Lauren Dane

Post-op Pain Management: Day of Surgery (1/2)

Sheila Dalton, 52 years old

Primary Concept
Pain
Interrelated Concepts (In order of emphasis)
1. Gas Exchange 2. Glucose Regulation 3. Perfusion 4. Inflammation 5. Clinical Judgment 6. Patient Education

FUNDAMENTAL Reasoning: STUDENT

Post-op Pain Management: Day of Surgery (1/2)

History of Present Problem:

Sheila Dalton is a 52-year-old woman who has a history of chronic low back pain and COPD. She had a posterior spinal fusion of L4-S1 today. She had an estimated blood loss (EBL) of 675 mL during surgery and received 2500 mL of Lactated Ringers (LR). Pain is currently controlled at 2/10 and increases with movement. She was started on a hydromorphone patient-controlled analgesia (PCA) with IV bolus dose of 0.1 mg and continuous hourly rate of 0.2 mg. Last set of VS in post-anesthesia care unit (PACU) P: 88; R: 20; BP: 122/76; requires 4 liters per n/c to keep her O2 sat >90 percent. You are the nurse receiving the patient directly from the PACU.

Personal/Social History:

Sheila is divorced and currently lives alone in her own apartment. She has two grown children from whom she is estranged.

What data from the histories are RELEVANT and have clinical significance to the nurse?

RELEVANT Data from Present Problem:	Clinical Significance:
- Hx of COPD - Pt on 9L/NC - post-op spinal fusion c 675mL of blood loss, but recieved LR bolus - pain is 2/10 - taking hydromorphone	- Pt may have delayed healing d/t ↓ O_2 2° COPD - Pt requires O_2 to keep Sats ↑ 90% - something to monitor continuously - Any blood loss > 500mL can be dangerous; should monitor pts H/H & monitor for s/s of Hypovolemia - Pain is controlled right now - Hydromorphone can cause constipation
RELEVANT Data from Social History:	**Clinical Significance:**
LIVES ALONE Children estranged	Pt has no one at home to help her c ADLs post-op. Can cause stress, which can delay healing. Will likely need to contact case management to set-up home-health nurse visits or something similar

Developing Nurse Thinking by Identifying Significance of Clinical Data

Patient Care Begins–Arrives from PACU to Surgical Floor

Current VS:	P-Q-R-S-T Pain Assessment (5th VS):	
T: 100.2 F/37.9 C (oral)	Provoking/Palliative:	Movement/lying still
P: 110 (regular)	Quality:	Ache
R: 24	Region/Radiation:	Lumbar-incisional
BP: 98/50	Severity:	6/10-gradually increasing
O2 sat: 88% 4 liters per n/c	Timing:	Continuous since arrival from PACU

What VS data are RELEVANT and must be recognized as clinically significant by the nurse?

RELEVANT VS Data:	Clinical Significance:
P - 110 RR - 24 BP - 98/60 O2 - 88% on 4L 6/10 pain Temp - 100.2	- ↓ BP / ↑ HR - could indicate hypovolemia - ↑ HR could also be due to pts 6/10 pain, but BP is soft - 88% on 4L/NC - the decrease in SpO_2 could be due to surgery, but pt could also be getting a fever. Temp was 100.2. Both cause an increase in O_2 demand. A low-grade temp can be normal after surgery as well - ↑ RR could be due to the ↑ in O_2 demand stated above - 6/10 pain means pts pain is not controlled * These VS could easily be due to pain, but we also want to closely monitor pts VS trends to prevent/catch a post-surgical infection (SEPSIS)

Current Assessment:	
GENERAL APPEARANCE:	Appears uncomfortable, body tense, frequent grimacing–last used PCA 10 minutes ago
RESP:	Breath sounds clear with equal aeration ant/post but diminished bilaterally, non-labored respiratory effort, occasional moist–nonproductive cough
CARDIAC:	Pale-pink, warm and dry, no edema, heart sounds regular–S1S2, pulses strong, equal with palpation at radial/pedal/post-tibial landmarks ✓ GOOD
NEURO:	Alert and oriented to person, place, time, and situation (x4) ✓GOOD
GI:	Abdomen soft/non-tender, bowel sounds hypoactive and audible per auscultation in all 4 quadrants, c/o nausea
GU:	Foley catheter secured, urine clear/yellow, 100 mL the past two hours
SKIN:	Skin integrity intact, skin turgor elastic, no tenting, dressing in place with no drainage noted

What assessment data are RELEVANT and must be recognized as clinically significant by the nurse?

