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Legal Issues in MedSurg Care

Legal issues affect all aspects of nursing care. Urgent care situations, in which the patient's life may be lost or potential quality of life compromised, require even more vigilant attention to nursing standards of care and best practices.

The nurse practice law of each state defines the scope of nursing practice for that state.
Advanced practice nurses, such as nurse midwives, nurse anesthetists, and clinical nurse specialists, function under a broader scope of practice.

- Know your state's nurse practice law; contact your state board of nursing for a copy.
- Know your state's requirements for licensure, and maintain your nursing license as required.
- Keep informed of local, state, and national nursing issues; get involved as a lobbyist in your state; contact your state representatives regarding issues that affect nursing practice.
- Know if and how a nursing union could affect your practice.

Nurses have a duty of care of careful and continuous monitoring of the patient's status.
Nurses assess and directly intervene on patients more than any other health-care professionals.

- Monitor each patient's vital signs, neurological status, intake and output, status per physician order, nursing care plan, hospital policy and procedure; increase frequency of vital signs if indicated, and notify the physician.
- Evaluate family members' concerns as soon as possible; the family often detects subtle changes in a patient's status.

Nurses have a duty to communicate the patient's status to the medical staff, particularly on an immediate/STAT basis when the patient's status warrants.
The nurse is usually the first team member to detect an urgent care situation and has an obligation to report any changes in patient condition to the medical staff for timely intervention.

- Notify the physician as soon as you detect any change in the patient's condition that indicates deterioration in status. Document assessment, time of call to physician, and nursing interventions and patient's response.
- Use the hospital's chain of command if the physician fails to respond within minutes. Notify the nursing supervisor if the physician does not respond immediately.

(Continued on the following page)

- The nurse must maintain accurate nursing notes, flow sheets, medical Kardexes, and nursing care plans that record the patient's symptoms, time symptoms were present, time physician was notified, and time physician arrived. The medical chart should be a factual record of the patient's medical treatment, responses thereto, vital signs, and all nursing interventions.

Nurses have a duty to administer medications safely at all times, including urgent care situations.

Medication errors are the most common source of nursing negligence. Procedural safeguards should be followed to prevent medication errors. The "five rights" of medication administration are minimum practice standards.

- Give the right drug in the right dose to the right patient by the right route at the right time.
- Document the five rights—which medication, to whom, in what dose, through which route, and at what time.
- Document fully any suspected adverse drug reaction, time and nature of the reaction, time physician notified, interventions taken, and patient's response.
- Nurses have a duty to know about all the drugs they administer: drug names, drug categories, dosage, timing, technique of administration, expected therapeutic response, duration of drug use, and procedures to minimize the incidence or severity of adverse drug effects.

Nurses have a duty to maintain safe patient care conditions.

This is akin to the nurse's duty to advocate for the patient at all times.

- Report an unsafe staffing condition to the nursing supervisor as soon as it is apparent. The nurse-patient ratio in intensive care settings should not exceed 1:2; on general floors, 1:6.
- Working beyond a 12-hour shift can create a substantial decline in performance.
- Know the nurse practice limitations on nurses under your supervision; licensed practical nurses and student nurses cannot perform all the actions of the registered nurse.

Nurses have a duty to keep the patient safe from self-harm.

The nurse must be vigilant regarding any changes in the patient's sensorium/mental status. Any patient can experience a psychiatric crisis from a myriad of causes, including hypoxia, drug reaction, drug withdrawal, ICU psychosis, or underlying organic disease.

- Assess the patient's mental status with each nursing intervention; note subtle changes, and notify the physician.
- Signs of impending psychiatric crisis include changes in orientation to person, place, and time; verbal abusiveness; restlessness; increased anxiety; and agitation.

