Original Article

# A Study To Access The Knowledge Regarding Myocardial Infarction Among Nurses At Keshlata School Of Nursing

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## Abstract

Myocardial infarction [MI] refers to the interruption of coronary blood supply to certain myocardial area which leads to irreversible myocardial tissue death.

**Key words:** myocardial, infarction,coronary,irreversible.

## INTRODUCTION

Acute myocardial infarction is a deadly condition which affects the physical mental and social health of the individual. Myocardial infarction is a medical emergency condition. MI are of two **types:** transmural and subendocardial. It is mainly caused by oxidative stress and atherosclerosis.

### Aim of the study

The aim of the study is to assess the knowledge of the nurses regarding quick assessment and nursing management of MI patients.

### A knowledge Assessment study

A study was carried out to access the level of knowledge regarding nursing assessment and management of myocardial infarction patients, among 20 student nurses GNM 2nd year at Keshlata Hospital Bareilly. Data was collected by structured questionnaire performa regarding assessment and nursing intervention of MI Patients. The study was carried out by pre test and post test. In pre-test out of 20 participants, 30 %had a poor knowledge, 55% had a average knowledge, and 15% had good knowledge regarding the nursing assessment and management of myocardial infarction .In post-test out of 20 participant,12% had a poor knowledge,14% had a average knowledge and 74%had a good knowledge regarding the nursing assessment and management of myocardial infarction.

### Hypothesis

**H1:** There would be significant difference between in pretest and posttest level of knowledge score of nurses regarding myocardial infarction.
**H2:** There would be significant association between pretest and posttest knowledge score of nurses regarding myocardial infarction.

## OBJECTIVES OF THE STUDY

- To gain deeper and broader knowledge regarding myocardial infarction assessment and management.
- To treat the patient promptly in the early signs of infarction.
- To priotize nursing care according to care plan.

## METHODOLOGY

Data was collected by structured questionnaire performa. This method involves 20 participants. This helped them to gain deeper knowledge regarding assessment of myocardial infarction patients

### Ethical consideration

Prior permission was obtained from the Principal, School of nursing and informed consent taken from each participant under the study. Objective of the study was maintained

## RESULT AND DISCUSSION:

The frequency and percentage regarding structured questionnaire-

| Pre test Score | | | |
|---|---|---|---|
| **Knowledge level** | | **(f)** | **%** |
| **1** | Good Knowledge | **3** | **15%** |
| **2** | Average Knowledge | **11** | **55%** |
| **3** | Poor Knowledge | **6** | **30%** |

| Post test Score | | | |
|---|---|---|---|
| **Knowledge level** | | **(f)** | **%** |
| **1** | Good Knowledge | **13** | **65%** |
| **2** | Average Knowledge | **3** | **15%** |
| **3** | Poor Knowledge | **4** | **12%** |

## STRUCTURED QUESTIONNAIRE PERFORMA REGARDING ASSESSMENT AND NURSING INTERVENTION OF MI PATIENTS

**1. A client is admitted to a hospital with acute myocardial infarction and is started on tissue plasminogen activator (t-PA, Activase) by infusion Of the following parameters, which on would a nurse determine requires the least frequent assessment to detect complications with this therapy ?**

a. Oxygen saturation
b. Neurological signs
c. Blood pressure and pulse
d. Complaints of abdominal and back pain

**2. A client with myocardial infarction (MI) has been transferred from a coronary care unit (CCU) to a general medical unit with cardiac monitoring via telemetry. A nurse plans to allow for which of the following client activities ?**

a. Strict bed test for 24 hours after transfer
b. Bathroom privileges and self-care activities
c. Unsupervised hallway ambulation with distances under 200 feet
d. Ad lib activities since the client is monitored

**3. A nurse notes bilateral 2+ edema in the lower extremities of a client with myocardial infarction (MI) who was admitted 2 days ago. The nurse would plan to do which of the following next?**

a. Review the intake and output records for the last 2 days.
b. Change the time of diuretic administration from morning to evening
c. Request a sodium restriction of 1g/day from the physician
d. Order daily weights starting on the following morning

