

TIME

CRITERIA						EVENTS / INTERVENTIONS
Central Nervous System						
States angina pain is "0" on pain scale * (Describe other pain)	*					
Alert & oriented x 3 spheres *	*					
Appropriate in general conversation *	*					
Moves all limbs						
No loss of sensation						
Follows commands						
Cardiovascular						
Color (no pallor, no cyanosis, no redness) *	*					
Skin warm & dry *	*					
No edema *	*					
Peripheral pulses palpable (+2) *	*					
Capillary refill < 3 sec						
Respiratory						
No shortness of breath *	*					
Chest clear *	*					
Breath sounds normal, equal bilaterally						
Regular, rhythmic						
No use of accessory muscles						
Gastro Intestinal						
Bowel movement *	*					
Abdomen not distended						
Abdomen soft / non tender						
Bowel Sounds x 4 quadrants						
Genitourinary						
Urine output > 240ml per 8 hr						
Urine clear, amber						
No pain / burning with voiding						
No discharge						
Psychosocial						
Patient expressing feelings related to cardiac event						
Patient states spiritual needs						
Substance Use (determine appropriate risk category)						
Smoking Withdrawal *	*					

ASSESSMENT / ASSESSMENT OUTCOMES: To be completed q 4 h x 24 hours.
 • Head to toe assessment at start of shift • Focal assessment (marked with *) thereafter if normal, initial only. If abnormal, describe in events/interventions section.

STEP 1

INTERVENTIONS/OUTCOMES		N	D	E	INTERVENTIONS/OUTCOMES		N	D	E
TESTS	<ul style="list-style-type: none"> CK q 8 hr x 3 Times: <input type="text"/> <input type="text"/> <input type="text"/> (Troponin q8h x 3 or until first positive result) INR/PTT: (based on ACS IV Heparin nomogram) Lipid Profile (HDL, LDL, Total cholesterol, Triglyceride, ratio, ALT, AST (add to admission sample from ED)) 12 Lead EKG <ul style="list-style-type: none"> Fibrinolytic Therapy Patients: 12 lead ECG at 1 hr <input type="checkbox"/> and 8 hrs <input type="checkbox"/> post infusion 12 lead EKG if ischemic chest pain not resolved with 3 nitro doses 				TEACHING	<ul style="list-style-type: none"> Give Patient Patient/Family Care Guide & Heart Attack and Back book Review Care Guide for Step 1 Review with patient/family: diagnosis & length of stay, procedures, initial explanation of medications, use of Nitro, next 24 hours of care, importance of reporting cardiac ischemia, not to strain during bowel movement Teach deep breathing and leg/foot exercises 			
	TREATMENTS (See Assessment Parameters)	<ul style="list-style-type: none"> Intake and output x 48 hours from admission Treatments (e.g. wound dressing/sheaths/central lines/dialysis, etc.) ... 					<ul style="list-style-type: none"> Patient demonstrates understanding of importance to report symptoms of cardiac ischemia Patient demonstrates understanding of the use of Nitro Patient demonstrates understanding of deep breathing & leg/foot exercises 		
MEDS/IV	<ul style="list-style-type: none"> IV NS infusing ≤ 35ml/hr x 48 hrs Check IV sites and rate q1h IV site patent, not reddened and infusing at ordered rate 				SPIRITUAL/ PSYCHOSOCIAL	Spiritual Care <ul style="list-style-type: none"> Assess emotional and spiritual concerns Opportunity to express concerns provided Emotional and spiritual needs addressed 			
NUTRITION	<ul style="list-style-type: none"> Modified fat, 100 mmol sodium and/or Controlled carbohydrate Controlled carbohydrate with hs snack Tolerates oral intake 					Nursing <ul style="list-style-type: none"> Assess patient and family's coping with illness Consult as needed: <ul style="list-style-type: none"> Social Work Other 			
SAFETY/ ACTIVITY	<ul style="list-style-type: none"> Orientation to unit & routine care Call system within reach & side rails up PRN Bedrest, stand/sit to void, commode Self care or assist with hygiene Deep breathing, leg/foot exercises q4h while awake Patient safety maintained 				DISCHARGE PLANNING	<ul style="list-style-type: none"> Assess home situation for discharge concerns Consult: <ul style="list-style-type: none"> Home Care 			
Smoking Assessment <div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; padding: 5px;"> ESTABLISH SMOKING STATUS NEVER SMOKER CURRENT SMOKER FORMER SMOKER </div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> <div style="border: 1px solid black; padding: 5px; width: 45%;"> How soon after waking do you have your first cigarette? <input type="checkbox"/> More than 1 hour = low nicotine dependence <input type="checkbox"/> 6 - 59 minutes = moderate nicotine dependence <input type="checkbox"/> Less than 6 minutes = high nicotine dependence Discuss options with MD </div> <div style="border: 1px solid black; padding: 5px; width: 45%;"> How many cigarettes, on average, do you smoke each day? <input type="checkbox"/> 15 or less = low nicotine dependence <input type="checkbox"/> 16 - 30 = moderate nicotine dependence <input type="checkbox"/> 31 or more = high nicotine dependence Discuss options with MD </div> </div> <p style="font-size: small; margin-top: 5px;"> • with moderate or high dependency scores on either of the above questions • note that patients who report smoking 15 or less cigarettes a day may have high nicotine dependency, especially if they have just recently cut down, are temporarily smoking less due to acute illness, or are under reporting • note that the form of Nicotine Replacement Therapy is based on an individual's preference </p>					PLAN REVIEWED	<ul style="list-style-type: none"> Plan Reviewed (Interventions completed, outcomes in shaded areas met) Move to Step 2 <input type="checkbox"/> Yes <input type="checkbox"/> No If no, place on extension map 			

