

# Irish Nurses Cardiovascular Association News

Volume 9 - Issue 2 April 2008

A Quarterly Publication of The Irish Nurses Cardiovascular Association [www.ncnm.ie/inca](http://www.ncnm.ie/inca)



## CONFERENCE EDITION APRIL 2008

[www.ncnm.ie/inca](http://www.ncnm.ie/inca)



### Inside this Issue

- Annual Scientific Conference Programme
- Oral Abstracts
- Poster Abstracts
- Special Interest Groups Programmes
- Cath Lab
- Chest Pain
- Heart Failure

## A Word From The President

Dear Colleagues,

Welcome to our 12th Scientific Conference and Annual General Meeting. We have a very interesting and broad range of topics within the programmes for you.

We're delighted to be running the Scientific Conference over two days again this year. Last year's Special Interest Groups Conference Day proved to be so popular that the two day conference will be the format for our Scientific Conference for future years.

The Special Interest Group sessions are open to all delegates and not just nurses working in those specialities. Delegates may attend any session on any programme as all the Special Interest Programmes follow the same time format.

Enclosed in this newsletter are abstracts of both the oral and poster presentations submitted for this conference.

You will find important dates for your diary of our future activities. Of particular interest are the submission dates for abstracts and posters for the 9th Spring Meeting on Cardiovascular Nursing, to be held in Dublin, Ireland 24th – 25th April 2009. We would really like a strong representation of oral and poster submissions from Irish delegates at this meeting.

Lastly, I am delighted to bring you details of the First Announcement of the 9th Spring Meeting on Cardiovascular Nursing in your delegate pack. This is a wonderful opportunity to attend an International Conference as it is being hosted in your own country. We look forward to you joining us at this International Meeting.

I do hope you enjoy this year's Scientific Conference and thank you for your continued support.

### Mary O'Connor

President

Irish Nurses Cardiovascular Association



Mary O'Connor

### Committee Members 2007-2008

#### Executive Committee

President: Mary O'Connor

Vice President/PRO: Vacant

Treasurer: Laura O'Connor

Scientific Secretary: Kate O'Donovan

General Secretary: Josie Dillon

#### Committee

Ann Cantwell

Fiona Colbert

Niamh Dixon

(Stroke Nurse Representative)

Maeve Frawley

Niamh Kiely

Ann Mc Shane

Elizabeth Reilly

Mary Ryder

(Newsletter Editor)

#### Ex-Officiate

Patricia Hall

Noeleen Fallon

#### Honorary Committee Members

Siobhan Kelly (North-North West representative)

Ann O'Dwyer (South-South West representative)

Carol Condon (ESC Council on Cardiovascular Nursing & Allied Professionals)

Michelle Carey (Heart failure representative)

Lisa Browne (Chest pain representative)

Siobhan Milliken

(Interventional Cardiology Nurses Representative)

# 12th Scientific Conference & Annual General Meeting

Arrol Suite, Guinness Storehouse on Fri 11th & Sat 12th April 2008

## "Contemporary Issues in Cardiovascular Nursing"

### Friday 11th April

- 08.30 – 09.00 Registration / coffee  
Welcome/ President's Address  
[Ms Mary O'Connor, President, Irish Nurses Cardiovascular Association](#)
- 09.05 – 09.30 Strengthening the Links between Contemporary Practice, Research and Education  
[Ms Rita Smith, Nurse Lecturer, University College Dublin.](#)

#### Session 1: Cardiovascular Drugs and Nurse Prescribing

- 09.30 – 09.50 Nurse Prescribing: The Experience  
[Dr Laserina O'Connor, MMUH, Dublin](#)
- 09.50 – 10.10 New Cardiovascular Agents  
[Ms Claire Kingston, Clinical Pharmacist, St Vincents University Hospital , Dublin.](#)
- 10.10 – 10.30 Abstracts x 2
- 10.30 – 11.00 **COFFEE**

#### Session 2: Disease Prevention

- 11.00 – 11.20 Diabetes and Cardiovascular Disease  
[Dr David Carmody, Diabetes Service,MMUH, Dublin](#)
- 11.20 – 11.40 Education in the Diabetic Population: Prevention of Cardiovascular Disease  
[Ms Jackie McMahon, Diabetic Nurse Specialist, Beaumont Hospital, Dublin](#)
- 11.40 – 12.10 ESC 9th Annual Conference on Cardiovascular Nursing  
[Ms Mary O'Connor, President INCA](#)
- 12.10 – 12.30 INCA Business Meeting & AGM
- 12.30 – 13.30 **LUNCH**