- If a patient is at risk of self-harm and/or of harming others, restraints can be applied.
- Most states require a written physician order before restraining the patient, except in an emergency. The physician must be notified immediately of the use of restraints.
- If restraints are applied, the patient must be monitored closely for changes in medical condition and mental status, for maintenance of adequate circulation, and for prevention of positional asphyxiation. Document all assessments and frequency of checks (no less frequent than every 15 minutes).
- Know the hospital's policy and procedure regarding use of restraints, and follow them at all times.

Nurses have a duty to carry out physician orders as required by state law, hospital policy and procedure, and nursing practice standards.

Concurrently, as patient advocate, the nurse must question an order he or she deems problematic, particularly when an urgent care situation is present or when one could arise from fulfillment of the order.

- Contact the physician immediately for any order that is unclear, contrary to standard drug dosage/route/frequency of administration, or that does not address the acuity of the patient's medical condition; e.g., an order for vital signs every shift for a postoperative patient recently transferred to a general surgical floor.
- Question an order for a patient's discharge from the hospital when the patient's medical condition is not stable, when delay in treatment resulting from discharge could injure the patient, or when the patient is going to a potentially unsafe environment. Document interaction with the physician and health-care team.
- Follow written physician orders; be particularly vigilant in carrying out an order that changes over time; e.g., tapering of medication or oxygen at specified time intervals.

Informed consent is the process of informing the patient, not simply completing the form with the patient's signature.

- Informed consent involves providing the patient with adequate medical information so that he or she can make a reasonable decision as to treatment based upon that information. In urgent care situations it can be impossible to obtain a patient's informed consent for an immediate intervention.
- State laws differ regarding the informed consent standards; know your state's informed consent law and the hospital's policy and procedure for obtaining informed consent.

(Continued on the following page)

- Exceptions to informed consent include an emergency in which the patient is incompetent and cannot make an informed choice, there is not sufficient time to obtain an authorized person's consent, and the patient's medical condition is life-threatening.
- If a patient is competent and refuses medical care, even when the condition is life-threatening, the patient's choice supersedes the opinion of the health-care provider.
- Ensure that each patient's advance directive or living will (patient's advance legal permission to the physician to withhold or discontinue treatment) is complied with and well documented in the medical chart per state law and hospital policy and procedure. Know if the patient has a do not resuscitate order, and ensure that it is well documented.

Nurses are held to the standard of care of the profession.
When nursing care falls below the standard of care, the care could be deemed to be negligent or deficient if that care (or lack of care) causes the patient some type of injury. This is the basis of a lawsuit against the health-care professional, called medical malpractice.

- *Each nurse owes every patient the duty of "reasonable care."* This is implicit in the standard of care defined by what nursing professionals generally recognize on a national level as correct patient care.
- Nationally recognized nursing textbooks, nursing journals, and nursing treatises that nurses generally regard as authoritative define the nursing standards of care.
- Whether a nurse's care of a patient met the applicable standards of nursing care in a medical malpractice case is determined by a nursing expert, a nurse who has the requisite experience and knowledge of the authoritative resources.

As nursing practice, along with medical technology, continues to become more sophisticated and complex, the standards of nursing care will likewise increase.

Documentation Guidelines for Urgent Situations

Documentation is critical in urgent situations. It enhances decision making and helps anyone who reads it understand what happened, how it was handled, and what the outcomes were. It is crucial in any legal analysis of care. Keep the following in mind as you document:

- Always document your assessment findings, your interventions, and what triggered the situation. Did you observe a problem, did the patient call for help, or did you find the patient in distress? What were your immediate interventions?

- Document as you go. It establishes a timeline for the incident as well as conveying the interventions and outcomes accurately. Time, date, and sign every individual entry.
- Always note at what time, by what route, and how much medication you or another member of the team has administered. Always record response to the medication and the time the response(s) occurred or the time you observed for a response, whether there was a response or not. The same applies to any non-drug intervention.
- Always note the time you called the physician or nurse practitioner and his or her response.
- If you do not get the response from the physician or nurse practitioner you think is required for the patient's best interests, call your administrative superior (nurse manager), and report the problems. Document your call and the supervisor's response. Do not blame or complain about someone; just note that you called the supervisor to report the patient's condition.
- If you fail to document something, write another entry called "Addendum" to the note above, and give the time and date of the first note.

