Addressograph Label
Client Label
DOB mm/dd/yyyy
PHIN/MHSC#
HRN

Acute Coronary Syndrome (ACS) Suspected Standard Orders

These orders are to be used as a guideline and do not replace sound clinical judgement and professional practice standards. Patient allergy and contraindications must be considered when completing these orders.

Page 1 ■ may be nurse implemented with CLI.5110.PL.002.FORM.01 Emergency Department Adult Clinical Decision Tool

■ Automatically activated (If not in agreement with an order cross out and initial).

☐ Requires a check (√) for activation and a prescriber signature.

Allergies: ☐Unknown ☐No ☐Yes(describe)_____ Height(cm)_____ Weight (kg)_____

For use if patient presents with Chest pain, or symptoms consistent with cardiac ischemia Date: _____ Time: _____

Chest Pain Assessment-Signs and Symptoms indicating need for immediate assessment and ECG (Electrocardiogram):

- ☐ Chest or epigastric discomfort, non-traumatic in origin with components typical for ischemia or MI
- ☐ Central substernal compression or crushing pain; pressure, tightness, heaviness, cramping, burning, aching sensation; unexplained indigestion, belching, epigastric pain; radiating pain in neck, jaws, shoulders, back, and/or one or both arms
- ☐ Associated dyspnea, nausea or vomiting, diaphoresis
- ☐ Palpitations, irregular pulse, or suspected arrhythmia
- ☐ Atypical Presentation (ie. Women-epigastric and unexplained indigestion; patients with diabetes-autonomic dysfunction; elderly patients generalized weakness, stroke, syncope or a change in mental status)

■ **Initial vitals documented on triage record (include both R and L arm BP)**

Risk Factors Assessment (check all that apply): ☐ Family history of CAD ☐ Obesity ☐ Diabetes Mellitus
☐ History of Coronary Artery Disease (CAD) ☐ Hypertension ☐ Dyslipidemia ☐ Smoker

Medication Triage:

Nitroglycerin prior to arrival ☐ Yes ☐ No Dose:_____Date: _____Time: _____
ASA taken within last 24 hrs ☐ Yes ☐ No Dose: _____ Date _____Time:_____
Cocaine or methamphetamine ☐ Yes ☐ No If YES, inform physician
Use of the following: Sildenafil (Viagra®) within 24 hrs. OR Vardenafil (Levitra®) within 24 hrs. OR Tadalafil (Cialis®) within 48 hrs.
☐ Yes ☐ No If YES, **hold** nitrates and notify physician

■ **Document all medications administered on the appropriate Medication Administration Record (MAR).**

■ Stat 12/15 Lead ECG performed and read within 10 minutes of patient arrival.
15 lead guidelines:
- ○ Cardiac chest pain GREATER than 15 minutes.
- ○ 12 Lead ECG showing ST depression in V1 and V2 with prominent R Waves
- ○ 12 Lead ECG showing signs of inferior MI (ST elevation Lead II, III, AVF)

■ Notify prescriber

■ If prescriber is not on site or if the ECG interpretation is uncertain, page Outside Call Cardiologist at 204-237-2053 and request assistance with ECG interpretation and direction for care.

■ ECG transmitted to Cardiac Services Program ☐ Yes ☐ No ☐ N/A

■ Repeat ECG in 2 hours at _____hours

■ ASA 160mg PO chew and swallow x 1 if not taken within 24 hrs dose given: _____mg

■ #1 IV Line – IV Ringers lactate at 50mL/hr. or lock; gauge: _____site:_____

■ #2 IV Line - for suspected STEMI patients only lock: gauge: _____site:_____

■ If SpO_2 less than 90% on room air, start O_2 and titrate up to achieve and maintain SpO_2 saturation 90% and/or above. O_2 started ☐Yes ☐ No

■ Vital signs and O_2 saturation (SpO_2):
Monitor every 15 min x 4; then every 30 min x 2; then every 1 hr. x 4; then every 4 hrs. until discharge/admission. Continue vital signs and SpO_2 every 15 min with ongoing chest pain and/or unstable vital signs (document on *Frequent Monitoring Record*)

■ Continuous cardiac monitoring. (View in Lead III and V3, if able, until origin of ischemia is identified)

☐ ST monitoring if available (document with vital signs)

■ Analyze initial rhythm strip & Mount all strips on *Cardiac Rhythm Strip Record*

AFTER ECG is analyzed and IV in SITU, and **only** if:

(1) **systolic** blood pressure greater than **90mmHg** (2) **pulse** greater than **50 beats/min** (3) no marked tachycardia
(4) no **inferior wall MI** and/or **RV infarction** and (5) no recent use of phosphodiesterase inhibitors (e.g., sildenafil or tadalafil)

☐ Nitroglycerin 0.4mg spray sublingual as needed every 5 minutes up to 3 doses for chest pain

■ CBC, Na, K, Cl, urea, creatinine, glucose, troponin, CO_2

☐ INR (based on clinical indication ie: warfarin)

■ Repeat high sensitivity troponin (hs TnT) in 2 hours (Regional Centres only) OR troponin I (TnI) in 4 hours at _____hours

■ Repeat ECG with ongoing chest pain in 30 minutes or change in pain description

☐ STEMI Reperfusion Standard Orders or	☐ ACS NSTEMI/UA Standard Orders or	☐ Cardiac not suspected

NURSE/PRESCRIBER SIGNATURE: _____PRINTED NAME: _____Date _____ Time _____

Order Transcribed	FAX/SCAN TO PHARMACY
Date: _____ Time: _____ Initials _____	Date: _____ Time: _____ Initials _____

Addressograph Label
Client Label
DOB mm/dd/yyyy
PHIN/MHSC#
HRN

Acute Coronary Syndrome (ACS) Suspected Standard Orders

Systems and Cues of Acceptable Parameters	Nursing: Complete Systems' Assessment Describe ALL Findings
Neurological Assessment: Alert and oriented to person, place and time. Behavior appropriate to situation. Obeys simple commands. Denies headache. No facial drooping. Speech clear and understandable. Denies difficulty swallowing. Purposeful and symmetrical movement of all extremities. **Cardiovascular Assessment:** No chest pain/pressure; Radial pulse 60-100 bpm at rest and regular. Cardiac monitor and radial pulses correlate. Skin color is uniform (consistent with ethnicity), warm, dry. No diaphoresis. Pedal pulses palpable. No edema or calf tenderness. Blood pressure remains within normal limits for patient. Only S1 & S2 heart sounds on auscultation. **Respiratory Assessment:** Respirations 10-20 per minute at rest, quiet and regular. Air entry adequate. No crackles or wheezes. Sputum absent/clear. No pallor or cyanosis. No pain with respiration. **Gastrointestinal Assessment:** Bowel sounds active in all 4 quadrants. Abdomen soft. No pain on palpation. No nausea or vomiting. No gastric reflux. No pain. **Genitourinary Assessment:** States able to empty bladder. No hematuria. Urine clear and yellow to amber in color. Bladder not distended on palpation. No pain. **Psychosocial Assessment:** Behavior appropriate to situation. **Other systems as applicable**	**Date/Time/Nurse's Signature:**