#### Session 3: Diagnosis and Intervention

- 13.30 – 13.50 ACS: Universal Definition of MI: Heart Attack Back to Basics  
[Mr Eamon Murphy, Chest Pain Nurse, MMUH, Dublin](#)
- 13.50 – 14.10 Complications Associated with Percutaneous Intervention  
[Ms Catherine McMahon, Cardiology Co - Ordinator St James's Hospital, Dublin](#)
- 14.10 – 14.30 Late Stent Thrombosis  
[Dr Niall Mulvihill, Consultant Cardiologist, St James's Hospital, Dublin](#)
- 14.30 – 14.50 Abstracts x 2

#### Session 4: Acute Cardiovascular Care

- 14.50 – 15.20 Pathophysiology of Cocaine Induced MI  
[Dr Eamonn Brazil, Consultant in Emergency Medicine, MMUH, Dublin](#)
- 15.20 – 15.50 Pre Hospital Emergency Care Council Update  
[Dr Geoff King, Director Pre Hospital Emergency Care Council, Kildare](#)
- 15.50 – 16.05 Poster & Abstract Award / Educational Bursary Announcements

**Closing Remarks**

## CATH LAB NURSES GROUP

Coopers Room, Guinness Storehouse  
12th April 2008

### Saturday 12th April

- 09.30 – 09.35 Welcome  
Chairperson – Siobhan Milliken
- 09.35 – 10.05 FFR (Fractional Flow Reserve)  
Dr Robert Kelly, Cardiologist, Beacon Hospital, Dublin
- 10.05 – 10.35 Tako Tsubo Cardiomyopathy  
Suzie Martos, CNM 1, Cath Lab – SVUH, Dublin
- 10.35 – 11.00 **Coffee Break**
- 11.00 – 11.30 Carotid Stenting/ Valvuloplasty  
David Lynch, CNM 2, Cath Lab, MMUH, Dublin
- 11.30 – 12.00 Instent Stenosis – Case Presentation  
Brid O'Meara, Clinical Facilitator, Cath Lab – SVUH, Dublin
- 12.00 – 13.00 **Open Forum / Election Of Secretary**

## Chest Pain Special Interest Group

Golden Harp Room, Guinness Storehouse  
12th April 2008

### Saturday 12th April

- 09.30 – 09.35 Welcome Address
- 09.35 – 10.05 The Assessment and Treatment of AMI: Latest Treatment Guidelines.  
Paul Stoneman, CNS, Chest Pain Service, Beaumont
- 10.05 – 10.35 Chest Pain Assessment. What to Do?  
Caitriona Minnock, ANP Candidate, Mater Private Hospital
- 10.35 – 11.00 **Coffee Break**
- 11.00 – 11.30 Cocaine and chest Pain in the ED.  
Michelle Lynch, CNS, JCMH, Blanchardstown.
- 11.30 – 12.00 Drawback of Chest Pain Assessment Services  
Gerry Kearns, ANP Cardiology, SVUH
- 12.00 – 13.00 **Open Forum**

## Irish Heart Failure Nurses Association

Golden Barley Room  
12th April 2008

### Saturday 12th April

09.30 – 09.35	Welcome Address
09.35 – 10.05	“Heart Failure and Exercise” Deirdre Hassett, Heart Failure Nurse, Wexford General Hospital
10.05 – 10.35	‘Database Analysis of HF in North East’ Catherine Gray, Heart Failure Nurse, Dundalk Hospital, Co. Louth
10.35 – 11.00	<b>Coffee Break</b>
11.00 – 11.30	‘Medication Mishaps’ Claire McNally, Heart Failure Nurse, Cavan General Hospital
11.30 – 12.00	Post Partum Dilated Cardiomyopathy Cecelia Tracey, Heart Failure Nurse, Mater Hospital Dublin
12.00 – 13.00	Open Forum Irish Heart Failure Nurses Association Review Members Meeting - Election of Committee Members
13.00	<b>Close of Meeting</b>

