Cardiac Sciences Program / Programme des sciences cardiaques

Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg
Caring for Health / À l'écoute de notre santé

Acute MI Care Map Utilization Guidelines

Note: Any discipline, with the admission diagnosis of Acute Myocardial Infarction (AMI), may start the AMI Care Map. A physician's order is not required.

Note: The AMI Care Map should NOT be initiated for acute coronary syndromes when the clinician is not convinced about an AMI, use clinical judgement.

Inclusion Criteria for AMI Care Map:

1. **All patients with an admission** diagnosis of AMI (ST Elevation and Non-ST Elevation) either to the CCU or the medical unit are to be included. If the patient is unstable on admission write a Progress Note stating the Care Map is ON HOLD until the patient is stabilized. Examples of instability include intubated patient, post code, intraaortic balloon pump, acute renal failure requiring dialysis, etc. All AMI patients are to be started on the AMI Care Map once stabilized.
2. Patient with a delayed presentation with an AMI should be placed on the Care Map as per discretion of the clinician and the decision should be individualized for each patient.

Exclusion Criteria for the AMI Care Map:

1. An AMI diagnosed post-operatively.
2. An AMI diagnosed during the course of their hospitalization, (e.g. a patient admission with pneumonia and develop and AMI on Day 5).

Note: If the admission diagnosis is rule out AMI or rule out Acute Coronary Syndrome and evolves to an AMI, this patient is **TO BE CARE MAPPED**.

Implementation Guidelines:

1. Start the AMI Care Map on admission day.
2. If the patient is admitted from another facility (rural or urban) start or continue the Care Map on the appropriate step.
3. If an AMI has occurred prior to hospital admission to the HSC (e.g. two days prior to admission) start the Care Map on the most appropriate step of the Care Map

Guidelines for Patient Awaiting Test or Procedure when an Increased Length of Stay is Anticipated (PTCA, MIBI, CABG, etc.):

1. If goal or standards of care are met, long lengths of stay, alternative diagnosis then decide if the map is to be continued or revert to regular charting system.
2. Leave of care map if awaiting cardiac investigations:
   - **Team** to decide activity, assessment parameter and diagnostic frequency. Based on this decision, determine which step would be appropriate for the patient. Obtain an order from the physician.
   - Leave the patient on the designated Care Map step. Repeat the step for this day until the test or procedure completed. Complete, if appropriate, the teaching sections of the Care Map with the exception of Step 4. There is NO maximum to the number of times the step is repeated in this situation.
   - On discharge ensure Step 4 of the Care Map is completed.
3. Discontinue Care Map if awaiting cardiac surgery.

The AMI Care Map can be Discontinued for the Following Reason:

1. Multi-system failure associated complex medical conditions.

Guidelines for Discontinuing the AMI Care Map:

1. Start/resume facility charting.

Nursing Head to Toe Assessment Parameters

Assessment Parameter	ICU	Ward	Normal Parameters
CNS			
Orientation	*	*	Oriented to person, place and time. General conversation is appropriate. Speech is clear and distinct. Anxiety controlled. CAM negative.
Motor/Sensory	*	*	Moving all limbs equally. No loss of sensation. Obeys commands.
Pain	*	*	States pain is "0" on pain scale. Practitioner must use 0 - 10 pain scale.
Cardiovascular			
Precordium	*		Apical pulsation may be visible, no lifts or heaves noted.
Peripheral Vascular System	* *	* *	Color variable dependent on ethnic origin: no pallor, cyanosis, and redness. No edema, warm and dry touch, elastic turgor, peripheral pulses + 2 all sites (radial and pedal pulses). Capillary refill less than 3 seconds.
Vital Signs	* * *	* * *	Pulse 60 - 100. Blood pressure Parameters: Refer to CHEP 2015 Guidelines Standing/sitting change: Systolic decrease less than 15 mmHg, Diastolic increase less than 5 mmHg Temperature: Oral range 36.4 - 37.5 degrees Celsius.
Rhythm Analysis	*		Regular with rate 60 - 100 beats/minute. PR 0.12 - 0.20 seconds QRS less than or equal to 0.12 seconds AV conduction 1:1 No ectopy
Respiratory System			
Inspection	*	*	Rate 12 - 24/minute. Rhythm regular and rhythmic. No use of accessory muscles, no intercostal bulging or retractions, O_2 saturation greater than or equal to 90% on room air. Able to speak in complete sentences without SOB.
Auscultation	*	*	Breath sounds normal and equal bilaterally: • Vesicular over peripheral lung fields, Bronchovesicular over 1st and 2nd ICS at sternal borders anterior and at T4 medial to scapulae posterior, Bronchial over trachea. No adventitious sounds (crackles, wheezes, rubs) audible.
Gastrointestinal			
Inspection	*	*	Skin color consistent with remainder of body. Abdomen is symmetrical in contour and appearance. Normal abdominal profiles may be flat, rounded or concave, no distension noted.
Auscultation	*	*	Bowel sounds occurring every 5 - 15 seconds in all quadrants.
Palpation	*	*	Abdomen non-tender and soft.
Bowel Movements	*	*	Not constipated, no obvious blood in stool. Colour, and bowel evacuation patterns vary with each individual, should be consistent with normal bowel habits for the individual.
Genitourinary			
Inspection	*	*	Fluid intake and urine output should approximate greater than 30cc/hour. Urine characteristics: no obvious blood or sediment in urine, no foul odor. No pain/burning with start of stream. No purulent discharge form urinary meatus or vaginal opening.
Integumentary System			
Inspection	*	*	Color consistent with abdominal area, will vary with ethnic origin (no hyper or hypopigmentation. No pallor, cyanosis, erythema, jaundice. Slight bruising may appear at venipuncture sites, no hematoma formation. No rashes, lesions. Braden Scale.
Substance Use/Smoking Assessment	*	*	Screen risk for withdrawal. Offer smoking cessation aids/resources.

Nursing Focused Assessment Parameters

Assessment Parameter	Normal Parameters
Level of Consciousness	Oriented to person, place and time, General conversation is appropriate. Speech is clear and distinct. Obey commands. CAM negative.
Pain	States pain is "0" on pain scale.
Peripheral Circulation	Color variable dependent on ethnic origin: no pallor, cyanosis, redness. No edema noted (peripheral or dependent). Warm and dry to touch. Peripheral pulses at + 2 (radial and pedal).
Vital Signs	• Pulse 60 - 100. • Blood pressure (position choice options) Lying: Refer to CHEP 2015 Guidelines Standing/sitting change: Systolic decrease less than 15 mmHg, Diastolic increase less than 5 mmHg. • Temperature: Oral range 36.4 - 37.5 degrees Celsius.
Respiratory	Rate 12 - 24/minute. Rhythm regular and rhythmic. No use of accessory muscles. Able to speak in complete sentences without SOB, O_2 saturation greater than or equal to 90% on room air if assessed. Breath sounds normal and equal bilaterally. • Vesicular over peripheral lung fields. Bronchovesicular over 1st and 2nd ICS at sternal boarders anterior and at T4 medial to scapulae posterior. Bronchial over trachea. • No adventitious sounds (crackles, wheezes, rubs) audible.
Gastrointestinal	Passing flatus or stool.
Genitourinary	States adequate urine output. Denies pain or burning with voiding. If urine output measured output greater than 240 mL/8 hours.