Patient _____ Chart No. – No du dossier _____ Patient _____ Chart No. – No du dossier _____

CRITICAL PATH

	Day of Admission (ER – HI)	Day 1	Day 2	Day 3	Day 4	Additional Days (Repeat Day 4)	Discharge Day	Intervention Day
Date (YY/MM/DD)								
Consults	• Cardiology Nsg Coordinator PRN (HI) • Smoking Cessation: ☐ Yes ☐ N/A	• Social work consult PRN • Patient Revascularization Registry Form Completed: ☐ Yes ☐ No	• Cardiac Rehabilitation Referral done ☐ • Patient Revascularization Registry Form Completed: ☐ Yes ☐ No	• Dietitian for ↑ Lipids & PRN • Physiotherapy PRN • Occupational Therapy PRN • Patient Revascularization Registry Form Completed: ☐ Yes ☐ No	• Patient Revascularization Registry Form Completed: ☐ Yes ☐ No			☐ **Post Cath Care** • Follow Post cath orders: Vital signs q 1h × 4 then QID _____ Vascular Assessment q 1h × 4 & PRN _____ • Blood work according to Heparin/ Integrelin protocol PRN _____ • CBC PRN _____
Tests	• ECG ☐ • Chest x-ray ☐ • CBC, platelets, Na, K, Cl, Cr, glucose, INR, PTT ☐ • Troponin q 8 h × 2 ☐ ☐ • CK q 8 h × 3 ☐ ☐ ☐ • If patient a known diabetic ***OR*** fasting glucose results >7.0 mmol/L ***OR*** random glucose results >11.0 mmol/L then do capillary glucose monitoring (CBG) QID • MRSA / VRE swabs sent: ☐ Yes ☐ No ☐ NA	• ECG ☐ • Consider Echo (AWMI) for day 3–4 ☐ Yes ☐ N/A • Fasting cholesterol, HDL, LDL, triglycerides, fasting glucose & Hba1c a.m. of Day 1 ☐	• ECG ☐ • Confirm PA & Lateral Chest x-ray done ☐ Yes ☐ N/A		• Echocardiogram ☐ Yes ☐ No ☐ N/A		• INR if on coumadin	
Assessments / Treatments	• Cardiac Monitor • O_2 by Titration Protocol • VS q4h while awake • Chest pain protocol • Fluid balance as required • Ensure saline lock in place _____	• Cardiac Monitor • O_2 by Titration Protocol • VS QID • Chest pain protocol • Fluid balance as required • Assess activity ability	• Ask Physician re Monitor • O_2 by Titration Protocol • VS BID & PRN • Chest pain protocol	• VS BID & PRN • O_2 by Titration Protocol • Chest pain protocol	• VS BID & PRN • O_2 by Titration Protocol • Chest pain protocol		• Patient discharge assessment	☐ **Post PCI 0Care** • ECG Post Procedure _____ • CK (stat) 4–6 hrs post procedure & in a.m. _____ • Blood work according to Heparin/ Integrelin protocol PRN _____ • CBC PRN _____ • Cardiac monitor _____ • VS q1h × 4 hrs then QID _____ • Vascular assessment q1h while sheaths in place then q1h × 4 PRN _____
Mobility / Safety	• Activity as tolerated when symptom free • Universal fall precautions ☐	• Activity as tolerated • Shower as tolerated • Universal fall precautions ☐	• Activity as tolerated • Shower as tolerated • Universal fall precautions ☐	• Activity as tolerated • Shower as tolerated • Assess re stairs • Universal fall precautions ☐	• Activity as tolerated • Shower as tolerated • Stairs accompanied as required • Universal fall precautions ☐		• Continue Day 4 • Shower as tolerated • Universal fall precautions ☐	**Femoral Sheath Removal** • Sheath removal _____ hrs post procedure _____ • Clamp on @ _____ • Clamp off @ _____ • Vital signs/Vascular assessment as per protocol _____ • Dressing change _____ • While on bed-rest, turn to affected side, HOB 30°, reposition q 1–2 hr _____ • Ambulate 4 hrs post sheath removal _____ • Diet as tolerated _____
Nutrition	• HI Diet (HI), AHA Diet (Gen) • Patient Specific Diet	• HI Diet (HI), AHA Diet (Gen) • Patient Specific Diet	• HI Diet (HI), AHA Diet (Gen) • Patient Specific Diet	• HI Diet (HI), AHA Diet (Gen) • Patient Specific Diet	• HI Diet (HI), AHA Diet (Gen) • Patient Specific Diet		• HI Diet (HI), AHA Diet (Gen) • Patient Specific Diet	