RELEVANT Assessment Data:	Clinical Significance:
"uncomfortable" "grimacing"	- Pt's pain is not being controlled by PCA pump
- Diminished breath sounds	- Expected ẗ COPD pt, BUT - post-op we're worried about PNE d/t decreased movement
- Hypoactive bowel sounds	- Expected post-op d/t paralytics - monitor, ↑ movement as tolerated, ↑ fluid as tolerated
- 100mL urine past two hours	- pt is hydrated ẗ Good renal function
- Nausea	- nausea is common post-op, but should be tx to make pt more comfortable

Developing Nurse Thinking through APPLICATION of the Sciences

Fluid & Electrolytes/Lab/diagnostic Results:

Complete Blood Count (CBC):	Current:	High/Low/WNL?	Prior:
WBC (4.5–11.0 mm 3)	11.8	HIGH	7.2
Hgb (12–16 g/dL)	10.4	LOW	15.2
Platelets (150–450 x10^3/µl)	220	WNL	258
Neutrophil % (42–72)	85	HIGH	68
Band forms (3–5%)	1	LOW	1

What lab results are RELEVANT and must be recognized as clinically significant by the nurse?

RELEVANT Lab(s):	Clinical Significance:	TREND: Improve/Worsening/Stable:
Hgb of 10.4	- Low Hgb could be d/t pts blood loss during surgery - ↓ O_2 being carried in blood	Hgb: WORSENING
WBC of 11.8	- ↑ WBC/Neutrophils could be early signs of infection but are also seen in post-op pts	WBC/Neutro: WORSENING
Neutrophil % 85		Platelets: Worsening but stable
Platelets 220	- WNL, but downhill trend	

Basic Metabolic Panel (BMP):	Current:	High/Low/WNL?	Prior:
Sodium (135–145 mEq/L)	134	LOW	136
Potassium (3.5–5.0 mEq/L)	3.8	WNL	3.9
Glucose (70–110 mg/dL)	148	HIGH	98
BUN (7–25 mg/dl)	20	WNL	22
Creatinine (0.6–1.2 mg/dL)	0.9	WNL	1.1

What lab results are RELEVANT and must be recognized as clinically significant by the nurse?

RELEVANT Lab(s):	Clinical Significance:	TREND: Improve/Worsening/Stable:
Na+ 134 Glucose 148 BUN/Creatinine WNL	LOW - monitor for neurological changes HIGH - elevated glucose is common c post-op pts or pts who are sick/stressed, but pt is at ↑ risk for delayed healing & infection BUN/creatinine WNL, but downhill trend	Kt: worsening BG: worsening BUN/creatinine: worsening but stable

Lab Planning–Creating a Plan of Care with a PRIORITY Lab:

Lab:	Normal Value:	Why Relevant?	Nursing Assessments/Interventions Required:
Hemoglobin Value: 10.4	12-16 Critical Value: <7.0	Hgb is what carries O2 in our blood; wounds need O2 to heal. ↓ Hgb could be due to acute blood loss during surgery	pt may require blood transfusion to increase Hgb - monitoring VS regularly/frequently - monitoring resp/cardiac status

Pharmacology:

Home Med:	Classification:	Mechanism of Action (in own words):	Nursing Considerations:
Atenolol	Beta Blocker	↓ cardiac output, ↓ HR/BP	- monitor BP/HR - Hold if apical pulse < 60 - monitor blood glucose
Lisinopril	ACE inhibitor	- inhibits peripheral vasoconstriction	- monitor BP - PT SAFETY!! (orthostatic hypotn) - monitor for s/s of angioedema
Citalopram	SSRI	↑ levels of seratonin in the brain	- ↑ risk of SI - monitor for s/s of seratonin sx - pt safety! may cause dizziness
Hydrocodone/ acetaminophen	opiod agonist c nonopiod analgesic	↓ pain	Risk of resp depression - monitor resp status
Aspirin	antiplatelet	↓ coagulation, ↓ risk of clotting	Fall precautions - pt at risk for bleeding

Pathophysiology:

1. What is the primary problem that your patient is most likely presenting?

acute pain post op

2. What is the underlying cause/pathophysiology of this primary problem?

- pain from spinal fusion surgery

Developing Nurse Thinking by Identifying Clinical RELATIONSHIPS

1. What is the RELATIONSHIP of the past medical history and current medications?
(Which medication treats which condition? Draw lines to connect)

Past Medical History (PMH):	Home Meds:
• Low back pain with lumbar compression fracture	Atenolol 50 mg daily
• Depression	Citalopram 40 mg daily
• COPD	Acetaminophen/hydrocodone 1-2 tabs every 4 hours prn pain
• Hypertension	Lisinopril 40 mg daily
• 2 ppd smoker x 32 years	Aspirin 81 mg daily