**4. A nurse is conducting a health history with a client with a primary diagnosis of heart failure. Which of the following disorder reported by the client does not play a role in exacerbating the heart failure?**

a. Recent upper respiratory infection
b. Nutritional anemia
c. Peptic ulcer disease
d. Atrial fibrillation

**5. A nurse is preparing for the admission of a client with heart failure who is being sent directly to the hospital from the physician's office. The nurse would plan on having which of the following medications readily available for use ?**

a. Diltiazem (Cardizem)
b. Digoxin (Lanoxin)
c. Propranolol (Inderal)
d. Metoprolol (Loperssor)

**6. A client with angina pectoris has a 12-lead ECG taken during an episode of chest pain. A nurse examines the tracing for which ECG change caused by myocardial ischemia ?**

a. Prolonged PR interval
b. Widened QRS complex
c. ST segment elevation or depression
d. Tall, peaked T waves

**7. You're educating a patient about the causes of a myocardial infarction. Which statement by the patient indicates they misunderstood your teaching and requires you to re-educate them ?**

a. Coronary artery dissection can happen.
b. The most common cause of a myocardial infarction is a coronary spasm from illicit drug use or hypertension.
c. Patients who have coronary artery disease are at high risk for developing a myocardial infarction.
d. Both A and B are incorrect

**8. You note in the patient's chart that the patient recently had a myocardial infarction due to blockage in the left coronary artery. You know that which of the following is true about this type of blockage ?**

a. A blockage in the left coronary artery causes the least amount of damage to the heart muscle.
b. Left coronary artery blockages can cause anterior wall death which affects the left ventricle.
c. Left coronary artery blockage can cause posterior wall death which affects the right ventricle.
d. The left anterior descending artery is least likely to be affected by coronary artery disease.

**9. A patient is 36 hours status post a myocardial infarction. The patient is starting to complain of chest pain when they lay flat or cough. You note on auscultation of the heart a grating, harsh sound. What complication is this patient mostly likely suffering from ?**

a. Cardiac dissection
b. Ventricular septum rupture
c. Mitral valve prolapse
d. Pericarditis

**10. After a myocardial infraction, at what time (approximately) do the macrophages present at the site of injury to perform granulation of the tissue ?**

a. 24 hours
b. 2 days
c. 10 days
d. 6 hours

**11. 24-36 hours after a myocardial infarction……….congregate at the site during the inflammation phase.**

a. Neutrophils
b. Eosinophils
c. Platelets
d. Macrophages

**12. A patient is complaining of chest pain. You obtain a 12-lead EKG and see ST elevation in leads II, III, AVF. What area of the heart does this represent ?**

a. Lateral
b. Septal
c. Anterior
d. Inferior

**13. A doctor has ordered cardiac enzymes on a patient being admitted with chest pain. You know that ………levels elevate 2-4 hours after injury to the heart and is the most regarded marker by providers.**

a. Myoglobin
b. CK-MB
c. CK
d. Troponin

**14. In regards to the patient in the previous question, after administering the first dose of Nitroglycerin sublingual the patient's blood pressure is now 68/48 the patient is still having chest pain and T-wave inversion on the cardiac monitor. What is your next nursing intervention ?**

a. Hold further doses of nitroglycerin and notify the Doctor immediately for further orders.
b. Administer Morphine IV and place the patient in reverse Trendelenburg position.
c. Administer Nitroglycerin and monitor the patient's blood pressure.
d. All the options are incorrect

**15. A patient recovering from a myocardial infarction is complaining of the taste of blood in their mouth . On assessment, you note there is bleeding on the anterior gums. Which medication can cause this ?**

a. Coreg
b. Cardizem
c. Lovenox
d. Lipitor

**16. A patient is on a Heparin drip post myocardial infarction. The patient has been on the drip for 4 days. You are assessing the patient's morning lab work. Which of the following findings in the patient's lab work is a potential life-threatening complication of Heparin therapy and requires intervention ?**
a. K+ 3.7
b. PTT 65 seconds
c. Hgb 14.5
d. Platelets 135,000

