

Value Improvement Project Form

Project Title: In Mint Condition

Team Leader: Lillian Russo

Project Approval Date: 10/6/2021

UD/CNS/Signature/date: _____

Date Initiated: 11/11/2021

Date Completed: 1/10/2022

EHC Strategic Plan Initiatives: **Clinical Quality, Patient and Family Experience, Commitment to Those Who Serve, Discovery & Innovation, Financial Strength or Nursing Quality Index**

Identify the associated Strategic Initiative or Readiness Index of your project

Follow the guidelines below to organize your project. The length and creativity of the project are unlimited. Please feel free to use the VIP Step-by-Step Guide as needed.

Purpose/Problem/Value and Background:

New graduate nurses (NGN) on Unit 6E at Emory University Hospital (EUH) lack the confidence and knowledge to handle acute changes in patient conditions after they have completed orientation and are working on their own. Currently on 6E, NGNs have posed questions regarding clinically deteriorating patient situations, asking, “What if I freeze up? What if I don’t know what to do? What if what I do is wrong and I make it worse? What if I could have prevented this?” This oversight in new nurses’ concerns allows the opportunity for delayed provider contact and hesitation in Code Medical Emergency Team (MET) activation by nurses (Granitto et al., 2020). A Code MET is an initiation to the entire hospital system that there is need for clinicians trained in critical care to assist and “treat patients who exhibit warning signs of deterioration or instability outside of the ICU”. This team works with the floor nurses to provide support and resources during emergency medical situations (Emory Healthcare, 2012). Additionally, early assessment, acknowledgement and intervention of worsening patient conditions can prevent the progression into a Code Blue situation. On average, patients show signs of worsening critical situations 6.5 hours between their previous health baseline to the start of a code event (Tilley & Spencer, 2020). Increased education on the early physiological signs of deteriorating patient situations and focused review of existing Emory protocols during orientation can promote more nurse-driven intervention during acute clinical circumstances (Granitto et al., 2020).

Unit 6E at EUH is a Cardiovascular Surgical Step-Down floor. Many of the patients that this unit admits are experiencing heart failure, require in-patient cardiac intervention, or are pre-/post-open-heart surgery. Between February to November of 2021, 6E has initiated 84 Code METs, with an average of 8.4 Code METs called per month. Meaning, there was a minimum of 84 instances where a patient began to clinically deteriorate and required more assistance than the bedside nurse could provide. According to the current orientation plan on 6E, NGNs partake in a total of 52 classes over their 14 to 16 week-long orientation to prepare them for the specific floor. Of these 52 classes, only one of them review Code MET or progressively critical situations, in which they specifically discuss how to document in the Code MET forms and talk through practice scenarios. However, this class does not include discussion of nurse-based interventions for acute circumstances, nor does it identify which interventions are nurse versus provider-driven in critical situations. For these reasons, the educational tool titled “Acute Changes in Patient Condition Reference Sheet” was implemented into NGNs’ orientation plan and included information focusing on situations identified in Emory’s Code MET policy, most witnessed acute cardiac or surgical conditions, and skills needed to initiate and conduct a Code MET on Unit 6E.

Pre-data was collected using a Pre-Review Self-Assessment checklist administered to 6E's NGNs of the Fall 2021 Cohort, Katrina and Jasmine, during their sixth and eighth week of dayshift orientation to the unit, respectively. This self-assessment measured the NGNs' view of their own level of comfort and knowledge for each situation identified in the "Acute Changes in Patient Condition Reference Sheet". For each acute condition, the new nurses assessed themselves on their ability to define critical ranges, identify symptoms, locate and collect supplies to intervene, and verbalize recommendations for treatment. The nurses placed a check mark next to the "Assessment Level" that corresponded best with their initial knowledge and comfort level for each competency. These Assessment Levels were then revisited after the review and education over the "Acute Changes in Patient Condition Reference Sheet" intervention.

Goal Statement(s):

The purpose of this intervention is to increase new graduate nurses' (NGN) knowledge of critically deteriorating patient conditions and their comfort level in responding to sudden changes in patients' clinical situation. The Self-Assessment checklist was taken pre- and post-review of the "Acute Changes in Patient Condition Reference Sheet" and access to the Reference ID Badge. The goal of this intervention was to observe an increase by one or more Assessment Level(s) from Pre- to Post-Review across 50% of the total competencies reviewed in the checklist.