Delegation Guidelines

The National Council of State Boards of Nursing defines delegation as "transferring to a competent individual the authority to perform a selected nursing task in a selected situation. The nurse retains accountability for the delegation." Check your state's nurse practice act for details about which nursing activities cannot be delegated.

Sample of nursing tasks that **cannot** be delegated:

- Initial assessment or assessments of change in patient condition
- Formulating the nursing diagnosis; creating the nursing plan of care
- Administration of medications by direct IV bolus (IV push)
- Administration of blood products
- Programming a PCA pump
- Changing a tracheotomy tube

Before delegating, determine the following:

- The complexity of the task and the potential for harm posed by the task (what psychomotor skills are required? what harm can occur if the procedure is done incorrectly?)
- The predictability or unpredictability of the outcome (is this procedure new to the patient, or has the patient tolerated this procedure well before?)

(Continued on the following page)

- The problem-solving or critical thinking abilities required (problem-prone activities such as changing a new colostomy appliance, for example, may require the more in-depth knowledge and problem-solving skills only the RN can supply)

Remember the Five Rights of Delegation:

- Right Task—is the task within the caregiver's scope of practice?
- Right Person—does the assigned caregiver have the knowledge and skill required?
- Right Circumstances—is the setting appropriate; are the right resources available? what is the current health status of the patient?
- Right Direction—clear description of the activity to be performed, relevant patient conditions, limits, and expectations.
- Right Supervision—monitoring performance, maintaining your availability to assist, receiving feedback about the procedure and patient's tolerance, providing feedback.

Remember: The RN delegates a task but retains responsibility and accountability. Specialized nursing skills and nursing judgment cannot be delegated.

Critical Thinking Guidelines

Identifying

- The first thing the nurse must do is identify that a problem exists. The triggering event is something unexpected. It may be as obvious as crushing chest pain or as subtle as a complaint of thirst. Big red flags are easy to see; do not ignore tiny red flags.
- Listen and observe. Know recent trends in the patient's status; understand normal and abnormal findings. Recognize differences and similarities.
  - Have you noticed or has the patient complained of something unexpected?
  - Follow up with questions any new complaint or unusual finding.
  - If you have any doubts, do not ignore them; ask a nurse who is senior to you, or notify the physician/NP.

Assessing

- Once a problem is identified, seek information; gather objective, subjective, historical, and current data.
- Perform a focused physical examination; obtain relevant laboratory and diagnostic reports; read recent entries in the chart.
- Order problems in importance; determine if the problem is urgent; if not, determine how important it is.

Analyzing

- Analysis involves breaking the whole into parts and discovering the relationships of the part to the whole. Is the problem hypotension? Think about the factors that influence blood pressure: What is the hemoglobin level, urinary output, recent blood loss? Can you assess cardiac output? Is the patient on medications that affect blood pressure?
- Think about what you have discovered through assessment. Ask if the laboratory values or tests suggest a cause.
- Consider if the data fit any of the known complications of the patient's condition. Do the data suggest something is worsening? Link the data to the patient's physical status. Do the data "fit"?
- Ask yourself if you are making the data fit and if you have overlooked another cause.
- Ask yourself what other information is needed. Do you need to assess another body system? Have you asked the patient about all recent related events? Should you check the medication record?
- Other types of problems may require a different set of information (What other supplies are needed? Does the patient require referral to a religious leader? Does the family need to see a social worker?).
- While you analyze, double-check that you are not making erroneous assumptions. Ask yourself if the data can be interpreted another way. Ask yourself what other issues or conditions could cause similar signs and symptoms.