## Dates For your Diary

### ESC 9th Annual Conference on Cardiovascular Nursing

April 24th - 25th 2009

RDS, Dublin, Ireland

Abstract submission from 1 October – 1st December 2008

Online pre registration early fee deadline 30th January 2009

### Irish Cardiac Society Nurses Scientific Conference

Thursday 9th October 2008

Radisson Hotel, Galway

*Any submissions/suggestions for newsletter please forward to [m.ryder@stmichaels.ie](mailto:m.ryder@stmichaels.ie)*

## Oral Abstracts

### EuroAspire III - a comparison between Irish and European results

S.Storey, L.Taylor, M.T.Cooney, A.Dundina, I.Graham  
 Dept of Cardiology, The Adelaide & Meath Hospital, Tallaght, Dublin 24  
 M.Hall, L.Hemeryck, J.Feely  
 Dept of Pharmacology & Therapeutics, St James Hospital, James Street, Dublin 8

#### Aims

EUROASPIRE (EAS) III was a Europe wide audit of secondary prevention organised by the European Society of Cardiology (ESC). The main aim of EAS III was to examine control of cardiovascular (CV) risk factors in patients with established heart disease (CHD) and to determine whether the recommendations advised by the Joint European Societies are being followed in clinical practice. Here we present the Irish results and compare them with those of other European countries.

#### Methods

The EAS III audit was conducted in late 2006 and early 2007 in 22 European countries. Irish patients were from the Adelaide and Meath Hospital and St James Hospital catchment areas. Patients were included if they were under 80 years and admitted to hospital within the previous 3 years with any of the following: myocardial infarction, myocardial ischaemia, coronary artery bypass surgery or percutaneous coronary intervention. Only patients who were at least 6 months post hospital discharge for the index event were included. Information on risk factor levels during admission was obtained from medical records. Patients were then interviewed regarding current lifestyle risk factors and clinical course since admission. Current risk factor levels were obtained by re-examining patients and by repeating laboratory measures.

#### Results

13935 patients were enrolled, of whom 636 were Irish. Blood pressure was above the recommended target in more than half the patients at time of interview. 73% Irish v 49% Europeans achieved total cholesterol targets 4.5mmol/l. The prevalence of smoking reduced from > 50% at admission to < 20% at time of interview except in Irish women. Diabetes was prevalent in 20% of Irish and 36% of Europeans. Over 80% were classified as being overweight and more than one third obese. Considerably more patients attended Cardiac

Rehabilitation in Ireland compared with Europe (67% v 32%). Irish patients suffered less anxiety and depression. Although risk factors were reasonably well documented at time of admission, this information was infrequently included in discharge summaries.

#### Conclusions

This audit shows that risk control in those with established CHD is still sub-optimal. The increasing use of statin therapy has substantially improved lipid control. However the percentage CHD patients achieving blood pressure control is still alarmingly low. A substantial increase in the prevalence of obesity and overweight is evident. Although Ireland showed better cholesterol control than Europe we still need to improve implementation of guidelines on secondary prevention and risk factor information needs to be more clearly documented in discharge summaries.

	Europe	Ireland
Total enrolled	13935	636
Number interviewed	8966/ 12275 (73%)	386/ 572 (67%)
↑BP at interview	56%	52%
Adequate control of BP (using any BP ↓ meds)	44%	48%
Target cholesterol 4.5mmol/l at interview	49%	73%
Smoking at 1 month prior to admission	52%	56%
Smoking at time of interview	17%	18%
HbA1c < 6.5%	35%	29%
Overweight (BMI > 25kg/m <sup>2</sup> )	82%	82%
Obese (BMI > 30kg/m <sup>2</sup> )	35%	35%
Statin use at time of discharge	79%	91%
Aspirin or other anti-platelet use at time of discharge	95%	99%
Cardiac Rehab attendance at least 1/2 the sessions	32%	67%

# ACS RESPONSE TIME INTERVENTION TRIAL

Dr Gabrielle McKee, Dr Sharon O'Donnell, Prof Debra Moser, Mary Mooney, Frances O'Brien.  
School of Nursing and Midwifery Studies, 24 D'Olier St. Dublin 2

## Introduction

Studies have demonstrated reluctance by patients with Acute Coronary Syndrome (ACS) symptoms to seek prompt medical help, which presents as a major mitigating factor against the timely receipt of reperfusion and other therapies. Major reasons for patient delay in seeking treatment include: symptoms occurring in the presence of family members, event occurred at home, failure to attribute symptoms to the heart or to appreciate the importance of symptoms and severity of symptoms. Certain identified groups consistently delay longer in seeking treatment in the face of suspected ACS, older people, women, ethnic minorities, those with lower education levels, and those with diabetes.

