Acute Coronary Syndrome

Proposed Process of Care
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GUIDELINES - DEFINITION

This guideline is designed for the general use of most cardiac patients, but it may need to be adapted to meet the special needs of an individual patient as determined by the patient’s care giver.
Statement of Purpose

Review and improve the process of care from the ED to discharge for patients with an Acute Coronary Syndrome.

Goals

For all ACS patients, our goals are as follows:
To standardize the processes of care to coordinate hospital resources;
To make the process of care simple and efficient for the cardiologists to manage their ACS patients;
To guarantee a consistent and high level of care to all ACS patients;
To establish a smooth, efficient working/transfer process between the BBMC Emergency Department and the BBHeart Hospital for all ACS patients:
To perform in the top 10th percentile for CMS/JCAHO core measure quality indicators.
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V. CARE COORDINATION ROUNDS
1. STAT 12-lead ECG. PRN recurrent chest pain
   ▪ If inferior AMI, do a 15 lead ECG to rule out RV infarct
2. Pulse oximetry, O$_2$ 2 L per NC, titrate to maintain SpO$_2$ ≥ 92%
3. Obtain initial set of vital signs and repeat as needed. Continuous ECG monitoring.
4. Obtain IV access(s)
5. Medications:
   ▪ STAT Aspirin 325 mg chew PO if not already given and not allergic
     If unable to take PO, give Aspirin 300mg PR
   ▪ Nitroglycerin 0.4 mg SL every 5 minutes X 3 PRN chest pain
   ▪ Morphine 2-4 mg IV every 5 minutes PRN ongoing chest pain to a max of 10 mg every 1 hour
6. Labs:
   ▪ CMP, CBC, Magnesium
   ▪ Cardiac Markers: CK-MB, Troponin-I, Myoglobin
   ▪ PT/INR if patient previously on warfarin (Coumadin$^\circledR$)
7. STAT Portable CXR.
8. Old charts / ECGs to Emergency Department
9. Diet and Activity: NPO except medications; strict bed rest
10. Additional Orders: ________________________________ ____________________________________
     _______________________________________________________
     _______________________________________________________
     _______________________________________________________

Physician Signature__________________________________________ Date/Time_________________

Revision 11.16.05
Chest Pain Presentation

STEMI

NSTEMI / Unstable Angina
Complete Risk Stratification

Stable Angina / Atypical Chest Pain
(Chest Pain Unit)

High and Intermediate Risk

Low Risk
EMERGENCY DEPARTMENT

ASSESSMENT

1. Symptoms
2. ECG Indicators
3. Cardiac Markers

STEMI

- CP ≥ 20-30 minutes
  - Persistent ST ≥ 1.0 mm in ≥ 2 contiguous leads
  OR
  - Hyperacute T-waves
  OR
  - New or presumed new LBBB
  OR
  - New pathologic Q waves in ≥ 2 contiguous leads
  AND
  - Cardiac Markers

NONSTEMI & High/Intermediate Risk Unstable Angina

- Prolonged rest angina or CP ≥20-30 minutes with^ frequency, duration, intensity, refractory
  - ST depression ≥0.5mm
  OR
  - Transient ST ≥0.6 to 1mm
  OR
  - T wave inversion ≥2.0 mm
  AND/OR
  - Cardiac Markers

Low Risk Unstable Angina

- Chest Pain > 20-30mins with^ frequency, duration, intensity
  - Normal or unchanged ECG
  - NO ^ Cardiac Markers

Chest Pain

- Predictable CP: no change in frequency, duration, intensity or atypical chest pain
  - Normal or unchanged ECG
  - NO ^ Cardiac Markers
ST-SEGMENT ELEVATION INFARCTION

1. Time since onset of symptoms
2. ECG indicators
   * New or presumed ST elevation in two or more contiguous leads
   * Hyperacute T-waves (may precede ST elevation)
   * New or presumed new LBBB
   * Development of any Q waves in leads V1 through V3, or the development of a Q-wave >0.30 ms in leads I, II, aVL, aVF, V4, V5, or V6 (Q wave changes must be present in any two contiguous leads and be >0.50 mm in depth)
3. Risk of Thrombolytics +
4. Time window to obtain Primary PCI
   - Door to balloon time < 90 minutes
   - Door to balloon time minus door to needle time < 60 minutes

Onset Of Symptoms: LESS than 3 hours

- Treatment (Either Option Appropriate)
  - Primary PCI
    - To Cath Lab Immediately
  - Thrombolytics +
    - Door to balloon time > 90 minutes

  Positive Response
  (Facilitated PCI)
  - Resolution of chest pain
  - Normal ST segments
  - Admit to ICU
  - To cath lab within 24 hours or with recurrent chest pain or ECG changes

  Negative Response
  (Rescue PCI)
  - Continued chest pain
  - No ST segments response
  - To cath lab immediately

Time is irrespective; PCI is Optimal
- Age > 75
- Shock
- Hypotension/Poor Perfusion
- Contraindications to Thrombolytics +

Onset Of Symptoms: MORE than 3 hours

- Treatment (Either Option Appropriate)
  - Thrombolytics +
    - Door to balloon time > 90 minutes
  - Primary PCI
    - (Preferred Option)
    - To Cath Lab Immediately

Positive Response
(Facilitated PCI)
- Resolution of chest pain
- Normal ST segments
- Admit to ICU
- To cath lab within 24 hours or with recurrent chest pain or ECG changes

Negative Response
(Facilitated PCI)
- Continued chest pain
- No ST segments response
- To cath lab immediately

Contraindication for Thrombolytics +
- Absolute
  1. Active Bleeding
  2. Any prior intracranial hemorrhage
  3. CVA, closed-head or facial trauma within 3 months
  4. CNS neoplasm
  5. Suspected Aortic Dissection
  6. Pericarditis
  7. Bleeding Diathesis
- Relative
  1. History of chronic, severe, poorly controlled hypertension
  2. Severe uncontrolled hypertension on presentation (SBP greater than 180 mm Hg or DBP greater than 110 mm Hg)
  3. History of ischemic stroke greater than 3 months
  4. Active peptic ulcers
  5. Pregnancy
  6. Age > 75

* Based on recommendations from the ACC/AHA 2002 Guidelines Update for the Management of Patients with ST-Segment Elevation Myocardial Infarction
ED Doctor Focus 1

STEMI

- Pt Presents with Chest Pain to ER
- EKG conducted
- EKG read/assessed by ED Doc (goal is within 10 min.)
- STEMI Diagnosed
- Activate MI Team*
  - Interventional Cardiologist returns within 10 min.? Yes
  - Interventional Cardiologist calls ED "Hot Phone" (Cell?) ETA < 30 mins for Interventional Cardiologist?
  - Yes
  - ED Charge RN Calls Cath Lab team – shares basic info about pt., cardiologist , ETA etc.
  - No
  - Stat page again
  - Interventional Cardiologist returns page within 10 min.? Yes
  - ED Doc and Interventional Cardiologist discuss
  - No
  - Interventional Cardiologist assess
  - Lytics indicated?
  - No
  - Use another Interventional Cardiologist*
  - Yes
  - Get alternate Interventional Cardiologist*
  - Pl. To Cath. Lab
  - Responds to Lytics?
  - No
  - Patient to ICU bed or Cath Lab at Heart Hospital
  - Yes
  - Patient to cath lab within 24 hours
- Non Stemi
- Stable Angina
- Unstable Angina
- ED Chest Pain Map & Orders

**FOR ACS:**
- Yes No
- Pt. To Cath. Lab
- Yes No
- To Charge RN steps
- ETNA < 30 mins for Interventional Cardiologist?
- No
- Use another Interventional Cardiologist

Answering Service – Use "911" page for: ?????????