**17. A patient taking Lovenox is having a severe reaction. What is the antidote for this medication ?**
a. Activated charcoal
b. Acetylcysteine
c. Narcan
d. Protamine sulfate

**18. A patient is being discharged home after receiving treatment for a myocardial infarction. The patient will be taking Coreg. What statement by the patient demonstrates they understood your education material about this drug ?**
a. "I will take this medication at night"
b. "I will take this medication as needed"
c. "I will monitor my heart rate and blood pressure while taking this medication.
d. "I will take this medication in the morning with grapefruit juice

**19. A patient's morning lab work shows a potassium level of 6.3. The patient's potassium level yesterday was 4.0 The patient was recently started on new medications for treatment of myocardial infarction. What medication below can cause an increased potassium level ?**
a. Losartan
b. Norvasc
c. Aspirin
d. Cardizem

**20. Which of the following EKG changes are abnormal findings that may indicate ischemia or injury to the cardiac muscle found on a 12-lead EKG ? SELECT- ALL-THAT-APPLY :**
a. Lengthening p-waves
b. ST-segment elevation
c. T-wave inversion
d. Tall t-waves
e. QT interval narrowing
f. ST-segment depression

ANSWER KEY:-

| | | |
|---|---|---|
| 1. | A | 11. A |
| 2. | B | 12. D |
| 3. | A | 13. D |
| 4. | C | 14. A |
| 5. | B | 15. C |
| 6. | C | 16. D |
| 7. | B | 17. D |
| 8. | B | 18. C |
| 9. | D | 19. A |
| 10. | C | 20. B,C,D,F |

## NURSING CARE PLAN FOR A PATIENT DIAGNOSIS – MYOCARDIAL INFARCTION

List of possible nursing diagnosis for MI patients
1. Airway clearance, ineffective : related to disease conditions
2. Cardiac output, alteration in decreased : related to disease conditions
3. Comfort, alteration in pain : related to disease conditions
4. Dependence on nursing supervision of cardiac monitoring
5. Anxiety : related to diseases MI, and future life adjustment
6. Fluid volume deficit, actual : due to fluid loss by vomiting
7. Nutrition, alteration in less than body requirements
8. Bowel elimination alteration in constipation
9. Sleep pattern disturbance : related to disease conditions
10. Self care deficit : bathing, hygiene, dressing, grooming, toileting related to MI
11. Knowledge deficit : related to MI

12. Excessive caffeine intake
13. Life style inappropriate to cardiac pathology

| Assessment | Nursing Diagnosi s | Objective | Nursing Intervention/ Implementation | Rationale/Scientific Principles | Evaluation |
|---|---|---|---|---|---|
| *Subjective Data*<br>Patient verbalized, 'Sister I can't breath properly'<br><br>*Objective Data*<br>*Cyanosis in lips and nails<br>*Drowsines s<br>*Coma<br><br>*Decreased movement of the chest<br>*Absent, decreased or wheezing breath sounds<br>*Absent voice sounds<br>*Thoracic dullness<br>*Rate less than eighty times a minute<br>*Sweating<br>*Coarse tremor<br>*Twitching | Airway clearance ineffectiv e related to disease condition | Patient's airway will be cleared within reasonable time | *To remove foreign particles and artificial dentures<br><br>*To suction the airway<br>*To administer humidified oxygen<br><br>*To remove constrictive clothing<br>*To attend the Pt constantly (until the episode subsides)<br>*To place patient in a sitting position<br><br>*To provide standby emergency equipments (oxygen, suction machine, defibrillator, etc)<br>*To explain the causes of the health problem | *Foreign particles may cause mucosal irritation, infection or obstruction of passages<br><br>*Secretion removal maintains a patient's airway, allowing for respiratory gas exchange<br>*When oxygen is humidified, the dry gas is converted to approximately the same moisture level as of the room air. The vapour thus created decreases the drying effect of oxygen on the respiratory mucosa. Oxygen therapy builds up a higher oxygen intake than provided by ordinary air.<br><br>*Constriction that prevents venous return will impair circulation and result in tissue damage<br>*Constant attention facilitates recognition of health disorders<br>*The sitting position facilitates and supports improved respirations and reduces tracheal edema<br><br>*Readily available emergency equipment and drugs can save a life when time is of the utmost importance<br><br>*Awareness of causes promotes comfort and reduces the internal tension and anxiety that results from the fear of the unknown | Patient was able to breathe properly after administration of oxygen |