## Aims and Objectives

The study is a randomised control trial whose aim is to determine whether an individualised focused educational intervention is effective in reducing pre-hospital delay in patients who present with symptoms of (ACS). The study will also determine whether selected demographic variables (i.e., age, gender, income, education and ethnicity) interact with the intervention to affect patient delay time, and determine the impact of the intervention on knowledge, attitudes and beliefs about heart disease and ACS symptoms, how knowledge attitudes and beliefs change over time and the main factors that influence them.

The pilot study showed the median delay time in presenting with ACS symptoms was 3.3 hours, and that 10.2% of patients have a re-occurrence of ACS symptoms within one year. Therefore the main study needs to recruit 2,000 patients to obtain the 200 patients who re-present with ACS symptoms. The study is carried out in four main Dublin hospitals from October 2007-October 2010.

## Methodology

Patients are generally recruited from the coronary care wards of the hospitals involved. After introduction to the study, confirming eligibility and obtaining informed consent the patients are allocated to either the control or the implementation group. The researchers with the assistance of the case notes and the patients complete the following 3 questionnaires at baseline:

1. Response time to ACS symptoms questionnaire
2. Socio-demographic and clinical history questionnaire
3. Knowledge, attitudes and beliefs questionnaire

The implementation group are then given 30-minute educational intervention. This intervention addresses information, emotional issues and social factors related to delay in response time in presenting with ACS symptoms. The patients are followed up for 1-2 years post recruitment to assess changes in knowledge, attitudes and beliefs and their response time if they should re-present with ACS symptoms.

# The Clinical Value of 24-Hour Ambulatory Blood Pressure Monitoring in Cardiac Rehabilitation.

Caroline Finn, Shirley Ingram, Noeleen Fallon, Nora Flynn.  
Cardiac Rehabilitation Dept. AMNCH, Tallaght, Dublin Ireland.  
Contact: caroline.finn@amnch.ie

## Introduction

Hypertension is a well-known risk factor for cardiovascular disease. The 2007 European Guidelines recommend reducing blood pressure levels below 140/90 mmHg (130/80 mmHg for diabetics). During Cardiac Rehabilitation (CR) patient's BP is recorded regularly. Early intervention, patient education and lifestyle modification are essential for effective management of hypertension. Confirmation of hypertension is necessary before embarking on life-long medication that may cause unwanted side effects. White coat hypertension where clinic BP measurements often overestimate a patient's baseline blood pressure has been found to occur in up to 30% of patients. Accurate diagnosis and monitoring of hypertension depends on reliable blood pressure measurement. Twenty-four hour ambulatory blood pressure monitoring (ABPM) provides more representative values of BP than clinical BP measurements and provides a means of delineating circadian variations in blood pressure. ABPM has also made it possible to determine the efficacy and duration of action of anti-hypertensive drugs. This study explores the benefit of 24-hour ABPM in assisting the nursing and medical staff within Cardiac Rehabilitation (CR) with decisions regarding the implementation and modification of antihypertensive therapy.

## Methodology

The indications for ambulatory monitoring included a clinical BP >140/90mmHg (>130/80mmHg for diabetics) consistently over a period of 3-weeks pre, during and post exercise. ABPM was performed on a sample of 46 patients of which 71% (n=32) were male and 29% (n=13) were female with a mean age

of 63 years over a period of 10 months. Ambulatory BP results were analysed using Space Labs software and then evaluated by the Cardiology Registrar in the CR clinic.

## Results

Of the total sample 76% (n=35) had pre-existing hypertension and 20% (n=9) of patients had a diagnosis of diabetes mellitus. ABPM recorded normal blood pressure results for 35% (n=16) of patients, avoiding unnecessary changes in anti-hypertensive treatment. White coat hypertension was diagnosed in 7% (n=3) of patients. Medication change was required in 58% (n=26) of patients and follow up included clinical BP monitoring until completion of CR. Post medical intervention, follow-up clinical BP measurements showed that 26% (n=12) continued to have a BP >140/90 mmHg and 15% (n=7) of diabetic patients continued to have a BP>130/80 mm Hg. As a result 42% (n=19) of patients had repeat ABPM. 58% (n=11) were controlled and 42% (n=8) required further medication changes. Follow up included one referral to GP and the remainder with general cardiology clinics at the hospital.