Diagnosing

- The end result of analysis is a conclusion. For nurses who are thinking critically about a problem, this conclusion is a nursing diagnosis or a definition of the problem.
- State the problem clearly, what the problem is related to, and what data support this conclusion. State the desired outcomes as well and in what time frame you expect them to be achieved.
- Determine the significance of this problem. Ask yourself again: Is it urgent? Does it have the potential to cause a sudden and rapid deterioration in the patient's health status? Is it imperative that you act immediately? Do you need help?

Planning

- Consider which intervention(s) will be most effective; predict the consequences of the intervention and if it will produce the desired outcome.
- **Urgent problems require that you immediately summon a physician or nurse practitioner.**
- Implement the plan; document all problems and interventions.

(Continued on the following page)

Evaluating

- Evaluation is the step that lets you know if the plan is working.
- Assess the status of the problem at appropriate intervals; evaluate if the interventions are effective.
- Determine if further intervention is required.

Enhance Your Clinical Reasoning Abilities

- The link between a problem and a positive outcome is sound professional judgment. Pose new questions to yourself every day. Ask yourself why a certain complication occurs or why a medication helps. Find out the answers. Ask others; consult the literature.
- Keep current. Read journals and other literature.
- Learn about other specialty areas such as oncologic nursing, wound care, respiratory or physical therapy.
- Know your real strengths, skills, and weaknesses. Correct weaknesses.
- Be alert in your observations and assessments. Realize that everybody makes assumptions and that assumptions can be wrong. Ask yourself what else might be responsible for the signs and symptoms.
- Work in other fields to gain experience. Challenge yourself.
- Ask questions of other experts in medicine, surgery, nursing, and related fields. All practioners fundamentally are teachers. Learn from them.

Principles of Pain Management

- Differentiate between acute and chronic pain. Patients in chronic pain may not exhibit signs of being in pain.
- Do not assume that the patient's pain is exaggerated because he or she asks for pain medicine frequently. Look for ways to better manage pain.
- Assess each patient's pain, and create an individualized treatment plan
- Reassure patients in pain or who expect to have pain that pain can be relieved.
- Assess any changes in pain pattern to ensure that new causes are not overlooked.
- Try the least invasive route first in patients with cancer or chronic pain. Keep dosage schedules simple.
- Monitor side effects. Use prevention strategies, especially for constipation when opiods are used.

- Be careful switching from oral to IV, IM, IT, or other route. Dosages change, and different drugs may not provide as much pain relief. Use an equianalgesic dosing table for guidance.
- Teach or arrange for instruction in biofeedback, relaxation exercises, and hypnosis.
- All can reduce pain and stress and give a greater sense of control.
- Do not avoid opioids because of fear the patient will become addicted.
- Encourage patients to request pain medication before pain becomes severe.
- Suggest administering medication on an around-the-clock schedule to maintain therapeutic blood levels.
- Suggest time-released pain medications to avoid peaks and valleys in pain control.
- Consult with a pain management clinical specialist, if available.
- Include family in pain control plan.

Pain Management

Numeric Scale

0	1	2	3	4	5	6	7	8	9	10
No pain	Mild pain		Moderate pain			Severe pain		Very severe pain		Worst possible pain

Visual Analog Scale

Text/image rights not available.

Wong-Baker FACES Pain Rating Scale. Use for children over 3 years. (From Hockenberry MJ, Wilson D, Winkelstein ML: *Wong's Essentials of Pediatric Nursing,* ed. 7, St. Louis, 2005, p. 1259. Used with permission. Copyright, Mosby.)

Using Pain Scales

- Most patients can use the numerical scale.
- Say: "On a scale of zero to ten, with zero meaning no pain and ten meaning the worst pain possible, tell me what level of pain you are feeling now."
- Ask how distressing the pain is, using a scale of 0–10.
- Some patients report a moderate to high numerical score (5 or above) but are not distressed and do not want medication.
- Some patients report a lower numerical value but are very distressed by the pain and may need medication or other intervention.
- Always ask the patient directly if he or she would like medication.
- Contact a pain care nurse, if available.
- For patients who cannot use the numerical scale, use the Wong-Baker FACES Pain Rating Scale. Tailor questions accordingly.