| Assessment | Nursing Diagnosi s | Objective | Nursing Intervention/ Implementation | Rationale/Scientific Principles | Evaluation |
|---|---|---|---|---|---|
| *Subjective Data*<br>Patient verbalised feeling of weakness, dizziness and fatigue<br><br>*Objective Data*<br>*Bp 80/70 mm of Hg<br>*Faint pulse<br>*Tachy cardia<br>*Skin cold and clammy<br>*Patient looks weak and pale | Cardiac output, alteration in decrease d; related to disease condition | Patient's BP will be in normal limits within reasonable time | *To administer intravenous fluids (ringer's lactates) or increase the intravenous infusions flow rate<br><br>*To give 200cc of hot milk or tea to the patient<br><br>*To place the foot elevated, head lowered (trendelenburg) position<br><br>*To cover with warm blankets and maintain a warm room temperature<br>*To withhold the drug if given for high B.P<br>*To explain the causes of health problem | *Intravenous infusions provide an immediate source of water, electrolytes and nutrients for the purpose of maintenance, replacement or as an avenue for drug administration. Intravenous fluid increase the vascular pressure, especially when administered rapidly during shock<br><br>*Theine in tea makes it mildly stimulating, causing temporarily improved circulation<br><br>*The blood circulation will be more through gravity to cardiac walls. Thus, increasing blood pressure through increasing the tension in the blood vessels<br><br>*Warm bed covering promotes comfort by increasing environment heat surrounding the body and maintaining normal temperature. It decreases body heat loss tio the environment<br><br>*Reduces the risk of low B.P<br><br>*Awareness of causes of problem reduces the anxiety | *Patient's blood pressure came to normal limits, about 110/80 mm of Hg within 1/2 an hour.<br><br>*Patient feels better than before and less weak |

| Assessment | Nursing Diagnosi s | Objective | Nursing Intervention/ Implementation | Rationale/Scientific Principles | Evaluation |
|---|---|---|---|---|---|
| *Subjective Data*<br>Patient verbalized, "Sister, I have severe pain in my chest"<br><br>*Objective Data*<br>* Drawn faces<br>*Facial tension<br>*Moaning | Comfort alteration in pain related to heart attack | Patient's pain will be relieved within reasonable time | *To administer injection of morphine 5mg g/m<br><br>*To provide dry, clean, smooth bed And To eliminate unnecessary noise and glaring light<br><br>*To place on complete bed rest | *Morphine is a narcotic which relieves pain and produces good sleep<br><br>*Wrinkled or soiled bed, glaring light interferes in patient's rest and sleep which causes fatigue and increased pain<br><br>*Complete bed rest prevents tissue injury and reduces the probability of complications associated with activity and decreases the consumption of O2 by the myocardial muscles | *After receiving an injection of morphine patient slept for 2 hours and his pain was relieved |
| **Assessment** | **Nursing Diagnosi s** | **Objective** | **Nursing Intervention/ Implementation** | **Rationale/Scientific Principles** | **Evaluation** |
| *Subjective Data*<br>Patient relies on nurses for:-<br>-surveillance for abnormal heart patterns<br>-<br>Interpretatio n of abnormal heart patterns<br>-recognition mechanical failure of monitoring system | **Dependen ce** on nursing super vision of cardiac monitori ng | Patient's ECG will come back to normal within reasonable time | *To recover patient verbally<br><br>*To monitor the cardiogram<br><br>*To provide standby emergency equipment and drugs (oxygen, defibrillator)<br><br>*To provide frequent patient | *Assuring to minimize worry and anxiety<br><br>*Monitor cardiogram to check patient's cardiac situation<br><br>*Emergency equipment kept ready near the patient's bedside can be used promptly and easily to save patient's life<br><br>*Frequent patient contact enhances the probability of detecting abnormal physical conditions<br><br>*To prevent getting shock because when water comes in contact with | *Patient's ECG came back to normal after 3 days |