TIME

ASSESSMENT / ASSESSMENT OUTCOMES: To be completed q4h x 24 hours from admission then q6h. Head to toe assessment at start of shift Focal assessment (marked with *) thereafter if normal, initial only. If abnormal, describe in events/interventions section.	CRITERIA						EVENTS / INTERVENTIONS
		Central Nervous System					
	States angina pain is "0" on pain scale * (Describe other pain)						
	Alert & oriented x 3 spheres *						
	Appropriate in general conversation *						
	Moves all limbs						
	No loss of sensation						
	Follows commands						
	Cardiovascular						
	Color (no pallor, no cyanosis, no redness) *						
	Skin warm & dry *						
	No edema *						
	Peripheral pulses palpable (+2) *						
	Capillary refill < 3 sec						
	Respiratory						
	No shortness of breath *						
	Chest clear *						
	Breath sounds normal, equal bilaterally						
	Regular, rhythmic						
	No use of accessory muscles						
	Gastro Intestinal						
	Bowel movement *						
	Abdomen not distended						
	Abdomen soft / non tender						
	Bowel Sounds x 4 quadrants						
	Genitourinary						
	Urine output > 240ml per 8 hr						
	Urine clear, amber						
	No pain / burning with voiding						
	No discharge						
	Psychosocial						
	Patient expressing feelings related to cardiac event						
	Patient states spiritual needs						
	Smoking Withdrawal *						