Mnemonics for Thorough Pain Assessment (PQRST and COLDERRA)
Perform pain assessment quickly but thoroughly prior to medicating. Always find out if the pain is new and different; if it is consistent with the patient's diagnosis, procedure, or surgery; or if it is typical and expected. New onset pain, or pain that is unusual for the diagnosis, procedure, or surgery, needs to be evaluated by the physician or nurse practitioner as soon as possible. Chest pain requires immediate assessment (see Chest Pain in CV tab).

PQRST

P (provokes/point)	What provokes the pain (exertion, spontaneous onset, stress, postprandial, etc.) Point to where the pain is.
Q (quality)	Is it dull, achy, sharp, stabbing, pressing, deep, surface, etc.? Is it similar to pain you have had before?
R (radiation/relief)	Does it travel anywhere (to the jaw, back, arms, etc.)? What makes it better (position, being still)? What makes it worse (deep inspiration, movement)?
S (severity/s/s)	Explain the 10/10 pain scale and have patient rate pain. Are there any signs or symptoms associated with this pain (n/v, dizziness, diaphoresis, pallor, SOB, dyspnea, abnormal vital signs, etc.)?
T (time/onset)	When did it start? Is it constant or intermittent? How long does it last? Sudden or gradual onset? Does it start after you have eaten? Frequency?

COLDERRA

Characteristics.....Dull, achy, sharp, stabbing, pressure?
Onset .....When did it start?
Location .....Where does it hurt?
Duration.....How long does it last? Frequency?
Exacerbation .....What makes it worse?
Radiation.....Does it travel to another part of the body?
Relief.....What provides relief?
Associated s/s .....Nausea, anxiety, autonomic responses?

Nursing Interventions for Pain Management

Provide comfort .....positioning, rest and relaxation
Validate patient's response to pain .....offering reassurance
Relieve anxiety and fears .....setting aside time with patient
Teach relaxation techniques.....rhythmic breathing, guided imagery
Provide cutaneous stimulation .....massage, heat and cold therapy
Decrease irritating stimulation .....bright lights, noise, temp

Comparison of Routes of Analgesic Administration

Route	Advantages	Disadvantages
Oral	Easiest, least invasive; consider oral first while taking into account patient status	Metabolized in the liver before reaching bloodstream—less drug available (40% to 60%) than with other routes; takes longer to act. Cannot be used if patient has difficulty taking oral medications.
IM	Quicker onset of action than oral route	Painful, potential nerve injury; difficulty finding sites in undernourished patients
Subcutaneous	No need for IV access; changing sites usually easy; 80% of drug available	Only small volumes of fluid can be injected each hour. Must use concentrated medications, which increases risk for drug error.

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Comparison of Routes of Analgesic Administration *(continued)*

Route	Advantages	Disadvantages
IV PCA	Immediate effect; can have a continuous rate and a bolus	IV sites are portal for infection. May not be appropriate for confused patient. NOTE: Never administer a dose for the patient—can lead to respiratory depression and death. Inform family also.
IT Epidural	Much lower doses, fewer side effects	Potential for infection or other complication
Transdermal	Easy to use. Slow buildup of drug, fewer side effects. Usually used for patients with cancer pain.	Not suitable for acute pain. Drug remains active for 14–25 hours after removal, which presents problems if patient overdosed.
Sublingual	Better absorption, quicker onset than oral route. Good for patients who cannot tolerate PO medications	Used primarily for break-through pain for cancer patients.

Cultural Sensitivity

It is not possible for nurses to know intimately all other cultures different from his or her own. It is possible, however, to acknowledge that significant cultural variations exist and to adopt an attitude of sensitivity that includes a desire to learn about and respect the culture of the patients for whom you care.

