

Reading ekg strips– nur 105



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if there is a P-wave, the rhythm will be one of these sinus rhythmssinus rhythm: normal sinus rhythm, sinus bradycardia, or sinus tachycardiaif you do not have a P-wave, the rhythm isventricular ONREADING EKG STRIPS-NUR 105 SPECIFICALLY FOR YOUFOR ONLY\$13. 90/PAGEOrder Nowdetermine the rate60-100 (NSR or AJR) <60 (SB or JR) > 100 (ST or JT)PR interval= 0.12-0.20 (3-5 little boxes)sinus rhythm, sinus brady, sinus tachPR interval=<0.12 (less than 3 boxes)junctional rhythm, next look at ratePR interval=>0.201st degree heart block--type of rhythm with 1st degree heart blockno p-waveventricular tachycardia, idioventricular, atrial flutter, fixed conductionregular QRS0.06-0.10super ventricular tachycardia <3 little boxeswhen do you cardiovertwhen you have a pulsewhen do you defibrillatewhen you have no pulsewhat drug(s) do you use for asystolepinephrine, atropinethe drug used to chemically cardiovert SVT isadenosinenursing diagnosis related to CABGfear, deficient knowledge, ineffective cardiac tissue perfusion, decreased cardiac output, impaired gas exchange, risk for imbalanced fluid volume, disturbed sensory perception, acute pain, ineffective tissue perfusion, ineffective thermoregulationCVP normal value: wedge pressure: PAPCVP: 0-4 wedge pressure: 8-15 PAP 20-30/5-15pulmonary edemamassive left sided heart failure, full of fluid, pink frothy secretions treatment: diuretics (lasix first line); if pt has renal failure (nitroglycerin and morphine)irregular rhythmsa-flutter, sinus arrhythmia, 2 degree or 3 degree heart block, a-fibnarrowing pulse pressure would be seen in which patienttamponade, also massive JVDpacemaker information required on chartmodel of pacemaker, type of generator, date and time of insertion, location of pulse generator, stimulation threshold, pacer settings (eg, rate,

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energy output, sensitivity, duration of interval between atrial and ventricular impulses)endocarditis infective risk factorsrisk factors: heart valve prosthesis, hx of heart disease (mitral valve prolapse), chronic disability disease, IV drug abuse and immunosuppressionpericarditisfriction rub, notched T wave

S/S: fever, positional chest discomfort, nonspecific ST segment elevation, elevated ESR erythrocyte sedimentation rate, retrosternal pain that worsens during supine positioning, pulsus paradoxushypokalemia wave from changesU waves after the Thyperkalemiatall QRS

complexeshypomagnesiumtorsades de pointesmedications to treat ventricular dysrhythmiaslidocaine, beta blockers, amiodarone (drug of choice for v-tac)right heart failure (chronic condition)JVD, dependent edema, right upper gastric pain (right heart handles systemic blood return)left heart failurebibasilar fine crackles, dyspnea, tachycardia, S3 and S4 heart sounds, fatigue, hemoptysis, non-productive cough, cool pale skin, PMI displaces toward the left anterior axillary lineinferior wall myocardial infarctiont-wave inversion: inadequate blood supply

ST segment elevation: injury, prolonged ischemia

pathological Q waves: are all signs of tissue hypoxiadigoxinhold if apical pulse is less than 60bpm

digitalis toxicity= vision changes (halos), dysrhythmia, anorexia, nausea, vomiting, headache, and malaise

increases force of myocardial contraction and decreases HRa-fibwarfarin to prevent clots and decrease risk of stroke, digoxin to control HR12 lead

EKGST elevation indicates immediate myocardial injury

ST depressions indicate myocardial ischemia

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Q wave forms several days after a myocardial infarction

U wave is a sign of hypokalemia
Lasix furosemide IV push: give at a rate of 20mg/min or less

rapid injection can cause hearing loss as a result of ototoxicity

normal daily dose: 40mg loop diuretic

nitroglycerin reduces oxygen consumption to reverse ischemia and relieve pain. vasodilator mainly in veins and reduces blood return to heart and preload is reduced. may cause a significant drop in cardiac output and BP if pt is hypovolemic at higher

doses
calcium channel blockers slows heart rate and decreases strength of contraction which decreases workload of heart. relaxes blood vessels

decreasing BP and increases coronary artery perfusion

rheumatic fever caused by strep/s of infective endocarditis
Osler's nodes (red, painful nodules on the fingers and toes), splinter hemorrhages, fever, diaphoresis, joint pain, weakness, abdominal pain, new murmur, Janeway's lesions (small,

hemorrhagic areas on fingers, toes, ear, and nose)
myocarditis s/s flu-like symptoms, fatigue, dyspnea, palpitations, and occasional discomfort in the chest and upper abdomen. may develop dysrhythmias, or ST-T wave

changes. systolic murmur, gallop rhythm
ACE inhibitors promote vasodilation and diuresis by decreasing afterload and preload
dobutamine left ventricular dysfunction. increases cardiac contractility. at high doses, it also increases

HR and incidence of ectopic beats and tachydysrhythmias. take care in pt with a-fib
CK-MB earliest increase, peak and return to normal 4-8hrs, peaks 12-24hrs, and returns to normal 1-3 weeks
troponin earliest increase, peak and return to normal 3-4hrs, peaks in 4-24hrs and returns to normal 1-

3 weeks
labs for heart failure BUN, TSH, CBC, BNP

mitral stenosis: rhythms, S/S dyspnea, progressive fatigue, hemoptysis, paroxysmal nocturnal

dyspnea, cough, wheeze, repeated respiratory infections

dysrhythmias like a-fib

tests doppler echocardiography aortic regurgitation: caused by

inflammatory lesions that deform the leaflets of the aortic valve. also

infective or rheumatic endocarditis, congenital abnormalities, diseases such as syphilis, dissecting aneurysm, blunt chest trauma, or valve

replacement aortic regurgitation: S/S forceful heartbeats in head and neck,

arterial pulsations that are visible or palpable at the carotid or temporal

arteries. exertional dyspnea, fatigue, progressive s/s of left ventricular failure

including breathing difficulties, orthopnea, PND valve replacement teaching:

pre and post take long term anticoagulant therapy, frequent follow up

appointments and blood lab studies. may need to take aspirin, prescribed

medication teaching cardiac tamponade: S/S life threatening need stat

interventions, fullness within the chest, substantial or ill defined pain, SOB,

massive JVD, falling systolic blood pressure, narrowing pulse pressure, rising

venous pressure (increased JVD) and distant heart sounds cardiac tamponade

treatment pericardiocentesis, pericardiectomy (pericardial window) CABG 70%

occlusion (60% if in the left main), artery must be patent beyond the

occlusion. use greater saphenous vein, lesser saphenous, cephalic and

basilic veins