Criteria for On-call: <30 min to be on-site
**STEMI Process**

**Cardiologist FOCUS 2**

- **MI TEAM**
  - ED Doc
  - Charge RN
  - Bedside RN
  - HUS
  - ED tech
  - X-Ray

- **ED Doc:**
  - Brief exam of patient

- **ED Charge Nurse:**
  - Locates bed in ED
  - Contacts AC at Heart for HH Bed
  - Facilitates transportation issues
  - Calls cath lab 7a-7p (Dr. & Lab availability)

- **ED RN:**
  - Starts IV
  - Admins Meds
  - Monitors patient

- **HUS:**
  - Starts STAT page process
  - Photocopies chart info to go with patient

- **Tech:**
  - Draws blood and other assists

- **X-ray Tech:**
  - Performs portable Chest x-ray

- **Does Patient have a cardiologist?**
  - **Yes**
    - HUS locates Patient's Cardiologist/group number
    - HUS calls (cell phone)/pages (with code) Interventional Cardiologist
  - **No**
    - HUS locates "on-call" I. cardiologist number (ER)
    - Interventional Cardiologist returns page to ED – within 10 minutes
    - ED Doc and Interventional Cardiologist converse

- **7a-5p call patient’s cardiologist**
  - After hours – call pt. cardiologist groups – Interventional cardiologist on-call

**ED Doc:**
- Brief exam of patient

**ED Charge Nurse:**
- Locates bed in ED
- Contacts AC at Heart for HH Bed
- Facilitates transportation issues
- Calls cath lab 7a-7p (Dr. & Lab availability)

**ED RN:**
- Starts IV
- Admins Meds
- Monitors patient

**HUS:**
- Starts STAT page process
- Photocopies chart info to go with patient

**Tech:**
- Draws blood and other assists

**X-ray Tech:**
- Performs portable Chest x-ray
**STEMI Process**

**ED FOCUS 3**

**ED Doc:**
- Brief exam of patient

**ED Charge Nurse:**
- Locates bed in ED
- Contacts AC at Heart for HH Bed
- Facilitates transportation issues
- Calls cath lab 7a-7p (Dr. & Lab availability)

**ED RN:**
- Starts IV
- Admins Meds
- Monitors patient

**HUS:**
- starts STAT page process
- Photocopies chart info to go with patient

**Tech:**
- draws blood and other assists

**X-ray Tech:**
- Performs portable Chest x-ray

---

**Does Patient have a cardiologist?**

- **Yes**
  - HUS locates Patient’s Cardiologist/group number
  - HUS calls (cell phone) /pages (with code)
  - Interventional Cardiologist
  - Interventional Cardiologist returns page to ED – within 10 minutes

- **No**
  - HUS locates “on-call” Interventional cardiologist number (ER)

---

**7a-5p call patient’s cardiologist**

- After hours – call pt. cardiologist groups – Interventional cardiologist on-call

---

**ME TEAM**
- ED Doc
- Charge RN
- Bedside RN
- HUS
- ED tech
- X-Ray

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**MT TEAM Process**

**ED Doc:**
- Brief exam of patient

**ED Charge Nurse:**
- Locates bed in ED
- Contacts AC at Heart for HH Bed
- Facilitates transportation issues
- Calls cath lab 7a-7p (Dr. & Lab availability)

**ED RN:**
- Starts IV
- Admins Meds
- Monitors patient

**HUS:**
- starts STAT page process
- Photocopies chart info to go with patient

**Tech:**
- draws blood and other assists

**X-ray Tech:**
- Performs portable Chest x-ray

---

**Does Patient have a cardiologist?**

- **Yes**
  - HUS locates Patient’s Cardiologist/group number
  - HUS calls (cell phone) /pages (with code)
  - Interventional Cardiologist
  - Interventional Cardiologist returns page to ED – within 10 minutes

- **No**
  - HUS locates “on-call” Interventional cardiologist number (ER)

---

**7a-5p call patient’s cardiologist**

- After hours – call pt. cardiologist groups – Interventional cardiologist on-call

---

**ED Doc:**
- Brief exam of patient

**X-ray Tech:**
- Performs portable Chest x-ray
DAYS
ED Charge RN calls the cath Lab 854-5440
Gives Pertinent info: 1. Patient Name 2. Location in the ED 3. Cardiologist Name 4. Phone number to call ED back

NIGHTS
On-Call Cath Lab team Activated
ED Contacted with: "I've activated the Cath Lab team"
Cath Lab gets ready/comes in
Information given: Room # & Availability and time
Cath Lab RN calls ED MI Team RN for report
Report is given. ETA of Cath Lab team to ED
2 of 3 Cath lab tm members go to get pt in ED
1 of 3 cath lab tm stays to prep room

ED Charge RN has coordinated pt. Transport to Cath Lab
Pt. is draped and prepared
Cath Lab procedure begins

AC Calls admitting with Pt. room #, Pt. name & contacts other dept. affected

ED Charge calls Heart AC

Pt. is transported to the Cath Lab

1. Cardiologist is ready in the Cath Lab

Cath Lab FOCUS 4

STEMI Process
Draft 4-4-05 Proposed

From MI Team Charge RN
1. STAT call to Cardiologist: ______________________________________________________

2. Allergies: ____________________________________________________________________

3. Patient’s Weight_________ kg □ estimated □ actual

**Check all appropriate boxes**

4. Medications:
   - STAT Aspirin 325 mg chew PO if not already given and not allergic
     If unable to take PO, give Aspirin 300mg PR
     If patient has a TRUE Aspirin allergy, give clopidogrel 75 mg PO
     □ DO NOT GIVE ASPIRIN. Reason: ______________________________________________
   - Metoprolol 5 mg IV every 5 minutes X 3 doses
     Hold if HR< 55, SBP < 90, Radiographic or Clinical Evidence of Active CHF
   - Metoprolol 25 mg PO X 1, give 15 minutes after last IV dose
     Hold if HR< 55, SBP < 90, Radiographic or Clinical Evidence of Active CHF
     □ DO NOT GIVE A BETA BLOCKER. Reason: _______________________________________
   - Nitroglycerin 0.4 mg SL every 5 minutes X 3 PRN chest pain
     If chest pain not relieved, start Nitroglycerin IV at 10 mcg/min and titrate for pain relief maintaining SBP ≥ 90 mmHg.
   - Morphine 2-4 mg IV every 5 minutes PRN ongoing chest pain to a max of 10 mg every 1 hour
   - Lorazepam 0.5-1 mg IV/PO one time PRN anxiety
   - Ondansetron 4 mg IV one time PRN nausea
   - Acetaminophen 650 mg PO/PR one time PRN discomfort / headache

5. Thrombolytic Therapy (Goal: Administer within 30 minutes of arrival to ED)
   □ Reteplase (RPA, Retavase®) 10 + 10 Units IV 30 minutes apart
   □ Half Dose Reteplase (RPA, Retevase®) 10 units IV for facilitated or rescue PCI

6. Anticoagulation:
   □ Enoxaparin 30mg IV bolus followed by Enoxaparin 1mg/kg Subcutaneous (Round to the nearest 10 mg)
   □ Heparin dosing (Round to nearest 50 units)
   1. Intravenous Heparin Loading Dose: If lytic ordered, give heparin bolus prior to lytic
      Dose (60 units/kg) = _______ units (maximum dose of 4000 units)
   2. Intravenous Heparin Infusion Rate:
      Infusion rate (12 units/kg/hr) = _______ units/hr (maximum of 1000 units/hr)
   3. Obtain aPTT 6 hours after infusion begins

7. IV Fluids: ____________________________________________________________________

8. Additional Meds / Orders: _______________________________________________________
   ______________________________________________________________________________
   ______________________________________________________________________________
   ______________________________________________________________________________
   ______________________________________________________________________________

Physician Signature_________________________________________________Date/Time___________

Revision 11.16.05
| CONSULTATION | □ Interventional Cardiologist |
| ASSESSMENT | Brief, targeted history and physical performed by physician  
Continuous telemetry with ST segment monitoring  
System assessment, pain assessment  
Vital signs with pulse ox  
I&O  
Weight  
□ Bleeding precautions with thrombolytics |
| LABS | • CK-MB, Troponin, Myoglobin  
• CMP, Magnesium, CBC  
• PT (if patient previously on warfarin)  
• Guiac all stools |
| DIAGNOSTICS / INTERVENTIONS | • 12 Lead EKG completed and read within 10 minutes  
• PCXR stat  
• Obtain IV access  
□ PCI (Primary Coronary Intervention)  
□ Facilitated PCI/Rescue PCI  
□ Thrombolytics |
| MEDICATIONS | □ STAT ASA (325 mg – chew)  
□ Ntg (0.4 mg sublingual STAT X 3, IV)  
□ Morphine  
□ Lopressor 5 mg IV every 5 minutes X 3  
□ Lopressor 25 mg PO (give 1st dose 15 minutes after last IV dose)  
□ Heparin / Lovenox |
| RESPIRATORY CARE | O2 @ 2L NC  
Maintain O2 sats > 92%, titrate O2 as indicated |
| ACTIVITY / SELF-CARE | Strict bedrest |
| NUTRITION | NPO, except medications |
| EDUCATION | Diagnosis and Treatment  
Plan for disposition  
Pain scale |
|  | Patient is pain free |
OUTCOMES

Door to balloon time < 90 minutes (cardiac cath lab)
Door to needle time < 30 minutes (thrombolytics)

Admit to:  □  ICU  □  Telemetry  □  IU

1. Diagnosis: Acute Coronary Syndrome:__________________________

2. Admitting Specialist: __________________________ Admitting Internist:_______________________________

Initiate orders 3-13

3. Initiate STEMI care map
4. Emergency Protocol
5. Cardiac Rehab Consult
6. Oxygen 2 Liters per NC. Titrate to maintain SpO\textsubscript{2} >92%
7. Cardiac Diet
8. Peripheral IV, saline lock if not in use
9. Labs:
   ▪  Admit Labs: **IF NOT DONE IN ED:** Troponin-I and CK-MB at 0, 6, and 12 hours, CBC, CMP, Magnesium, PT/INR if patient previously on warfarin, Fasting Lipid Profile, UA
   ▪  Daily Labs: CBC, BMP, Magnesium, PT/INR if patient on warfarin  □  Phosphorus  □ Other
   ▪  PRN Labs: RN may obtain as clinically indicated: CXR, ABG, Hgb/Hct, BMP, Magnesium, aPTT, PT/INR, CKMB until enzymes peak
10. ECG on Admission, Daily for 3 days, and PRN Chest Pain
11. Chest X-Ray:  Daily for 2 days or ________________________________
   If patient not diabetic and has a Fasting Blood Sugar <110, discontinue blood glucose monitoring.

