

# Tegan c.c.c.

**On arrival to Emergency department**  
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A- patient

- B- SpO2 increased OR reported as 97%
- No accessory muscle use & chest clear
- Stable vitals on arrival, unable to get peripheral SpO2. Occasional SpO2 85% on 4L via NP
- HR 135, improved vitals to 70's
- Non-rebreather at 15L, sputum white sputum improving to 84%

1-40 continued (MP 11 & MP 1 on P02 2.8 SpO2 improved to 85-95% pre-transport with:

- C- Emp. cool & poorly perfused peripheries
- Paradoxical O2 saturation, hyperactive to normal
- D- ECG 11, Atrial pace
- E- Changed into gown, stable

**Further interventions**  
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- 2x 1cc
- C2B. Chest clear
- Wounds healed with 100% included
- Paradoxical vitals and reflexes commencing
- ECG showed 11
- Fluid bolus for persistent hypotension
- Arterial line inserted and ABG taken
- ECG treated
- HR exam- confirmed mitral

**What happened:**  
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- Pt lives at home with wife
- 2x episodes of tachycardia
- On 2nd episode of Atrial fibrillation
- Atrial fibrillation
- Ambulance called and on arrival pt was hypotensive, diaphoretic & pale
- Ambulance unable to attach SpO2 as "noisy" with pulse

**Blood gas results**  
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Venous	Arterial
pO2: 55	pO2: 90
pH: 7.40	pH: 7.44
pCO2: 39	pCO2: 32
pO2: 14	pO2: 59
HCO3: 24.2	HCO3: 21.7
Lac: 4.5	Lac: 1.8
Hb: 155	Hb: 154

**Emergency Department Nursing Issues**

- 1-40 continued (MP 11 & MP 1 on P02 2.8 SpO2 improved to 85-95% pre-transport with:
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- Paradoxical O2 saturation, hyperactive to normal
- ECG 11, Atrial pace
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**Patient:**  
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- Changed into gown, stable

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# Tegan C.C.C.

## On arrival to Emergency Department Thecasesolutions.com

A- patient  
B- Spont, increased RR (reported as 80%),  
Nil accessory muscle use & creps  
bilaterally on auscultation. Unable to get  
peripheral SpO2. Ocular SpO2 65% on 4L  
via NP.  
HM 15L improved sats to 70%.  
Non-rebreather at 15L applied with sats  
improving to 84%.

B/PAP commenced- VPAP 10 & EPAP 5 on FiO2 1.0.  
SpO2 improved to 89-95%, pt tolerating well.

C- Grey, cool & poorly perfused peripherally,  
Monitored in ST 112bps, hypertensive but  
systolic.  
D- GCS 15, denies pain.  
E- Changed into gown, abetrol.

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## Further Interventions Thecasesolutions.com

- 2x IVC
- CXR- Chest clear
- Bloods taken with VSC included
- Paracetamol 1000 and infusion commenced
- ECG- showed ST
- Fluid bolus for permissive hypertension
- Arterial line inserted and ABG taken
- JCC inserted
- Pt exam- confirmed no trauma

## What happened: Thecasesolutions.com

- Pt lives at home with wife.
- 2x episodes of malaise
- On 2nd episode pt had conscious  
collapse
- Ambulance called and on arrival pt was  
hypotensive, dizzy & pale
- Ambulance unable to attain SpO2 as  
"leaky" sats probe

## Blood gas results Thecasesolutions.com

Venous	Arterial
0653	0908
pH- 7.40	pH- 7.44
pCO2- 39	pCO2- 32
pO2- 14	pO2- 69
HCO3- 24.2	HCO3- 21.7
Lac- 4.6	Lac- 1.8
Hb- 153	Hb- 134

## Emergency Department Nursing Issues

While the patient was stable with no haemodynamic  
instability related to a STEMI she had the following  
the team was involved in:  
• Patient's current status of deteriorating without any particular  
trigger and without clear evidence of STEMI. She was  
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trigger and without clear evidence of STEMI. She was  
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trigger and without clear evidence of STEMI. She was

## Patient: Thecasesolutions.com

55 y.o. 70kg male  
PMH:  
• Ischaemic stroke 6/07 prior  
• Hypertension treated with Lisinopril & Amlodipine  
• IHD  
• COPD  
• Dyslipidaemia  
• GAD  
• Appendicectomy & Cholecystectomy 25/10  
• Pt eye congenitally blind

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## Patient:

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Bill is a 79 y/o male

PHx:

- Ischaemic stroke 6/52 prior
  - presented with dysarthria & dysphagia
- HTN
- OA
- Diverticular disease
- Gout
- Appendectomy & Cholecystectomy 1970
- R) eye congenital blindness

## What happened:

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- Pt lives at home with wife.
- 2x episodes of malaena
- On 2nd episode pt had conscious collapse
- Ambulance called and on arrival pt was hypotensive, dizzy & pale
- Ambulance unable to attain SpO<sub>2</sub> as "faulty" sats probe

## On arrival to Emergency Department

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A- patent

B- Spont, increased RR (reported as 80's), Nil accessory muscle use & creps bilaterally on auscultation. Unable to get peripheral SpO<sub>2</sub>, Occular SpO<sub>2</sub> 65% on 4L via NP.

HM 15L improved sats to 70's.

Non-rebreather at 15L applied with sats improving to 84%.

BiPAP commenced- IPAP 10 & EPAP 5 on FiO2 1.0.  
SpO2 improved to 89-95%, pt tolerating well.

C- Grey, cool & poorly perfused peripherally.  
Monitored in ST 110bpm, hypotensive 94  
systolic.

D- GCS 15, denies pain.

E- Changed into gown, afebrile.

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## Further Interventions

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- 2x IVC
- CXR- Chest clear
- Bloods taken with VBG included
- Pantoprazole bolus and infusion commenced
- ECG- showed ST
- Fluid bolus for persistent hypotension
- Arterial line inserted and ABG taken
- IDC inserted
- PR exam- confirmed malaena



# Blood gas results

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## Venous:

0653

pH- 7.40

pCO<sub>2</sub>- 39

pO<sub>2</sub>- 14

HCO<sub>3</sub>- 24.2

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## Arterial

0908

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