Write your problem or clinical question in PICOT format:

P-Population of interest: New graduate nurses (NGNs) on Unit 6E at EUH, Fall Cohort 2021

I-Intervention/area of interest: Education focused on detecting clinically deteriorating patient conditions and implementing nurse-driven interventions for each condition.

C-Comparison interventions or group: Self-assessment of knowledge pre- and post- education/intervention.

O-Outcome: An increase by one or more Assessment Level(s) for 50% of total competencies reviewed.

T-Time:

- Jasmine: November 11th, 2021 – December 21st, 2021 (end of night shift orientation).
- Katrina: November 11th, 2021 – January 1st, 2022 (possible end of night shift orientation)

Literature/Evidence review; synthesize/summarize findings here (attach reference list).

Reference list attached.

Actions/Intervention(s):

The "Acute Change in Patient Conditions Reference Sheet" is an educational tool that organizes the most common critical situations seen on Unit 6E. This sheet covers the defining ranges that distinguishes a critical situation, as well as the potential symptoms, nurse-driven interventions, and possible treatments to recommend for each clinically deteriorating condition. Additionally, all interventions are color-coded to distinguish which one(s) are within a nurse's scope of practice to implement, and which require a provider order.

The new graduate nurses (NGNs), Katrina and Jasmine, were given a Self-Assessment checklist to measure their level of knowledge and comfort when reacting to each condition mentioned on the Reference Sheet. The Self-Assessment sheet contains two separate checklists, a Pre-Review Self-Assessment and Post-Review Self-Assessment. The Pre-Review checklist was completed by Katrina and Jasmine during their sixth and eighth week of orientation, respectively, before they reviewed the Reference Sheet. This was to measure their initial level of understanding surrounding the information they would soon be educated on. Once the NGNs started on the night shift portion of orientation, they were asked to review the "Acute Changes in Patient Condition Reference Sheet" with their preceptor during their second week of night shift. Lillian Russo, a Nurse Clinician II on 6E, conducted the reviews of the Reference Sheet for both Katrina and Jasmine so that the delivery of the information remained as consistent as possible. Additionally, the NGNs were given Reference ID Badge Reels that contained a summarized version of the information listed in the Reference Sheet. The purpose of the ID Badge Reels was for the NGNs to have quick access to information from the Reference Sheet attached to their person. The educational intervention was not initiated until the nurses began night shift, so they had time prior, during day shift orientation, to become acclimated with the unit, patient population and overwhelming aspect of their new job before adding the additional project to their schedule.

The Post-Review portion of the checklist was completed by the nurses after the Reference Sheet was reviewed, and before they finished their night shift orientation. This Post-Review checklist evaluated the same competencies that

were measured during the Pre-Review checklist, using the same Assessment Level tool. The Post-Review checklist was completed on the NGNs' last week of night shift orientation.

The success of the intervention was measured by comparing the self-designated Assessment Levels of the Pre-Review checklist to the Assessment Levels of the Post-Review checklist for each nurse. The total number of checkmarks in each Assessment Level was tallied pre- and post-review to distinguish if an improvement in over-all knowledge and confidence in acute changes in patient conditions was achieved by the NGNs.

Date	Steps toward Change	Person Responsible	Date Due	Outcome/Evaluation
11/11/21	Both new graduate nurses, Jasmine and Katrina, complete initial Pre-Review portion of Self-Assessment Checklist	Lillian Russo	11/11/21	RNs completed Pre-Review portion of checklist while Lillian was present. RNs did not have access to Reference Sheet or other external education materials while completing Pre-Review. No clarifying questions or comments were stated.
12/15/21 – Jasmine's second week of nightshift orientation	Review "Acute Changes in Patient Condition Reference Sheet" and Reference ID Badge with Jasmine, RN	Lillian Russo	12/18/21 – End of Jasmine's second week of nightshift orientation	Jasmine & Lillian reviewed the "Acute Changes in Patient Condition Reference Sheet" and distributed the Reference ID Badge. Jasmine understood and followed the Reference Sheet well. She asked follow-up and clarifying questions regarding clinical expectations but had no questions regarding the layout or design of the sheet. Review was done during the shift and had few interruptions because her preceptor took over her patients while Jasmine was reviewing education with Lillian.
12/29/21 – Jasmine's first week off orientation	Complete Post-Review portion of Self-Assessment Checklist with Jasmine, RN	Lillian Russo	1/1/22 – End of Jasmine's first week off orientation	Jasmine completed the Post-Review portion on her own without the presence of Lillian. Jasmine did have access to Reference Sheet, Reference ID Badge, and external education materials while completing Post-Review portion. No clarifying questions or comments were stated.
1/16/22 – Katrina's second week of nightshift orientation	Review "Acute Changes in Patient Condition Reference Sheet" and Reference ID Badge with Katrina, RN	Lillian Russo	1/22/22 – End of Katrina's second week of orientation	<i>Results Pending</i>
1/30/22 – Katrina's first week off orientation	Complete Post-Review portion of Self-Assessment Checklist with Katrina, RN	Lillian Russo	2/5/22 – End of Katrina's first week off orientation	<i>Results Pending</i>