Psycho-social Support	• Identify & address psycho-social concerns • Identify contact person • Assess patient behaviour re anxiety	• Ongoing assessment/community support needs • Communicate with contact PRN • Identify & support individual's cultural values & spiritual concerns	• Ongoing assessment/community support needs • Communicate with contact PRN	• Ongoing • Communicate with contact PRN	• Ongoing • Communicate with contact re discharge		• Ongoing	**Radial Artery Removal Procedure** • Clamp release start _____ • Clamp release finish _____ • Vital signs/Vascular assessment on arrival to unit then q 15 min × 4 or until 2nd clamp release then q 30 min until clamp removed _____ • AAT _____ • Diet as tolerated _____
Patient Education	• Physical Environment _____ • Pain Assess/management _____ • Explain medications given _____ • Discuss visiting policies with patient & family _____ • Review expectations for next 24 hrs _____ • Advise patient to quit smoking: ☐ Yes ☐ No	• Assess patient/family perception of condition _____ • Provide Cardiology book _____ • Review activity tolerance _____ • Procedural Teaching PRN _____ • Advise patient to quit smoking: ☐ Yes ☐ No • Initiate Patient Discharge Information Tool _____	• Review patient/family perceptions _____ • Review Cardiology book _____ • Review Cardiac Risk Factors _____ • Review Procedural Teaching PRN _____ • Review pain assess/management _____ • Reinforce activity tolerance _____ • Book Discharge Class (HI) _____ • "Eat For Your Heart's Content" handout given: ☐ Yes ☐ No • Review Patient Discharge Information Tool _____	• Reinforce Cardiology book info _____ • Teach use of Nitroglycerine _____ • Nutrition class PRN _____ • Review patient medications _____ • "Eat For Your Heart's Content" handout given: ☐ Yes ☐ No • Review Patient Discharge Information Tool _____	• Reinforce Cardiology book info _____ • Review use of Nitroglycerine _____ • Discuss 24/7 telephone call line (HI) _____ • Review patient medications _____ • Discuss follow-up possibilities _____ • Review "Eat For Your Heart's Content" handout _____ • Review Patient Discharge Information Tool _____		• Ensure patient has prescriptions _____ • Ensure patient has discharge letter _____ • Has attended D/C class: (HI) ☐ Yes ☐ No • Plans to return for class: (HI) ☐ Yes ☐ No • Ensure patient D/C info form (GAP Tool) complete • Review Patient Discharge Information Tool _____	**Patient Education** • Ambulation expectations _____ • Sheath removal _____ • PCI results reviewed _____
Discharge Planning	• Identify discharge concerns as per patient history _____ • Identify/document family physician name on admission sheet _____ • *Unmet care needs should be highlighted for next day* _____ • Patient D/C info form (GAP Tool)	• Discuss pending discharge concerns _____ • Assess financial concerns re drug costs _____ • Patient has drug plan: ☐ Yes ☐ No • Review discharge plan _____ • *Unmet care needs should be highlighted for next day* _____	• Discuss pending discharge concerns _____ • *Unmet care needs should be highlighted for next day* _____ • Patient d/c info form (GAP Tool)	• Review discharge plans _____ • Discuss & plan transportation arrangements _____ • *Unmet care needs should be highlighted for next day* _____ • Patient d/c info form (GAP Tool)	• Review medication _____ • Reassess financial concerns re drug costs _____ • *Unmet care needs should be highlighted for next day* _____ • Patient D/C info form (GAP Tool)		• Review discharge plans _____ • D/C expected by 0900	**Discharge Planning** • Review discharge plans _____
Problem List	• Initiate Problem List **D** _____ **N** _____	• Review/update **D** _____ **N** _____	• Review/update **D** _____ **N** _____	• Review/update **D** _____ **N** _____	• Review/update **D** _____ **N** _____	**RN Signature:** **D** _____ **N** _____	• Review/update **D** _____ **N** _____	• Review/update **D** _____ **N** _____
RN Signature	**D** _____ **N** _____	**D** _____ **N** _____	**D** _____ **N** _____	**D** _____ **N** _____	**D** _____ **N** _____	**RN Signature:** **D** _____ **N** _____	**D** _____ **N** _____	**D** _____ **N** _____