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| *Objective Data*<br>*Patient is being monitored for cardiac irregularities<br>*Subjective Data*<br>Patient verbally asked many questions about the disease<br>*Objective Data*<br>-Facial tension<br>-Drawn face<br>-Poor eye contact | Anxiety related to disease Myocardi al Infarctio n and future life adjustme nt | Patient's anxiety will be minimised within reasonable time | contact<br><br>*To unplug the electrical monitor during a bath<br><br>*To consult with the physician (as needed)<br><br>*To encourage the patient to express feelings<br><br>*To listen attentively<br><br>*To answer the questions patiently and honestly regarding the disease<br><br>*To administer injection valium 5mg | electrical equipment the possibility of electrical shock is highly probable<br><br>*Nursing consultation with the patient's physician provides patient safety and comfort<br>*Allows for better coping behaviour and emotional support<br>*Encourages patient to talk more<br>*Calmer patient attitude fosters communications<br>*To minimise anxiety and help sleep | *Patient looks less fearful and has relaxed facial expressions<br><br>*Patient slept well for 2 hours |

| Assessment | Nursing Diagnosi s | Objective | Nursing Intervention/ Implementation | Rationale/Scientific Principles | Evaluation |
|---|---|---|---|---|---|
| *Subjective Data*<br>-Thirst<br>-Generalised weakness<br>-Dryness of oral cavity<br>-Burning in micturation<br>-Nausea<br><br>*Objective Data*<br>-Daily fluid intake is less than 800cc<br>-Dry skin and mucous membrane<br>-Decreased urinary output coloured dark yellow<br>-Poor skin | Fluid volume deficit, actual : due to fluid loss by vomiting | -Patient will take 2000cc of fluid over 24 hours<br><br>-The fluid electrolyte balance will maintain within reasonable time | *To start intravenous fluids stat, about 3 pints<br><br>*To give injection stemital intra muscular in case of vomiting<br><br>*To give fluid by mouth when vomiting stops, like juice, milk, dal soup or veg soup 30cc every 2 hours<br><br>*To provide patient with fresh drinking water<br><br>*To give mouth washes every 4 hours<br><br>*To maintain an accurate intake/output<br><br>*To monitor blood pressure every hour | *Intravenous infusions provide an immediate source of water, electrolytes and nutrients for the purpose of maintenance of body tissue, and also increases urinary output<br><br>*Stops vomiting and also helps to decrease the nausea<br><br>*Increases fluid intake moistens the mucous membrane, and also gives strength thus maintains the electrolyte balance in the body<br><br>*Fresh water relieves thirst, promotes comfort and assists in illness dependency<br><br>*Frequent mouth wash refreshes the patient and keeps the mouth moist and prevents dryness<br><br>*The treatment depends on it and it is essential to maintain and assess the progress of the patient<br><br>*Decreased systolic BP is associated with reduced circulatory blood volume and cardiac output, decreased diastolic BP is associated with decreased peripheral resistance caused by vasodilatation | *Patient's output of urine over 24 hours was 1500cc and urine was clear, pale colour<br><br>*Patient's vomiting stopped and he was not feeling nauseated<br><br>*Patient looks fair and is able to take fluid by mouth |