## Conclusion

Fifty nine percent of patients who participated in Phase 3 CR over a period of 10-months were found to have uncontrolled hypertension despite anti-hypertensive medication. Sixty nine percent were controlled with medication changes, lifestyle advice and follow up. CR provides an ideal environment to detect ongoing uncontrolled hypertension. This study demonstrates the clinical value of ABPM in CR not only in selecting patients for treatment but also in assessing the effects of treatment.

# A mixed method study analysing the factors and reasons for non-attendance to and drop out from a phase III cardiac rehabilitation programme.

M. Kerins<sup>1</sup>, G. McKee<sup>2</sup>, K. Bennett<sup>2</sup>.

<sup>1</sup>St James's Hospital, Dublin, <sup>2</sup>Trinity College, Dublin.

## Purpose

The purpose of the study was to examine the factors and reasons contributing to patients, not attending a phase III cardiac rehabilitation programme after enrolling and dropping out after commencing.

## Methods

The study was a single site study. A mixed method design was used. A telephone survey was carried out of all the patients who enrolled and subsequently did not attend or dropped out of a programme (n= 80). Patients were asked to give a reason why they could not attend the programme. A convenience sample from these patients were selected for semi-structured interviews (n=7). The interviews were an in depth analysis of the factors that contributed to their not attendance or drop out from the programme. Analyses of the demographics of the total cohort and the results of the survey were carried out using excel and the statistical package SPSS. The qualitative data was analysed using a priori themes and a template analytical approach using the computerized package "Nvivo 2".

## Results

Of the 267 patients who enrolled in the cardiac rehabilitation programmes over the time course of the study, 70% completed the programme, 11% did not attend the programme and 19% did not complete the programme. Pearson's chi-squared was applied to analyse the demographic factors that influenced the attendance, non-attendance and non-completion distribution. The clients that did not attend or complete, were significantly more likely to

be manual or unskilled workers ( $P = 0.029$ ) or smokers ( $p = 0.000$ ). There was no significant difference among the three groups when factors such as age, gender and co-morbidities including depression were analysed. The initial survey revealed that the most common reason cited by those who dropped out was "illness". The most common reason cited by for not attending after enrolling was "not interested". The follow up interview findings of the factors that influenced their drop out or non-attendance were categorized into three major categories: physical, psychological & organizational. Further exploration of the physical theme revealed that these reasons could be categorised into health reasons, access difficulties and difficulties with exercise. The main psychological reasons were classified as depression, issues relating to self and stress and the main organisational reasons were education; issues with the cardiac rehabilitation programme itself, the health system and work issues.

## Conclusions

The patients that did not attend or complete, were more likely to be manual or unskilled workers and smokers. Patient cited illness as the most common reason for dropping out of the programme and not interested as the most common reason for not attending the programme after enrolling in the telephone survey. The follow up interview findings were categorized into three major categories: physical, psychological & organizational. Depression emerged as a predominant finding. Work and exercise issues emerged as the themes that linked the two parts of the study.

## Poster Presentations

### Orientation of cardiac nurses in AMNCH

Shirley Ingram, Ann Connolly, Ashling Tierney, Sinead Van Der Hoeven, Georgina Bell, Annmarie Devenny, Breda Burke, Michelle Carey, Sarah Fall, Jim Byrne.

Dept of Cardiology AMNCH, Tallaght, Dublin 24 Contact: shirley.ingram@amnch.ie

It is the policy of the Adelaide and Meath Hospital, Dublin, incorporating the National Children's Hospital that all new and existing employees, whether permanent or temporary should receive orientation training. Orientation aims to ensure that staff are welcomed to the organisation and become effective members of the team. This objective is facilitated by the orientation process, which begins at recruitment and continues up to where the employee reaches efficient worker standard. In addition, the orientation must include existing employees who are changing position within the organisation.

#### What is Orientation Training

Orientation training is the process of receiving and welcoming staff when they join an organisation, giving them an overview and introduction to the organisation and the basic information and training they need to settle down and quickly perform their duties in a safe and effective manner.

#### Orientation has three aims:

1. To smooth the preliminary stages when everything is likely to be strange and unfamiliar.
2. To establish quickly a favourable attitude to the organisation in the mind of the new employee.
3. To obtain effective output from the new employee in the shortest possible time.

