I have completed 5 shifts in the adult ED and have learned so much. I have started and discontinued multiple IVs, done blood draws, given meds PO, IVP, IVPB, IM, and subQ, checked blood sugars, taken patient history and helped triage patients. I also have done focused respiratory and cardiac assessments, applied oxygen via nasal canula and non-rebreather mask, and learned how to correctly attach 12 lead EKGs. Even though I am not an ED nurse, I have learned and contributed to the care of patients and learned valuable communication skills during my clinicals.

The most memorable patient experience was a 78 year old female that arrived via EMS ambulance that had suffered a stroke with symptoms of left sided facial drooping, left sided weakness to her arm, and responsive aphasia. Her blood pressure was low (110/72) and her heart rate was in the 150s. Two weeks prior to her emergency, she had coronary stents placed. She had a history of hyperlipidemia as well. Upon arrival the team of ED nurses quickly started a second IV line and applied the 12 lead EKG and found that she was in A flutter with SVT. We took the patient to CT to make sure she did not have a brain bleed but could not do an MRI because we did not know what type of stents had been placed. After establishing that she did not have a bleed, we started TPA.

One of the issues that we faced was the low blood pressure and high heart rate. We really wanted her blood pressure up to ensure her brain was being perfused, but did not want her heart rate to stay in the 150s and also the risk of possible clots moving to her brain again. The physician decided to try to cardiovert the patient with adenosine. We learned in module 7, that the first dose of adenosine is 6mg followed by another at 12mg if needed. This physician ordered the initial dose to be 12mg. As soon as the adenosine was pushed, I could see both the extreme drop in heart rate and the patient's response (she had a panicked expression and almost

looked as though she was choking). Within seconds she recovered and her heart went into Afib and her heart rate continued to stay in the 150s. The next medication that was administered was amiodarone. We gave a bolus of 300mg with a slight response and then started a drip of 5mL/hr which we later had to increase to 10mL/hr. Eventually, her heart rate did drop down to 109 for which we were grateful because it had been so high for so long.

Another issue we faced was conflicted orders from the different physicians that were assigned to her. The neurologist wanted the MRI and had the patient put on TPA. Then the cardiologist on duty wanted her to have metoprolol and Plavix because she had recently had the stents in place. When my nurse saw the order for Plavix, he contacted both the physicians to notify them of each others conflicting plans along with the pharmacists and we were able to hold the Plavix. The next day the patient was still in the ED because there wasn't an ICU bed available (thank you COVID). A nurse practitioner from her cardiologist assessed the patient that morning and again insisted that she had to start Plavix immediately because of the stents their office had placed. My nurse wasn't in the room when he told the patient and her daughter this, so I was in the position to advocate for the patient's safety. I told the NP that it had not been 24 hours since the TPA had been administered and that it is standard not to give any other blood thinners in the 24 hr period because of the risk of bleeding. His response was "I don't care about TPA, she has to have the Plavix." I told my nurse and the pharmacist what he had said, and we ended up giving the Plavix. It was eye-opening to see how vital it is to know your patient's condition and to be in the room with each physician that is assigned in order to collaborate and inform each caregiver of the treatments that have already been done and what is being ordered, to keep everyone on the same page and most importantly to keep the patient safe.