Staff Education Materials:

All staff education materials can be found after this paper on pages 7, 8 and 9, including “Acute Changes in Patient Condition Reference Sheet” and Reference ID Badge Reel.

Participants:

- a. Lillian Russo, BSN, RN is a Nurse Clinician I on Unit 6E at EUH and was the sole lead on this value improvement project. Lillian conducted the preliminary research, created the “Acute Changes in Patient Condition Reference Sheet”, Reference ID Badge, and Self-Assessment checklist, educated the new graduate nurses (NGNs) on these education tools, and collected and analyzed the resulting data.
- b. Katrina Lagen, BSN, RN and Jasmine Taylor, BSN, RN are both Nurse Residents/NGNs of Fall Cohort for 2021 on Unit 6E at EUH. Katrina and Jasmine were the participants and test subjects for this intervention.
- c. Helen Seely, BSN, RN, PCCN is the Unit Nurse Educator on Unit 6E, EUH. Helen provided information for pre-data collection regarding NGNs orientation class list and information.
- d. Courtenay Brown, MSN, APRN, CCNS, PCCN is a Clinical Nurse Specialist & Nurse Residency Coordinator within EUH Nursing Administration. Courtenay reviewed the “Acute Changes in Reference Sheet”, Reference ID Badge, and Self-Assessment checklist.
- e. Jennifer Holder, BSN, RN – Interim Unit Director, 6E, Cardiovascular Surgical Services, EUH
- f. Kali Neal, MSN, RN, NE-BC – Previous Unit Director, 6E & Rollins, Cardiovascular Surgical Services, EUH

Outcomes:

Below are the tables and chart showing the outcomes for both the pre- and post-review data from the Self-Assessment Checklist for Jasmine. Unfortunately, the other new graduate nurse, Katrina, that was prepped for this intervention was unable to complete the review due to inability to complete intervention within necessary timeframe. This occurrence is further debriefed in the “Limitations” section of this paper.

There was a total of 48 competencies reviewed in the “Acute Changes in Patient Condition – Self-Assessment Checklist”. *Table 1* shows Jasmine’s initial level of comfortability and preparedness for each competency prior to the review of “Acute Changes in Patient Condition Reference Sheet” and access to the Reference ID Badge. The Pre-Review data resulted in a total of 29 check marks for Assessment Level 1 – “No experience and limited knowledge of competency. Not comfortable reacting to this clinical situation alone”, 19 check marks for Assessment Level 2 – “Acceptable experience and knowledge of competency. Comfortable reacting to this clinical situation with another experienced RN present”, and zero check marks for Assessment Level 3 – “Mastery experience and knowledge of competency. Comfortable reacting to this clinical situation as primary RN.”

Table 2 shows Jasmine’s results from the Post-Review self-assessment, after completing the education with Lillian and being given access to the Reference Sheet and Reference ID Badge. The Post-Review data resulted in a total of zero check marks for Assessment Level 1, 17 check marks for Assessment Level 2, and 31 check marks for Assessment Level 3.

Chart 1 represents a comparison of Jasmine’s Pre- and Post-Review Assessment Levels broken down more specifically by competency area reviewed in the Reference Sheet and ID Badge.