There are normally two stages or phases in an orientation process. Phase 1 is orientation to the organisation, or general orientation. This phase is carried out centrally by the Education and Training Department. Phase 2 is orientation to the department or work area, orientation to the job, which can include any or all of the training which is necessary for the employee to do his/her job efficiently and effectively.

#### Phase 2

##### Nursing orientation to cardiac nursing areas

To facilitate new staff nurse phase 2 orientation to the Coronary Care Unit (CCU) a standardised induction/education programme over a two week period, followed by a staged education programme over a further 12 weeks was developed. The aim is to ensure staff are given the knowledge and skills to work safely within the CCU and achieve core competencies of practice. Due to the success of the CCU orientation programme staff induction/education programme and utilising the CCU template have been developed for the areas of Cardiac Procedures & Heart Efficiency (Heart Failure), further programmes are being developed for Cardiac Rehabilitation and cardiac cath lab. The key success to the development and utilisation of the programmes were the teamwork required to create such a programme and that a number of core competencies are relevant to most areas of cardiology. The poster presentation will show each stage in detail.

# New Technology in CPAU-Preliminary Audit of Multi-Detector Cardiac CT in a chest pain service in Dublin

Caitriona Minnock RN BSc (Hons), MSc Advanced Nursing Practice, Chest Pain Nurse, Mater Private Hospital, Dublin.

## Background

The diagnosis of coronary heart disease (CHD) in the patients who present with chest pain can be complex. An appropriate physical examination and history is essential, but additional investigation is also required to establish the diagnosis, estimate prognosis, and determine appropriate treatment. Coronary angiography is considered the "gold standard" for diagnosis, but because it is invasive and costly, it is appropriate as an initial diagnostic but may be normal in 20% of cases. Several non-invasive tests are available that vary in both accuracy and cost.

Multi-detector Cardiac Computer Tomography (MDCCT) can image the coronary arteries non-invasively, and may potentially reduce the need for invasive angiography in selected patients. Its role in a chest pain assessment unit (CPAU) is currently unclear. MDCCT is usually reserved for patients with a low to intermediate probability of coronary disease in whom functional testing is either not possible or inconclusive. The purpose of this audit was to determine the experience of using a relatively new diagnostic modality such as MDCCT for patients presenting to our CPAU.

## Purpose

Review the results of MDCCT in patients attending a chest pain assessment service. Specifically three questions were explored as follows:

1. How often is the decision to refer patients for MDCCT appropriate?

2. How do the pre-test probability estimates of CHD compare with the MDCCT findings?
3. What was the incidence of non-obstructive/obstructive coronary disease amongst the target population?

## Methods

The audit sample was drawn from all patients attending the chest pain service during a twelve-month period referred for MDCCT. A consultant cardiologist with dual specialisation in interpretation of MDCCT and performance of invasive coronary angiography was asked to evaluate the documentation to give an appropriateness score for the decision to refer individuals for MDCCT. This criterion was established by the ACC/AHA 2006. Pre-test probability of obstructive coronary disease was calculated based on age, sex and symptoms. Results Data is still being collected and will end in March

## Conclusions

The role of MDCCT in the CPAU is still being refined. In this audit, all patients with low pre-test probability for obstructive coronary disease referred for MDCCT were successfully evaluated non-invasively, normality confirmed and the necessity for invasive coronary arteriography obviated. In patients with intermediate pre-test probability, MDCCT was useful in avoiding invasive coronary angiography in some patients, but false positive MDCCT is a problem. MDCCT is not recommended in the evaluation of high-risk patients or symptomatic patients with the highest pre-test probability.

## The development of The Coronary Care Unit Patient Information Booklet and Patient Satisfaction Survey.

Ashling Tierney CNM2 CCU, Shirley Ingram CNM3 Cardiology, Phillippa Ryan Withero Nurse Practice Development, Karen Dunney Audit Secretary and all the staff in The Coronary Care Unit, Dept of Cardiology AMNCH, Tallaght Dublin 24

### Introduction

Health Care Organisations are operating in a culture of continuous quality improvement and strive to attain the optimum accreditation level. Patient Satisfaction Surveys have taken centre stage as the primary means of measuring the effectiveness of health care delivery. By conducting Patient Satisfaction Surveys health care providers can capture, measure and evaluate patient feedback and integrate findings into quality improvement plans.

