Interior Health

NON-ST ELEVATION MI / ACUTE CORONARY SYNDROME ORDERS

Weight (kg)

Bulleted orders are initiated by default, unless crossed out and initialed by the physician / prescriber. Boxed orders (☐) require physician / prescriber check mark (☑) to be initiated.

Please see reverse pages for supplemental information*

1. ALLERGIES: see #826234 - Allergy and Adverse Reaction Record

2. ADMISSION INSTRUCTIONS: ☐ Admit to: _____ MRP: _____ Diagnosis: _____

☐ Transfer to Kelowna General Hospital when bed available ****OR**** _____

3. CODE STATUS

- Refer to completed Medical Orders for Scope of Treatment (MOST) #829641

4. INITIAL MANAGEMENT

- Start oxygen if SpO_2 less than 90%, titrate or wean for goal SpO_2 between 90 to 94%
- Insert IV and Saline Lock IV line, flush with normal saline 0.9% Q12H ****OR**** IV fluid at _____ mL / H
- Bed rest with bedpan/commode if ongoing chest pain or hemodynamic instability
- Progress to chair with bathroom privileges when chest pain free. Once stable, activity as tolerated. *(See reverse of page 3 for criteria)*

5. DIET

- Heart Healthy Diet as tolerated, if diabetic enter Diabetic diet

☐ Other _____

6. MONITORING *(See reverse of page 3 for further information on criteria)*

- Continuous cardiac monitoring × minimum 24H, then MRP to discontinue when appropriate
  - ☐ May discontinue cardiac monitoring for short periods (ie. Shower or diagnostic testing) if clinically stable
  - ☐ May discontinue cardiac monitoring for inter-facility transport
- HR, RR, Sp02, BP (in both arms initially, then use arm with highest reading) Q1H until stable, then follow VS policy appropriate for area (ie. Critical Care Routines and Responsibilities or IH Vital Signs Monitoring Care Standard)
- Temp Q4H until stable, then Q12H and PRN
- Weight: Obtain baseline within 24 hours of admission. DAILY weights if on diuretic therapy

7. LABORATORY

- Troponin, Na, K, Cl, CO_2 (lytes4), urea, creatinine, random glucose, AST, CBC, INR, PTT, STAT
- Na, K, Cl, CO_2 (lytes4), urea, creatinine, random glucose, CBC DAILY × 5 days
- Hemoglobin A1C, lipid panel (draw with first daily bloodwork)
- Troponin 6 and 18 hours after the first STAT troponin; to coincide with facility lab draws

☐ TSH ☐ BNP ☐ ALT, ALK Phos, GGT, bilirubin

☐ Other: _____

Date (dd / mm / yyyy)	Time	Prescriber's Signature	Printed Name or College ID#
/ /			

ANTIPLATELET SELECTION GUIDE

Suggested Antiplatelet	Clinical Scenario
ticagrelor	• Use if planned invasive management of ACS • Allergy to clopidogrel • Previous in-stent thrombosis, recurrent myocardial infarction while on clopidogrel • Not previously loaded with clopidogrel but requires urgent percutaneous coronary intervention • History or ECG changes suggestive of left main or 3-vessel coronary artery disease requiring coronary artery bypass grafting
clopidogrel	• Use if conservative management and patient requires Pharmacare coverage • If requiring an oral anticoagulant for atrial fibrillation, history of or active venous thromboembolism (deep vein thrombosis or pulmonary embolism), or left ventricular thrombus etc. • Use if history of medication non-compliance

ANTICOAGULANT SELECTION GUIDE

Suggested Anticoagulant	Clinical Scenario
unfractionated heparin	• Early invasive strategy (planned angiogram / angioplasty within 24 hours)
enoxaparin	• Uncertain treatment strategy (i.e. invasive or conservative management) • Delayed invasive strategy (planned angiogram / angioplasty greater than 24 hours) • Patients with eGFR 15-30 mL / min, reduce dosing interval to Q24H
fondaparinux	• Planned conservative treatment / medical management • Do not use if eGFR less than 30 mL / min

HOME / PRIOR ANTITHROMBOTIC THERAPY: Dosing and administration guidelines

* Provided as a guide only and may not apply in every clinical situation. Contact cardiologist / internist for advice if additional clinical advice is required.)

