

# NORTH BAY GENERAL HOSPITAL

## ACUTE MYOCARDIAL INFARCTION CARE MAP

Expected Length of Stay is 6 Days

Addressograph here

### DOCTOR'S ORDERS (MEDICAL DIRECTIVES) SUPERCEDE THE CARE MAP.

THIS CARE MAP:

1. IS A GUIDE ONLY
2. DOES NOT REPLACE CLINICAL JUDGEMENT
3. SUPPORTS THE USE OF NURSING GUIDELINES FOR THE POST MY PATIENT
4. IS TO REMAIN PART OF THE PATIENTS HEALTH RECORD.

#### PROCEDURE:

1. Addressograph the right upper corner of this page.
2. Store at the front of the Multidisciplinary Notes section of the patient's chart.
3. Nursing is responsible for documenting whether Expected Patient Outcomes are **met, not met** or **not applicable**, in their own notes and initiating follow up prn. Outcomes that are specific to other disciplines are identified as such.
4. The Care Map should be **discontinued** when the doctor / nurse considers that the care outlined no longer meets the needs of the patient.  
**Draw a line through the applicable day**, date, initial and make notation in your charting as to the reason(s) this patient is no longer appropriate for the Care Map.

**Patient Potential Problem List** may include (document other specific problems / outcomes on Patient Care Plan (Kardex))

1. **Chest pain and / or other anginal symptoms** : related to myocardial ischemia.
2. **Activity intolerance**: related to altered tissue perfusion
3. **Unstable vital signs**: due to myocardial muscle damage or arrhythmia
4. **Knowledge deficit**: related to underlying nature of disease and risk factors
5. **Shortness of breath**: related to compromised myocardium secondary to smoking, obesity etc.
6. **Language or culture barrier.**

™ **The four indicators which will be monitored are:**

1. **Door to drug thrombolytic time** (when applicable) in the Emergency department.
2. **Length of Stay** and reason(s) for failure to discharge by day 6.
3. **Readmission** (within one week of discharge) if related to Myocardial Infarction
4. \* **Critical Indicator Achievement** and reason(s) for Non-Achievement  
"CPK has peaked and is returning to normal by Day 2"

		Day of Admission ( Day 0 )	
		Emergency Room	CCU/ Nursing Unit
Consults	<p>Notify MRP Notify Family Physician</p> <p>Notify Internal Medicine as ordered Pastoral Care prn</p>		
Tests	<p>ER Medical Directives for lab and x-ray. PT/PTT if patient requires thrombolytic Stat ECG ; V4R with inferior MI, 15 lead if ordered Repeat ECG after thrombolytic Portable chest x-ray as soon as possible.</p>	<p>Blood work : see Medical Directives ECG as ordered Chest X-ray if ordered and not done in ER</p>	
Assessment and Treatment	<p>Rapid triage for anginal pain with vital signs. Brief targeted history / anginal pain assessment. Notify MD immediately of positive ECG Assess for contraindications to ASA</p> <p>a) Allergy to ASA or NSAIDS b) ASA given en route to hospital c) Acute Bleeding Disorder d) History of Asthma e) Recent head injury / stroke (24 hours)</p> <p>Cautious use of Nitroglycerine when:</p> <p>a) Right Ventricular MI (confirmed with V4R) as they are dependent on pre-load for cardiac output. b) Systolic BP &lt; 90; Heart rate &lt; 40 or &gt; 150</p> <p>Assess effects of interventions and document.</p> <p>Treatment:</p> <ul style="list-style-type: none"> <li>Oxygen with angina / to keep SaO2 &gt; 95%</li> <li>Start/ maintain IV(s) as ordered</li> <li>Continuous cardiac monitoring</li> <li>Intake and Output</li> <li>Thrombolytic Protocol prn</li> </ul>	<p>Follow Nursing Assessment Guidelines for the Post MI Patient. Plus assess:</p> <ul style="list-style-type: none"> <li>episodes of angina</li> <li>tolerance to any activity</li> <li>effectiveness of analgesic ongoing</li> </ul> <p>Review CPK values Start / complete Nursing Assessment Form</p> <p>Treatment :</p> <ul style="list-style-type: none"> <li>Follow Nursing Guidelines for the Post MI Patient</li> <li>Maintain IV's as required</li> </ul>	
Activity	<p>Bed rest Bleeding Precautions with/ after thrombolytics</p>	<p>Bed rest until angina free /hemodynamically stable. Bed rest with bedside commode privileges. Bleeding Precautions prn</p>	
Nutrition	<p>Ice chips if no nausea</p>	<p>Fluids as tolerated</p>	
Medication	<p>Consider:</p> <ul style="list-style-type: none"> <li>Thrombolytic</li> <li>antiplatelet therapy</li> <li>anticoagulation therapy</li> <li>Nitroglycerine (NTG) prn.</li> <li>Beta Blocker unless contraindicated.</li> </ul> <p>Analgesics / antiemetics as required. <b>Review patient's own medications.</b></p>	<p>→</p> <p>→</p> <p>→</p>	
Teaching / Discharge Planning	<p>Pain Scale and usage. Inform family / friends of admission</p>	<p>Advise patient / family re.</p> <ul style="list-style-type: none"> <li>Expected Length of Stay / Unit routine</li> <li>Activity level</li> <li>Pain scale usage and to notify nurse of any anginal symptoms</li> </ul>	
EXPECTED PATIENT OUTCOMES	<p>1. Door to Drug time is 30 minutes or less when thrombolytic is applicable.</p>	<p>1 . Anginal symptoms are relieved with interventions.</p>	

