

Instructions for use of ACS Clinical Pathway

1. Clinical Pathway documentation is based upon the charting by exception model. **Only deviations to the plan are charted.** Staff will initial and time (if appropriate) where indicated by a blank line. It is assumed that the standards of care have been met and provided for the patients unless otherwise indicated.
2. The ACS Clinical Pathway documentation includes:
 - Physician Pre Printed Order Sheets
 - Clinical Pathway
 - Patient/Family Information
 - Case History
 - Clinical Flow Sheet/part of documentation
 - Patient Discharge Information ACS
3. The physician orders should indicate that the patient is ordered on the clinical pathway.
4. On admission to the Heart Institute, all ACS patients will start the clinical pathway on the day of admission column. This includes all patients transferred from other hospitals. This will ensure that all tests, consults and assessments will be done.
5. The ACS Clinical pathway serves as standing orders for tests, treatments, consults, activity level, diet, and patient teaching for all patients on the pathway.
6. Medications, IV's, and patient specific test and treatments (in addition to those indicated on the Clinical pathway) are ordered by the physicians on the Order Sheet.

7. Members of the interdisciplinary team in consultation with the attending physician will determine if a specific patient's care would be managed better off the Clinical Pathway. A physician's order is required to discontinue the Clinical pathway.
8. Previous systems of documentation resume when a patient is taken off the Clinical Pathway.
9. Dates are entered on the top of the Clinical Pathway to indicate Day 1, Day 2, etc.
10. The Clinical Pathway proceeds to the next date/Clinical Pathway day at 0715 hours.
11. Communicate to next shift by circling undone/incomplete care and putting an arrow to the next day.
12. Assessment of variance is done on outcome section of the Clinical Pathway.
13. Patient progress and variances are documented on the clinical Pathway, nurse's notes and medical notes.
14. Staff are required to sign at the end of each shift in the RN Signature box on the Clinical Pathway.
15. Information that needs to be documented, but is not on the clinical pathway should be entered in the nurse's progress notes
16. The pathway consists of 4 days. Some patients may be waiting for tests, interventions or surgery and will be hospitalized more than 4 days. If additional days are required, day 4 of the clinical pathway can be repeated. The intervention day is to be used when patients go for cath/PCI.

17. Completed information should be initialed on the clinical pathway when space has been provided. When this method of documentation is utilized, it is not necessary to document the findings elsewhere in the chart.
18. Completion of the problem list continues to be required with use of the pathway. The pathway contains a reminder to complete the initiation/review/update of the problem list.
19. The pathway includes a discharge day. On discharge day it is important to complete the discharge day column, documenting that the patient has prescriptions, discharge letter, received and understands cardiac education, and any other plans have been discussed.
20. Patient Education material regarding medications can be found at the following website: <http://www.healthyontario.com/english/index.asp>)
21. The Patient Discharge Information tool will indicate the medications the patients will take on discharge and give them information about best practice care received and planned for the near future. ***On discharge the Patient Discharge Information ACS must be completed and signed by both nurse and patient.***
22. All ACS patients who come to the University of Ottawa Heart Institute, even those who are not on the ACS Clinical Pathway should have the Patient Discharge Information ACS completed at the time of discharge.