Initiate the Following Medications, Check All Appropriate Boxes:

14. Medications
   ▪  STAT Aspirin 325 mg chew PO if not already given in ED and not allergic, then start 81 mg PO daily
      If unable to take PO, give Aspirin 300 mg PR
      If patient has a TRUE Aspirin allergy, give clopidogrel 75 mg PO daily
      □  DO NOT GIVE ASPIRIN. Reason: ________________________________
   □  Give Clopidogrel 75 mg PO daily, in addition to aspirin therapy
   ▪  Metoprolol 25 mg PO every 6 hours x 48 hours total, then 50mg PO BID,
      Hold for HR < 55 or SBP < 90, Radiographic or Clinical Evidence of Active CHF
      or: ________________________________, Hold for HR < ______ or SBP < ______
      □  DO NOT GIVE A BETA BLOCKER. Reason: ____________________________
   ▪  Captopril 6.25 mg PO every 8 hours, begin within 24 hours of STEMI, Hold for SBP < 100
      or: ________________________________, Hold for SBP < ______
      □  DO NOT GIVE AN ACE INHIBITOR. Reason: _________________________
   □  Losartan 25mg PO daily, Hold for SBP < 100

STEMI Admission Orders
or: _______________________________________________________. Hold for SBP < ______

☐ DO NOT GIVE AN ARB. Reason: ______________________________________
  - Pravastatin 80 mg PO at bedtime or:

☐ DO NOT GIVE A STATIN. Reason:
  - Senakot 1 tablet PO BID. If no results use BCOC.
  - Lorazepam 1 mg PO/IV every 4 hours PRN anxiety/sleep
  - Temazepam 15 mg PO at bedtime PRN sleep, may repeat x 1
  - Acetaminophen 650 mg PO/PR every 4 hours PRN discomfort / headache
    (Dos NOT exceed 4 gm/day total acetaminophen)
  - Ondansetron 4 mg IV every 6 hours PRN nausea
  - Antacid of Choice

15. Anticoagulation:
   ☐ Regular Dose Enoxaparin 1 mg/kg Subcutaneous every 12 hours (Round to the nearest 10 mg)
   ☐ Renal Dose Enoxaparin (CrCl <30 ml/min)
     Enoxaparin 1 mg/kg Subcutaneous every 24 hours (Round to the nearest 10 mg)
   ☐ Heparin dosing (Round to nearest 50 units)
     1. Target aPTT is 57-80 seconds
     2. Obtain aPTT 6 hours after infusion begins
     3. If aPTT OBTAINED within 12 HOURS of initiation of thrombolytic therapy:
        - DO NOT discontinue or decrease infusion unless significant bleeding occurs or aPTT is >150
        - DO ADJUST rate of infusion if aPTT < 57 seconds
     4. Heparin Dosage Adjustments:

<table>
<thead>
<tr>
<th>aPTT (sec)</th>
<th>Bolus Dose</th>
<th>Hold Infusion</th>
<th>Rate change</th>
<th>Repeat aPTT</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;45</td>
<td>70 units/kg</td>
<td>No</td>
<td>↑ 2 ml/hr (200 units/hr)</td>
<td>6 hrs</td>
</tr>
<tr>
<td>45-56</td>
<td>None</td>
<td>No</td>
<td>↑ 1 ml/hr (100 units/hr)</td>
<td>6 hrs</td>
</tr>
<tr>
<td>57-80</td>
<td>None</td>
<td>No</td>
<td>None</td>
<td>12 hours x 1, then daily</td>
</tr>
<tr>
<td>81-100</td>
<td>None</td>
<td>No</td>
<td>↓ 1 ml/hr (100 units/hr)</td>
<td>12 hours</td>
</tr>
<tr>
<td>&gt;100</td>
<td>None</td>
<td>60 min</td>
<td>↓ 2 ml/hr (200 units/hr)</td>
<td>6 hrs</td>
</tr>
</tbody>
</table>

*Repeat aPTT draw time is to begin at the time the adjustment is made (ie when infusion held or changed)

16. IV Fluids: _____________________________________________________________

17. Additional Meds/Orders:

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
Physician
Signature_______________________________________________Date/Time________________________________

Revision 11.16.05
<table>
<thead>
<tr>
<th>Aspect of Care</th>
<th>Admission / Day 1</th>
<th>Day 2</th>
<th>Day 3 through Discharge</th>
<th>Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ASSESSMENT</strong></td>
<td>□ Admission Database □ COA □ Advance Directive □ Bleeding precautions with thrombolytics Continuous Telemetry with ST segment monitoring Systems assessment every 4 hr VS with pulse ox and pain assessment: • ICU = every 1 hr • Tele = every 4 hr I&amp;O every shift Daily AM weight</td>
<td>□ Bleeding precautions with thrombolytics Continuous Telemetry with ST segment monitoring Systems assessment every 4 hr VS with pulse ox and pain assessment: • ICU = every 1 hr • Tele = every 4 hr I&amp;O every shift Daily AM weight</td>
<td>Continuous Telemetry with ST segment monitoring Systems assessment every 4 hr VS with pulse ox and pain assessment every 4 hr I&amp;O every shift Daily AM weight</td>
<td>Continuous Telemetry with ST segment monitoring Systems assessment every 4 hr VS with pulse ox and pain assessment every 4 hr I&amp;O every shift Daily AM weight</td>
</tr>
<tr>
<td><strong>LABS</strong></td>
<td>□ Review of ED labs □ CK-MB, Troponin (0.6, 12 hr) □ Fasting lipid profile □ UA H/H, plts with thrombolytics PTT per Heparin protocol FS blood glucose if diabetic</td>
<td>H/H, plts with thrombolytics BMP, Magnesium PT, PTT per Heparin protocol FS blood glucose if diabetic Guia all stools</td>
<td>H/H, plts with thrombolytics BMP, Magnesium PT, PTT per Heparin protocol FS blood glucose if diabetic Guia all stools</td>
<td>H/H, plts with thrombolytics BMP, Magnesium PT, PTT per Heparin protocol FS blood glucose if diabetic Guia all stools</td>
</tr>
</tbody>
</table>
### DIAGNOSTICS / INTERVENTIONS

**EF% = ____________**

- Cath lab procedure: ________
- IABP
- 12 lead EKG am/prn
- PCXR prn
- Echocardiogram (at the discretion of the cardiologist)

### MEDICATIONS

**Protocols –**

- Emergency
- Potassium
- Magnesium
- Insulin
- BCOC

**Active Medications:**

- ASA
- Plavix (PCI, allergy to ASA)
- Beta blocker
- ACEI/ARB (begin within 24 hrs)
- Statin
- Insulin protocol (goal BG < 150)

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- ASA
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**Active Medications:**

- ASA
- Plavix (PCI, allergy to ASA)
- Beta blocker
- ACEI/ARB (begin within 24 hrs)
- Statin
- Insulin protocol (goal BG < 150)

### RESPIRATORY CARE

- Maintain O₂ sats > 92%
- Titrate O₂ as indicated
- Maintain O₂ sats > 92%
- Titrate O₂ as indicated
- Maintain O₂ sats > 92%
- Wean O₂ to room air
- Maintain O₂ sats > 92%
- Wean O₂ to room air

### ACTIVITY / SELF-CARE

- Bedrest until enzymes have peaked
- and removal of sheaths – position of comfort
- BRP if no discomfort/distress
- Chair for meals
- Monitored ambulation: 25-100 feet (1-2 times)
- Distance walked: ____________
- Chair for meals
- Monitored ambulation: 50-200 feet (2-4 times)
- Distance walked: ____________
- Chair for meals
- Monitored ambulation: 150-300 feet (2-4 times)
- Distance walked: ____________

- NPO until stable, then progress
- Cardiac diet – progress from
- Cardiac diet (ADA if indicated)
- Cardiac diet (ADA if indicated)
### NUTRITION
- to clear liquids (N/V, CP free)
- NPO as tolerated

### ADDITIONAL ELEMENTS OF CARE
- **Pain**
- **Skin / tissue integrity**
- **Elimination**
- **High Fall Risk**
- **Other:**