<b>DAY 1 OF ADMISSION</b>	
<b>CONSULTS</b>	
<b>TESTS</b>	Follow Admission Orders ECG with angina prn / Angina Protocol for Nursing Units Possible Echocardiogram
<b>Assessments and Treatments</b>	Follow <b>Nursing Guidelines</b> for the Post MI Patient. Document level of activity attempted and tolerance. Document all episodes of angina. Review CPK values/ ECG's Treatments: Follow Nursing Guidelines for the Post MI Patient Maintain Intravenous. Saline lock second IV if stable.
<b>Activity</b>	NBGH Cardiac Progressive Ambulation level as per physician order. Bed bath with some assistance. Continue bleeding precaution as required.
<b>Nutrition</b>	Cardiac diet.
<b>Medication</b>	Enteric Coated ASA unless contraindicated Heparin as applicable Nitroglycerine prn / Angina Pain Protocol for Nursing Unit Consider Beta Blocker unless contraindicated Consider ACE Inhibitor unless contraindicated Analgesics / antiemetics as required Ensure patient's own medications ordered as needed Offer stool softener as needed
<b>Teaching / Discharge Planning</b>	Give patient their own MI Care Map and review as appropriate. Reinforce <ul style="list-style-type: none"> <li>- limited activity levels</li> <li>- significance of avoiding Valsalva manoeuver</li> </ul> Nurse Clinician 1 <sup>st</sup> visit today or tomorrow
<b>EXPECTED PATIENT OUTCOMES</b>	<ol style="list-style-type: none"> <li>1. Tolerates up in chair for bed making with stable cardiac rhythm and no anginal symptoms.</li> <li>2. No signs / symptoms of Congestive Heart Failure.</li> <li>3. CPK has peaked.</li> </ol>

<b>DAY 2 OF ADMISSION</b>	
<b>CONSULTS</b>	Nurse Clinician if not seen on Day 1
<b>TESTS</b>	Follow Admission Orders ECG with angina prn / Angina Protocol for Nursing Unit.
<b>Assessments and Treatments</b>	Follow <b>Nursing Guidelines</b> for Post MI Patient Document level of activity attempted and tolerance. Document all episodes of angina. Assess any anxiety re. possible transfer to Medical unit. Review CPK values/ ECG's Treatments: <ul style="list-style-type: none"> <li>- Follow <b>Nursing Guidelines</b> for the Post MI Patient</li> <li>- Maintain IV as ordered. Unless no alternate site, discontinue all IV's over 72 hours. Maintain (restart) one IV prn.</li> </ul>
<b>Activity</b>	NBGH Cardiac Progressive Ambulation level as per physician order. Bed bath with some assistance. Continue bleeding precautions as required. i.e. Heparin infusion.
<b>Nutrition</b>	Cardiac diet
<b>Medication</b>	EC ASA unless contraindicated Heparin as applicable Nitroglycerine prn ( intravenous infusions need to be discontinued prior to transfer to Medical Unit)/ Angina Pain Protocol for Nursing Units. Consider Beta Blocker unless contraindicated Consider ACE Inhibitor unless contraindicated Analgesics / antiemetics as required Offer stool softeners as needed
<b>Teaching / Discharge Planning</b>	<b>ASSESS PATIENT AND FAMILY FOR HOME SUPPORTS.</b> ie. Older adult Unmarried, living alone Needs help with activities of daily living History of COPD, CHF Anticipated increase in length of stay Give binder by Heart and Stroke "Recovery Road" Explain Telemetry if discharged from CCU to Nursing Unit on Telemetry.
<b>EXPECTED PATIENT OUTCOME</b>	<ol style="list-style-type: none"> <li>1. Walked in room with stable cardiac rhythm and vital signs and no anginal symptoms.</li> <li>2. CPK has peaked and is falling.</li> </ol>

