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CHEST PAIN R/O M.I. CLINICAL PATHWAY

DRG NO 143

PATIENT IDENTIFICATION

Initiating UNIT:	Initiating DATE:	Initiating TIME:	DRG NO: 143	LENGTH OF STAY: <24 Hours
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	ER Admission	0 - 15 mins	15 - 60 mins	Hours 1 - 3	Hours 3 - 6	Hours 6 - 10	Hours 10 - 15	Hours 15 - 23
ACTIVITY	<input type="checkbox"/> Bedrest	<input type="checkbox"/> Bedrest	<input type="checkbox"/> Bedrest	<input type="checkbox"/> Bedrest	<input type="checkbox"/> Bedrest with bathroom privileges	—————>	—————>	—————>
TEST SPECIMENS	<input type="checkbox"/> *EKG and assessment within 1st 15 minutes	LABS: <input type="checkbox"/> CKO within 1st 30 min - send STAT <input type="checkbox"/> CCP <input type="checkbox"/> CBC <input type="checkbox"/> PT + PTT <input type="checkbox"/> Type + Screen <input type="checkbox"/> M B Draw + Hold	<input type="checkbox"/> Portable CXR - if indicated <input type="checkbox"/> Send all bloods drawn except Type + Screen - stat <input type="checkbox"/> Repeat EKG at 60 min if chest pain present	<input type="checkbox"/> Check CKO results at 1 hour post sent <input type="checkbox"/> Check CBC at 1 hour post sent <input type="checkbox"/> Check CXR results <input type="checkbox"/> Repeat EKG	<input type="checkbox"/> EKG *2	<input type="checkbox"/> CK6 at Hour 6 <input type="checkbox"/> Check CK6 results 1 hour post sent	<input type="checkbox"/> CK12 at Hour 12 <input type="checkbox"/> Check CK12 results 1 hour post sent	
DIET		<input type="checkbox"/> NPO	<input type="checkbox"/> NPO	<input type="checkbox"/> Clear Liquids	<input type="checkbox"/> As Appropriate	—————>	—————>	—————>
MEDS		<input type="checkbox"/> Consider SL Nitro <input type="checkbox"/> If pulse ox 98% and chest pain, start O2	<input type="checkbox"/> Consider Nitro if pain persists: NTG 1/150 SL q 5 min x 3 <input type="checkbox"/> Topical Nitrates if appropriate	<input type="checkbox"/> ASA 325 mg po				
CONSULTS		<input type="checkbox"/> Assign to Cardiac Track II or Track IV		<input type="checkbox"/> Notify PMD <input type="checkbox"/> Discuss need for Cardiology Consult + Sestamibi *1 testing	<input type="checkbox"/> If Cardiology requests rest or stress Sestamibi testing, arrange w/ Nuclear Med <input type="checkbox"/> Others as indicated	<input type="checkbox"/> Social Services, Dietary as indicated		<input type="checkbox"/> Review enzymes & stress test results <input type="checkbox"/> Make admission or discharge decision IF ADMIT, INITIATE NEW PATHWAY
IV'S		<input type="checkbox"/> Insert Saline Lock Fluids as indicated	—————>	—————>	—————>	—————>	—————>	—————>

*1 Sestamibi testing available: M-F from 0700-2100; Sat from 0700-1600

*2 Any changes in pain (re-occurs or exacerbates) - EKG repeat

*3 If admitted, change diagnosis from R/O MI to appropriate diagnosis

☆ THIS PATHWAY IS FOR CARDIAC Track III or Track IV

Track I Acute MI Pathway (ST elevation, new LBBB, posterior MI)

Track II Unstable Angina Pathway - Typical symptoms, ST depression (new onset CHF)

Track III Chest Pain Pathway - Typical symptoms >30mins, unchanged EKG or Atypical symptoms w/ non-diagnostic EKG

Track IV Chest Pain Pathway - Typical symptoms <30mins, or Atypical symptoms + normal EKG or cocaine use + normal EKG