### COMFORT CARE
- **Partners in Caring**
- **Backrub**
- **Pet Therapy**
- **Reiki Therapy**
- **Spiritual Care**
- **Humor Therapy**
- **Other:**

### EDUCATION
- *Document on Patient Education Record - see reverse*
- **Change of Heart Book**
- **Smoking cessation**
- **Diagnosis and Treatment Pain Scale**
- **Cardiac Rehab for MI education and activity**
- **Films as appropriate**

### CARE COORDINATION
- **Care Coordination Rounds**
- **Care Coordination Team:**
  - **Specialist**
  - **Internist**
  - **Charge Nurse**
  - **Patient’s nurse**
  - **Case Manager**
  - **Social Work**
  - **Other -**
- **Home health referral**
- **Discharge instructions given to patient:**
  - Medications
  - Diet
  - Activity
  - Home exercise
  - S/S to report to doctor
  - Follow-up
  - Smoking cessation
  - Outpatient cardiac rehab

### CARE COORDINATION
- **Care Coordination Rounds**
- **Care Coordination Team:**
  - **Specialist**
  - **Internist**
  - **Charge Nurse**
  - **Patient’s nurse**
  - **Case Manager**
  - **Social Work**
  - **Other -**
- **Arrangements for discharge**
<table>
<thead>
<tr>
<th>OUTCOMES</th>
<th>Patient pain free (without angina)</th>
<th>Patient pain free (without angina)</th>
<th>Patient without arrhythmias</th>
<th>Medications appropriately prescribed</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Hemodynamic stability –</td>
<td>Hemodynamic stability</td>
<td>Patient and significant other verbalize understanding of all education and teaching</td>
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<tr>
<td></td>
<td>• SBP &gt; 90 mmHg</td>
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<td></td>
<td>Smoking cessation counseling provided</td>
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<tr>
<td></td>
<td>• HR &gt; 50</td>
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<td></td>
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</tr>
<tr>
<td></td>
<td>• Stable cardiac rhythm</td>
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<table>
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<tr>
<th>SIGNATURES</th>
<th>AM RN: ___________________</th>
<th>AM RN: ___________________</th>
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<tr>
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<td>PM RN: ___________________</td>
<td>PM RN: ___________________</td>
<td>PM RN: ___________________</td>
<td>PM RN: ___________________</td>
</tr>
</tbody>
</table>

|                   |                                   |                                   |                              |
|                   |                                   |                                   |                              |
|                   |                                   |                                   |                              |
|                   |                                   |                                   |                              |
|                   |                                   |                                   |                              |
|                   |                                   |                                   |                              |
|                   |                                   |                                   |                              |
ER NSTEMI-UA High to Intermediate Risk Orders

1. STAT call to Cardiologist: ________________________________
2. Allergies: _______________________________________________
3. Patient’s Weight: ___________ kg □ estimated □ actual
4. TIMI Risk Score: __________
   Check all appropriate boxes
5. Medications:
   ▪ STAT Aspirin 325 mg chew PO if not already given and not allergic
     If unable to take PO, give Aspirin 300mg PR
     If patient has a TRUE Aspirin allergy, give clopidogrel 75 mg PO
     □ DO NOT GIVE ASPIRIN. Reason: ____________________________
   ▪ Metoprolol 5 mg IV every 5 minutes X 3 doses
     Hold if HR< 55, SBP < 90, Radiologic or Clinical Evidence of Active CHF
     Metoprolol 25 mg PO X 1, give 15 minutes after last IV dose
     Hold if HR< 55, SBP < 90, Radiologic or Clinical Evidence of Active CHF
     □ DO NOT GIVE A BETA BLOCKER. Reason: ___________________
   ▪ Nitroglycerin 0.4 mg SL every 5 minutes X 3 PRN chest pain
     If chest pain not relieved, start Nitroglycerin IV at 10 mcg/min and titrate for pain relief maintaining SBP ≥ 90 mmHg.
   ▪ Morphine 2-4 mg IV every 5 minutes PRN ongoing chest pain to a max of 10 mg every 1 hour
   ▪ Lorazepam 0.5-1 mg PO one time PRN anxiety
   ▪ Ondansetron 4 mg IV every 6 hours PRN nausea
   ▪ Acetaminophen 650 mg PO/PR every 4 hours PRN discomfort / headache
     (Do NOT exceed 4 gm/day total acetaminophen)
6. Anticoagulation:
   □ Enoxaparin 1 mg/kg Subcutaneous every 12 hours (Round to the nearest 10 mg)
   □ Renal Dose Enoxaparin (CrCl <30 ml/min)
     Enoxaparin 1mg/kg Subcutaneous every 24 hours (Round to the nearest 10mg)
   □ Heparin dosing (Round to nearest 50 units)
     1. Intravenous Heparin Loading Dose:
        Dose (60 units/kg) = _______ units (maximum dose of 4000 units)
     4. Intravenous Heparin Infusion Rate:
        Infusion rate (12 units/kg/hr) = _______ units/hr (maximum of 1000 units/hr)
     5. Obtain aPTT 6 hours after infusion begins
7. Initiate Glycoprotein IIb/IIIa inhibitors as requested by cardiologist
   □ Eptifibatide (Integrilin®) For normal renal function:
     Eptifibatide 180 mcg/kg IV bolus over 2 minutes, then 2 mcg/kg/min IV infusion
   □ Eptifibatide (Integrilin®) For CrCl < 50 ml/min:
     Eptifibatide 180 mcg/kg IV bolus over 2 minutes, then 1 mcg/kg/min IV infusion
8. IV Fluids: ________________________________________________
9. Additional Meds / Orders: ___________________________________

Physician Signature ______________________________ Date/Time_____________
Revision 11.16.05
ER Unstable Angina Low Risk Orders

1. STAT call to Cardiologist: __________________________________________

2. Allergies: _________________________________________________________

3. Patient’s Weight: ________ kg □ estimated □ actual

4. TIMI Risk Score: _________

Check all appropriate boxes

5. Medications:
   - STAT Aspirin 325 mg chew PO if not already given and not allergic
     If unable to take PO, give Aspirin 300mg PR
     If patient has a TRUE Aspirin allergy, give clopidogrel 75 mg PO
     [ ] DO NOT GIVE ASPIRIN. Reason: __________________________
   - Metoprolol 25 mg PO one time
     Hold if HR< 55, SBP < 90, Radiographic or Clinical Evidence of Active CHF
     [ ] DO NOT GIVE A BETA BLOCKER. Reason: ____________________
   - Nitroglycerin 0.4 mg SL every 5 minutes X 3 PRN chest pain
     If chest pain not relieved, start Nitroglycerin IV at 10 mcg/min and titrate for pain relief maintaining SBP ≥ 90 mmHg.
   - Morphine 2-4 mg IV every 5 minutes PRN ongoing chest pain to a max of 10 mg every 1 hour
   - Lorazepam 0.5-1 mg PO one time PRN anxiety
   - Ondansetron 4 mg IV every 6 hours PRN nausea
   - Acetaminophen 650 mg PO/PR every 4 hours PRN discomfort / headache
     (Do NOT exceed 4 gm/day total acetaminophen)

6. Anticoagulation:
   [ ] Enoxaparin 1 mg/kg Subcutaneous every 12 hours (Round to the nearest 10 mg)
   [ ] Renal Dose Enoxaparin (CrCl <30 ml/min)
     Enoxaparin 1mg/kg Subcutaneous every 24 hours (Round to the nearest 10mg)
   [ ] Heparin dosing (Round to nearest 50 units)
     1. Intravenous Heparin Loading Dose:
        Dose (60 units/kg) = _______ units (maximum dose of 4000 units)
     6. Intravenous Heparin Infusion Rate:
        Infusion rate (12 units/kg/hr) = _______ units/hr (maximum of 1000 units/hr)
     7. Obtain aPTT 6 hours after infusion begins

7. IV Fluids: _________________________________________________________

8. Additional Meds / Orders: ____________________________________________

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

_____________________________________________________________________

Physician Signature ______________________________________ Date/Time _______________________

Revision 11.16.05
<table>
<thead>
<tr>
<th>CONSULTATION</th>
<th>□ Cardiologist</th>
</tr>
</thead>
</table>
| ASSESSMENT | Brief, targeted history and physical performed by ED physician  
Risk stratification to -  
□ High/Intermediate Risk  
□ Low Risk  
Continuous telemetry with ST segment monitoring  
System assessment, pain assessment  
Vital signs with pulse ox  
I&O  
Weight |
| LABS | • CK-MB, Troponin, Myoglobin  
• CMP, Magnesium, CBC  
• PT (if patient previously on warfarin)  
• Guiac all stools |
| DIAGNOSTICS / INTERVENTIONS | • 12 Lead EKG completed and read within 10 minutes  
• PCXR stat  
• Obtain IV access |
| MONA | □ STAT ASA (325 mg – chew)  
□ Ntg (0.4 mg sublingual STAT X 3, IV)  
□ Lopressor 5 mg IV every 5 minutes X 3  
□ Lopressor 25 mg PO (hold HR < 55, SBP<90, CHF)  
□ Heparin / Lovenox  
□ GP IIb/IIIa (High and intermediate risk patients only) |
| RESPIRATORY CARE | O2 @ 2L NC  
Maintain O2 sats > 92%, titrate O2 as indicated |
| ACTIVITY / SELF-CARE | Bedrest |
| NUTRITION | NPO, except medications |
| EDUCATION | Diagnosis and Treatment  
Plan for disposition  
Pain scale |
| OUTCOMES | Patient is pain free  
Patient hemodynamically stable  
Cardiologist to direct patient care |
NSTEMI / UA High to Intermediate Risk Admission Orders