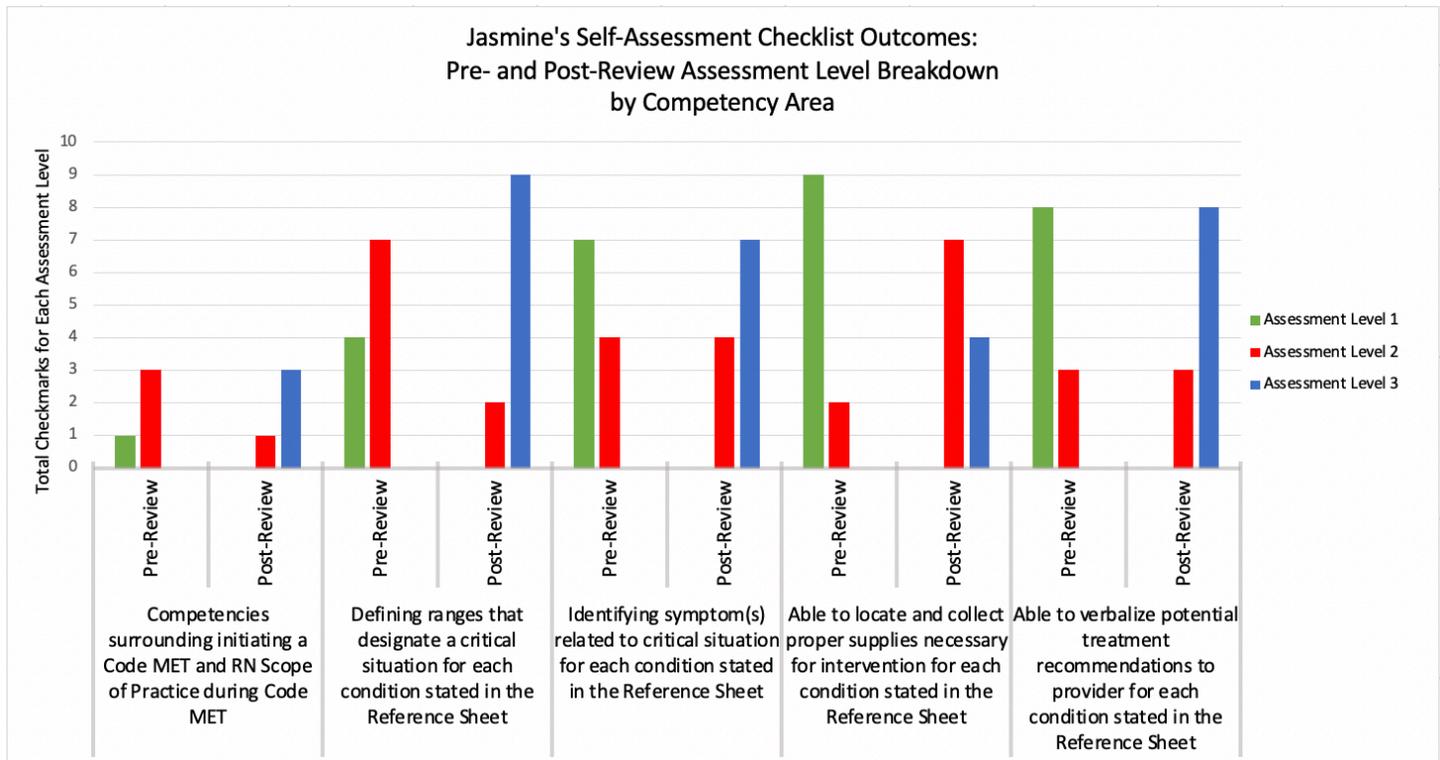
Table 1: Jasmine’s Pre-Review Self-Assessment Totals

Assessment Level	Total Check Marks
Assessment Level 1	29
Assessment Level 2	19
Assessment Level 3	0

Table 2: Jasmine’s Post-Review Self-Assessment Totals

Assessment Level	Total Check Marks
Assessment Level 1	0
Assessment Level 2	17
Assessment Level 3	31

Chart 1:



The original sheet with a detailed listing of the Assessment Levels Jasmine marked for each individual competency can be found after this page, under the sheet titled “Acute Changes in Patient Condition – SELF-ASSESSMENT CHECKLIST”.