*2. Is there a **RELATIONSHIP** between any disease in PMH that may have contributed to the development of the current problem? (Which disease likely developed FIRST then began a "domino effect"?)*

PMH:	What Came FIRST:
• Low back pain with lumbar compression fracture • Depression • COPD • Hypertension • 2 ppd smoker x 32 years	2 ppd smoker x 32yrs **What Then Followed:** COPD, HTN, low back pain c compression fx, then depression

*3. What is the **RELATIONSHIP** between the primary care provider's orders and primary problem?*

Care Provider Orders:	How it Will Resolve Primary Problem/Nursing Priority:
Hydromorphone PCA–Settings: *Bolus: 0.1–0.3 mg every 10" *Continuous: 0.1–0.3 mg *Max every 4 hours: 6 mg	Help control pain
Continuous pulse oximetry	monitors resp status since major SE of med is resp depression
Ondansetron 4 mg IV push every 4 hours prn nausea	Helps ↓ pt's nausea
Titrate O2 to keep sat >90%	maintains SpO_2 to ↑ O2/perfusion in the body
Incentive spirometer (IS) 5–10x every hour while awake	prevent post-op resp complications, but may be contraindicated in COPD pt d/t air-trapping

0.9% NS 100 mL/hour IV	Help ↻ hydration / electrolytes
Clear liquids/advance diet as tolerated	prevents dehydration, helps ↻ peristalsis
Apply lumbar orthotic brace when up in chair or ambulating	will help client ↻ stability + ↑ pain ↻ movement
Basic Metabolic Panel (BMP) in morning	monitoring electrolytes, esp. since pt's Nat was low
Complete Blood Count (CBC) in morning	monitors H&Ht and WBC

Developing Nurse Thinking by Identifying Clinical PRIORITIES

***1.* Which Orders Do You Implement First and Why?**

Care Provider Orders:	Order of Priority:	Rationale:
1. Hydromorphone PCA	4	Airway, breathing, circulation are most important. It's also important to keep our pt comfortable to decrease stress & promote healing
2. Continuous pulse oximetry	2	
3. Ondansetron (Zofran) 4 mg IV push every 4 hours prn nausea	5	
4. Titrate O2 to keep sat >90%	1	
5. Incentive spirometer (IS)	3	
6. Apply lumbar orthotic brace when up in chair or ambulating	6	
7. Clear liquids/advance diet as tolerated	7	

2. What nursing priority(ies) will guide your plan of care? *(if more than one-list in order of PRIORITY)*

airway, pt SAFETY, infection risk, pt comfort / healing after surgery

3. What interventions will you initiate based on this priority?

Nursing Priority:	Nursing Interventions:	Rationale:	Expected Outcome:
Airway	- O2, monitoring RR, SpO2, IS, encourage TCDB	Keeping airway patent is PRIORITY	↓ risk of PNE, ↑ perfusion
Safety	- Bed alarm, non-slip socks, walker, call light within reach, assistance ↻ walking	Preventing falls to keep pt safe, esp. post-op & meds	pt won't fall ☺ ↓ risk of bleed / fx
Infection	- keep surgical site clean / dry, washing hands, monitor nutrition status	- infection puts pt at risk for delayed healing, sepsis & death	pt will not get post-op infection ☺ & she'll go home
Comfort / healing + pain	- provide pillows for support, calming music, ↓ pt stress	- By ↓ our patient's stress, she'll have better outcome	- pt will heal well after surgery!

4. *What are the PRIORITY psychosocial needs that this patient and/or family likely have that will need to be addressed?*

PAIN, anxiety/fear, limitations in daily living

5. *How can the nurse address these psychosocial needs?*

-Treat pain

- Talk to pt about anxiety/ fears - inform pt every step of the way

- Assist c ADLs, utilize PT

6. *What educational/discharge PRIORITIES will be needed to develop a teaching plan for this patient and/or family?*

- Teaching pt about proper diet, moving as tolerated, STOP SMOKING

- will need assistance from case mgmt to set up pt c home assistance

Caring & the "Art" of Nursing

1. *What is the patient likely experiencing/feeling right now in this situation?*

- Pt is likely anxious about functioning after surgery

- She may also feel depressed about being alone during this difficult time

2. *What can I do to engage myself with this patient's experience, and show that he/she matters to me as a person?*

ASK the pt how she's feeling & LISTEN to her fears/anxiety

Use Reflection to THINK Like a Nurse

Reflection-IN-action (Tanner, 2006) is the nurse's ability to accurately interpret the patient's response to an intervention in the moment as the events are unfolding to make a correct clinical judgment and transfer what is learned to improve nurse thinking and patient care in the future.