Admit to:  □ ICU  □ Telemetry  □ IU
1. Diagnosis: Acute Coronary Syndrome:____________________________________________________________
2. Admitting Specialist: __________________________ Admitting Internist:_______________________________
   Initiate orders 3-13
3. Initiate NSTEMI/UA High/Intermediate Risk care map
4. Emergency Protocol
5. Cardiac Rehab Consult
6. Oxygen 2 Liters per NC.  Titrate to maintain SpO\(_2\) >92%
7. Cardiac Diet
8. Peripheral IV, saline lock if not in use
9. Labs:
   ▪ Admit Labs: **IF NOT DONE IN ED**: Troponin-I and CK-MB at 0, 6, and 12 hours, CBC, CMP, Magnesium, PT/INR if patient previously on warfarin, Fasting Lipid Profile, UA
   ▪ Daily Labs: CBC, BMP, Magnesium, PT/INR if patient on warfarin  □ Phosphorus  □ Other__________
   ▪ PRN Labs: RN may obtain as clinically indicated: CXR, ABG, Hgb/Hct, BMP, Magnesium, aPTT, CKMB until enzymes peak
10. ECG on Admission, Daily for 3 days, and PRN Chest Pain
11. Chest X-Ray:  Daily for 2 days or __________________________
   If patient not diabetic and has a Fasting Blood Sugar <110, discontinue blood glucose monitoring.
   **Initiate the Following Medications, Check All Appropriate Boxes:**
14. Medications
   ▪ STAT Aspirin 325 mg chew PO if not already given in ED and not allergic, then start 81 mg PO daily
     If unable to take PO, give Aspirin 300 mg PR
     If patient has a **TRUE** Aspirin allergy, give clopidogrel 75 mg PO daily
     □ **DO NOT GIVE ASPIRIN.  Reason:**________________________________________
   □ Give Clopidogrel 75 mg PO daily, in addition to aspirin therapy
   ▪ Metoprolol 25 mg PO every 6 hours x 48 hours total, then 50mg PO BID,
     Hold for HR < 55 or SBP < 90, Radiographic or Clinical Evidence of Active CHF
     or: ____________________________________________, Hold for HR < ______ or SBP < ______
     □ **DO NOT GIVE A BETA BLOCKER.  Reason:**________________________________________
   ▪ Captopril 6.25 mg PO every 8 hours, Hold for SBP < 100
     or: ____________________________________________, Hold for SBP < ______
     □ **DO NOT GIVE AN ACE INHIBITOR.  Reason:**________________________________________
   □ Losartan 25mg PO daily, Hold for SBP < 100
     or: ____________________________________________, Hold for SBP < ______
     □ **DO NOT GIVE AN ARB.  Reason:**________________________________________
   ▪ Pravastatin 80 mg PO at bedtime or: ________________________________________________
     □ **DO NOT GIVE A STATIN.  Reason:**________________________________________
- Senakot 1 tablet PO BID, If no results use BCOC.
- Lorazepam 1 mg PO/IV every 4 hours PRN anxiety/sleep
- Temazepam 15 mg PO at bedtime PRN sleep, may repeat x 1
- Acetaminophen 650 mg PO/PR every 4 hours PRN discomfort / headache
  (Do NOT exceed 4 gm/day total acetaminophen)
- Ondansetron 4 mg IV every 6 hours PRN nausea
- Antacid of Choice

15. Anticoagulation:
- Regular Dose Enoxaparin 1 mg/kg Subcutaneous every 12 hours (Round to the nearest 10 mg)
- Renal Dose Enoxaparin (CrCl <30 ml/min)
  Enoxaparin 1 mg/kg Subcutaneous every 24 hours (Round to the nearest 10 mg)
- Heparin dosing (Round to nearest 50 units)
  1. Target aPTT is 57-80 seconds
  2. Obtain aPTT 6 hours after infusion begins
  3. Heparin Dosage Adjustments:

<table>
<thead>
<tr>
<th>aPTT (sec)</th>
<th>Bolus Dose</th>
<th>Hold Infusion</th>
<th>Rate change</th>
<th>Repeat aPTT</th>
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<tbody>
<tr>
<td>&lt;45</td>
<td>70 units/kg</td>
<td>No</td>
<td>↑ 2 ml/hr (200 units/hr)</td>
<td>6 hrs</td>
</tr>
<tr>
<td>45-56</td>
<td>None</td>
<td>No</td>
<td>↑ 1 ml/hr (100 units/hr)</td>
<td>6 hrs</td>
</tr>
<tr>
<td>57-80</td>
<td>None</td>
<td>No</td>
<td>None</td>
<td>12 hours x 1, then daily</td>
</tr>
<tr>
<td>81-100</td>
<td>None</td>
<td>No</td>
<td>↓ 1 ml/hr (100 units/hr)</td>
<td>12 hours</td>
</tr>
<tr>
<td>&gt;100</td>
<td>None</td>
<td>60 min</td>
<td>↓ 2 ml/hr (200 units/hr)</td>
<td>6 hrs</td>
</tr>
</tbody>
</table>

*Repeat aPTT draw time is to begin at the time the adjustment is made (ie when infusion held or changed)

16. Glycoprotein IIb/IIIa Inhibitor:
- Eptifibatide (Integrel™) For normal renal function:
  Eptifibatide 180 mcg/kg IV bolus over 2 minutes, then 2 mcg/kg/min IV infusion
- Eptifibatide (Integrel™) For CrCl < 50 ml/min:
  Eptifibatide 180 mcg/kg IV bolus over 2 minutes, then 1 mcg/kg/min IV infusion

17. IV Fluids: ________________________________

18. Additional Meds/Orders:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

19. Cardiac Diagnostic Procedures:
- Exercise Stress Test
- Adenosine Stress Test
- Dobutamine Stress Test

Test to be scheduled and performed if enzymes are negative and there is no ongoing chest pain.
If either present, contact Attending Cardiologist
☐ Transthoracic ECHO
☐ Stress ECHO

Diagnostic Test to be read by _________________________ Number __________________________

☐ Cardiac Catheterization (Cardiologist to schedule procedure)

Physician
Signature_________________________________________ Date/Time_____________________

Revision 11.16.05
## Non-STEMI / Unstable Angina (High & Intermediate Risk)

### Aspect of Care

<table>
<thead>
<tr>
<th>CONSULTATIONS</th>
<th>Admission / Day 1</th>
<th>Day 2</th>
<th>Day 3 through Discharge</th>
<th>Discharge</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Date ___________</td>
<td>Date ___________</td>
<td>Date(s) ____________</td>
<td>Date ___________</td>
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<tr>
<td>□ Cardiac Rehab</td>
<td>□ Cardiac Rehab</td>
<td>□ Cardiac Rehab</td>
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<tr>
<td>□ Dietary (Nutrition Screen)</td>
<td>□ Dietary (Nutrition Screen)</td>
<td>□ Dietary (Nutrition Screen)</td>
<td>□ Dietary (Nutrition Screen)</td>
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<td>□ Chaplain</td>
<td>□ Chaplain</td>
<td>□ Chaplain</td>
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<tr>
<td>□ Clinical Pharmacist</td>
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<td>Address needs as identified</td>
<td>Address needs as identified</td>
<td>Address needs as identified</td>
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<table>
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<tr>
<th>ASSESSMENT</th>
<th>Admission Database</th>
<th>Continuous Telemetry with ST segment monitoring</th>
<th>Continuous Telemetry with ST segment monitoring</th>
<th>Continuous Telemetry with ST segment monitoring</th>
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<tr>
<td></td>
<td>□ COA</td>
<td>Systems assessment every 4 hr</td>
<td>Systems assessment every 4 hr</td>
<td>Systems assessment every 4 hr</td>
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<tr>
<td></td>
<td>□ Advance Directive</td>
<td>VS with pulse ox and pain assessment:</td>
<td>VS with pulse ox and pain assessment:</td>
<td>VS with pulse ox and pain assessment:</td>
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<td>- ICU = every 1 hr</td>
<td>- ICU = every 1 hr</td>
<td>- ICU = every 1 hr</td>
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<td></td>
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<td>PT, PTT per Heparin protocol</td>
<td>PT, PTT per Heparin protocol</td>
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<tr>
<td></td>
<td></td>
<td>FS blood glucose if diabetic</td>
<td>FS blood glucose if diabetic</td>
<td>FS blood glucose if diabetic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Guia all stools</td>
<td>Guia all stools</td>
<td>Guia all stools</td>
</tr>
</tbody>
</table>