As shown in the data provided above and on the following page, Jasmine showed an increase by one or more Assessment Levels from Pre- to Post-Review for 47 out of 48 of the competencies discussed, resulting in a 97.9% improvement. This result exceeds the original goal of an increase by one or more Assessment Levels from Pre- to Post-Review for 50% of the competencies listed. The only competency that did not show an improvement by one or more Assessment Levels was “Able to verbalize potential treatment recommendations to provider for: Narcotic Overdose” and is highlighted on the following page.

Limitations:

Limitations of this value improvement project include the inability to control how new graduate nurses (NGNs) will evolve through their orientation on the unit and the time it will take for them to complete the necessary steps to progress towards night shift orientation. One of the NGNs included in the pre-data collection for this project was unable to complete the post-data information because her day shift orientation was extended longer than that of her peer. Another limitation was the inability to measure any external education and experiences of critical conditions during the implementation phase of the project for each NGN. This could allow for a skew in self-assessment of knowledge and comfortability for each competency that is unable to be distinguished as a result from review of the Reference Sheet or the external information experienced.

Summary Statement:

The purpose of this project was to assess the growth in knowledge and comfort level of new graduate nurses’ (NGNs) on the topics of acute changes in patient conditions most commonly experienced on Unit 6E at Emory University Hospital (EUH). Education tools were developed, including the “Acute Changes in Patient Condition Reference Sheet” and Reference ID Badge to improve the knowledge of these situations, and were reviewed with the NGNs by the creator of the tools. The growth in knowledge pre- and post-review of the education materials was measured through a Self-Assessment Checklist that required the NGNs to assess their own level of understanding for each competency covered in the Reference Sheet.

Of the two NGNs that started the intervention, Jasmine, RN was the only one able to complete the Post-Review Checklist within the designated timeframe for the project. The goal of the intervention was to show an increase in one or more Assessment Level(s) from Pre- to Post-Review of the Reference Sheet for 50% of total competencies reviewed. Results showed an increase of one or more Assessment Levels in 97.9% of total competencies. Meaning, in 47 of the 48 skills reviewed in the “Acute Changes in Patient Condition Reference Sheet”, the NGN had only one competency that they viewed did not improve as a result of reviewing the educational tools.

These results show great potential success for educating future NGNs on Unit 6E in critical changes in the conditions of their patients and improved sense of support when facing an acute clinical situation. In the future, this education material and quantitative measurement tool will be re-evaluated and revised for the next cohort of NGNs on 6E. The plan is to alter the time in which the education material is introduced by incorporating the “Acute Changes in Patient Condition Reference Sheet” and Self-Review Checklist into the pre-existing orientation classes taken by the NGNs. This way, time is not taken away from the NGNs to educate while they are working on the floor and is instead allotted during established class time. This will prevent NGNs from getting distracted while learning the new information and will ensure that they are all educated in the same manner and at the same time, so no one is missing the valuable information. Additionally, the Self-Assessment Checklist will be added to the pre-existing orientation checklists of all NGNs on Unit 6E. Eventually, all current staff nurses and preceptors of NGNs will be trained on this Reference Sheet and educated on how to review the information with future preceptees so that the information remains consistent for each NGN and staff nurses.

Name _____
Unit _____
Contact Phone Number _____
Email Address _____
Date _____

ACUTE CHANGES IN PATIENT CONDITION REFERENCE SHEET

*CALL A CODE MET AT ANY TIME (**2-1777**)

*ALWAYS get another set of vitals & assess for symptoms *first*.

*ALWAYS check patient Medication/PRN list.

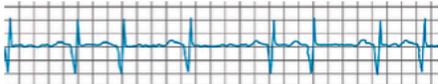
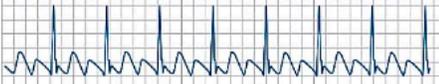
Key:

■ = does NOT require provider order, within RN scope

■ = REQUIRES provider order

Bradycardia:	- Acute Δ in HR <50 bpm or HR \downarrow by 20 bpm.	Tachycardia:	- Acute Δ in HR >150 bpm, or any HR >160 bpm.
Symptom(s): <ul style="list-style-type: none"> • Syncope • Dizziness • Fatigue • SOB • Confusion 	Intervention/Treatment(s) <ol style="list-style-type: none"> 1. Admin 2-4L O₂ NC (1-2L O₂ if COPD) 2. Stat ECG 3. Labs: CMP, CBC w/ Diff 4. Give: <ol style="list-style-type: none"> a. Atropine 0.5mg IV b. Repeat x1 q5 min if S/Sx: <ol style="list-style-type: none"> 1) SBP <80 2) Dizzy 3) Diaphoretic 4) Altered mental status 	Symptom(s): <ul style="list-style-type: none"> • Palpitations • SOB • Syncope • CP/tightness • Fever 	Intervention/Treatment(s): <ol style="list-style-type: none"> 1. Admin 2-4L O₂ NC (1-2L if COPD) 2. Check BG 3. Stat ECG 4. Labs: BMP, MG, CBC w/ Diff, Type & Cross 5. Give: <ol style="list-style-type: none"> a. BBs – Metoprolol IV b. CCBs c. Amiodarone (depending on ECG)
Hypotension:	- Acute Δ in SBP <80, or MAP <60.	Hypertension/ Hypertensive Crisis:	- SBP>150 or DBP >120, MAP >110
Symptom(s): <ul style="list-style-type: none"> • Dizziness • Confusion • Nausea • Palpitations/ CP • \downarrow UOP 	Intervention/Treatment(s) <ol style="list-style-type: none"> 1. Elevate feet in bed (<i>not</i> Trendelenburg) 2. Admin 2-4L O₂ NC (1-2L O₂ if COPD) 3. Labs: CMP, Mg, CBC w/ Diff, PT/INR, Type & Cross 4. Give: <ol style="list-style-type: none"> a. IV NS 0.9% 500mL bolus OR b. Colloids (Albumin for HF pts) / Crystalloids 5. *Code MET RN* \rightarrow assess for Septic Shock: <ol style="list-style-type: none"> a. Hypotension b. Tachycardia c. Respiratory Distress 	Symptom(s): <ul style="list-style-type: none"> • Headache • Dizziness • CP • Blurred vision • N/V • Seizures • Coma/Stroke 	Intervention/Treatment(s): <ol style="list-style-type: none"> 1. Stat ECG 2. Labs: BMP, CBC w/ Diff, Mg, PT/INR, Troponin 3. Give: <ol style="list-style-type: none"> a. Nitroprusside, NTG b. Labetalol IV, Esmolol c. Hydralazine
Respiratory Distress:	- Acute Δ in RR <10 or >30, or Acute Δ in O ₂ Saturation <92%.	Acute CP/ Heart Attack:	- Any new, worsening, or unexplained chest pain.
Symptom(s): <ul style="list-style-type: none"> • SOB • CP • Coughing • Agonal/ irregular breathing • Use of accessory muscles • Shallow breathing • Wheezing/stridor 	Intervention/Treatment(s) <ol style="list-style-type: none"> 1. Admin 2-4L O₂ NC, until sat >94% 2. Get: Non-rebreather & suction tubing 3. Call: Respiratory Therapy 4. Labs: STAT ABG, CBC w/ Diff 5. If pt has Tracheostomy \rightarrow SUCTION 6. Give: Respiratory Treatment 	Symptom(s): <ul style="list-style-type: none"> • CP, radiating • SOB • Upper body discomfort in 1/both arms • Back, neck, jaw, epigastric pain • N/V • Diaphoretic 	Intervention/Treatment(s): <ol style="list-style-type: none"> 1. CALL A CODE MET 2. Stat ECG, if shows: <ol style="list-style-type: none"> a. "Acute MI/STEMI" \rightarrow Activate "STEMI", call: 2-7107 b. "Unclear or new LBBB" \rightarrow Fax ECG to: 1-1522, Page: 50334, Inform MD of poss. STEMI. c. "No STEMI" \rightarrow refer to provider's orders. 3. Admin O₂ NC if SpO₂ <94% 4. Labs: BMP, Mg, CBC w/ Diff, Troponin 5. Give: <ol style="list-style-type: none"> a. Nitroglycerine (NTG) 0.4mg sublingual. <ol style="list-style-type: none"> 1) Do NOT give if: <ol style="list-style-type: none"> i. SBP <90 ii. HR <50 iii. Taken Viagra OR Milrinone in <24 hrs. b. Pain meds (Ex: Tylenol, Oxycodone, etc.) c. Aspirin (ASA) 325mg chewable

