.
- Identify abnormalities in the color and odor of urine. Pregnancy Tests and Pregnancy Urine Tests

1. Sputum Specimen

For some Respiratory Disorders, a Sputum Specimen is obtained for culture or other examination to determine if any pathogens or blood are present.

The specimen should be collected early in the morning before the patient eats, brushes his teeth, or uses mouthwash.

The specimen is more likely to contain sputum at this time, rather than just saliva.

Specimens are often taken for three consecutive days because it is difficult for the patient to cough up enough sputum at one time, and an organism may be missed if only one culture is done.

2. Procedure for Sputum Specimen

- Wash your hands and gather the equipment.
- Provide privacy for the patient and explain the procedure.
- Place the tissues nearby and have the patient rinse his mouth with clear water to remove any food particles.
- Assist the patient to a sitting position, if necessary, and ask him to cough deeply and spit into the container.

3. After the Collection of the Sputum Specimen

- ✓ Close the container immediately after collecting the specimen to prevent the spread of any organisms from the specimen.
- ✓ Offer tissues for the patient to wipe his mouth.
- ✓ Wash your hands,
- ✓ label the container, and
- ✓ complete the laboratory request form.

Deliver the specimen to the laboratory immediately; allowing the specimen to remain in a warm place will result in the overgrowth of any organisms that may be present.

Record the amount, consistency, and color of the sputum collected, as well as the time and date in the nursing notes.

4. Supplies and Equipment for Sputum Specimen

- ✓ Supplies and equipment required to collect a sputum specimen are sterile containers with tight-fitting lids.
- ✓ Box of tissues.
- ✓ Gloves.
- ✓ Laboratory request form (SF 553).

5. Stool Specimens

Stool Specimens are collected for many examinations.

Explain the reason for the test and the procedure to the patient.

- The most common is the ova and parasites test, a microscopic examination of feces for detecting parasites such as amebas or worms.
- Stool specimens are often tested for blood.

6. Procedure for Stool Specimen

The procedure to perform a Stool Specimen is as follows;

- ✓ Ask the patient to tell you when he feels the urge to have a bowel movement.
- ✓ Wear gloves when handling any bodily discharge.
- ✓ Give the bedpan when the patient is ready.
- ✓ If the patient wants to urinate first, give a male the urinal or give a female the extra bedpan. Remove the bedpan.
- ✓ Use the tongue blade to transfer a portion of the feces to the specimen container.

7. After the Stool Specimen is taken

The following outlines the procedure after the specimen is taken from the patient;

- Complete the appropriate laboratory request form, noting any special examination ordered.
- Take the specimen to the lab immediately; examination for parasites, ova, and organisms must be made while the stool is warm.
- If an infant's stool is to be examined, place the diaper in a leak-proof bag, label it, and take the diaper and request form to the lab immediately.

8. Guaiac Test

The purpose of this test, using guaiac as a reagent, is to detect the presence of occult blood (blood that appears from a nonspecific source, with obscure signs and symptoms), which is not visible.

Each method of testing has a specific procedure, which must be followed to get accurate results. If it is done at the nursing station, instructions should be kept with the reagents used.

Follow the manufacturer's instructions and consult hospital standing operating procedures (SOP).

9. Urine Specimen

Urinalysis is included in a health examination and as part of the admission process for all inpatients.

Simple urine tests, such as for sugar and acetone, are often performed by the nurse in the hospital or by the patient at home.

Urine is assessed first for its physical appearance:

Color. Freshly voided urine is transparent and light amber in color. The amount and kinds of waste in the urine make it lighter or darker.

Physical Examination – Function

- The Physical Assessment is the first Step in the nursing process.
- It provides the foundation for the nursing care plan in which your observations play an integral part in the assessment, intervention, and evaluation phases.
- The chances of overlooking important data are greatly reduced because the physical assessment is performed in an organized, systematic manner, instead of a random manner.
- An accurate Physical Assessment requires an organized and systematic approach using the techniques of inspection, palpation, percussion, and auscultation.
- It also requires a trusting relationship and rapport between the nurse and the patient to decrease the Stress the patient may have from being physically exposed and vulnerable.
- The patient will be much more relaxed and cooperative if you explain what will be done and the reason for doing it.
- While the findings of a nursing assessment do sometimes contribute to the identification of a medical diagnosis, the unique focus of a nursing assessment is on the patient's responses to actual or potential problems.

After completing this lesson, the learner should be able to:

- ✓ Define physical assessment.
- ✓ Cite the purposes for performing a physical assessment.
- ✓ Cite the nursing considerations for preparing a patient for a physical assessment.
- ✓ Identify the basic techniques used in performing a physical assessment.

The following examination techniques are used during Physical Assessment.

Auscultation is an examination by listening for sounds produced within the body

Inspection is comprised of the Visual examination.

Palpation examination by touch.

Percussion is an examination of the body by tapping it with the fingers.

Auscultation

Examination by listening for sounds produced within the body is called auscultation. The sounds most frequently listened for are those of the abdominal and thoracic viscera and the movement of blood in the cardiovascular system. Direct auscultation, using the ear only, is seldom done. Indirect auscultation is generally carried out with a stethoscope.

Percussion

Is a special assessment skill that the practical nurse is not required to perform. This technique is usually performed by a registered nurse (RN) or a physician.

Inspection

The visual examination of a person is called inspection. This is done in an orderly manner, focusing on one area of the body at a time.

Palpation

Examination by touch is called palpation. The nurses feel for texture, size, consistency, and location of body parts.

Percussion

Examination of the body by tapping it with the fingers is called percussion.

Physical assessment is an organized systemic process of collecting objective data based on health history and head-to-toe or general Systems examination.

A physical assessment

should be adjusted to the patient, based on his needs. It can be a complete physical assessment, an assessment of a body System, or assessment of a body part.