1. *What did I learn from this scenario?*

- It's very important to monitor trends in VS/Lab values

- Pain has a big impact on our entire body

2. *How can I use what has been learned from this scenario to improve patient care in the future?*

- By monitoring VS/Lab trends closely, I can help prevent infection/Sepsis

- Tx pain before it gets out of control to promote healing, reduce risk of infection

Post-op Pain Management: Cardiac Arrest *(2/2)

Sheila Dalton, 52 years old

Primary Concept
Perfusion
Interrelated Concepts (In order of emphasis)
1. Gas Exchange 2. Acid-Base Balance 3. Fluid and Electrolyte Balance 4. Clinical Judgment 5. Patient Education 6. Communication 7. Collaboration

UNFOLDING Reasoning Case Study: STUDENT

Post-op Pain Management 2/2: Cardiac Arrest

History of Present Problem:

Sheila Dalton is a 52-year-old woman who has a history of chronic low back pain and COPD. She had a posterior spinal fusion of L4-S1 earlier today. Her pain is currently controlled at 2/10 and increases with movement. She was started on a hydromorphone patient-controlled analgesia (PCA) with IV bolus dose that is 0.2 mg and continuous rate of 0.2 mg/hour.

The nurse reported that her nausea has improved after receiving ondansetron IV four hours ago. She was having increased pain despite using the PCA every 10 minutes. Her pain has decreased from 6/10 to 2/10 since the PCA bolus was increased from 0.1 mg to 0.2 mg of hydromorphone IV one hour ago.

Current VS:
T: 99.8 F/37.7 C (oral)
P: 78
R: 12
BP: 92/48
O2 sat: 89% room air 4 liters n/c

What data from the history is RELEVANT and has clinical significance to the nurse?

RELEVANT Data from History:	Clinical Significance:
Receiving hydromorphone at 0.2mg (up from 0.1mg) via PCA	Risk for resp. depression, and resp arrest if given too much - monitor resp status

Your shift continues…

Thirty minutes later she is feeling more nauseated, and you administer ondansetron 4 mg IV push prn. Five minutes later she puts the call light on again. You are not able to respond immediately because you are helping your other patient get on the commode. Little do you know that Sheila is going to depend on your ability to THINK LIKE A NURSE and clinically reason to save her life. When you arrive in her room you observe the following…

Patient Care Begins:

Current Assessment:	
GENERAL APPEARANCE:	Lethargic, unresponsive, ashen pale in color
RESP:	Minimal spontaneous respiratory effort present. When you arrive at the bedside you observe that her mouth is full of liquid emesis with chunks of undigested food that is drooling out the side of her mouth
CARDIAC:	Unable to palpate radial pulse, you go straight to the carotid pulse on the neck and note a weak pulse with 2 palpable beats in 5 seconds. Calculate pulse rate: 24 /minute
NEURO:	Unresponsive, does not arouse or awaken to vigorous physical stimuli
GI:	Not assessed
GU:	Not assessed
SKIN:	Not assessed

What assessment data is RELEVANT and must be recognized as clinically significant by the nurse?

RELEVANT Assessment Data:	Clinical Significance:
-Lethargic/unresponsive, pale -minimal/spontaneous resp -Liquid emesis & chunks in mouth -PR ~24 BPM	*Medical emergency - not neurologically intact *OBSTRUCTED AIRWAY *minimal cardiac output

Current VS:
T: not assessed
P: 24
R: 4
BP: 72/40
O2 sat: 76% 4 liters n/c

What VS data is RELEVANT and must be recognized as clinically significant by the nurse?

RELEVANT VS Data:	Clinical Significance:
RR 4; 76% 4L HR 24 BP 72/40	- Resp depression - ↓ Cardiac output

Clinical Reasoning Begins…

1. *What is the primary problem that your patient is most likely presenting with?*

   - Resp arrest

2. *What is the underlying cause/pathophysiology of the primary problem?*

   Resp depression/arrest 2° opiod overdose

3. *What nursing priority(ies) will guide your plan of care? (if more than one-list in order of PRIORITY)*

   AIRWAY
   BREATHING
   CIRCULATION

4. *What interventions will you initiate based on this priority?*

Nursing Interventions:	Rationale:	Expected Outcome:
* call rapid response	- pt is going into respiratory arrest - need to initiate code / ACLS protocol	Advanced measures used to save pt's life