ACUTE CHANGES IN PATIENT CONDITION REFERENCE SHEET

Acute Δ LOC or Agitation:			
Hypoglycemia:	- BG <70	Hyperglycemia:	- BG >250; notify MD if BG >180 with NO orders to treat.
<u>Symptom(s):</u> <ul style="list-style-type: none"> • Shaking • Sweating • Confusion • Blurred Vision 	<u>Intervention/Treatment(s)</u> <ol style="list-style-type: none"> 1. Give (if able to swallow): 15g Carbohydrates → juice, milk, candy, crackers <ol style="list-style-type: none"> a. Recheck BG q15 min. 2. Give (if NPO): Dextrose 50% 25gm IV push <ol style="list-style-type: none"> a. Recheck BG q15 min. b. If BG still <60 → repeat Dextrose 50% 25gm IV 	<u>DKA Symptom(s):</u> <ul style="list-style-type: none"> • ↑UOP • ↑Thirst • ↑Hunger • Blurred vision • Nausea 	<u>Intervention/Treatment(s):</u> <ol style="list-style-type: none"> 1. Order: Urine Analysis (UA) 2. Give: IV NS 0.9% 250 mL
Narcotic Overdose:		- RR <10 or unable to arouse pt. w/ a pulse.	
<u>Symptom(s):</u> <ul style="list-style-type: none"> • Not arousable • ↓O₂ Sat • + Pulse 	<u>Intervention/Treatment(s):</u> <ol style="list-style-type: none"> 1. Admin 2-4L O₂ NC 2. Give: Naloxone (Narcan) 0.4 mg – *DILUTE in 10 mL NS* <ol style="list-style-type: none"> a. Push SLOWLY in 1mL increments <ol style="list-style-type: none"> i. If pt returns to baseline → take VS q15 min x4 b. ONLY give 2nd dose of Narcan with MD order. 		
Atrial Fibrillation (A. Fib.):	<ul style="list-style-type: none"> - "Quivering"/"fibrillating" atria - <u>Rate:</u> rapid <ul style="list-style-type: none"> • AF "Controlled": 60-100 bpm • AF "Rapid": 100-150 bpm • AF "RVR (Rapid Ventricular Response): >150 bpm - <u>Rhythm:</u> irregular - <u>P-Wave:</u> NOT identifiable - <u>QRS:</u> normal (sometimes wide if BBB) - NO ratio of P-Wave : QRS 	Atrial Flutter (A. Flutt.):	<ul style="list-style-type: none"> - "Sawtooth"/"fluttering" atria - <u>Rate:</u> rapid - <u>Rhythm:</u> regular (rarely irregular) - <u>P-Wave:</u> sawtooth/flutterlike - <u>QRS:</u> normal (sometimes wide if BBB) - Ratio present between P-Wave : QRS <ul style="list-style-type: none"> • 2:1 or 3:1
<u>Physiology:</u> <ul style="list-style-type: none"> - Impulses generated from an ectopic focus(es) in atria, or abnormal origins in the atria outside of the SA node. - Impulses depolarized by AV node at an IRREGULAR rapid rate. - "quivering" atria contract inefficiently → reduced filling pressures in ventricles. 			
<u>Physiology:</u> <ul style="list-style-type: none"> - Impulses generated from ONE single ectopic focus in atria - Impulses depolarized by AV node at a REGULAR rapid rate. - Usually rarer & more unstable than A. Fib. 			
<u>Indications/ Symptom(s):</u> <ul style="list-style-type: none"> • ↓ CO = <ul style="list-style-type: none"> - Lightheaded - Fatigue - SOB - ↓ BP • ↑ Risk for clots = <ul style="list-style-type: none"> - MI - PE - Stroke 	<u>Intervention/ Treatment(s)</u> <ol style="list-style-type: none"> 1. Give: <ol style="list-style-type: none"> a. BBs, CCBs b. Amiodarone c. Anti-coagulants d. Adenosine (if ↑ HR) 2. Intervention: <ol style="list-style-type: none"> a. Cardioversion b. Pacing c. Ablation 	<u>Indications/ Symptom(s):</u> <ul style="list-style-type: none"> • *Same as A. Fib • ↑ Atrial pressures 	<u>Intervention/ Treatment(s):</u> <ol style="list-style-type: none"> 1. Give: <ol style="list-style-type: none"> a. BBs, CCBs b. Amiodarone 2. Intervention: <ol style="list-style-type: none"> a. Cardioversion b. Ablation

