OVERVIEW OF IN-PATIENT CARDIAC EDUCATION

Inpatient rehabilitation should begin as soon as possible after admission to hospital. It is recognized that the length of hospital stay continues to decrease and, as a consequence, not all elements will be addressed for every patient (NHFA & ACRA*).

Where there is insufficient time available for completing the recommended in-patient mobilization and education program, the emphasis should be on providing:

1. Basic information and reassurance
2. Supportive counseling
3. Guidelines for mobilization
4. Appropriate discharge planning, including the involvement of the general practitioner/primary care provider and follow-up
5. Referral to outpatient cardiac rehabilitation.

A system should be in place that ensures every eligible patient has access to an individualized program and, where possible, group education and discussion while they are an inpatient.

Main elements of inpatient rehabilitation

1. Basic information and reassurance

It is recognized that after admission to hospital patients often have difficulty understanding and absorbing detailed and complicated information. Information given should be clear, simple and based on the individual needs of the patient and their family. Reassurance, support and empathy should underpin all discussions. The following topics should be considered for discussion, individually or in a group setting:

- Reassurance and explanation of cardiac condition, treatment and procedures
- Psychological issues e.g. mood (depression), emotions, sleep disturbance
- Social factors e.g. family and personal relationships, social support/isolation
- Explanation of the inpatient activity (mobilization) program
- Development of an action plan by patient and caregiver to ensure early response to symptoms of possible heart attack
- Medications, highlighting the importance of concordance
- Identification and modification of risk factors
- Wound care (if applicable)
- Resumption of physical, sexual and daily living activities (including driving and return to work)
- Information about income support/entitlements.

Group education sessions may supplement individual education and discussion; however, not all topics will be relevant for everyone. It is also recognized that group sessions are often not practical in the short-stay hospital environment.

2. Supportive counselling

Counselling in this context does not necessarily mean specialized professional counselling, but rather integrating individualized attention with information provision, reassurance and support for the patient and their family as part of routine daily care.


The mobilization program balances the risks of premature activity with the deleterious effects associated with continued bed rest. It also promotes self-confidence. It usually commences within 24 hours of admission and can be quite rapid. The inpatient mobilization program aims for a progressive increase in activity so that the patient can be independent in basic self-care at the time of discharge.
Early mobilization programs will vary according to individual patient need and hospital protocols. The rate of progress through a program will depend on factors such as co-morbidity, age, habitual activity, surgical or medical condition and specific medical instructions. In some situations, e.g. uncomplicated myocardial infarction, cardiac surgery or coronary angioplasty, some stages may be notional and mobilization may be achieved in a single day. In more complicated conditions, e.g. cardiac failure, mobilization may be much slower. A six-stage progression of mobilization has been developed (see below).

Progression through the stages of the program will vary according to the patient’s capacity and symptoms. Changes in symptoms suggesting possible deterioration or instability will require medical review.

4. Discharge planning

Appropriate discharge information should include:
• Assessment of a patient’s suitability for discharge (including level of self-care and availability of, and access to, relevant health and community services)
• Routine referral to outpatient cardiac rehabilitation and promotion of its benefits
• communicating with specialist, general practitioner and/or other health professionals as determined by assessment of individual need and confirming follow-up appointments
• Patient information including:
  • Medications
  • Specific plan for management of symptoms at home including provision of suitable written information about the educational topics covered and guidelines for the resumption of daily living activities
  • Written information to reinforce verbal information
  • Contact details for local community resources including patient support groups (NHFA & ACRA*).

### OPTIMUM CONTINUUM OF CARE FOR STEMI, ACS, PCI

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Adapted from AACVPR Cardiac Rehabilitation Guidelines 2006.
Mobility Guidelines for the STEMI, ACS and PCI patient
Mobility should not be initiated for a minimum of 8-12 hours or until the patient is free of angina, significant ECG abnormalities, and has no new or worsening signs of congestive heart failure.

Mobility Progression (for STEMI, ACS, PCI)
- Supine bed rest to sitting on the side of the bed
- Sitting on the side of the bed to standing
- Standing to sitting in a chair
- Sitting in a chair to walking
- Resumption of activities of daily living

Purpose (for STEMI, ACS, PCI)
- Help patients rebuild self confidence and self esteem
- Identify high risk individuals who, during progression, develop recurrent angina, ECG abnormalities, or worsening heart failure which would indicate further cardiac investigation

Teaching Objectives (for STEMI, ACS, PCI)
- Self Care
- Patient specific education and counseling
- Risk factor management
- Lifestyle Modification
- Community resources and Outpatient Cardiac Rehabilitation options


OPTIMUM CONTINUUM OF CARE FOR CARDIAC SURGERY

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Adapted from AACVPR Cardiac Rehabilitation Guidelines 2006.

**Mobility Guidelines for the Cardiac Surgery patient
Mobility is initiated in the intensive care unit within 24 hours of surgery if the patient’s status is stable.
Mobility Progression (for Cardiac Surgery)
- Supine bed rest to sitting on the side of the bed
- Sitting on side of bed to standing
- Standing to sidesteps up bedside
- Taking few steps to sit in chair
- Sitting in chair to walking
- Gradual progression of walking distance
- Stairs with supervision or assistance
- Resumption of daily activities using sternal precautions

Purpose (for Cardiac Surgery)
- Monitor post surgical lung function
- Monitor and assist mobility progression
- Educate patient and family on care of condition
- Assess and arrange equipment needs
- Rebuild self-confidence and self-esteem

Teaching Objectives (for Cardiac Surgery)
- Patient specific education and counseling
  - Breathing Exercises
  - Sternal Precautions
  - Home Exercise Program
  - Transfers (bed, bathroom, automobiles)
  - Stairs

(New Brunswick Heart Centre, Getting Ready for Heart Surgery, April 2005)
References


2. Cardiac Rehabilitation Patient Referral From an Inpatient Setting. http://content.onlinejacc.org/cgi/content/full/50/14/1400/TBLA1


8. New Brunswick Heart Centre Patient Discharge Information Checklist