<p>| LABS | Review of ED labs | CBC, BMP, Magnesium | CBC, BMP, Magnesium | CBC, BMP, Magnesium |
|      | CK-MB, Troponin (0, 6, 12 hr) | PT, PTT per Heparin protocol | PT, PTT per Heparin protocol | PT, PTT per Heparin protocol |
|      | Fasting lipid profile | FS blood glucose if diabetic | FS blood glucose if diabetic | FS blood glucose if diabetic |
|      | UA | Guia all stools | Guia all stools | Guia all stools |
|      | PTT per Heparin protocol | FS blood glucose if diabetic | FS blood glucose if diabetic | FS blood glucose if diabetic |</p>
<table>
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<tr>
<th>DIAGNOSTICS / INTERVENTIONS</th>
<th>EF% = __________</th>
<th>□ Echocardiogram</th>
<th>□ Cath lab procedure: _______</th>
<th>□ IABP</th>
<th>□ Adenosine Stress Test (at the discretion of the cardiologist)</th>
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<tbody>
<tr>
<td>12 lead EKG am/prn PCXR prn</td>
<td>12 lead EKG am/prn PCXR prn</td>
<td>□ Echocardiogram (if not done on Day 1)</td>
<td>□ Cath lab procedure: _______</td>
<td>□ IABP</td>
<td>□ Adenosine Stress Test (at the discretion of the cardiologist)</td>
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<tr>
<td>MEDICATIONS</td>
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<td>MONA</td>
<td>12 lead EKG am/prn</td>
<td>12 lead EKG am/prn</td>
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<td>Protocols –</td>
<td>□ IV Ntg</td>
<td>□ IV Ntg</td>
<td>Active Medications:</td>
<td>Active Medications:</td>
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<tr>
<td>• Emergency</td>
<td>□ Heparin / Enoxaparin</td>
<td>□ Heparin / Enoxaparin</td>
<td>□ ASA</td>
<td>□ ASA</td>
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<tr>
<td>□ Potassium</td>
<td>□ GP IIb/IIIa</td>
<td>□ GP IIb/IIIa</td>
<td>□ Plavix (PCI, allergy to ASA)</td>
<td>□ Plavix (PCI, allergy to ASA)</td>
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<tr>
<td>□ Magnesium</td>
<td>□ Active Medications:</td>
<td>□ Beta blocker</td>
<td>□ Beta blocker</td>
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<tr>
<td>□ Insulin</td>
<td>□ ACEI/ARB (begin within 24 hrs)</td>
<td>□ ACEI/ARB (begin within 24 hrs)</td>
<td>□ ACEI/ARB (begin within 24 hrs)</td>
<td>□ ACEI/ARB (begin within 24 hrs)</td>
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<tr>
<td>□ BCOC</td>
<td>□ Statin</td>
<td>□ Statin</td>
<td>□ Statin</td>
<td>□ Statin</td>
<td></td>
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<tr>
<td></td>
<td>□ Insulin protocol (goal BG &lt; 150)</td>
<td>□ Insulin protocol (goal BG &lt; 150)</td>
<td>□ Insulin protocol (goal BG &lt; 150)</td>
<td>□ Insulin protocol (goal BG &lt; 150)</td>
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<td></td>
<td>□ Discussed with physician for non-active medications</td>
<td>□ Discussed with physician for non-active medications</td>
<td>□ Discussed with physician for non-active medications</td>
<td>□ Discussed with physician for non-active medications</td>
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<tr>
<td></td>
<td>□ MAR corrections to pharmacy</td>
<td>□ MAR corrections to pharmacy</td>
<td>□ MAR corrections to pharmacy</td>
<td>□ MAR corrections to pharmacy</td>
<td></td>
</tr>
<tr>
<td>RESPIRATORY CARE</td>
<td>Maintain O₂ sats &gt; 92% Titrate O₂ as indicated</td>
<td>Maintain O₂ sats &gt; 92% Titrate O₂ as indicated</td>
<td>Maintain O₂ sats &gt; 92% Wean O₂ to room air</td>
<td>Maintain O₂ sats &gt; 92% Wean O₂ to room air</td>
<td></td>
</tr>
<tr>
<td>ACTIVITY / SELF-CARE</td>
<td>BRP if no discomfort/distress</td>
<td>Bedrest until sheath removal, then OOB as tolerated Chair for meals</td>
<td>Chair for meals</td>
<td>Chair for meals</td>
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<tr>
<td></td>
<td>Chair for meals</td>
<td>Monitored ambulation: 25-100 feet (1-2 times)</td>
<td>Monitored ambulation: 50-200 feet (2-4 times)</td>
<td>Monitored ambulation: 150-300 feet (2-4 times)</td>
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<tr>
<td>NUTRITION</td>
<td>Cardiac diet – progress from NPO as tolerated</td>
<td>Cardiac diet (ADA if indicated)</td>
<td>Cardiac diet (ADA if indicated)</td>
<td>Cardiac diet (ADA if indicated)</td>
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<tr>
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<td>---------------------------------</td>
<td>---------------------------------</td>
<td>---------------------------------</td>
<td></td>
</tr>
<tr>
<td>ADDITIONAL ELEMENTS OF CARE</td>
<td>□ Pain □ Skin / tissue integrity □ Elimination □ High Fall Risk □ Other:</td>
<td>□ Pain □ Skin / tissue integrity □ Elimination □ High Fall Risk □ Other:</td>
<td>□ Pain □ Skin / tissue integrity □ Elimination □ High Fall Risk □ Other:</td>
<td>□ Pain □ Skin / tissue integrity □ Elimination □ High Fall Risk □ Other:</td>
<td></td>
</tr>
<tr>
<td>COMFORT CARE</td>
<td>□ Partners in Caring □ Backrub □ Pet Therapy □ Reiki Therapy □ Spiritual Care □ Humor Therapy □ Other: ____________</td>
<td>□ Partners in Caring □ Backrub □ Pet Therapy □ Reiki Therapy □ Spiritual Care □ Humor Therapy □ Other: ____________</td>
<td>□ Partners in Caring □ Backrub □ Pet Therapy □ Reiki Therapy □ Spiritual Care □ Humor Therapy □ Other: ____________</td>
<td>□ Partners in Caring □ Backrub □ Pet Therapy □ Reiki Therapy □ Spiritual Care □ Humor Therapy □ Other: ____________</td>
<td></td>
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<tr>
<td>EDUCATION</td>
<td>□ Change of Heart Book □ Smoking Cessation □ Diagnosis and Treatment □ Risk factor modification □ Cardiac Rehab for ACS education and activity</td>
<td>□ Smoking cessation □ Diet / Weight / Exercise □ Risk factor modification □ Films as appropriate</td>
<td>□ Smoking cessation □ Reinforce education □ Home activity / exercise plan □ Films as appropriate</td>
<td>□ Smoking cessation □ Reinforce education</td>
<td></td>
</tr>
<tr>
<td>CARE COORDINATION</td>
<td>Care Coordination Rounds □ Specialist □ Internist □ Charge Nurse □ Patient’s nurse</td>
<td>Care Coordination Rounds □ Specialist □ Internist □ Charge Nurse □ Patient’s nurse</td>
<td>CARE Coordination Rounds □ Specialist □ Internist □ Charge Nurse □ Patient’s nurse</td>
<td>□ Discharge instructions given to patient: ▪ Medications ▪ Diet ▪ Activity ▪ Home exercise ▪ S/S to report to doctor</td>
<td></td>
</tr>
<tr>
<td>OUTCOMES</td>
<td>SIGNATURES</td>
<td></td>
<td></td>
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<td>-------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
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<tr>
<td>- Patient pain free (without angina)</td>
<td>AM RN: ___________________</td>
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<tr>
<td>- Hemodynamic stability –</td>
<td>PM RN: ___________________</td>
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<td></td>
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<tr>
<td>- SBP &gt; 90 mmHg</td>
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<td>- HR &gt; 50</td>
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<tr>
<td>- Stable cardiac rhythm</td>
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<td></td>
</tr>
<tr>
<td>- Patient pain free (without angina)</td>
<td>AM RN: ___________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Patient with stable cardiac rhythm</td>
<td>PM RN: ___________________</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>- Patient with stable cardiac rhythm</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Patient and significant other verbalize understanding of all education</td>
<td>AM RN: ___________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>and teaching</td>
<td>PM RN: ___________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Smoking cessation counseling provided</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
Unstable Angina Low Risk Admission Orders