5. *What body system(s) will you most thoroughly assess based on the primary/priority concern?*

Resp. / cardiac

6. *What is the worst possible/most likely complication to anticipate?*

cardiac arrest / death

7. *What nursing assessments will identify this complication EARLY if it develops?*

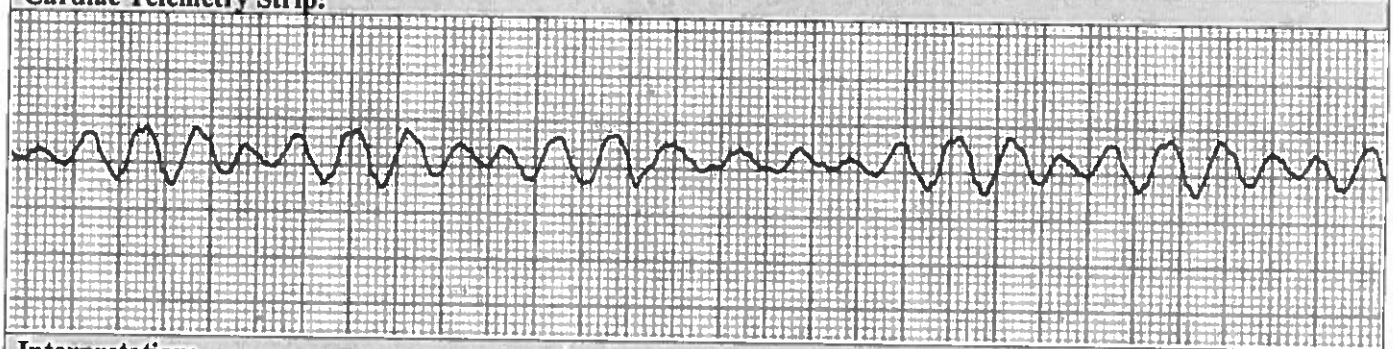
cardiac

8. *What nursing interventions will you initiate if this complication develops?*

ACLS protocol

A crash cart is brought into the room, and the patient is placed on the cardiac monitor/defibrillator. The following rhythm is displayed:

Cardiac Telemetry Strip:



Interpretation:

V-fib

Clinical Significance:

Arrythmia - no cardiac output

Medical Management: Rationale for Treatment & Expected Outcomes

I recognize that most students/new nurses have not had ACLS training or exposure to this certification in nursing school. It is important for the new nurse to understand the most common ACLS algorithms as it is relevant to clinical practice. If and when ACLS certification as a registered nurse is taken, this case study will have provided practice of this essential skill! Please recognize that doing this case study does not qualify for ACLS interventions in practice! You must be officially certified to actually intervene with these measures in a code.

Nurses who are BLS certified can have an active part in the code such as chest compressions; pulse check; bag ventilation; and vital sign checks. Nurses should feel that they can work within their scope and certification. So many times, nurses who are not ACLS certified will not even do those things that are taught in the BLS certification course.

But there is a place for a nurse who is not ACLS certified during a code that is an important role...the RECORDER. Every crash cart has a simple 1-2 page form that documents the code and is self-explanatory. Though this role should ultimately be done by a certified ACLS nurse when one arrives, until then begin documentation and remain present in the room so that you as the primary nurse can communicate to the code team and physician the patient's story and what led up to the code. ***Once the code team arrives, the role of the primary nurse is to contact physician, family, and pastoral care to update on patient status and assist with care.***

Care Provider Orders:	Rationale:	Expected Outcome:
ACLS Priorities: High-quality CPR Defibrillation Medications (Epinephrine)	↑ cardiac output, maintain airway, ↑ Resp Put heart back into normal rhythm Get the ♡ pumping again, get back into normal rhythm	Blood /O2 will be perfused to body Heart back into normal rhythm Heart will beat on its own in normal rhythm

Medication Dosage Calculation:

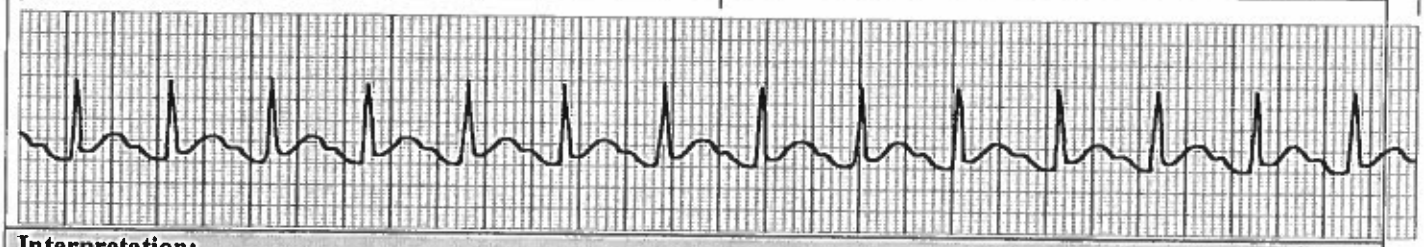
Medication/Dose:	Mechanism of Action:	Volume/time frame to Safely Administer:	Nursing Assessment/Considerations:
Epinephrine 1:10,000 1 mg/10 mL IV/IO every 3-5" push	Stimulate adrenaline output	10 mL syringe IV Push: Volume every 15 sec? 2.5mL	Cardiac assessment / O2 Sat

Medication/Dose:	Mechanism of Action:	Volume/time frame to Safely Administer:	Nursing Assessment/Considerations:
Amiodarone 300 mg IV push 150 mg/3 mL vial	Helps ♡ arrhythmias	IV Push: Volume every 15 sec? 1.5mL	Monitor EKG -HR -rhythm

TEN minutes post-arrest:

After two doses of epinephrine and amiodarone bolus and the third defibrillatory unsynchronized shock at 360 joules, the following rhythm is present on the monitor:

Cardiac Telemetry Strip:



Interpretation:

Sinus tach

Clinical Significance:

Heart in normal rhythm, but beating too fast could lead to clot → Stroke MI HF

Nursing Priority Intervention:

Continuosly monitor cardiac/resp status

The in-house physician running the code orders a stat ABG right after she is successfully resuscitated and is now intubated. You obtain the following results:

Arterial Blood Gases:	Current:	High/Low/WNL?
pH (7.35–7.45)	7.15	LOW
pO2 (80–100)	64	LOW
pCO2 (35–45)	78	HIGH
HCO3 (18–26)	22	WNL
O2 sats (>92%)	90%	LOW
Oxygen delivery	100%	HIGH

What lab results are RELEVANT and must be recognized as clinically significant by the nurse?

RELEVANT Lab(s):	Clinical Significance:
pH, CO_2, HCO_3	Pt is in Resp. Acidosis c NO compensation
O_2 Sat >	Want >92%, ↓ O_2 perfusion

Lab Planning: Creating a Plan of Care with a PRIORITY Lab:

Lab:	Normal Value:	Why Relevant?	Nursing Assessments/Interventions Required:
pH Value: 7.15	7.35-7.45 Critical Value: < 7.20 or > 7.65	Indicative of resp acidosis/failure	1. Respiratory Assessment -monitoring kidney fxn as well

Evaluation: ONE minute post-resuscitation:

After determining that her current rhythm also has a pulse, you collect the following assessment data:

Current VS:
T: 99.1 F/37.3 C (oral)
P: 128 (regular)
R: ambu bag rate of 20/minute (physician ordered increased rate)
BP: 128/88
O2 sat: 92% 100% O2

Current Assessment:	
GENERAL APPEARANCE:	Resting comfortably, appears in no acute distress
RESP:	Color slightly improved. Is pale/pink, coarse crackles/rhonchi scattered in both lung fields even after suctioning. No spontaneous resp. effort. Requires ambu bagging
CARDIAC:	Pulses 2+ throughout. Strong femoral pulse. No edema in extremities. Heart rate regular–S1S2.
NEURO:	Remains unresponsive. Responds to pain stimuli by bringing both hands toward the source of pain
GI:	Abdomen soft, non-tender with active bowel sounds
GU:	Foley placed, 30 mL clear, yellow urine present in bag
SKIN:	Surgical incision intact, no redness, drainage, or dehiscence present

1. *What clinical data is RELEVANT that must be recognized as clinically significant?*

RELEVANT VS Data:	Clinical Significance:
P 128 BP 128/88	- improved cardiac output
RR 20 via BVM	- pt requires support to breathe, not breathing on her own
RELEVANT Assessment Data:	**Clinical Significance:**
- coarse crackles/rhonchi	- Fluid in lungs; likely aspirated vomit
- Responds to painful stimuli	- improved neurological function
- 30mL of urine	- good kidney function = good cardiac output
- pulses 2+	- Strong pulses means ♡ is beating well

2. *Has the status improved or not as expected to this point?*

Improved

3. *Does your nursing priority or plan of care need to be modified in any way after this evaluation assessment?*

Pt needs to be transferred to higher level of care

4. *Based on your current evaluation, what are your nursing priorities and plan of care?*

