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

**DRG NO 143**

**PART OF THE MEDICAL RECORD**

### PATIENT IDENTIFICATION

<table>
<thead>
<tr>
<th>Initiating UNIT:</th>
<th>Initiating DATE:</th>
<th>Initiating TIME:</th>
<th>DRG NO: 143</th>
<th>LENGTH OF STAY: &lt;24 Hours</th>
</tr>
</thead>
</table>

### ER Admission

<table>
<thead>
<tr>
<th>0 - 15 mins</th>
<th>15 - 60 mins</th>
<th>Hours 1 - 3</th>
<th>Hours 3 - 6</th>
<th>Hours 6 - 10</th>
<th>Hours 10 - 15</th>
<th>Hours 15 - 23</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACTIVITY</strong></td>
<td>Bedrest</td>
<td>Bedrest</td>
<td>Bedrest</td>
<td>Bedrest with bathroom privileges</td>
<td></td>
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<tr>
<td><strong>TEST SPECIMENS</strong></td>
<td><em>EKG and assessment within 1st 15 minutes</em></td>
<td>Portable CXR - if indicated</td>
<td>Check CKO results at 1 hour post sent</td>
<td>EKG <em>2</em></td>
<td>CK6 at Hour 6</td>
<td>CK12 at Hour 12</td>
</tr>
<tr>
<td><strong>DIET</strong></td>
<td>NPO</td>
<td>NPO</td>
<td>Clear Liquids</td>
<td>As Appropriate</td>
<td></td>
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</tr>
<tr>
<td><strong>MEDS</strong></td>
<td>Consider SL Nitro</td>
<td>Consider Nitro if pain persists: NTG 1/150 SL q 5 min x 3</td>
<td>ASA 325 mg po</td>
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<tr>
<td><strong>CONSULTS</strong></td>
<td>Assign to Cardiac Track II or Track IV</td>
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<tr>
<td><strong>IV'S</strong></td>
<td>Insert Saline Lock Fluids as indicated</td>
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</tbody>
</table>

### Notes:

- *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

**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 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

- THIS PATHWAY IS FOR CARDIAC Track III or Track IV

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**8850195 Rev. 05/05**

Chest Pain R/O M.I Clinical Pathway_ER_MEDICAL AFFAIRS

PAGE 1 of 3
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#### TREATMENTS
- [ ] Intake & Output
- [ ] On Presentation
- [ ] At 15 min
- [ ] Pulse Ox
- [ ] Continuous cardiac monitoring until 12 lead done & evaluated by MD
- [ ] VS q 1 hour x 2
- [ ] VS q 2 hour x 2
- [ ] VS q 2 hour x 2

#### VITAL SIGNS

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hours 1 - 3</td>
<td>Continuous cardiac monitoring</td>
</tr>
<tr>
<td>Hours 3 - 6</td>
<td>VS q 1 hour x 2</td>
</tr>
<tr>
<td>Hours 6 - 10</td>
<td>VS q 2 hour x 2</td>
</tr>
<tr>
<td>Hours 10 - 15</td>
<td>VS q 2 hour x 2</td>
</tr>
<tr>
<td>Hours 15 - 23</td>
<td>Assortment of home / family resources / support systems</td>
</tr>
</tbody>
</table>

#### DISCHARGE PLANNING
- [ ] Review discharge instructions
- [ ] Discharge planning and evaluation

#### TEACHING
- [ ] Orient patient to physical surroundings.
- [ ] Explain admission & plan of care to patient and family.
- [ ] Assess risk factors.
- [ ] Medication instruction as indicated-symptom management
- [ ] Reinforce med symptom management teaching

#### EVALUATION

<table>
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<tr>
<th>ON TRACK</th>
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<th>ON TRACK</th>
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<th>ON TRACK</th>
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</thead>
<tbody>
<tr>
<td>[ ] Yes</td>
<td>[ ] No</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
<td>[ ] Yes</td>
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<thead>
<tr>
<th>RN Initials</th>
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<th>RN Initials</th>
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</table>

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

- Urine clear, yellow to amber, no difficulty voiding, no bladder distention

### DIALYSIS DAYS

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<tr>
<th>Day</th>
<th>M</th>
<th>TH</th>
<th>SA</th>
<th>T</th>
<th>F</th>
<th>SU</th>
<th>W</th>
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### MUSCLOSKELETAL

- 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

### SITE

- Post-Operative Dressing / Incision Assessment
- Post-Operative Wound Drainage Assessment
- Post-Operative Wound Care

### ICE PACK

Initials: ____________

### PART ONE: RESTRAINT INTERVENTIONS

1. Indication for use of restraints:  
   - Interference with medical treatment
   - Risk of falls
2. Alternative intervention(s) attempted prior to restraint applications:  
   - Diversional activity - i.e., music, puzzles, etc.
   - Spend more time with patients
3. Alternative measures effective:  
   - Yes
   - No
4. Education:  
   - Patient / significant other educated on restraint alternatives + reason(s) for restraint use:  
     - Yes
     - No
   - Patient / significant other verbalized understanding:  
     - Yes
     - No

### PART TWO: OBSERVATION FLOWSHEET

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

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<th>0200</th>
<th>0400</th>
<th>0600</th>
<th>0800</th>
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<th>1600</th>
<th>1800</th>
<th>2000</th>
<th>2200</th>
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<td>Hydration / Nutrition</td>
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<td>Toilet / Comfort</td>
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<td>Skin Checked</td>
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<td>Staff Initials</td>
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### POST OPERATIVE WOUND CARE

- Post-Operative Dressing / Incision Assessment
- Post-Operative Wound Drainage Assessment
- Post-Operative Wound Care
- Ice Pack

Initials: ____________

### PART OF THE MEDICAL RECORD