Admit to: □ ICU  □ Telemetry  □ IU
1. Diagnosis: Acute Coronary Syndrome: ____________________________________________________________
2. Admitting Specialist: __________________________ Admitting Internist:______________________________

Initiate orders 3-13
3. Initiate NSTEMI/UA Low Risk care map
4. Emergency Protocol
5. Cardiac Rehab Consult
6. Oxygen 2 Liters per NC. Titrate to maintain SpO₂ >92%
7. Cardiac Diet
8. Peripheral IV, saline lock if not in use
9. Labs:
   ▪ Admit Labs: **IF NOT DONE IN ED**: Troponin-I and CK-MB at 0 and 6 hours, Myoglobin at 0 and 3 hours, CBC, CMP, Magnesium, PT/INR if patient previously on warfarin, Fasting Lipid Profile, UA
   ▪ Daily PT/INR if patient on warfarin
   ▪ PRN Labs: RN may obtain as clinically indicated: CXR, ABG, Hgb/Hct, BMP, Magnesium, aPTT, CKMB until enzymes peak
10. ECG on Admission, and PRN Chest Pain
11. Chest X-Ray **IF NOT DONE IN ED**
    If patient not diabetic and has a Fasting Blood Sugar <110, discontinue blood glucose monitoring.
13. Follow Potassium and Magnesium Protocol

Initiate the Following Medications, Check All Appropriate Boxes:
14. Medications
   ▪ STAT Aspirin 325 mg chew PO if not already given in ED and not allergic, then start 81 mg PO daily
     If unable to take PO, give Aspirin 300 mg PR
     □ DO NOT GIVE ASPIRIN. Reason: ____________________________________________________________
   □ Give Clopidogrel 75 mg PO daily, in addition to aspirin therapy
   ▪ Metoprolol 25 mg PO BID, Hold for HR <55, SBP <90, Radiographic or Clinical Evidence of Active CHF
     or: ________________________________________________, Hold for HR < _____ or SBP < _____
     □ DO NOT GIVE A BETA BLOCKER. Reason: ____________________________________________________
   □ Captopril 6.25 mg PO every 8 hours, Hold for SBP < 100
     or: ____________________________________________________________, Hold for SBP < _____
     □ DO NOT GIVE AN ACE INHIBITOR. Reason: __________________________________________________
   □ Losartan 25mg PO daily, Hold for SBP < 100
     or: ____________________________________________________________, Hold for SBP < _____
     □ DO NOT GIVE AN ARB. Reason: ____________________________________________________________
   ▪ Pravastatin 80 mg PO at bedtime or: __________________________________________________________
     □ DO NOT GIVE A STATIN. Reason: __________________________________________________________
   ▪ Senakot 1 tablet PO BID. If no results use BCOC.
   ▪ Lorazepam 1 mg PO/IV every 4 hours PRN anxiety/sleep
   ▪ Temazepam 15 mg PO at bedtime PRN sleep, may repeat x 1
   ▪ Acetaminophen 650 mg PO/PR every 4 hours PRN discomfort / headache
     (Do NOT exceed 4 gm/day total acetaminophen)
   ▪ Ondansetron 4 mg IV every 6 hours PRN nausea
15. Anticoagulation:
   - Regular Dose Enoxaparin 1 mg/kg Subcutaneous every 12 hours (Round to the nearest 10 mg)
   - Renal Dose Enoxaparin (CrCl <30 ml/min)
     - Enoxaparin 1 mg/kg Subcutaneous every 24 hours (Round to the nearest 10 mg)
   - Heparin dosing (Round to nearest 50 units)
     1. Target aPTT is 57-80 seconds
     2. Obtain aPTT 6 hours after infusion begins
     3. Heparin Dosage Adjustments:

<table>
<thead>
<tr>
<th>aPTT (sec)</th>
<th>Bolus Dose</th>
<th>Hold Infusion</th>
<th>Rate change</th>
<th>Repeat aPTT</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;45</td>
<td>70 units/kg</td>
<td>No</td>
<td>↑ 2 ml/hr (200 units/hr)</td>
<td>6 hrs</td>
</tr>
<tr>
<td>45-56</td>
<td>None</td>
<td>No</td>
<td>↑ 1 ml/hr (100 units/hr)</td>
<td>6 hrs</td>
</tr>
<tr>
<td>57-80</td>
<td>None</td>
<td>No</td>
<td>None</td>
<td>12 hours x 1, then daily</td>
</tr>
<tr>
<td>81-100</td>
<td>None</td>
<td>No</td>
<td>↓ 1 ml/hr (100 units/hr)</td>
<td>12 hours</td>
</tr>
<tr>
<td>&gt;100</td>
<td>None</td>
<td>60 min</td>
<td>↓ 2 ml/hr (200 units/hr)</td>
<td>6 hrs</td>
</tr>
</tbody>
</table>

*Repeat aPTT draw time is to begin at the time the adjustment is made (ie when infusion held or changed)*

16. IV Fluids: _______________________________________________________________________

17. Additional Meds/Orders:
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

18. Cardiac Diagnostic Procedures:
   - Exercise Stress Test
   - Adenosine Stress Test
   - Dobutamine Stress Test
   - Transthoracic ECHO
   - Stress ECHO

   Test to be scheduled and performed if enzymes are negative and there is no ongoing chest pain.
   If either present, contact Attending Cardiologist

   Diagnostic Test to be read by _________________________ Number __________________________

   - Cardiac Catheterization (Cardiologist to schedule procedure)

Physician _______________________________ Signature __________________________ Date/Time ____________

11.16.05
# Unstable Angina (Low Risk)

<table>
<thead>
<tr>
<th>Aspect of Care</th>
<th>Admission / Day 1 Date</th>
<th>Day 2 through Discharge Date(s)</th>
<th>Discharge Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONSULTATIONS</td>
<td>□ Cardiac Rehab</td>
<td>□ Cardiac Rehab</td>
<td>□ Cardiac Rehab</td>
</tr>
<tr>
<td></td>
<td>□ Dietary (Nutrition Screen)</td>
<td>□ Dietary (Nutrition Screen)</td>
<td>□ Dietary (Nutrition Screen)</td>
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<td></td>
<td>□ Social Work</td>
<td>□ Social Work</td>
<td>□ Social Work</td>
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<td></td>
<td>□ Chaplain</td>
<td>□ Chaplain</td>
<td>□ Chaplain</td>
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<tr>
<td></td>
<td>□ Clinical Pharmacist</td>
<td>□ Clinical Pharmacist</td>
<td>□ Clinical Pharmacist</td>
</tr>
<tr>
<td></td>
<td>Address needs as identified</td>
<td>Address needs as identified</td>
<td>Address needs as identified</td>
</tr>
</tbody>
</table>

### ASSESSMENT
- □ Admission Database
- □ COA
- □ Advance Directive
- Continuous Telemetry with ST segment monitoring
- Systems assessment every 4 hr
- VS with pulse ox and pain assessment every 4 hr
- I&O every shift
- Daily AM weight

### LABS
- □ Review of ED labs
- □ Myoglobin (0, 3 hr)
- □ CK-MB, Troponin (0, 6 hr)
- □ Fasting lipid profile
- □ UA
- PTT per Heparin protocol
- FS blood glucose if diabetic
- Guiac all stools

### DIAGNOSTICS / INTERVENTIONS

#### EF% =

### MONA
- □ SL Ntg
- □ Heparin / Enoxaparin
- Active Medications:
  - □ ASA
  - □ Plavix (PCI, allergy to ASA)
  - □ Beta blocker
  - □ ACEI/ARB (begin within 24 hrs)

### MONA
- □ SL Ntg
- □ Heparin / Enoxaparin
- Active Medications:
  - □ ASA
  - □ Plavix (PCI, allergy to ASA)
  - □ Beta blocker
  - □ ACEI/ARB (begin within 24 hrs)

### MEDICATIONS

#### Protocols –
- • Emergency
- □
- • Potassium
- □

Active Medications:
- □ ASA
- □ Plavix (PCI, allergy to ASA)
- □ Beta blocker
- □ ACEI/ARB (begin within 24 hrs)
- □ Statin
| **• Magnesium** | □ Statin | □ Insulin protocol (goal BG < 150) | □ Insulin protocol (goal BG < 150) | □ Insulin protocol (goal BG < 150) |
| **• Insulin** | □ Insulin protocol (goal BG < 150) | □ Discussed with physician for non-active medications | □ Discussed with physician for non-active medications | □ Discussed with physician for non-active medications |
| **• BCOC** | □ MAR corrections to pharmacy | □ MAR corrections to pharmacy | □ MAR corrections to pharmacy | □ MAR corrections to pharmacy |