### Methodology

Existing Patient Satisfaction Surveys on the Internet were researched to identify essential questions most relevant to our working environment. Prior to developing the Patient Satisfaction Survey, patients were asked what questions or areas of care they thought would identify the issues pertinent to them and staff members of Coronary Care Unit were asked for suggestions deemed important in assessing aspects of our service.

A Patient satisfaction survey was developed utilising the Likert scaling method. The survey aimed to assess three main areas 1) satisfaction with information given both verbally and in written form, 2) satisfaction with the level of service provision to them and 3) included open ended questions to allow patients to freely write aspects of our service which we do well and also aspects which need improvement.

All patients admitted to the CCU over a three-month period were given the questionnaire. The response rate was 58%. Questionnaires allow for collation of both qualitative and quantitative data, and these results will be outlined on the poster presentation.

### Results

Findings showed Patients being 90% very satisfied with the overall amount of information given to them regarding their condition and treatment. A bar chart showing the Patient Satisfaction level of service provided by all members of staff within the unit is outlined. Patient quotes are also provided on the poster. Patients written comments can be powerful and add meaning to the numerical scores.

### Conclusion

The overall response from patients has been extremely positive and encouraging to all staff involved. As a result of findings from the Patient Satisfaction Survey, we have revised our unit educational care plans. We ensure that the information we provide is easy to understand, and specific to an individual's cardiac condition. All information leaflets given are tested for readability using the Flesch-Kincaid Reading Ease score.

## “Medicines for Your Heart” - A Patient Guide to Cardiac Medications

Noeleen Fallon, Dawn Davin, Caroline Finn, Shirley Ingram.  
Cardiac Rehabilitation Dept. AMNCH, Tallaght, Dublin 24  
Contact: noeleen.fallon@amnch.ie

### Introduction

To maximise the effectiveness of any information given, it is important that it is presented in a manner which makes it easy to understand and remember. The information should be pitched at a level consistent with the individual's present knowledge. The language used should be appropriate to the person whom the information is being given. Anxiety interferes with concentration and memory; so many people may simply not take in or retain any information given in an educational session. Patient information leaflets are useful to compliment and consolidate verbal information.

### Aim

To provide a resource from which patients and their families may develop knowledge and understanding of their cardiac condition.

### Methodology

“Medicines for your heart” - a patient guide to cardiac medications are a selection of patient information cards designed to provide concise and clear information on cardiac medications for patients with a diagnosis of coronary heart disease. In 2000 this information package was first developed by the cardiac rehabilitation and pharmacy departments in the Adelaide and Meath Hospital. In 2007, this package has undergone revision and updating, creating new and additional information for cardiac patients in coronary care and those attending phase three Cardiac Rehabilitation. Information relating to patient care should be generated by a multidisciplinary team, rather than an individual. This may save time and benefit the patient by ensuring information is consistent.

The guide consists of a folder with selected educational cards required by each individual patient from a choice of information about the following

medications: Aspirin, Clopidogrel, Angiotensin-Converting Enzyme Inhibitors, Angiotensin-II receptor antagonists, Beta Blockers, Calcium Channel Blockers, Diuretics, Nitrates, and Lipid Lowering drugs. New cards included are information on Alpha blockers, Trimetazidine, Nicorandil. Information such as “How to obtain Medications after discharge from hospital,” a personal “My details” medication recording card and “Things you should know about your medications” are also available. The medication leaflets have been tested for literacy using the Flesch-Kincaid Grade level and the Flesch Reading Ease scores. They have been approved by the practice development team and the drugs and therapeutics committee within the hospital.

A pilot study of three leaflets given to cardiac rehab patients demonstrated their success for readability, patient understanding and knowledge gain. These leaflets will now be given to appropriate patients in coronary care and utilised for patient education about their medication in phase three cardiac rehabilitation.

### Conclusion

Patient information is an essential ingredient of caring, which needs to be both carefully considered and consistent. The anxiety of being admitted to the coronary care unit can often impede patient comprehension and understanding therefore the simplicity of this medication guide proves beneficial to both the patient and their family. Creating information leaflets should be a collaborative effort, involving members of a multi-disciplinary team. Patient information leaflets are a cost-effective resource that can enhance the quality of care. They provide a focus for clearer understanding between patients, relatives and members of the healthcare team. Additional benefits include patient compliance and empowerment.

