

Medication Management Improvement System CARDIAC STANDARD FOR NURSES

These standards are based on the Medication Management Improvement System's research and evidence that includes expert panel recommendations, national standards such as JVC-7 guidelines, and best nursing practices in home care:

1. Vital sign assessment (Initial health assessment and nursing follow-up assessment):

a. **BP assessment:** Blood pressure should be taken at every nursing visit and out-of-range readings must be reported to the client's primary care physician (and cardiologist, if applicable). ***Rationale:*** Sub-optimally controlled blood pressure or under-treatment of hypertension can be potential medication errors. JNC guidelines are evidence-based standard practice.

— If the BP on first reading is elevated ($\geq 160/90$), a *second reading* is recommended during the visit to confirm a potential problem (see HTN protocol). ***Rationale:*** Later in the visit, when greater comfort has been established for the client, BP may return to normal range.

b. **Orthostasis assessment:** Nurses will assess BP in at least two positions whenever possible and based on client's condition, e.g. sitting/standing, or lying/sitting. ***Rationale:*** Orthostasis is often related to medication. Identifying orthostasis and rectifying potential causes can prevent falls, preferably all three.

— Enter BP reading data into MSSPCare database as soon as possible, according to agency policy timeframe. ***Rationale:*** These assessment and medication data will be analyzed by the MSSPCare risk assessment algorithm and alert for potential problems.

c. **Pulse:** Nurses will assess and document heart rate at each visit. Assessment of **apical rate and rhythm** are recommended at each visit. ***Rationale:*** Slow pulse of <55 may be medication related and require MD follow-up to re-evaluate medications. The risk assessment algorithm will analyze heart rate data and medications and alert staff/pharmacist to potential problems.

— If pulse is slow, i.e. <55 , continue with further assessment:

- ◆ Ask if client has a pacemaker and/or if there is a history of low pulse. If there are no mitigating clinical factors and client is taking drugs known to decrease pulse (e.g. digoxin or atenolol) proceed with Slow Pulse protocol

— Enter pulse data into MSSPCare as soon as possible, according to agency timeframe. Consult with the pharmacist as needed.

Note: Some agencies may choose to set a standard of HR <60 rather than <55 to notify MD.

2. Other cardiac assessment considerations:

To supplement the vital signs and provide comprehensive cardiac assessment, we recommend assessing the following signs/symptoms:

- ◆ pre-syncope/syncope,
- ◆ chest pain,
- ◆ new shortness of breath,
- ◆ orthopnea,
- ◆ PND (paroxysmal nocturnal dyspnea),
- ◆ edema,
- ◆ fluid intake,
- ◆ recent vomiting,
- ◆ diarrhea,
- ◆ generalized weakness.

— **Hypertension:** Also assess/consider compliance with medication regimen and diet

— **Orthostasis:** Ask client about dizziness on standing, recent falls.

— **Low blood pressure:** Assess heart rate, regular rhythm, signs of dehydration.

— **Slow Pulse:** Especially if changes in pulse and/or irregular rhythm are noted, ask client about recent generalized weakness, new shortness of breath, orthopnea, PND, nausea and assess edema,