Reference ID Badge Reel

Critical Condition:	Definition:	Intervention:
Bradycardia	- Acute Δ in HR <50 or HR ↓ by 20.	<ol style="list-style-type: none"> Admin O₂ Stat ECG Labs: CMP, Mag, CBC w/ Diff Give: <ol style="list-style-type: none"> Atropine 0.5mg IV
Tachycardia	- Acute Δ in HR >150, or any HR >160	<ol style="list-style-type: none"> Admin O₂ Stat ECG Check BG Labs: BMP, Mag, CBC w/ Diff, Type & Cross Give: <ol style="list-style-type: none"> BBs, CCBs Amiodarone

Critical Condition:	Definition:	Intervention:
Acute CP/ Heart Attack	- Any new, worsening, or unexplained chest pain.	<ol style="list-style-type: none"> CALL A CODE MET Stat ECG <ol style="list-style-type: none"> "Acute MI/STEMI" → call: 2-7107 "Unclear or new LBBB" → Fax ECG to: 1-1522, Page: 50334, & inform MD of possible STEMI "No STEMI" → refer to providers orders Admin O₂ Labs: BMP, Mag, CBC w/ Diff, Troponin Give: <ol style="list-style-type: none"> Nitroglycerine (NTG) 0.4mg sublingual Do NOT give if: SBP<90, HR <50, Taken Viagra or Milrinone in <24 hrs. Pain medicine Aspirin (ASA) 325 mg

Critical Condition:	Definition:	Intervention:
Atrial Fibrillation	- "Quivering" of atria - Irregular rhythm w/ NO identifiable P-waves; no correlation to QRS.	<ol style="list-style-type: none"> Give: <ol style="list-style-type: none"> BBs, CCBs Amiodarone Anti-coagulants Adenosine Intervention: <ol style="list-style-type: none"> Cardioversion Pacing Ablation
Atrial Flutter	- "Sawtooth" - Usually regular rhythm w/ sawtooth-like P-waves, presented in a ratio to QRS of 2:1 or 3:1	<ol style="list-style-type: none"> Give: <ol style="list-style-type: none"> BBs, CCBs Amiodarone Intervention: <ol style="list-style-type: none"> Cardioversion Ablation

Critical Condition:	Definition:	Intervention:
Hypoglycemia	- BG <70	<ol style="list-style-type: none"> Give (<i>if able to swallow</i>): 15g Carbohydrates – ex: juice, milk, candy, etc. <ol style="list-style-type: none"> Recheck BG q15 min Give (<i>if NPO</i>): Dextrose 50% 25 gm IV push <ol style="list-style-type: none"> Recheck BG q15 min If BG still <60 → repeat.
Hyperglycemia	- BG >250; notify MD if BG >180 with NO orders to treat	<ol style="list-style-type: none"> Order: Urine Analysis (UA) Give: IV NS 0.9%

Critical Condition:	Definition:	Intervention:
Hypotension	- Acute Δ in SBP <80, or MAP <60.	<ol style="list-style-type: none"> Elevate feet in bed Admin O₂ Labs: CMP, Mag, CBC w/ Diff, PT/INR, Type & Cross Give: <ol style="list-style-type: none"> IV NS 0.9% or Colloids/Crystalloids Code MET RN → assess for Sepsis
Hypertension	- Any SBP >150, DBP >120, or MAP >110	<ol style="list-style-type: none"> Stat ECG Labs: BMP, CBC w/ Diff, Mag, PT/INR, Troponin Give: <ol style="list-style-type: none"> BBs IV Hydralazine Nitroprusside, NTG

Critical Condition:	Definition:	Intervention:
Narcotic Overdose	- RR <10 or unable to arouse pt WITH a pulse	<ol style="list-style-type: none"> Admin O₂ Give: Narcan 0.4 mg *DILUTE in 10 mL NS* <ol style="list-style-type: none"> Push SLOWLY in 1mL increments Take VS q15min x4 Only give 2nd dose with MD order.
Respiratory Distress	- Acute Δ in RR <10 or >30, or acute Δ in O ₂ saturation <92%.	<ol style="list-style-type: none"> Admin O₂ Get: Non-rebreather & suction supplies Call: Respiratory Therapy Labs: STAT ABG, CBC w/ Diff If pt has tracheostomy → SUCTION Give: Respiratory Tx

References

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