# Improving Participation in Cardiac Rehabilitation Phase III using other formats of programme delivery

By: Caroline Finn, Cardiac Rehabilitation, AMCH, Tallaght, Dublin

## Introduction

Cardiac Rehabilitation (CR) is a well recognised, recommended and accepted treatment modality for cardiac patients. The concept of CR incorporates risk factor reduction, consequently reducing the chance of a subsequent cardiac event and may slow or stop the progression of cardiovascular disease thus improving quality of life. Since the implementation of Building Healthier Hearts (1999) hospitals offering CR Phase III have increased from 29 % to 95%. Despite the potential benefits and the increased availability of structured CR programmes a median estimate of only 60% of eligible patients attended CR in 2005. The CR programme offered by the Adelaide and Meath hospital is up to 10 weeks in duration, providing 2 to 3 sessions per week and consists of education sessions on cardiovascular risk management and supervised exercise prescription. Whilst CR Phase III has traditionally been delivered as an out-patient hospital based programme this type of service is not always amenable to many eligible patients.

For various reasons such as expected early return to work, holiday plans and transportation problems some patients who initially accept an invite consequently choose not to participate. Identifying exactly why patients do not attend enables CR staff to tailor a programme suitable to the needs of the individual.

## Objective

The objective of this study was to identify the barriers to participation in CR Phase III and to ascertain the patient's preference for an alternative rehabilitation format to the traditional hospital based programme. The two alternative rehabilitation formats suggested were:

- 1) A community based Cardiac Rehabilitation Programme at a venue nearer my home/work
- 2) A home based Cardiac Rehabilitation Programme with an accompanying manual/DVD.

## Methodology

Data was collected from a convenience sample of 136 participants who did not attend CR Phase III over a period of 18 months. Participants were categorised into two groups:

**Group 1** included patients who were invited to CR but did not accept a referral to CR Phase III.

**Group 2** included patients who accepted an invite to CR Phase III but subsequently did not attend.

Reasons given for non attendance to CR Phase III were examined using the Cardiac Rehabilitation Information System (CRIS) dataset. Patients who reported barriers such as disinterest, return to work, transport, domestic issues and time commitment were included in the study. Patients who reported other illness/infirmity as a reason for non attendance was excluded from the study. A short questionnaire was designed and an accompanying letter explaining the reason for the study was posted to 107 patients in Group 1 and 29 patients in Group 2.

## Results

A major limitation of the study is the overall response rate of 24%. In Group 1 a total of 25 questionnaires were returned and 8 patients completed questionnaires in Group 2. Seventy seven percent of patients from Group 1 indicated a preference for a home based CR programme with an accompanying manual/DVD and the preference was similar for both a home based and community based CR programme in Group 2. Transport was the main reason given in Group 1 for not being in a position to accept a place on the programme while time involved in committing to the programme was the reason given in Group 2 for not attending CR Phase III. Our findings suggest that attention needs to be placed on developing alternative CR Phase III formats if we aim to increase participation rates.

## Conclusion

Knowledge of the reasons for non-attendance to CR may enable strategies to be developed for eligible patients to avail of this timely service. Other formats of delivery of CR Phase III such as a home or community based programs that will fit not only the patient's cardiac condition but also his or her lifestyle may be offered. To further develop CR Phase III other formats of delivery should be explored to increase uptake and attendance rates for eligible patients.

## 12th Scientific Conference and Annual General Meeting

*The Irish Nurses Cardiovascular Association  
would like to acknowledge the support of the following companies  
towards this conference*

### EXHIBITION STANDS

**A. Menarini**

**Astra Zeneca**

**Biosyn Diagnostics**

**Bristol Myers Squibb/Sanofi Aventis**

**Merck Sharpe & Dohme**

**Novartis Ireland Ltd**

**Pfizer**

**Servier Laboratories (Ireland) Ltd.**

### SPECIAL INTEREST GROUPS

**Chest Pain Nurses:** Bristol Myers Squibb/Sanofi Aventis

**Heart Failure Nurses:** Merck Serono

**Cath Lab Nurses:** Boston Scientific, Johnson & Johnson

### BEST ORAL ABSTRACT/BEST POSTER

**Bracco UK Ltd**



**Irish Nurses Cardiovascular Association**  
**[www.ncnm.ie/inca](http://www.ncnm.ie/inca)**