| Assessment | Nursing Diagnosi s | Objective | Nursing Intervention/ Implementation | Rationale/Scientific Principles | Evaluation |
|---|---|---|---|---|---|
| *Subjective Data*<br>-Patient verbalized, "Sister, I am feeling nauseated"<br>-Does not like to eat<br>-Weakness<br><br>*Objective Data*<br>-Prolonged vomiting<br>-Chronically poor eating habits<br>-Patient vomits soon after eating anything | Nutrition alteration is less than the body **requirem ent** related to vomiting | Patient will be able to take a diet of 1800cal | *To give low cholesterol meals<br><br>*To give prescribed diet to the patient<br>Breakfast 8AM<br>-Milk(non fat) dry instant 200cc 10 AM -2 slices of bread with jam<br>-Oats 50cc<br>Lunch -2 chapati<br>-Vegetable<br>-Dal 100cc<br>-A fruit, preferably banana<br>-Salad<br>4AM -Milk 200cc<br>Dinner<br>- Chapati or rice<br>-Lean meat<br>-Salad<br>-Fruit, preferably apple<br><br>*To give vitamin C containing foods, such as, fruits and lemon juice<br><br>*To give small frequent feedings. give nourishing food at least 6 times a day, like complan, horlics, bournvita | *High cholesterol diet causes harmful effects on patient's health<br><br>*Balanced nutritional intake is essential to body cell activity and energy production from foods.<br>Relief of visceral hunger promotes comfort<br><br>*Vitamin C is required for the healing of the infarct cardiac muscles<br><br>*Small amount of food as easily digested prevents extra load to heart, fatigue and abdominal distension and maintain balanced nutritional intake | *Patient was able to take the prescribed diet, that is approximately 1800cc<br><br>*Patient was able to take small frequent meals |

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| | | | *To avoid cholesterol containing foods such as egg yolk, saturated fats, groundnuts, fatty meat, cheese<br><br>*To explain the reason for and intended effect of the therapy | *Cholesterol is deposited in the blood vessels and make the vessels narrow and blocked and causes less blood supply and thus, leads to heart attack<br><br>*Knowledge about the effect of this nutritional therapy will reduce anxiety and promote comfort | |
| | | | | | |
| **Assessment** | **Nursing Diagnosi s** | **Objective** | **Nursing Intervention/ Implementation** | **Rationale/Scientific Principles** | **Evaluation** |
| *Subjective Data*<br>-Headache<br>-Indigestion<br>-Abdominal pain,<br><br>fullness or spasms<br>-Abdominal tenderness in the right lower abdominal cecum area<br><br>*Objective Data*<br>-Hard small round masses of stool in lower colon<br>-Flatulence<br>-Alternating very large and very small stools | Bowel eliminati on alteration<br><br>In constipati on | Patient constipatio n will be relieved within reasonable time | *To give fresh fruits daily<br><br>*To provide bed side commode for elimination<br><br>*To administer an enema<br><br>*To give laxatives<br><br>*To instruct to increase fluid intake<br><br>*To advise not to take enemas and laxatives (chronically) | *Fresh fruits contain indigestible cellulose that supplies bulk for normal comfortable elimination. Fresh fruits supply nutritional Vitamins<br><br>*Providing commode prevents staining by patient, it offers a normal position for defecating and less energy is required<br><br>*One pint enema distend the colon sufficiently to stimulate peristalsis<br><br>*Laxatives consists of chemical that combines with body processes to improve elimination<br><br>*Increased fluid intake in certain situations assumes adequate hydration of body tissues<br><br>*Frequent use of enemas and laxatives gradually make the intestinal tissues insensitive to normal elimination and stimulation and decreases the normal muscle tone required for elimination. | Patient's constipation was relieved after giving laxatives within 6 hours |