Track V Very atypical symptoms, obvious non-cardiac etiology

PART OF THE MEDICAL RECORD

CHEST PAIN R/O M.I. - CLINICAL PATHWAY

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	ER Admission	0 - 15 mins	15 - 60 mins	Hours 1 - 3	Hours 3 - 6	Hours 6 - 10	Hours 10 - 15	Hours 15 - 23
TREATMENTS		<input type="checkbox"/> Intake & Output	—————>	—————>	—————>	—————>	—————>	—————>
VITAL SIGNS	<input type="checkbox"/> On Presentation	<input type="checkbox"/> At 15 min <input type="checkbox"/> Pulse Ox <input type="checkbox"/> Continuous cardiac monitoring until 12 lead done & evaluated by MD	<input type="checkbox"/> Continuous cardiac monitoring <input type="checkbox"/> VS q 30 min x 2	<input type="checkbox"/> VS q 1 hour x 2	<input type="checkbox"/> VS q 2 hour x 2	<input type="checkbox"/> VS q 2 hour x 2	—————>	—————>
DISCHARGE PLANNING					<input type="checkbox"/> Assessment of home / family resources / support systems			<input type="checkbox"/> Review discharge instructions
TEACHING			<input type="checkbox"/> Orient patient to physical surroundings. Explain all procedures. Assess risk factors.	<input type="checkbox"/> Explain admission & plan of care to patient and family.		<input type="checkbox"/> Medication instruction as indicated-symptom management		<input type="checkbox"/> Reinforce medic symptom management teaching
EVALUATION	<u>ON TRACK</u> <input type="checkbox"/> Yes <input type="checkbox"/> No	<u>ON TRACK</u> <input type="checkbox"/> Yes <input type="checkbox"/> No	<u>ON TRACK</u> <input type="checkbox"/> Yes <input type="checkbox"/> No	<u>ON TRACK</u> <input type="checkbox"/> Yes <input type="checkbox"/> No	<u>ON TRACK</u> <input type="checkbox"/> Yes <input type="checkbox"/> No	<u>ON TRACK</u> <input type="checkbox"/> Yes <input type="checkbox"/> No	<u>ON TRACK</u> <input type="checkbox"/> Yes <input type="checkbox"/> No	<u>ON TRACK</u> <input type="checkbox"/> Yes <input type="checkbox"/> No
	RN Initials	RN Initials	RN Initials	RN Initials	RN Initials	RN Initials	RN Initials	RN Initials

PATIENT NAME:	AGE:	ROOM #:	PHYSICIAN:
ADMISSION DATE:	ADMISSION TIME: (Military Time)	DISCHARGE DATE:	DISCHARGE TIME: (Military Time)
		ACTUAL LOS:	

PART OF THE MEDICAL RECORD

USE (√) TO INDICATE PERFORMANCE. USE LARGER SPACE FOR BRIEF COMMENT

	NORMAL	√	N (Init. _____)	√	D (Init. _____)	√	E (Init. _____)
GU	Urine clear, yellow to amber, No difficulty voiding, No bladder distention DIALYSIS DAYS <input type="checkbox"/> M <input type="checkbox"/> TH <input type="checkbox"/> SA <input type="checkbox"/> T <input type="checkbox"/> F <input type="checkbox"/> SU <input type="checkbox"/> W	W / I Normal Limits					
		Urine cloudy:					
		color:					
		Frequency					
		Burning					
		Dysuria					
		* Urinary Incontinence					
		Foley / Suprapubic / Nephrostomy					
		Dialysis					
		Ostomy (type)					
MUSCLOSKELE	Moves all extremities independently, full / spontaneous ROM; self care; independent bed mobility, transfers, steady gait; ambulates without assistive device; absence of joint swelling or tenderness	W / I Normal Limits					
		* Weakness / Location					
		* Paralysis / Location					
		* Amputation / Type / Location					
		* Assistive Device / Type / Prosthesis					
		* Immobilization Device / Type					
		Skin Assessment					
		Traction / Type / Location / Wgt					
		Joint Pain _____					
		Swelling _____					
Erythema							

POST OPERATIVE WOUND CARE

SITE	N	D	E
Post-Operative Dressing / Incision Assessment			
Post-Operative Wound Drainage Assessment			
Post-Operative Wound Care			
Ice Pack			
Initials			

PART ONE: RESTRAINT INTERVENTIONS

N/A If initial order, document time restraints applied: _____ AM PM

1 Indication for use of restraints: Interference with medical treatment Risk of falls

2 Alternative intervention(s) attempted prior to restraint applications Nursing interventions - i.e., securing tubing, dressing
 Diversional activity - i.e., music, puzzles, etc. Environment change Reality orientation Bed alarm
 Spend more time with patients Reduce stimuli Family / significant other involvement

3 Alternative measures effective: Yes No

4 Education
a. Patient / significant other educated on restraint alternatives + reason(s) for restraint use: Yes No
b. Patient / significant other verbalized understanding: Yes No Not understood by patient; significant other unavailable

5 Type and location of restraint(s) in use: _____

6 a. Restraint Standard for Acute Care Setting in use: Yes No
b. Acute Confusional State Standard in use: Yes No

PART TWO: OBSERVATION FLOWSHEET

Directions: Document Observations every 2 hours (MST may complete)

TIME	0000	0200	0400	0600	0800	1000	1200	1400	1600	1800	2000	2200
Hydration / Nutrition												
Toilet / Comfort												
Skin Checked												
ROM												
Circulation Checked												
LOC / Mental / Emotional Status												
Staff Initials												

PART OF THE MEDICAL RECORD