**RESPIRATORY CARE**
- Maintain O₂ sats > 92%
- Titrate O₂ as indicated
- Bedrest until sheath removal, then OOB as tolerated
- Chair for meals
- Monitored ambulation: 25-100 feet (1-2 times)
- Distance walked: ____________
- Chair for meals
- Monitored ambulation: 150-300 feet (2-4 times)
- Distance walked: ____________

**ACTIVITY / SELF-CARE**
- BRP if no discomfort/distress
- Bedrest until sheath removal, then OOB as tolerated
- Chair for meals
- Monitored ambulation: 25-100 feet (1-2 times)
- Distance walked: ____________
- Chair for meals
- Monitored ambulation: 150-300 feet (2-4 times)
- Distance walked: ____________

**NUTRITION**
- Cardiac diet
- NPO for procedures
- Cardiac diet
- NPO for procedures
- Cardiac diet (ADA if indicated)

**ADDITIONAL ELEMENTS OF CARE**
- □ Pain
- □ Skin / tissue integrity
- □ Elimination
- □ High Fall Risk
- □ Other:
- □ Pain
- □ Skin / tissue integrity
- □ Elimination
- □ High Fall Risk
- □ Other:
- □ Pain
- □ Skin / tissue integrity
- □ Elimination
- □ High Fall Risk
- □ Other:

**COMFORT CARE**
- □ Partners in Caring
- □ Backrub
- □ Pet Therapy
- □ Reiki Therapy
- □ Spiritual Care
- □ Humor Therapy
- □ Other: ________________
- □ Partners in Caring
- □ Backrub
- □ Pet Therapy
- □ Reiki Therapy
- □ Spiritual Care
- □ Humor Therapy
- □ Other: ________________
- □ Partners in Caring
- □ Backrub
- □ Pet Therapy
- □ Reiki Therapy
- □ Spiritual Care
- □ Humor Therapy
- □ Other: ________________

**EDUCATION**
- □ Change of Heart Book
- □ Smoking Cessation
- □ Smoking Cessation
- □ Change of Heart Book
- □ Smoking Cessation
- □ Change of Heart Book
- □ Smoking Cessation
- □ Change of Heart Book
- □ Smoking Cessation

- □ Diagnosis and Treatment
- □ Pain Scale
- □ Cardiac Rehab for ACS education and activity
- □ Reinforce education

**CARE**
- Care Coordination Rounds
- Care Coordination Team:
  - □ Specialist
  - □ Internist
  - □ Charge Nurse
- Care Coordination Rounds
- Care Coordination Team:
  - □ Specialist
  - □ Internist
  - □ Charge Nurse
- Care Coordination Rounds
- Care Coordination Team:
  - □ Specialist
  - □ Internist
  - □ Charge Nurse
- Care Coordination Rounds
- Care Coordination Team:
  - □ Specialist
  - □ Internist
  - □ Charge Nurse

- □ Discharge instructions given to patient:
  - □ Medications
  - □ Diet
  - □ Activity
| COORDINATION | □ Patient’s nurse  
□ Case Manager  
□ Social Work  
□ Other - | □ Patient’s nurse  
□ Case Manager  
□ Social Work  
□ Other -  
□ Home health referral  
□ Community health referral  
□ Outpatient cardiac rehab order obtained and arranged | • Home exercise  
• S/S to report to doctor  
• Follow-up  
• Smoking cessation  
• Outpatient cardiac rehab |
| OUTCOMES | Patient pain free (without angina)  
Hemodynamic stability –  
• SBP > 90 mmHg  
• HR > 50  
• Stable cardiac rhythm | Patient pain free (without angina)  
Patient with stable cardiac rhythm | Medications appropriately prescribed  
Patient and significant other verbalize understanding of all medications  
Smoking cessation counseling provided |
| SIGNATURES | AM RN: ___________________  
PM RN: _________________ | AM RN: ___________________  
PM RN: _________________ | AM RN: ___________________  
PM RN: _________________ |
**Chest Pain Unit: Chest Pain of Possible Cardiac Origin**

1. Place in Chest Pain Unit (CPU) on Observation Status Time: ___________________________________
2. Diagnosis: _____________________________________________________________________________
3. Consult Cardiologist upon movement to CPU:  ________________________________________________
4. Allergies:  _______________________________________________________________________
5. Patient’s Weight___________ kg  □ estimated  □ actual

**Initiate orders 5-12**
6. Initiate Chest Pain Unit care map
7. Oxygen 2 Liters per NC. Titrate to maintain SpO\textsubscript{2} >92%
8. Cardiac Diet
9. Peripheral IV, saline lock if not in use
10. Labs:
   - Cardiac Markers: Troponin-I and CK-MB at 0 and 6 hours, Myoglobin at 0 and 3 hours
   - BMP, CBC, Fasting Lipid Profile, PT/INR if patient previously on warfarin (Coumadin\textsuperscript{®})
   - □ TSH
11. Second ECG 6 hours after initial ECG, and PRN for persistent or recurrent chest pain (Notify Physician)
12. Portable CXR.  **IF NOT DONE IN ED**
13. Education: Offer materials as appropriate: □ Smoking Cessation  □ Diet  □ CAD  □ CHF

**Initiate the Following Medications, Check All Appropriate Boxes:**
14. Medications:
   - STAT Aspirin 325 mg chew PO if not already given in ED and not allergic, then start 81 mg PO daily
     If unable to take PO, give Aspirin 300 mg PR
     If patient has a **TRUE** Aspirin allergy, give clopidogrel 75 mg PO daily
   - Nitroglycerin 0.4 mg SL every 5 minutes X 3 PRN chest pain
     If chest pain not relieved, start Nitroglycerin IV at 10 mcg/min and titrate for pain relief maintaining SBP ≥ 90 mmHg.
   - Morphine 2-4 mg IV every 5 minutes PRN ongoing chest pain to a max of 10 mg every 1 hour
   - Lorazepam 1 mg PO/IV every 4 hours PRN anxiety/sleep
   - Acetaminophen 650 mg PO/PR every 4 hours PRN discomfort / headache
     (Do NOT exceed 4 gm/day total acetaminophen)
   - Ondansetron 4 mg IV every 6 hours PRN nausea
   - Senakot 1 tablet PO BID PRN constipation. If no results use BCOC.
   - Antacid of Choice

15. IV Fluids: _________________________________________________________________________________
16. Additional Meds /
    Orders:______________________________________________________________________________

17. Cardiac Diagnostic Procedures:
   □ Exercise Stress Test
   □ Adenosine Stress Test
   □ Dobutamine Stress Test
   □ Transthoracic ECHO
   □ Stress ECHO

Test to be scheduled and performed if enzymes are negative and there is no ongoing chest pain.
If either present, contact Attending Cardiologist
Diagnosis Test to be read by __________________________ Number __________________________

- Cardiac Catheterization (Cardiologist to schedule procedure)

18. Disposition: Discharge patient if ordered by consultant and cardiac markers are negative

Physician signature: _______________________________ Time __________________________

Revision 11.16.05

<p>| Chest Pain Unit Care Map – Emergency Department (Low Risk, Stable Angina, Atypical Chest Pain) |
|---|---|
| <strong>CONSULTATION</strong> | □ Cardiologist: _________________________________ |
| <strong>ASSESSMENT</strong> | Brief, targeted history and physical performed by ED physician |
| | Continuous telemetry with ST segment monitoring |
| | System assessment, pain assessment |
| | Vital signs with pulse ox |
| | I&amp;O |
| | Weight |
| <strong>LABS</strong> | • Myoglobin at 0, 3 hrs |
| | • CK-MB, Troponin at 0, 6, 12 hrs |
| | • CMP, Magnesium, CBC |
| | • PT (if patient previously on warfarin) |
| | • Guiac all stools |
| <strong>DIAGNOSTICS / INTERVENTIONS</strong> | • PCXR |
| | • Obtain IV access |
| | □ Exercise Stress Test |
| | □ Adenosine Stress Test |
| | □ Dobutamine Stress Test |
| | □ Stress ECHO |
| | □ TEE |
| | □ Cardiac Catheterization |
| <strong>MONA</strong> | |
| | □ STAT ASA (325 mg – chew) |
| | □ Ntg (0.4 mg sublingual STAT X 3, IV) |
| <strong>MEDICATIONS</strong> | |
| | <strong>RESPIRATORY CARE</strong> |
| | O2 @ 2L NC |
| | Maintain O2 sats &gt; 92%, titrate O2 as indicated |
| <strong>ACTIVITY / SELF-CARE</strong> | Bedrest, advance to BRP as tolerated |</p>
<table>
<thead>
<tr>
<th><strong>NUTRITION</strong></th>
<th>NPO until stable, then advance to cardiac diet as tolerated</th>
</tr>
</thead>
</table>
| **EDUCATION** | Diagnosis and Treatment  
Plan for disposition  
Pain scale |
| **OUTCOMES**  | Patient is pain free  
Patient hemodynamically stable  
Cardiologist to direct patient care |