Evaluation Of Acute MI medically treated for Phase I rehabilitation:

Clinical Reasoning:

Age	Functional recovery/ dependence/ new job responsibilities/ degeneration/strength and balance.
Sex	Baseline assessment and ongoing assessment
Occupation	Functional recovery/ demand of work load/ type of rehabilitation required/ ergonomic advice.
Diagnosis:	Baseline assessment/ type specific rehabilitation.
Chart review	Baseline assessment and an ongoing assessment/indications and contraindications.
Present history	Knowing the status of the patient before the commencement of the treatment.
Temperature	Decreased O 2 transport/ circulation to periphery.
SPO2	Poor gas exchange in the affected regions at low lung volumes.
BP	Monitoring the baseline and ongoing assessment for the rehabilitation program.
Respiratory Rate	Increased work of breathing/ use of accessory muscles.
Respiratory support/ other gadgets.	Level of dependency / functional residual capacity baseline and an ongoing assessment.
Level of consciousness	Level od co operation/ understanding ability.
Sputum examination	Infection/ frequency/ recurrent infection.
Chest expansion	Unilateral/bilateral chest expansion residual capacity reduction.
Auscultation	Retention of secretions/ abnormal heart murmurs.
Mobility	Decreased mobility / poor exercise tolerance.
Functional evaluation status	Baseline assessment and ongoing assessment.
Pain	Incisional pain (VAS), chest musculoskeletal, peripheral and vascular.
Breathlessness	Level of retention of secretions/ sedation effects of drugs/ reduced FRC due to medications.
Functional Status.	Distance walked before onset of pain and ease of movement.
Medical history	Type of medication and mode of delivery for the beta-blockers affects the heart rate during exercise.
Swelling of calf	DVT/ right heart failure
Weight	Poor nutrition
ECG	Resting ST segment changes >2 mm ST Segment depression inV2 and V3 shows anterior wall MI.
Do's	Take into account of the patients previous functional level and customize the rehabilitation program to the patients ability
Don'ts	A referral to the outpatient rehabilitation for continued treatment and lifestyle modification to begin as early as 2 to 3 days after

		discharge patients who are not referred immediately and are not given a date or return before discharge are less likely to return therefore optimally this referral is a standing order for all patients with cardiac dysfunction or disease upon discharge
Home program		Explain the purpose of the exercises and reassure the patient about the safety conditions and about closed supervision of the attender towards patient.
Follow up		Insist the patient about the importance of the phase II rehabilitation.
Therapist in-charge		
Day 1:	Level 1 (1 METs)	Allow gentle active range of motion exercises, along with bronchial hygiene and lung expansion therapy exercises (Patient with oral analgesia, NSAID, Opioids, ENTONOX have some side effects have low cardiac output, peripheral vasodilatation, pneumothorax, subcutaneous emphysema)
Day 2:	Level 2 (2 METs)	Allow sitting up in a chair for meals and walking to the bathroom or inside the room (up to 50 ft) a few times a day. Allow performing activities of daily living. Increase repetitions of active range- of-motion exercises
Day 3	Level 3 (3 METs)	Allow a sitting shower. Ambulate up to 250 ft 3 to 4 times per day
Day 4	Level 4 (4 METs)	Perform activities of daily living independently and ambulate up to 1000 ft 3 to 4 times per day. Allow climbing 1 flight of stairs