

PROTOCOL FOR: Chest Pain (Suspected Cardiac Origin)

POLICY: Patients with complaints of suspected cardiac origin will have immediate initial assessment, EKG, stabilization, and consideration for transfer to the Cardiac Cath Lab, ICU, or Cardiac Step-Down Unit as deemed appropriate.

DESIRED PATIENT
OUTCOMES: The patient will be hemodynamically stable, have pain controlled and exhibit decreased anxiety with the ultimate goal of preserving myocardial function.

ASSESSMENT/
GENERAL NURSING
CARE: Perform primary assessment and re-assess as needed according to patient's acuity level.

1. Perform primary assessment and re-assess as needed according to patient's acuity level.
2. Obtain EKG within 10 minutes of arrival to ED following the attached algorithm.
3. EKG will be handed off to attending MD for interpretation
4. Cath lab activation if deemed appropriate per MD.
5. Patients with normal EKG may be placed back in WR if appropriate.
6. Consider life-threatening causes: acute coronary syndrome, aortic aneurysm/dissection, pulmonary embolism, pneumothorax.
7. Treat life-threatening occurrences immediately (i.e., loss of airway, respiratory distress, cardiac compromise or arrhythmia.)
8. Initiate oxygen at 2-4L per MD order nasal cannula and titrate to maintain oxygen saturation >90%.
9. Place on cardiac monitor, NIBP, and pulse oximeter and obtain full set of vital signs.
10. Establish IV and obtain blood for CBC, CHEM7, PT/PTT, CK, CK-MB, Troponin, T&S.
11. Administer aspirin 325mg PO unless contraindicated.
Contraindications include:
 - a. ASA within the last 12 hours
 - b. Anaphylaxis to ASA
 - c. On anticoagulant medication(s)
 - d. Evidence of active bleeding

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12. Evaluate pain using 0-10 pain scale.
13. Administer meds for pain control, per MD order (i.e. nitroglycerine, morphine) and evaluate response, using pain scale.
14. Obtain portable CXR per MD order.
15. Perform secondary assessment and re-assessments according to patient's acuity level, with vital sign as indicated (i.e. every 15 minutes with active medication titration), minimally every two hours.
16. Administer other meds as ordered by MD (i.e., Heparin, Integrelin, Lopressor).
17. Prepare for transfer to Cardiac Cath Lab, ICU, or Cardiac Step-Down Unit as deemed appropriate.
18. Obtain vital signs/ pain reassessment upon discharge/transfer from the ED.
19. Transport patient with RN/Defib to Cath Lab/ICU/CSDU.

PATIENT TEACHING: Explain all procedures to the patient/family.
Keep patient/family informed of plan of care.

REPORTABLE CONDITIONS: Document all vital signs, assessments, interventions and response to interventions on ED record.

APPROVAL: Nursing Standards Committee
Emergency Department Standards Committee
Emergency Department Manager & Medical Director

EFFECTIVE DATE: 6/04

REVISION DATES: 9/05, 9/08, 2/09

REVIEW DATE: 2/06