STEP 2

INTERVENTIONS/OUTCOMES		N	D	E	INTERVENTIONS/OUTCOMES		N	D	E
	Carry over interventions/outcomes from Step 1				SAFETY/ACTIVITY	Nursing			
						<ul style="list-style-type: none"> Progression of activity: dangle at bedside → up in chair → ambulate to bathroom Self care seated at <input type="checkbox"/> sink <input type="checkbox"/> bedside No symptoms of cardiac ischemia with mobilization 			
						Physiotherapy			
						<ul style="list-style-type: none"> Ambulates within room Distance _____ RHR _____ EHR _____ <input type="checkbox"/> Independent <input type="checkbox"/> Assistance Needed/Aids _____ Tolerates Step 2 activities Activity outcomes met but experienced the following: _____ 			
TESTS	<ul style="list-style-type: none"> During a.m. rounds determine appropriate risk stratification. In conjunction with the Attending Physician, book test for the morning of day 4 for rural patients and within 5 working days post-discharge for patients living in the city or as clinically indicated and determined by M.D. CK q 8 h x 3 from admission then OD in a.m. Troponin with CK until 1st positive result 12 Lead EKG in a.m. Fasting bloodwork - CBC, platelets, electrolytes, urea, Cr, glucose, TCO₂ in a.m. CXR in a.m. (if not done in ED on day 1) PTT based on ACS IV Heparin Nomogram 12 Lead EKG if ischemic pain not resolved with 3 nitro doses (If using extension, evaluate need to repeat tests)				TEACHING	Nursing			
						<ul style="list-style-type: none"> Review Patient/Family Care Guide Step 2 Reinforce warning signs of cardiac ischemia Complete the Risk Factor profile with patient ("Heart Attack and Back" book page 36 - 37). If a smoker, review smoking cessation options Transcribe lipid profile from ER to page 37 Patient has understanding of the risk factors and smoking cessation program (if applicable) 			
						Physiotherapy Education			
TREATMENTS <small>(See Assessment Parameters)</small>	<ul style="list-style-type: none"> Intake and output x 48 hours from admission Treatments (e.g. wound dressing/sheaths/central lines/dialysis, etc.) Vital signs stable O₂ saturation (SpO₂) ≥ 92% 				DISCHARGE PLANNING				
						<ul style="list-style-type: none"> Heart Attack and Back Book pages 11 - 17 Angina - Action Plan Heart Attack - Differences between Heart Attack & Angina Patient has understanding of: <ul style="list-style-type: none"> Angina - Action Plan Heart Attack - Differences between Heart Attack & Angina 			
MEDS/IV	<ul style="list-style-type: none"> IV NS infusing ≤ 35ml/hr x 48 hrs from admission Check IV sites and rate q1h IV site patent, not reddened and infusing at ordered rate 				DISCHARGE PLANNING	<ul style="list-style-type: none"> Discuss with Attending Physician re: telemetry or ward transfer 			
NUTRITION	<ul style="list-style-type: none"> Modified fat, 100 mmol sodium and Controlled carbohydrate Controlled carbohydrate with hs snack Tolerates oral intake 				PLAN REVIEWED	<ul style="list-style-type: none"> Plan Reviewed (Interventions completed, outcomes in shaded areas met) Carry over interventions/outcomes met <input type="checkbox"/> Yes <input type="checkbox"/> No Move to Step 3 <input type="checkbox"/> Yes <input type="checkbox"/> No If no, place on extension map			



ACUTE MI CARE MAP

STEP 3

(Extension Map Used # _____)
(clarify bloodwork)

<p align="center">Assessment Parameters</p> <ul style="list-style-type: none"> • Focal assessment q shift • VS BID • Cardiac monitoring until discontinued by physician 	<p>Date _____</p> <p>Weight _____ kg (if on diuretic)</p>
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TIME	Angina Pain (0-10 Scale)	Temperature	Systolic	Diastolic	Mean	P Screen	U Radial	S Apical	Blood Pressure S/D	Rhythm	Ectopy	Heart Rate	ST Monitoring/Lead	O ₂ Delivery	Respiratory Rate	O ₂ Saturation (SpO ₂)	Initials

TIME	OTHERS											I.V. SOLUTIONS					
	IV	IV	IV	IV	IV	COLLOID	ORAL	TF	OTHER	URINE	NG EMESIS	NO.	TIME	TYPE	AMOUNT	SITE	INITIAL
2400																	
0100																	
0200																	
0300																	
0400																	
0500																	
0600																	
0700																	
TOTALS																	

8 HOUR INTAKE _____												OUTPUT _____					
TIME	IV	IV	IV	IV	IV	COLLOID	ORAL	TF	OTHER	URINE	NG EMESIS	NO.	TIME	TYPE	AMOUNT	SITE	INITIAL
0800																	
0900																	
1000																	
1100																	
1200																	
1300																	
1400																	
1500																	
TOTALS																	

8 HOUR INTAKE _____												OUTPUT _____					
TIME	IV	IV	IV	IV	IV	COLLOID	ORAL	TF	OTHER	URINE	NG EMESIS	NO.	TIME	TYPE	AMOUNT	SITE	INITIAL
1600																	
1700																	
1800																	
1900																	
2000																	
2100																	
2200																	
2300																	
TOTALS																	

- KEY:**
- Volume Expanders (ml) (Colloid)**
- Blood = W.B. 450
 - Packed Cells = P.C. 250
 - Human Serum Albumin = H.S.A. 100
 - Fresh Frozen Plasma = F.F.P. 260
- I.V. Fluids (Crystalloid)**
- 5% Dextrose Injection 5-D/W
 - 5% Dextrose and 0.9% Sodium Chloride 5-D/S
 - 0.9% Sodium Chloride N/S
 - 5% Dextrose and 0.45% Sodium Chloride 5-D-1/2S
 - 10% Dextrose Injection 10-D/W
 - Lactated Ringers Injection RL
 - 5% Dextrose Lactated Ringers 5-D/RL
 - 0.45% Sodium Chloride 1/2NS
 - 3.3% Dextrose and 0.3% Sodium Chloride 2/3 - 1/3
- Oral Fluids (ml)**
- Aladdin Mug 200
 - Aladdin Tumbler 250
 - Aladdin Soup Bowl 175
 - Aladdin Juice Cup 125
 - Aladdin Juice Tumbler 180
 - Styrofoam Cup #107 150
 - Soft Drink Glass 150
 - Pre-portioned Juice 114
 - Pre-portioned Milk 120
 - Ice Cream Dixie 100
 - Sherbet 100
 - Jello 100
 - Creamer 10