| Assessment | Nursing Diagnosi s | Objective | Nursing Intervention/ Implementation | Rationale/Scientific Principles | Evaluation |
|---|---|---|---|---|---|
| *Subjective Data*<br>Annoyance if disturbed while sleeping at odd times or hours<br><br>*Objective Data*<br>-Patient sleeps during the day and stays awake during night<br>-Sleeps when one would normally be awake<br>-Is awake when one would normally be asleep<br>-Eat irregularly because of reversed sleep pattern | Pattern disturban ce related to disease condition | Patient's sleep pattern will be sound and regular within reasonable time | *To promote patient's sleep during the night by keeping the unit calm and quiet and restrict the visitors<br><br>*To observe the pattern of sleep. note down the times of day, when patient sleeps and how consistently the sleep schedule is followed<br><br>*To give sedatives like calmpose if patient is unable to sleep at night<br><br>*During the day time give sufficient rest to the patient. Do not let patient exert himself<br><br>*To provide comfort measures to the patient while turning, bathing, etc<br><br>*To explain significant factors that brought about the patient's health problem | *A consistent sleep is necessary for patient's good health and for quick recovery from the disease MI<br><br>*It is essential for normal functioning<br><br>*It helps to produce sound sleep to the patient<br><br>*Over exertion causes extra load to the heart and may cause pain to the patient<br><br>*To keep the patient comfortable<br><br>*Awareness of the causes of the problem reduces anxiety that is associated with the unknown and decreases the potential for reoccurrence of the problem | *Patient slept well for about 8 hours at night<br><br>*Patient looks comfortable after getting sound sleep |

| Assessment | Nursing Diagnosi s | Objective | Nursing Intervention/ Implementation | Rationale/Scientific Principles | Evaluation |
|---|---|---|---|---|---|
| *Subjective Data*<br>-Patient verbalised that he is not keen to take a bath<br>-He also verbalised that he feels too sick to take a bath<br><br>*Objective Data*<br>-Sweating odour<br>-Uncombed hair<br>-Dirty feet<br>-Infrequent bathing<br>-Dirty teeth and tongue | Self care deficit : bathing, hygiene, dressing, grooming , toileting related to MI | Patient will be able to take bath, maintain hygiene, grooming, toileting within reasonable time | *To give daily bed bath to patient after 3rd day of attack. Do not move too much<br><br>*To take care of the foot<br><br>*To give back care every 4 hours<br><br>*To inspect the skin for breakdown, redness or abnormal colour<br>*Palpate the skin for temperature<br><br>*To comb hair twice a day<br><br>*To encourage and give hand washing before and after washing perineum | *Cleaning of the skin removes accumulated perspiration secretion, microorganisms and debris from skin. Too much movement of the body causes stress to heart (myocardium)<br>*It provides comfort, freshness and relaxation, eliminates odour<br>*Assisting the patient to appear all groomed tends to improve self- esteem<br>*Warm water dilates the blood vessels, circular rubbing to skin surface increase the blood supply<br><br>*Unclean feet cause heel cracks, which may bleed and cause infection<br><br>*Massage increases local circulation and nutrition to the cells and muscle relaxation, prevents pressure sores<br><br>*Redness and increase in temperature is an indication that skin may break<br><br>*It removes accumulation of dandruff, nits and exercise to scalp<br><br>*This prevents gastro intestinal disease | *Patient verbalised he felt fresh and clean<br><br>*Patient did not develop any pressure sores<br><br>*Patient looked neat and tidy<br><br>*Patient maintains grooming and hygiene |

| Assessment | Nursing Diagnosi s | Objective | Nursing Intervention/ Implementation | Rationale/Scientific Principles | Evaluation |
|---|---|---|---|---|---|
| *Subjective Data*<br>Patient verbalised, what is MI<br>and what are the causes of MI<br>And how to prevent reoccurring<br><br>*Objective Data*<br>Patient have no knowledge regarding MI. | Knowled ge deficit : related to MI, it's causes and predisposi ng factors and preventiv e measures | Patient will verbalize about the predisposin g factors and preventive measures of disease (MI) | *To explain to patient all about MI, it's causes and predisposing factors<br><br>*To explain by using poster or chart showing relationship of causes of disease through the auto nervous system<br><br>*To tell about some simple exercise to keep the body and mind fit<br><br>*To explain to patient about diet. To avoid food which contain high cholesterol for example : chocolate, cow's milk, fatty meal, eggs, cheese, groundnuts, etc | *Patient will understand about MI and reduce the risk of reoccurrence<br><br>*Patient has better understanding when he is taught by the use of posters and charts<br><br>*Simple exercise keeps body and mind fit and thus prevent strain to the heart<br><br>*Helps to maintain the blood vessels function properly reduces the risk of narrowing of arteries | *Patient gets the knowledge about MI its causes and he started doing simple exercises<br><br>*Patient understood in a better way after seeing posters |