Potential for Stereotyping

Books that list cultural characteristics of various groups have some value but can lead to stereotyping. Too often people make assumptions based on the

color of someone's skin or other overt characteristics. The challenge for nurses is to learn whether a person considers himself or herself to be a member of a group and to recognize that significant variation exists within groups.

Cultural Assessment

Cultural assessment covers many factors, too numerous for this book. Keep in mind that cultural variation is frequently expressed within domains applicable to any culture. Maintain a respectful and open attitude as you learn about each patient. Common domains of importance related to health care include:

- Communication styles—eye contact, personal space, tone of voice, and more. Observe each patient, and follow his or her lead. If you are not sure, ask politely and respectfully.
- Religion—you may ask how important religion is to the patient in daily life and if he or she consults with another member of that religion in health-care matters.
- Language—it is very important to use competent interpreters when obtaining and receiving health information. Do not automatically use a family member. Sensitive information may be embarrassing for the two people to discuss. Try to get someone of about the same age and gender as the patient. Always ask if the patient is willing to use the interpreter. In an emergency, communicate through the oldest family member present.
- Family relationships—families may have a hierarchy that includes a spokesperson, so to speak. Show respect for that person's role. As always, do not reveal confidential information about a person's health without the express consent of the patient.
- Food preferences—providing the patient's preferred food can be instrumental in rate of recovery. Ask about any natural remedies the patient has or is using.
- Health beliefs—What causes illness, how care is provided, how the patient handles being ill or in pain are powerful cultural beliefs. Ask the patient or family members about these issues and integrate the information into your plan of care.
- Birth and death rituals—End-of-life beliefs can vary significantly within any culture. Suggest meeting with the family if the patient approves of you sharing or receiving information about personal preferences. Discuss issues such as organ donation, autopsy if applicable to the case, special care of the body, and what the family will want to do in the immediate time after death.

Spiritual Care

Providing spiritual care means different things to different people. Some nurses may be too intimidated to address this issue. Many do not feel competent to do so or that it is none of their business. You can always ask the patient how he or she feels spiritually. The answer will be very revealing in terms of willingness to discuss the topic. Follow the patient's lead, and never impose your own beliefs. Often, the best spiritual intervention is to ask open-ended questions and then listen.

Focused Assessment of the CV System

- A focused assessment of CV status includes:
  - The **core cardiovascular system**—the heart, its rate and rhythm, the carotid arteries, blood pressure, and other hemodynamic measures.
  - The **peripheral vascular system**—the extremities, particularly the lower extremities.
  - The **lungs**—adventitious sounds, cough, and oxygenation status.
  - **Mental status**—level of alertness, restlessness, confusion, irritability, or stupor.
- **Vital signs:**
  - Blood pressure, heart rate, respiratory rate, O_2 saturation.
- **Mental status, head and neck:**
  - Look for restlessness, ↓ LOC, circumoral cyanosis, color of conjunctiva, jugular venous distention.
- **Inspect the anterior chest:**
  - Look for visible pulsations of the chest wall.
- **Palpate the anterior chest:**
  - Locate apical beat, which is the point of maximum impulse (PMI).
  - Assess for heaves—a very forceful PMI.
  - Assess for thrills—a palpable murmur; feels like a cat purring.
- **Auscultate the heart and lungs:**
  - Obtain rate and rhythm; assess for rhythm abnormalities.
  - Listen for normal heart sounds and possible murmurs.
  - Use the diaphragm of stethoscope first, then the bell.
  - Listen for carotid abdominal and femoral bruits.
- **Assess extremities:** Check for:
  - Cyanosis, temperature, color, and amount of moisture.
  - Capillary refill time in hands and feet.
  - Changes in foot color, ulcers, varicose veins.
  - Edema of lower extremities (check sacrum if client is bedridden).
  - Presence and equality of pedal pulses. If pulses are not palpable, use a Doppler sonogram.
- **Assess current symptoms:**
  - **RED FLAG** symptoms require immediate attention and intervention.