Nursing priority would be maintaining airway/breathing/circulation

Think ABC's…

A: AIRWAY–Maintain placement and integrity of endotracheal tube

B: BREATHING–Impaired gas exchange

C: CIRCULATION–Maintain adequate blood pressure and stable cardiac rhythm (impaired tissue perfusion)

TEN minutes post-resuscitation:

Medical Management: Rationale for Treatment & Expected Outcomes:

Care Provider Orders:	Rationale:	Expected Outcome:
ACLS Priorities: maintaining airway	Keep O2 circulating, keep pt breathing	↑ Respirations & good O2 sat (SpO2 92-98%)
maintaining hemodynamic parameters	maintaining good cardiac output will decrease risk of tissue damage/death	↑ perfusion to the rest of the body

Medication/Dose:	Mechanism of Action:	Volume/time frame to Safely Administer:	Nursing Assessment/Considerations:
Nalaxone 0.02 mg IV push every 2 minutes 0.4 mg maximum dose	- Reverses/ blocks effects of opioids	10mL **IV Push:** **Volume every 15 sec?** 2.5mL	- monitor Resp. Status, cardiac Status, neurological status

The room is now ready and it is now time to transfer to ICU. Effective and concise handoffs are essential to excellent care and if not done well can adversely impact the care of this patient. You have done an excellent job to this point, now finish strong and give the following SBAR report to the nurse who will be caring for this patient:

Situation:

Name/age:
Sheila Dalton 52y/F

BRIEF summary of primary problem:
Pt admitted for posterior spinal fusion of L4/S1 earlier today.

Day of admission/post-op #: Day ①

Background:

RELEVANT past medical history:
Hx of chronic lower back pain sp lumbar compression fx, Hx of COPD

Assessment:

Most recent vital signs:
T: 99.1°F R: BVM rate 20
HR: 128 O_2: 92% 100% O_2
BP: 128/88

RELEVANT body system nursing assessment data:
Resp - course crackles/rhonchi throughout, no spontaneous resp effort
Cardiac - 2+ pulses throught, sinus tach on the monitor
Neuro - responsive to painful stimuli

RELEVANT lab values:
ABG:
pH - 7.15
pCO_2 - 78
HCO_3 - 22

INTERPRETATION of current clinical status (stable/unstable/worsening):
Pt is Stable

Recommendation:

Suggestions to advance plan of care:
Pt needs higher level of care

TWENTY minutes post-resuscitation:

Radiology Reports: Portable Chest X-ray

What diagnostic results are RELEVANT and must be recognized as clinically significant by the nurse?

RELEVANT Results:	Clinical Significance:
Tip of ET tube 1 cm above the carina. Heart size normal.	ET tube in correct place & not the stomach

Arterial Blood Gases:	Current:	High/Low/WNL?	Prior:
pH (7.35–7.45)	7.29	LOW	7.15
pO2 (80–100)	102	HIGH	64
pCO2 (35–45)	48	HIGH	78
HCO3 (18–26)	23	WNL	22
O2 sats (>92%)	100%	WNL	90%
Oxygen delivery	100%	HIGH	100%

What lab results are RELEVANT and must be recognized as clinically significant by the nurse?

RELEVANT Lab(s):	Clinical Significance:	TREND: Improve/Worsening/Stable:
pH - 7.29 pCO_2 - 48 HCO_3 - 23	Pt still in respiratory acidosis c no compensation	Improving

Complete Blood Count (CBC):	Current:	High/Low/WNL?	Prior:
WBC (4.5–11.0 mm 3)	8.9	WNL	7.8
Hgb (12–16 g/dL)	10.2	LOW	11.8
Platelets (150-450 x10³/µl)	148	LOW	155
Neutrophil % (42–72)	85	HIGH	81

What lab results are RELEVANT and must be recognized as clinically significant by the nurse?