| Assessment | Nursing Diagnosi s | Objective | Nursing Intervention/ Implementation | Rationale/Scientific Principles | Evaluation |
|---|---|---|---|---|---|
| *Subjective Data*<br>Patient verbalized that he relies on coffee to offset fatigue after doing work all day<br><br>*Objective Data*<br>-Patient consumes five or more cups of coffee a day<br>-Prefers black coffee<br>-Needs coffee to get started in the morning<br>-Is irritable without coffee | Excessiv e caffeine intake | Patient will stop drinking coffee within reasonable time | *To encourage fruit juices such as lemon juice in place of coffee<br><br>*To encourage protein food intake (to offset fatigue)<br><br>*To substitute caffeine free coffee<br><br>*To emphasize the danger of excessive coffee consumption for the protection from physical harm | *Coffee contains caffeine which when taken in excessive amounts, stimulate the central nervous system. Which eventually effect on blood vessels and this causes heart attack<br><br>*Vitamin C helps to lower the cholesterol level in the blood vessels and needed for the healing of the tissues and muscle of the myocardium<br><br>*Proteins are essential for tissue growth and repair. Protein increase immunity, resistance to infection and body heat production<br><br>*When regular coffee is restricted from the diet, offer a non caffeine substitute. It does not cause cardiac and respiratory simulation<br><br>*Drinking five or more cups of coffee a day increases BP. It causes arteriosclerosis and disguises fatigue | *Patient gave up taking coffee and he started taking other drinks like fruit juices and vegetable soup<br><br>*Patient understood the harmful effect of coffee on health |

| Assessment | Nursing Diagnosi s | Objective | Nursing Intervention/ Implementation | Rationale/Scientific Principles | Evaluation |
|---|---|---|---|---|---|
| *Subjective Data*<br>-Patient verbalized, 'Sister I always leave for work before time<br>-I always read the news paper while eating breakfast<br>-I have no other interests except my job<br><br>*Objective Data*<br>-Irregular daily schedule<br>-Frequent geographic changes through travelling<br>-Multiple jobs<br>-Crowded living conditions<br>-Rarely takes vacations | Life style inappropr iate to cardiac patholog y | Patient's life style pattern will come back to normal limits within reasonable time | *To assist the patient in maintaining his life style<br><br>*To encourage moderate physical exercise<br><br>*To discourage strenuous activities<br><br>*To encourage adequate rest<br><br>*To discourage oral stimulants like alcohol, coffee, tea, etc<br><br>*To discourage smoking<br><br>*To advise that highly emotional situation be avoided | *Maintaining life style keeps the person both physically and mentally healthy<br><br>*Moderate activity supports normal functioning of body systems and reduces internal tension<br><br>*Strenuous activities causes stress and stress leads to heart diseases. It also hinders in healing of necrosed cardiac muscle<br><br>*Rest is essential for restoring cardiac muscles and for repair of the necrosed myocardial muscles<br><br>*Oral stimulants can allow cardiac patters being recorded by monitor. Alcohol depresses the central nervous system even though initially it appears to stimulate it<br><br>*Smoking has nicotine vasoconstructive effect, its suspected to cause cardiac anomalies. It stimulates the heart rate 8-10 beats faster per minute, and often makes sleeping difficult. Its simulative effect can alter cardiac patterns<br><br>*Intense emotions stimulate adrenal secretions which affect cardiovascular respiratory and gastric activity | *Patient's life style came back to normal limits<br><br>*Patient started taking rest in day time for 2 hours and sleeps well at night |

## CONCLUSION-

This study aims to provide an overview to nurses to quick assessment and nursing management of myocardial infarction patients.

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