    Shortness of breath.
    Chest pain, possibly with neck, jaw, or left arm pain.
    Syncope possibly with palpitations and shortness of breath.
    Palpitations possibly with chest pain and dizziness.
    Cyanosis of lips, fingers, or nailbeds.
    Pain, coolness, pallor, or pulse changes in extremities.
    Sweating, nausea, vomiting, fatigue (especially in women).

Assessment Guides

Circulation Scale

Capillary Refill	
Normal	**= <3 sec**
Delayed	**= >3 sec**

Pulse Scale

Pulse Strength		
Absent	=	**0**
Weak	=	**+1**
Normal	=	**+2**
Full	=	**+3**
Bounding	=	**+4**

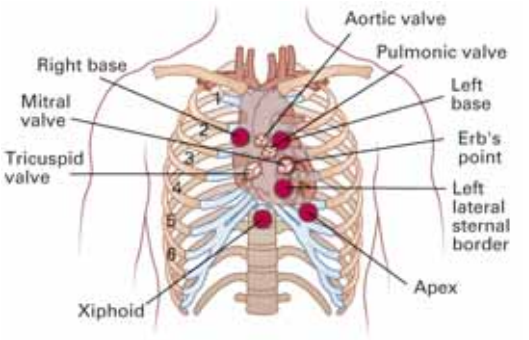
Edema Scale

Press thumb carefully into edematous area, usually on the shin (pretibial edema) or dorsum of foot (pedal edema):

0–1/4 inch; disappears in <5 sec	=	**+1**
1/4–1/2 inch; disappears in 10–15 sec	=	**+2**
1/2–1 inch; disappears in 1–2 min	=	**+3**
>1 inch; disappears >2 min	=	**+4**

Possible Causes of Shortness of Breath

Source	Potential Causes
Cardiac	Coronary artery disease, angina, MI, heart failure, cardiomyopathy, valve disease, left ventricular hypertrophy, pericarditis, dysrhythmias
Pulmonary	COPD, asthma, pneumothorax, pulmonary embolus (PE), pulmonary edema
Combined cardiopulmonary	COPD with comorbid cardiac disorder, deconditioning, chronic pulmonary emboli, trauma
Other	Metabolic acidosis, pain, neuromuscular disorders, upper airway disorders, anxiety, panic, hyperventilation



Cardiac auscultation sites.

Arterial Hematoma

CLINICAL PICTURE

The patient may have:

- Pressure dressing to radial/brachial/femoral artery insertion site that is saturated with blood.
- Cannulated artery that has been inadvertently decannulated and is hemorrhaging.
- Hematoma, possibly pulsatile, around arterial puncture site.

IMMEDIATE INTERVENTIONS

- Notify physician or NP.
- Place patient in a supine position with affected limb extended.
- Don sterile gloves and, using folded sterile gauze dressings, apply firm pressure 2 cm above puncture site, using the first three fingers of one hand.
- Continue to apply pressure for 10 minutes or more, until bleeding has been controlled.

- Once bleeding is controlled, apply sterile gauze dressing overlayed with a pressure dressing (Elastoplast). Depending on institution protocol, use a sandbag or other pressure device over the pressure dressing for added pressure.
- Document patient's status, phone call to physician or NP, and physician or NP response.

FOCUSED ASSESSMENT

- Monitor distal pulses, skin color, temperature, and sensation of affected limb.
- Assess VS, noting decrease in BP or increase in HR.
- Assess LOC and patient's ability to maintain extremity in immobile, neutral position.
- Assess for pain.

STABILIZING AND MONITORING

- Instruct patient to maintain supine position a minimum of 6 hours.
- Frequently assess site for rebleeding.
- Monitor circulation, mobility, and sensation in affected extremity.
- Frequently monitor VS for changes in BP and HR.
- Reassess for pain.
- Assess for history of preexisting conditions such as clotting abnormalities or blood dyscrasias or for recent/current administration of antiplatelet or anticoagulant medications.
- Chart patient status, and convey to physician or NP.