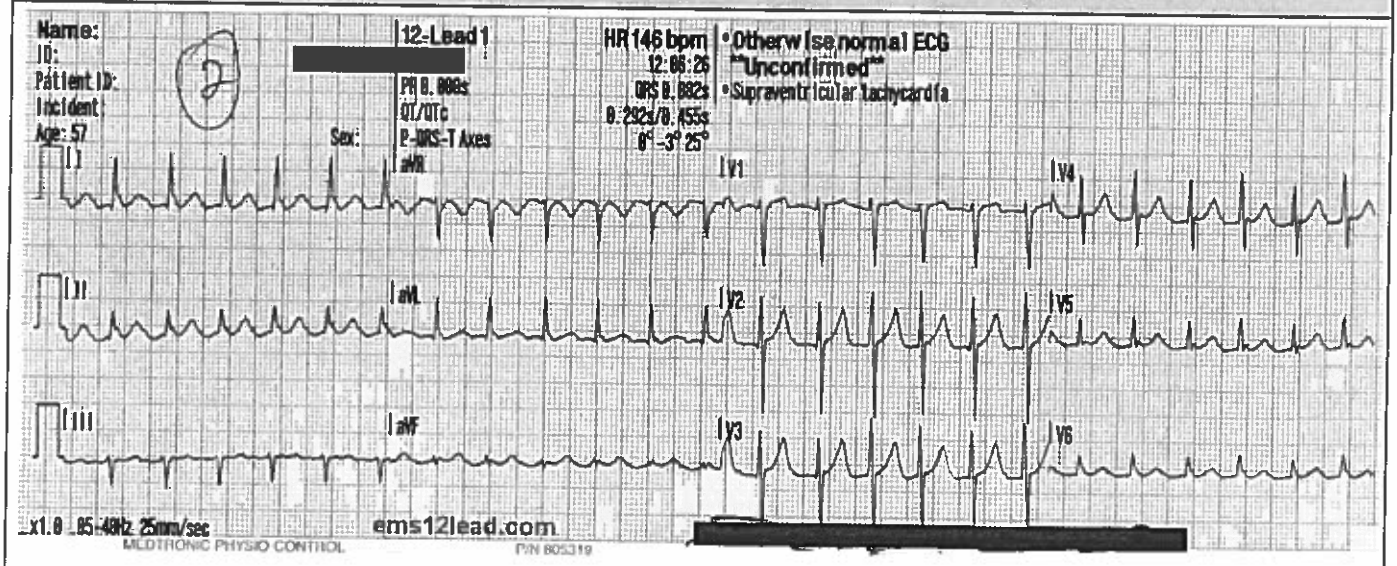
RELEVANT Lab(s):	Clinical Significance:	TREND: Improve/Worsening/Stable:
Hgb Platelets	- Risk for bleeding - Pt not perfusing O2 due to low Hgb	Worsening for both

Basic Metabolic Panel (BMP):	Current:	High/Low/WNL?	Prior:
Sodium (135–145 mEq/L)	138	WNL	140
Potassium (3.5–5.0 mEq/L)	4.1	WNL	3.8
CO2 (Bicarb) (21–31 mmol/L)	20	LOW	22
Glucose (70–110 mg/dL)	152	HIGH	122
Creatinine (0.6–1.2 mg/dL)	1.7	HIGH	1.1
Misc:			
Lactate (<2.6)	4.9	HIGH	N/a

What lab results are RELEVANT and must be recognized as clinically significant by the nurse?

RELEVANT Lab(s):	Clinical Significance:	TREND: Improve/Worsening/Stable:
HCO_3 - 20 Creatinine	> impaired kidney function	- Worsening
Glucose - 158	- Due to infection/illness	- Worsening
Lactate 4.9	- could be from impaired tissue oxygenation	- Worsening

12 Lead EKG:



Interpretation:

SVT

Clinical Significance:

dysrhythmia - may weaken the heart, lead to heart failure, or stroke

Education Priorities/Discharge Planning

1. *What will be the most important discharge/education priorities you will reinforce with their medical condition to prevent future readmission with the same problem?*

   - Be cautions of respiratory depression & overdose when taking opiods

2. *What are some practical ways you as the nurse can assess the effectiveness of your teaching with this patient?*

   * Ask them to teach it back to me

Caring and the "Art" of Nursing

1. *What is the patient and FAMILY likely experiencing/feeling right now in this situation?*

Well, the pt has no family, but if she did they'd likely be experiencing a lot of anxiety

2. *What can you do to engage yourself with this patient's experience and show that he/she matters to you as a person?*

-Ask the pt/family why they're anxious, listen to them and educate them about pt's condition as much as possible.

Use Reflection to THINK Like a Nurse

Reflection-IN-action (Tanner, 2006) is the nurse's ability to accurately interpret the patient's response to an intervention in the moment as the events are unfolding to make a correct clinical judgment and transfer what is learned to improve nurse thinking and patient care in the future.

1. *What did I learn from this scenario?*

I learned about heart rhythms and a little about ACLS

2. *What would I do differently (if applicable) in this situation to prevent this outcome?*

* monitor pts closely who are taking opiods
* Ask for assistance, delegate to ULP as much as I can

3. *How can I use what has been learned from this situation to improve patient care in the future?*

* I now understand just how quickly a pt's condition can decline and I will monitor my pts more closely