<b>DAY 3 OF ADMISSION - Possible transfer to Medical Ward</b>	
<b>CONSULTS</b>	Send referral to Discharge Planner prn.
<b>TESTS</b>	Follow Admission Orders If transferred out of CCU - follow Discharge Orders from CCU
<b>Assessments AND Treatments</b>	Follow Nursing Guidelines Telemetry if ordered Document level of activity attempted and tolerance. Document all episodes of angina.  Treatments If Telemetry ordered: follow Telemetry Practice Policy IV / Saline lock
<b>Activity</b>	NBGH Cardiac Progressive Ambulation level as per physician order. Shower with nursing supervision if allowed
<b>Nutrition</b>	Cardiac diet
<b>Medication</b>	<b>If transferred to Medical Nursing Unit : Anginal pain protocol if ordered.</b> Assess need for Coumadin. EC ASA unless contraindicated Nitro prn Consider Beta Blocker unless contraindicated Consider ACE Inhibitor unless contraindicated Offer stool softener as needed
<b>Teaching / Discharge Planning</b>	<u><b>PRIOR TO DISCHARGE</b></u> Dietitian : - diet for healthy heart 2 <sup>nd</sup> Visit Nurse Clinician: - Risk factors, heart disease/ heart medications including Nitro usage prn, - 911 Emergency Medical System - Lifestyle changes (i.e Cessation of smoking) - Activity levels Physiotherapist: - Exercise and Activity Guidelines
<b>EXPECTED PATIENT OUTCOMES</b>	1. Tolerates walk in hall with no anginal symptoms.

**DAY 4 and  
DAY 5 OF ADMISSION**

<b>CONSULTS</b>	Pharmacy / Nurse Clinician if for discharge on Coumadin.
<b>TESTS</b>	Stress test if ordered.
<b>Assessments and Treatments</b>	<p>Follow Nursing Unit Guidelines for the Post MI Patient. Telemetry if ordered Document level of activity attempted and tolerance. Document all episodes of angina.</p> <p><b>Treatment:</b> If Telemetry ordered : Follow Telemetry Practice Policy. Consider discontinuation of Telemetry prior to discharge . IV / Saline lock. Consider discontinuation if possible discharge.</p>
<b>Activity</b>	NBGH Cardiac Progressive Ambulation level as per physician order. Shower with nursing supervision if allowed.
<b>Nutrition</b>	Cardiac diet
<b>Medication</b>	<p>Anginal Pain Protocol if ordered. Coumadin if indicated. EC ASA unless contraindicated Consider Beta Blocker unless contraindicated Consider ACE Inhibitor unless contraindicated Offer stool softener as needed</p>
<b>Teaching / Discharge Planning</b>	<p>Assess readiness for discharge ie.</p> <ul style="list-style-type: none"> <li>- Tolerates activities of daily living with no anginal symptoms for the last 24 hrs.</li> <li>- Stress Test acceptable to physician</li> </ul> <p>If possible discharge:</p> <ul style="list-style-type: none"> <li>- All needed support services are in place</li> <li>- Person arranged for possible patient pick up tomorrow in AM.</li> </ul>
<b>EXPECTED PATIENT OUTCOMES</b>	<ol style="list-style-type: none"> <li>1. Has performed activities of daily living with no anginal symptoms for the last 24 hours.</li> <li>2. Vital signs have been within patient's norm for the last 24 hours.</li> </ol>

## EXPECTED DISCHARGE OUTCOMES

1. Has performed activities of daily living with no anginal symptoms for the last 24 hours.

2. Vital signs have been within patient's norm for the last 24 hours..

### Discharge Instructions may include:

- Reinforce information about medication, for example Nitro administration if applicable.  
Consider giving patient Nitro spray container used in hospital to patient.

### Follow up appointment(s) may include:

- Family doctor
- Internist
- Stress Test
- Nurse Clinician
- Dietitian
- Physiotherapist
- CCAC