24 HOUR FLUID BALANCE	24 HOUR BALANCE ±
TOTAL INTAKE ▶	TOTAL OUTPUT ▶
CUMULATIVE BALANCE ±	

TIME

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	States angina pain is "0" on pain scale (Describe other pain) *						
	Alert & oriented x 3 spheres *						
	Appropriate in general conversation *						
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	Skin warm & dry *						
	No edema *						
	Peripheral pulses palpable (+2) *						
	Respiratory						
	No shortness of breath *						
	Chest clear *						
	Gastro Intestinal						
	Bowel movement *						
Genitourinary							
Psychosocial							
Smoking Withdrawal *							

STEP 3

INTERVENTIONS/OUTCOMES		N	D	E	INTERVENTIONS/OUTCOMES		N	D	E	
Carry over interventions/outcomes from Step 2					TEACHING	Nursing • Review Patient/Family Care Guide Step 3				
						Physiotherapy Education From the Heart Attack and Back Book pages 48 - 59 • Normal and abnormal response to activities				
						• Home exercise program				
						• Patient understands the normal and abnormal responses to activity, home exercise program, appropriate level and progression of activities				
TESTS	<input checked="" type="checkbox"/> 12 Lead EKG in a.m. <input checked="" type="checkbox"/> CBC, platelets, in a.m. <input checked="" type="checkbox"/> ALT/AST (If using extension, evaluate need to repeat tests)					Occupational Therapy • Review resuming of activities: driving (page 59), back to work (page 59), sexual activity (page 54), home management (page 24) (Heart Attack and Back book)				
TREATMENTS (See Assessment Parameters)	• Treatments (e.g. wound dressing/sheaths/central lines/dialysis, etc.) ... _____ _____ • Vital signs stable					• Patient has understanding of appropriate level of activities to do at home				
MEDS/IV	<input checked="" type="checkbox"/> IV _____ <input checked="" type="checkbox"/> IV to saline lock if being transferred to telemetry <input checked="" type="checkbox"/> Discontinue IV if transferred to medical unit • Check IV site and rate q1h • IV site patent, not reddened and infusing at ordered rate • IV discontinued @ _____ with catheter intact					Clinical Nutrition • For patients residing in Winnipeg <input type="checkbox"/> Refer to cardiac nutrition class • For Rural patients <input type="checkbox"/> Review nutritional guidelines (Heart Attack and Back Book pages 40 - 47) • Review nutritional guidelines related to hyperlipidemia and/or diabetes if applicable • Patient aware of heart healthy food choices				
NUTRITION	<input checked="" type="checkbox"/> Modified fat, 100 mmol sodium and/or <input type="checkbox"/> Controlled carbohydrate <input type="checkbox"/> Controlled carbohydrate with hs snack • Tolerates oral intake					PSYCHO-SOCIAL	Nursing • Complete "Coping with a Heart Attack, How are You Doing?" checklist with patient			
SAFETY/ACTIVITY	Nursing/Physiotherapy • Ambulates in hall as tolerated • Self care at sink/bedside • No symptoms of cardiac ischemia with mobilization Physiotherapy • Ambulates in hall: Distance _____ RHR _____ EHR _____ <input type="checkbox"/> Independent <input type="checkbox"/> Assistance Needed/Aids • Tolerates Step 3 activities • Activity outcomes met but experienced the following: _____						• Psychological referral criteria met <input type="checkbox"/> Yes <input type="checkbox"/> No			
							• Referral to Clinical Psychologist <input type="checkbox"/> Declined <input type="checkbox"/> Accepted			
					PLAN REVIEWED	• Plan Reviewed (Interventions completed, outcomes in shaded areas met) • Carry over interventions/outcomes met <input type="checkbox"/> Yes <input type="checkbox"/> No .. • Move to Step 4 <input type="checkbox"/> Yes <input type="checkbox"/> No If no, place on extension map				