CLINICAL PATHWAY – PLAN CLINIQUE

Acute Coronary Syndrome – Syndrome coronairien aigu

Patient _____ **Chart No. – No du dossier** _____

UNIVERSITY OF OTTAWA HEART INSTITUTE
INSTITUT DE CARDIOLOGIE DE L'UNIVERSITÉ D'OTTAWA

The Ottawa Hospital | L'Hôpital d'Ottawa

☐ Heart Institute
☐ General

CLINICAL PATHWAY – PLAN CLINIQUE
Acute Coronary Syndrome – Syndrome coronairien aigu

PATIENT OUTCOMES

VARIANCES

104_Recurrent Chest Pain
110_Heart Failure
109_Arrhythmia requiring intervention
102_Vital Signs
800_Awaiting Placement/Transfer
101_Post procedure Vascular Complications

Pathway Discontinued – Date: dd ____ mm ____ yy ____

Waiting for procedure:

☐ Diagnostic test
☐ Cath
☐ Surgery

Reason(s): _____ , _____

_____
_____
_____
_____
_____
_____

PATIENT OUTCOMES

	Day of Admission (ER – HI)	Day 1	Day 2	Day 3	Day 4	Additional Days (Repeat Day 4)			Discharge Day	Intervention Day
Date (YY/MM/DD)										
Management of Chest Pain & Ischemia	• Patient notifies staff of chest pain • No ECG ST segment shifts or conduction defects • Patient is pain free	• Patient notifies staff of chest pain • No ECG ST segment shifts or conduction defects • Patient is pain free	• Patient notifies staff of chest pain • No ECG ST segment shifts or conduction defects • Patient is pain free	• Patient notifies staff of chest pain • No ECG ST segment shifts or conduction defects • Patient is pain free	• Patient notifies staff of chest pain • Patient is pain free					• Patient notifies staff of chest pain • Patient is pain free
Potential for Bleeding Complications	• No evidence of bleeding or neurological change • Hgb within 20 gm of baseline	• No evidence of bleeding or neurological change • Hgb within 20 gm of baseline	• No evidence of bleeding or neurological change • Hgb within 20 gm of baseline	• No evidence of bleeding or neurological change • Hgb within 20 gm of baseline						• Hematoma < 4 cm • No evidence of excess bleeding or pseudoaneurysm
Hemodynamic Stability	• No arrhythmia requiring intervention • VS within normal limits • No CHF Symptoms	• No arrhythmia requiring intervention • VS within normal limits • No CHF Symptoms	• No arrhythmia requiring intervention • VS within normal limits • No CHF Symptoms	• No arrhythmia requiring intervention • VS within normal limits • No CHF Symptoms						• Patient maintains pre-procedure vascular status • No arrhythmia • No CHF Symptoms
Activity Tolerance	• Tolerates activity (pain free, no SOB)	• Tolerates activity (pain free, no SOB) • No limitations to activity	• Tolerates activity (pain free, no SOB) • No limitations to activity	• Tolerates activity (pain free, no SOB) • No limitations to activity	• Pain free					
Anxiety	• Patient verbalizes feelings re admission	• Patient acknowledges absence of anxiety • Patient identifies no need for social &/or financial support	• Patient acknowledges absence of anxiety • Patient identifies no need for social &/or financial support	• Patient acknowledges absence of anxiety • Patient identifies no need for social &/or financial support	• Patient acknowledges absence of anxiety • Patient identifies no need for social &/or financial support					
Education	Patient/family able to discuss/understand: • Importance of close observation during early stage of hospitalization _____ • Rationale for progressive activity _____ • Usual visiting hours _____ • Probable length of stay _____ • Need to report chest pain/discomfort _____ • Appropriate pain management & use of nitroglycerin IV/SL _____ • Need for treatment & monitoring _____ • Other _____ ***Unmet teaching needs should be highlighted next day.***	Patient/family able to discuss/understand: • Perception of condition _____ • Basic elements of CAD, (MI vs UA) _____ • Need to report chest pain/discomfort _____ • Appropriate pain management & use of nitroglycerin IV/SL _____ • Need for treatment & monitoring _____ • Appropriate diagnostic tests _____ • Other _____ ***Unmet teaching needs should be highlighted next day.***	Patient/family able to discuss/understand: • Aware of lipid profile _____ • Understands risk factors in general _____ • Understands personal risk factors _____ • Appropriate diagnostic tests _____ • Appointment made for discharge & nutrition classes _____ • Need to report chest pain _____ • Need for treatment & monitoring _____ • Other _____ ***Unmet teaching needs should be highlighted next day.***	Patient/family able to discuss/understand: • Appropriate pain management & use of nitriglycerin SL _____ • Lipid profile awareness _____ • Controllable risk factors _____ • Necessary lifestyle changes _____ • Activity guidelines _____ • Rehabilitation referral _____ • Financial concerns regarding discharge medications _____ • The value of cardiology booklet for further information _____ • Other _____ ***Unmet teaching needs should be highlighted next day.***	Patient/family able to discuss/understand: • Medication & its use on discharge _____ • Availability of community resources including: family physician and community pharmacist _____ • Reinforce previous information _____ • Other _____ ***Unmet teaching needs should be highlighted next day.***				Patient/family able to discuss/ understand: • When its appropriate to seek medical advice _____ • The value of cardiology booklet for further information _____ • Appropriate response to episodes of chest pain _____ • Reasons for taking medications and need to fill prescriptions the day of discharge _____ • Other _____ ***Reassess unmet teaching needs.***	**Verbalizes understanding of:** • Activity restrictions _____ • Procedure results _____ • Management of puncture site _____ • Need to seek medical advice _____
RN Signature	**Variance** _____ , _____ **D** _____ **N** _____	**Variance** _____ , _____ **D** _____ **N** _____	**Variance** _____ , _____ **D** _____ **N** _____	**Variance** _____ , _____ **D** _____ **N** _____	**Variance** _____ , _____ **D** _____ **N** _____	**RN Signature:** **D** _____ **N** _____	**RN Signature:** **D** _____ **N** _____	**RN Signature:** **D** _____ **N** _____	**Variance** _____ , _____ **D** _____ **N** _____	**Variance** _____ , _____ **D** _____ **N** _____