Hypertensive Patient

A post op cardiovascular patient has a BP of 180/90.

Review and initiate the following order. Work calculations and then start pump.

Order: Nicardipine (Cardene) 25 mg in 250 mL NS

Initiate infusion at 5 mg/hr and titrate by 1 – 2.5 mg/hr every 15 minutes to keep SBP less than 150 mmHG

Check vital signs every 15 minutes with titration, then every 1 hour and PRN.

Recommended Maximum dose: 15 mg/hr

After 15 minutes the BP is 170/80. What should the nurse do now?

When should the nurse notify the health care provider that the nicardipine is ineffective?

Hypotensive Patient

A patient admitted with septic shock has a BP of 78/50 (59).

Review and initiate the following order. Work calculations and then start pump.

Order: Norepinephrine (Levophed) 4 mg in 250 mL NS

Initiate infusion at 5 mcg/min and titrate by 1 – 5 mcg/min every 5 minutes to keep MAP ≥ 65 mmHG

Check vital signs every 15 minutes with titration, then every 1 hour and PRN

Recommended maximum dose: 50 mcg/min

After 5 more minutes the BP is 82/40 (54). What should the nurse do now?

Why is it important to assess the patient's fluid status prior to administering a vasopressor like norepinephrine?

Sedation Patient

A 198 lb. patient was intubated and placed on a ventilator.

Review and initiate the following order. Work calculations and then start pump.

Order: Propofol (Diprivan): 1000 mg in 100 mL

Initiate infusion at 5 mcg/kg/min and titrate by 5 – 10 mcg/kg/min every 5 minutes to RASS Score of 0 to –2.

Recommended maximum dose: 70 mcg/kg/min

Change IV tubing every 12 hours. Order triglyceride level on every 4th day of sedation if drip continues.

Richmond Agitation and Sedation Scale (RASS)		
+4	Combative	violent, immediate danger to staff
+3	Very Agitated	Pulls or removes tube(s) or catheter(s); aggressive
+2	Agitated	Frequent non-purposeful movement, fights ventilator
+1	Restless	Anxious, apprehensive but movements not aggressive or vigorous
0	Alert & calm	
-1	Drowsy	Not fully alert, but has sustained awakening to *voice* (eye opening & contact ≥ 10 sec)
-2	Light sedation	Briefly awakens to *voice* (eye opening & contact < 10 sec)
-3	Moderate sedation	Movement or eye-opening to *voice* (but no eye contact)
-4	Deep sedation	No response to voice, but movement or eye opening to *physical* stimulation
-5	Unarousable	No response to *voice or physical* stimulation

The patient continues to pull against the wrist restraints, gag on the ETT, and try to sit up despite the nurse's calming reassurance. What is the patient's Richmond Agitation Sedation Scale (RASS) score? What is the RASS goal?

What should the nurse do now?

4 hours later the nurse turns the Propofol infusion off for a "sedation vacation". What is the priority assessment?

The patient nods appropriately that they are in pain. What should the nurse do next?

DKA Patient

0815 The nurse receives an order to start a regular insulin drip. The patient weighs 70 kg. Current blood glucose is 550 mg/dL.

Review and initiate the following order. Work calculations and follow insulin protocol.

Order: Regular insulin IV 100 U/100 mL.

Start insulin gtt at 0.1 units/kg/hour. Follow the insulin protocol.

BG 75-99 mg/dL	BG 100-139 mg/dL	BG 140-199 mg/dL	BG ≥ 200 mg/dL	INSTRUCTIONS*
		BG ↑ by > 50 mg/dL/hr	BG ↑	↑ INFUSION by "2Δ"
	BG ↑ by > 25 mg/dL/hr	BG ↑ by 1-50 mg/dL/hr *OR* BG UNCHANGED	BG UNCHANGED *OR* BG ↓ by 1-25 mg/dL/hr	↑ INFUSION by "Δ"
BG ↑	BG ↑ by 1-25 mg/dL/hr, BG UNCHANGED, *OR* BG ↓ by 1-25 mg/dL/hr	BG ↓ by 1-50 mg/dL/hr	BG ↓ by 26-75 mg/dL/hr	NO INFUSION CHANGE
BG UNCHANGED *OR* BG ↓ by 1-25 mg/dL/hr	BG ↓ by 26-50 mg/dL/hr	BG ↓ by 51-75 mg/dL/hr	BG ↓ by 76-100 mg/dL/hr	↓ INFUSION by "Δ"
BG ↓ by > 25 mg/dL/hr *see below*†	BG ↓ by > 50 mg/dL/hr	BG ↓ by > 75 mg/dL/hr	BG ↓ by > 100 mg/dL/hr	HOLD x 30 min, then ↓ INFUSION by "2Δ"

*D/C INSULIN INFUSION; √BG q 30 min; when BG ≥ 100 mg/dL, restart infusion @75% of most recent rate.

*CHANGES IN INFUSION RATE ("Δ") are determined by the current rate:

Current Rate (U/hr)	Δ = Rate Change (U/hr)	2Δ = 2X Rate Change (U/hr)
< 3.0	0.5	1
3.0 - 6.0	1	2
6.5 - 9.5	1.5	3
10 - 14.5	2	4
15 - 19.5	3	6
20 - 24.5	4	8
≥ 25	≥ 5	10 *(consult MD)*

0915 BG is 530 mg/dL. What should the nurse do now?

1015 BG is 470 mg/dL. What should the nurse do now?

What medication should the nurse anticipate adding when the BG is less than 250 mg/dL?