Patient Already On This Agent Prior to Admission	Recommendation
ASA 81 to 325 mg PO daily	• Still load with ASA 160 mg PO then 81 mg PO daily
clopidogrel 75 mg PO daily	• Still load with clopidogrel then 75 mg PO daily
ticagrelor 90 mg PO BID	• Still load with ticagrelor 180 mg PO then 90 mg PO BID
warfarin	• Still give ASA and clopidogrel (avoid ticagrelor due to increased risk of bleeding) • Hold warfarin • Start selected IV or SC anticoagulant (heparin, enoxaparin, fondaparinux) when INR less than 2
Direct oral anticoagulant (DOAC): apixaban, dabigatran, edoxaban or rivaroxaban	• Still give ASA and clopidogrel (avoid ticagrelor due to increased risk of bleeding) • If **invasive management**: Stop DOAC and start IV or SC anticoagulant 12 hours after last dose of dabigatran or apixaban and 24 hours after last dose of rivaroxaban or edoxaban • If **conservative management**: Continue DOAC and reassess need for clopidogrel. Suggest consultation with cardiologist / internist.

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8. DIAGNOSTICS

- 12 lead ECG **URGENT** ☐ 16 lead (extended lead) ECG
- 12 lead ECG QAM × 2 days and PRN for increase or recurrence of chest discomfort, chest pain unrelieved by nitroglycerin or for sustained rhythm changes
- Chest X-ray (portable) on admission: _____

☐ Echocardiogram with Doppler +/- contrast. Urgency: _____ Indication: _____

☐ Diagnostic heart cath with or without PCI (refer to Cardiologist). Physician to complete Pre-Cardiac Cath PPO #829908.

☐ Other: _____

9. MANAGEMENT STRATEGY *(See reverse of page 1 for anticoagulation and antiplatelet guidelines)*

ANTIPLATELETS

- **acetylsalicylic acid [ASA] chewable 160 mg (2 × 80 mg TAB) chewed STAT** (unless already given)**, then 81 mg EC PO DAILY**
- Select **ONE** of the following *(see reverse of page 1 for antiplatelet selection)*:
  - ☐ **ticagrelor 180 mg PO STAT then 90 mg PO BID** ***(FIRST CHOICE for invasive approach)***
    *****OR*****
  - ☐ **clopidogrel 600 mg PO STAT then 75 mg PO DAILY** *(Invasive approach)*
    *****OR*****
  - ☐ **clopidogrel 300 mg PO STAT then 75 mg PO DAILY** *(conservative management)*
    *****OR*****
  - ☐ No P2Y12 inhibitor (ticagrelor / clopidogrel) preload

ANTICOAGULATION: Select **ONE** of the following:

☐ **enoxaparin 1 mg / kg** _____ **mg subcutaneously** ☐ **Q12H** *****OR***** ☐ **Q24H** (eGFR 15 – 30 mL / min), **first dose STAT**

☐ **unfractionated heparin IV bolus (60 units / kg)** _____ **units STAT** (maximum 4,000 units); then start infusion and adjust per site specific heparin PPO

☐ **fondaparinux 2.5 mg subcutaneously Q24H, first dose STAT** (choice for conservative management only)

☐ No anticoagulation. Reason: _____

10. MEDICATIONS

- Notify MRP if nitrates, beta blocker, ACE-I / ARB held per indications in each medication section.

NITRATES *(see reverse of page 2 for contraindications / precautions)*

☐ No nitrates [Pharmacy do not process nitroglycerin spray order below]

- **nitroglycerin spray 0.4 mg sublingual Q5MIN PRN × 3 doses** for ischemic symptoms (if unresolved after 3 doses, call physician and if ordered, start nitroglycerin infusion)

☐ **nitroglycerin IV infusion, start at 10 mcg / min** for ischemic symptoms unresolved with nitroglycerin spray and titrate per Interior Health Medication Manual (for parenteral drugs)

☐ **nitroglycerin patch** _____ **mg / hour, apply at 0800 HR and remove at 2000 HR DAILY**
(*****OR***** apply at _____ HR and remove at _____ HR)

**Hold nitroglycerin patch if symptomatic hypotension (dizziness, presyncope, syncope) or if nitroglycerin infusion running

Date (dd / mm / yyyy)	Time	Prescriber's Signature	Printed Name or College ID#
/ /			

Use Beta-Blocker with caution if:

- Signs of acute heart failure
- Evidence of low output state
- Cocaine use
- 2nd or 3rd degree heart block without a pacemaker

Use Nitroglycerin with caution if:

- SBP below 90 mmHg or if SBP drops more than 30 mmHg below baseline
- Cautious use with Inferior MI. Avoid for known / suspected Right Ventricular infarct
- Critical aortic stenosis
- Recent use of phosphodiesterase inhibitors:
  - within 24H of last dose of sildenafil (Viagra®) or vardenafil (Levitra®)
  - within 48H of last dose of tadalafil (Cialis®)

Proton Pump Inhibitors (PPI):

- Consider PPI for those on dual antiplatelet therapy at high risk of bleeding, including history of GI bleed or peptic ulcer disease or multiple risk factors such as age greater than 65 years, concurrent oral anticoagulation or corticosteroids

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10. MEDICATIONS *(cont'd)*

BETA BLOCKER

- ☐ **metoprolol** _____ **mg PO BID**
- ☐ **bisoprolol** _____ **mg PO DAILY**
- ☐ **Other**: _____
- ☐ **No beta blocker. Reason:** _____

**Hold beta blocker if symptomatic hypotension or bradycardia (dizziness, presyncope, syncope)

ANGIOTENSIN CONVERTING ENZYME INHIBITORS/ANGIOTENSIN RECEPTOR BLOCKERS

- ☐ **ramipril** _____ **mg PO** _____
  (frequency)
- ☐ **perindopril** _____ **mg PO DAILY**
- ☐ **candesartan** _____ **mg PO DAILY**
- ☐ **Other:** _____
- ☐ **No ACE-I or ARB. Reason:** _____

**Hold ACE I / ARB if symptomatic hypotension (dizziness, presyncope, syncope)

LIPID LOWERING

- ☐ **atorvastatin 80 mg PO DAILY**
- ☐ **Other:** _____
- ☐ **No lipid lowering therapy. Reason:** _____

PRN MEDICATIONS

- **acetaminophen 325 to 975 mg PO Q4H PRN** pain (maximum 4 g / day)
- **antacid 30 mL PO Q6H PRN** indigestion or heartburn
- **atropine 0.5 to 1 mg IV Q5MIN PRN** for symptomatic heart rate less than 50 bpm (maximum 3 mg total dose)
- **morphine 2 to 5 mg IV Q5MIN PRN** chest pain unresponsive to nitroglycerin or if nitroglycerin contraindicated (maximum 20 mg / hour)
- If tobacco user, to complete NICOTINE REPLACEMENT THERAPY PPO # 829435
- Complete site specific bowel elimination protocol
- ☐ **dimenhyDRINATE 50 mg PO or 25 mg IV Q6H PRN** nausea
- ☐ **LORazepam 0.5 mg sublingual Q6H PRN** anxiety
- ☐ **zopiclone 3.75 to 7.5 mg PO HS PRN** insomnia

11. OTHER

- Transport personnel may continue Non-ST Elevation MI / Acute Coronary Syndrome PPO during inter-facility transport
- Cardiac Rehab Referral

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Mobilization Criteria for vital signs and mobilization:

May mobilize if:

- Hemodynamically Stable (free of symptomatic hypotension or symptomatic bradycardia)
- Free of ischemic symptoms (chest pain, shortness of breath, etc.) for minimum 24 hrs following admission for STEMI / NSTEMI or coronary anatomy fixed (i.e. Cardiac Surgery or PCI)
- Free of persistent arrhythmia causing hypotension, signs of shock or altered mental status

Do NOT mobilize if:

- Recurrent chest pain and coronary anatomy is unknown
- Recurrent chest pain with Left Main Stenosis (or Left Main Equivalent)

Cardiac Monitoring Discontinuation Criteria

(Must meet all criteria prior to ordering discontinuation of cardiac monitoring)

- Hemodynamically stable
- Return to baseline rhythm or controlled arrhythmia
- Free of ischemic symptoms (chest pain, shortness of breath etc)
- Does not require IV cardiac medications for ischemic symptoms or rate / rhythm control

May be transferred to Regional Cardiac Catheterization lab without HART team if:

- Hemodynamically stable
- Free of ischemic symptoms (chest pain, shorness of breath) for 24 hours
- Free of any significant bradyarrhythmia or tachyarrhythmia for 24 hours