BE PREPARED TO

- Assist physician or NP with cannulation of an alternate arterial site.
- Obtain IV access for the administration of blood, clotting factors, or anticoagulant reversal agents such as protamine sulfate.

POSSIBLE ETIOLOGIES

- Hemophilia, von Willebrand's disease, thrombocytopenia, DIC, vascular trauma or iatrogenic arterial injury, anticoagulant therapy, antiplatelet therapy, thrombolytic therapy.

Arterial Occlusion

CLINICAL PICTURE

The patient may have:

- Numbness, tingling, severe burning pain, or coolness in affected extremity.
- Loss of sensation in the extremity.

- Pale, mottled, cyanotic, or ashen extremity.
- Edematous, tight, shiny skin over affected extremity.
- Capillary refill >3 sec or absent.

IMMEDIATE INTERVENTIONS

- Check all arterial pulses in the affected extremity. Compare with those in contralateral extremity.
- Assess any sites of arterial puncture (e.g., arteriogram puncture site or A-line insertion site) for swelling or hematoma.
- Assess mobility of affected extremity; compare with that of contralateral extremity.
- Assess VS.
- Notify physician or NP.
- Document patient's status, phone call to physician or NP, and physician or NP response.

FOCUSED ASSESSMENT

- Assess for *p*allor, *p*ain, *p*aresthesias, *p*aralysis, and *p*ulselessness (5 *P*s) by assessing circulation (skin color, capillary refill, pulses), movement (flexion, extension, rotation), and sensation (response to pinprick or light touch; pain level) of affected extremity.
- Assess pulses with Doppler amplification.
- Assess bandages or cast proximal to diminished pulses.

STABILIZING AND MONITORING

- Continue to monitor condition of extremity.
- Keep extremity at heart level to promote arterial flow without diminishing venous return.
- Remove or do not use ice on the extremity.
- Control and manage pain.

BE PREPARED TO

- Remove any external fixtures (casts) on the extremity, or assist the physician or NP with fasciotomy for immediate relief of pressure.
- Prepare the patient for surgery.
- Initiate large-bore IV access.

POSSIBLE ETIOLOGIES

- Compartment syndrome, major vascular injury, thrombus, ruptured aortic aneurysm, local or regional block anesthesia, cord injury, lymphedema, fracture, hypotension, hypothermia, dehydration, shock.

Bradycardia

CLINICAL PICTURE

The patient may have:

- HR <60 bpm.
- Nausea and vomiting, dizziness or lightheadedness.
- Signs of unstable bradycardia:
  - Altered LOC.
  - Chest pain, shortness of breath (SOB).
  - Hypotension, pulmonary congestion, and/or cyanosis.

IMMEDIATE INTERVENTIONS

- Have patient sit or lie down in bed.
- Administer supplemental O_2.
- Assess BP.
- Notify physician or NP.
- Obtain a 12-lead ECG.
- Check for patent IV access.
- Document patient's status, phone call to physician or NP, and physician or NP response.

FOCUSED ASSESSMENT

- Assess LOC and orientation.
- Assess BP and HR.
- Assess respirations for rate and effort; assess Sao_2 if readily available.
- Assess skin for color, moistness, and temperature. Assess for associated symptoms (chest pain, SOB, hypotension).
- If patient on telemetry or cardiac monitor, assess ECG.

STABILIZING AND MONITORING

- Monitor VS.
- Set up cardiac monitoring, and monitor rate and rhythm.
- Assess recent laboratory results.
- Chart patient status, and convey to physician or NP.

BE PREPARED TO

- Administer oral or IV medications as ordered.
- Obtain or order laboratory tests.
- Titrate O_2 to Sao_2 >90%.
- Obtain IV access if none available.
- Assist with external pacing.
- Transfer patient to ICU or telemetry unit.