Overall purposes for a physical assessment are as follows:

- To obtain baseline physical and mental data on the patient.
- To supplement, confirm, or question data obtained in the nursing history.
- To obtain data that will help the nurse establish nursing diagnoses and plan patient care.
- To evaluate the appropriateness of the nursing interventions in resolving the patient's identified pathophysiology problems.

The Purpose of the Physical Assessment is as follows:

- ✓ A comprehensive patient assessment yields both subjective and objective findings.
- ✓ Subjective findings are obtained from the health history and body systems review.
- ✓ Objective findings are collected from the physical examination.
- ✓ Data means more than signs or Symptoms; it also includes demographics, or patient information that is not related to a disease process.

Subjective data

are apparent only to the person affected and can be described or verified only by that person. Pain, itching, and worrying are examples of subjective data.

Objective data

are detectable by an observer or can be tested by using an accepted standard.

A blood pressure reading, discoloration of the skin, and seeing the patient in the act of crying are examples of objective data.

Objective data are sometimes called signs, and subjective data are sometimes called symptoms.

Establish a Positive Nurse/Patient Rapport.

This relationship will decrease the stress the patient may have in anticipation of what is about to be done to him.

Explain the Purpose of the Physical Assessment.

The purpose of the nursing assessment is to gather information about the patient's health so that you can plan individualized care for that patient.

All other steps in the nursing process depend on the collection of relevant, descriptive data. The data must be factual, not interpretive.

Obtain an Informed, Verbal Consent for the Assessment.

The chief source of data is usually the patient unless the patient is too ill, too young, or too confused to communicate clearly.

Patients often appreciate the detailed concern for their problems and may even enjoy the attention they receive.

Ensure Confidentiality of All Data. If possible, choose a private place where others cannot overhear or see the patient.

Explain what information is needed and how it will be used. It is also important to convey where the data will be recorded and who will see it.

In some situations, you should explain to the patient his rights to privileged communication with health care providers.

Provide Privacy from Unnecessary Exposure.

Assure as much privacy as possible by using drapes appropriately and closing doors.

Communicate Special Instructions to the Patient.

As you proceed with the examination, inform the patient of what you intend to do and how he can help, especially when you anticipate possible embarrassment or discomfort.

Appearance and Behavior Examination

Areas of General Appearance and Behavioral Assessment is done by collecting the following patient personal data;

- ✓ Demographic Data
- ✓ Body Build
- ✓ Posture and Gait
- ✓ Hygiene and Grooming
- ✓ Skin Lesions
- ✓ Dress
- ✓ Body and Breath Odors
- ✓ Attitude

Learning Outcomes

After completing this lesson, the learner should be able to;

- Cite the specific areas assessed when performing a general appearance and behavioral assessment.
- Identify the components of a systemic, head-to-toe physical assessment.

1. Demographic Data

Demographic Data - identifies the patient and includes the following important personal data.

- ✓ Name
- ✓ Age
- ✓ Sex

- ✓ marital status
- ✓ race and religion

2. Body Build

Body Build is observed along with the patient's general appearance and health state in relation to his age and lifestyle.

Determine the patient's height, weight, and vital signs at this time.

3. Posture and Gait

Posture and Gait during the Physical Assessment are observed to determine whether the patient is erect or slouched, steady or unsteady.

Posture can indicate mood, for example, a slumped position may reflect depression; too rigid and upright a position may indicate anxiety.

4. Hygiene and Grooming

Hygiene and Grooming are observed for the cleanliness of nails, hair, skin, and overall appearance.

Usually, you can assess these gradually while observing other parts of the body for data.

Observe the skin for color, texture, temperature, and lesions.

5. Lesions and Grooming

Lesions warrant particular attention during the assessment. Some primary skin lesions are as follows;

- ✓ Nodule—a solid mass extending into the dermis.
- ✓ Tumor—a solid mass larger than a nodule.

- ✓ Cyst—an encapsulated fluid-filled mass in the dermis or subcutaneous layer.
- ✓ Wheal—a relatively reddened, flat, localized collection of fluid.
- ✓ Hives.
- ✓ Vesicle—circumscribed elevation containing serous fluid or blood. An example is chickenpox.

6. Dress

The patient's Dress and clothing are observed about age, climate, socioeconomic status, and culture.

Notice whether the clothing is clean, properly buttoned, or zipped. The patient's dress may reflect the cold intolerance of hypothyroidism. Slippers or untied shoelaces suggest edema.

7. Body and Breath Odors

Body and Breath Odors. Malodorous body or breath may indicate pulmonary infections, uremia, or liver failure.

A breath Odor of acetone may be due to diabetes.

Although odors give important clues, avoid the common mistake of assuming that alcohol on a patient's breath explains neurologic or mental status findings.

Alcoholic breath does not necessarily mean alcoholism.

8. Attitude

Attitude. The patient's attitude is reflected in his appearance, speech, and behavior.

The patient may be aloof and unwilling to participate in the interview. He may verbalize anger or fear.

Some patients have a “take care of me” attitude and expect nurses and other healthcare personnel to magically know everything about them.

Such findings should be noted as part of your general impression.

9. Affect/Mood

Affect/Mood. Affect is the emotional state as it appears to others. Mood is the emotional state as described by the patient.

Observe the patient's facial expression.

No part of the body is as expressive as the face.

Feelings of joy, sadness, fear, surprise, anger, and disgust are conveyed by facial expressions.

Facial expressions generally are not consciously controlled.

10. Speech

Speech. Assess the patient's speech for loudness, clarity, pace, and coherence. Observe the patient for poor articulation of words and language difficulty.

Patients who are not fluent in English or have limited education are sometimes mistakenly labeled as “indifferent” or “no communicative.”