Lippincott Clinical Leaders: Chest Pain

[PODCAST TRANSCRIPT – July 29, 2024]

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Lisa Bonsall: Hello, I'm Lisa Bonsall, Senior Clinical Editor for Lippincott NursingCenter. Welcome to Lippincott Clinical Leaders podcast. I'm joined today by Doctor Anne Dabrow Woods. Doctor Woods is Chief Nurse of Wolters Kluwer Health Learning, Research and Practice, adjunct faculty at two prestigious universities in the Philadelphia area, and also an acute care nurse practitioner for Penn Medicine Chester County Hospital. Thanks, Anne, for being here today.

Anne Dabrow Woods: Thanks for having me, Lisa.

Lisa Bonsall: Today we're going to get down and dirty and talk about the chest pain patient.

Anne Dabrow Woods: Well, this is a really, really important topic and I'm so glad we're going to discuss it.

Lisa Bonsall: So what are the priorities of care when a patient presents with chest pain?

Anne Dabrow Woods: So the main priorities of care are to use the nursing process. So you need to assess your patient, make a plan, do your intervention and then evaluate whether what you've done has made a difference. And how you want to approach the assessment is to really understand when that patient developed the signs and symptoms related to that chest pain. And we use the words OLD CART. So O stands for “onset”, L is “location”, D is for “duration” of chest pain, C are “characteristics” of that pain, A is for “aggravating factors”, R is for “radiation”, and T is “timing”. So if you use OLD CART to describe the signs and symptoms, you're going to do a much better job understanding what's going on with the patient. But you don't stop there. You also have to do a focused assessment of that patient.

So that means assessing their neurological status. Are they awake, alert, and oriented? Assessing their cardiovascular status, the pulmonary status. If they're having any type of GI symptoms, you also want to do a GI assessment as well. And it's always a good idea to make sure they don't have a palpable pulsatile mass in the abdomen. Also, get a fresh set of vital signs and get a 12-lead ECG as well.

Lisa Bonsall: Okay. Thank you, Anne. So after you assess the patient, what's next?

Anne Dabrow Woods: So what's next is that if you don't have a provider at the bedside, you need to get one there as quickly as possible because they need to be able to really interpret what the 12-lead ECG is saying to you. If you do have a provider or if you have an order, you want to give that patient sublingual nitroglycerin or nitroglycerin spray as long as the blood pressure's adequate. Get that 12-lead ECG done and get that patient's pertinent history ready for the provider when they get there. And remember, use that SBAR communication. That's going to be a key thing. So quick communication to the provider usually takes about 30 seconds so the provider can decide what to do next.

Lisa Bonsall: Great. And how about what interventions should be considered?

Anne Dabrow Woods: Well you definitely need that 12-lead ECG. That is a key thing because you need to find out: is the patient actively infarcting or are they just having injury. What is exactly going on with that patient. Nitroglycerin. Because you need to get them some vasodilation, open up those blood vessels. Again don't give it if they're hypotensive. So nitroglycerin you can use sublingual or spray. You can give it every five minutes up to about three doses. And then you need to think about going over to a nitroglycerin infusion if that's ineffective.

If their oxygen saturation on room air is less than 92%, then we need to put them on some supplemental oxygen. But remember, oxygen is a drug. You don't want to give them too much, but you don't want to give them too little either. Aspirin is really key here. And what we normally give for the aspirin dose, and this would be ordered by the provider, is 2 to 4 chewable baby aspirin or one adult aspirin that is chewed. Because remember if it's enteric-coated it's not going to get absorbed right away. So it's got to be chewable. You can think about giving some morphine PRN if needed. If they don't have relief from the chest pain from the nitroglycerin. you need to have at least two really good IV lines. You need to get some labs, including CK, troponin, as well as other things like your chemistry, the CBC, make sure the platelets is in the CBC and then Coags as well.

And then you need to be thinking about that patient may need to have a Heparin infusion to help anti-coagulate them. So it's always a good idea if your patient is on a factor Xa inhibitor. When was the last time they had that medication. That's going to be a key thing. And like you said before they may also need a nitroglycerin infusion as well.

Lisa Bonsall: Okay. So now let's talk about evaluation. Why is that step so important.

Anne Dabrow Woods: Well it's really, really important because you need to decide. Number one did your patient get relief from the chest pain by the medications we're giving them or not. And if they didn't and they're showing ST-elevation on their 12-lead EKG, then they're going to have to go to the cardiac cath lab for intervention. So we need to think about if they didn't have chest pain relief, we're going to have to call cardiology and get them involved pretty quickly because they're going to have to call in the cath lab team.

Lisa Bonsall: Thank you very much, Anne, for breaking down the steps to assessing a patient when they present with chest pain.

Anne Dabrow Woods: You're welcome.

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