Cardiac Rehabilitation Pathway

Written by the All Wales Cardiac Rehabilitation Working Group 2010
Simplified Management Pathway

‘CARDIAC REHABILITATION PHASE 1’

Cardiac Rehabilitation Patient Groups

**Inclusion Criteria**

- Acute Coronary Syndromes;
- Post Revascularisation (to include post CABG & post primary, rescue & elective PCI);
- Newly diagnosed Angina;
- Heart Failure;
- Established Stable Angina;
- Pre-hab (pre-CABG/elective PCI);
- Valve and other Cardiac Surgery;

**PATIENT IS IDENTIFIED FOR CARDIAC REHABILITATION AND REFERRED TO CARDIAC REHABILITATION TEAM WITHIN TWO WORKING DAYS OF DIAGNOSIS [NSF QR 146]**

<table>
<thead>
<tr>
<th>PRIMARY CARE</th>
<th>SECONDARY CARE</th>
<th>TERTIARY CARE</th>
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<tbody>
<tr>
<td><strong>Patient is identified for Cardiac Rehabilitation in Primary Care, having been either:</strong></td>
<td><strong>Patient is identified for Cardiac Rehabilitation as an in-patient:</strong></td>
<td><strong>Patient is identified for Cardiac Rehabilitation Team within two working days of diagnosis [NSF QR 146]</strong></td>
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<tr>
<td>• Diagnosed with any of the above within the previous month and not yet known to local Cardiac Rehabilitation Team; or:</td>
<td><strong>PHASE 1 (In patient care)</strong></td>
<td><strong>SECONDARY CARE  (to include ‘Self - Referral’)</strong></td>
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<td>• Diagnosed with any of the above and previously known to Cardiac Rehabilitation, but now presenting with new or specific secondary prevention needs that require specialist intervention</td>
<td>Patient is seen by Cardiac Rehabilitation Team as an inpatient and as a minimum is given:</td>
<td><strong>TERTIARY CARE  ( to include ‘Self - Referral’)</strong></td>
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<td></td>
<td>1. An initial assessment.</td>
<td><strong>PATIENT IS CONTACTED BY LOCAL CARDIAC REHABILITATION TEAM WITHIN SEVEN WORKING DAYS OF REFERRAL FROM PRIMARY CARE OR DISCHARGE FROM SECONDARY / TERTIARY CARE AND ARRANGEMENTS FOR ON-GOING MANAGEMENT ARE AGREED [NSF QR 152]</strong></td>
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<td>2. An initial exercise and mobilization programme. [NSF QR 147]</td>
<td><strong>EARLY CONTACT (Pre-Phase 2)</strong></td>
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<td>Referred to specialist services if need identified (e.g. smoking cessation, specialist dietary advice, psychology service, counselling and psychological support, etc)</td>
<td><strong>Patient proceeds to ‘Phase 2’</strong></td>
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<td><strong>Patient is referred by Primary Care to local Cardiac Rehabilitation Team for ongoing management.</strong></td>
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<td><strong>On discharge, patient is referred to local Cardiac Rehabilitation Team for ongoing management.</strong></td>
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‘CARDIAC REHABILITATION PHASE 2’
(Post-Discharge Cardiac Rehabilitation)

EACH PATIENT RECEIVES A COMPREHENSIVE INDIVIDUAL ASSESSMENT. THIS COMMENCES FROM FIRST CONTACT, AND AT LATEST IS COMPLETED AT PHASE 2 PRIOR TO COMMENCEMENT OF A PHASE 3 STRUCTURED CARDIAC REHABILITATION PROGRAMME.
(This may be conducted by Telephone, Home Visit or Clinic Consultation depending on patient need)

AS A MINIMUM, A PHASE 2 CARDIAC REHABILITATION CONSULTATION WILL CONSIST OF:
[NSF QR 148, 153 &154]

Patient Assessment
Assessment of Symptoms & Risk Stratification:
• Patient clinical assessment
• Assessment of current activity level
• New York Heart Association Classification
• History and clinical presentation based on diagnosis and investigation results (e.g. exercise tolerance test, echocardiography, angiography 1,2.)
Psychological/Quality of Life Status:
• Assessment of patient and carer’s psychological support needs
• HAD Psychological Assessment
• Dartmouth Quality of Life Assessment or a similar validated quality of life assessment tool
Functional Status:
• Functional assessment of activities of daily living

Risk Factor Assessment
• Blood Pressure
• Lipid Profile
• Smoking History
• Waist Circumference
• Weight/BMI
• Alcohol Consumption
• Dietary Habits
• Previous CHD
• Family History
• Physical Activity
• Diabetes
• Stress & Anxiety

Education & Goal Setting
• Patient and carer’s understanding of diagnosis
• Risk factors and targets for reduction
• Symptom recognition and management
• Activity advice and goals
• Medication and compliance awareness
• Advice on return to work and leisure activities
• Indications for further investigations
• Health beliefs & misconceptions
• Advice on importance of basic life support training

Medication Review
• Patient understanding
• Compliance
• Contraindications
• Side effects
• Optimisation
• ‘Over the counter’ medications

Future Management
• Issue / updating patient hand-held record
• Giving any additional information that is required
• Agreement of the structured programme of Cardiac Rehabilitation, including involvement of patient’s partner / carer
• Giving a contact number for further advice

CARDIAC REHABILITATION PLAN
AN INDIVIDUALISED CARDIAC REHABILITATION PLAN IS DEVELOPED WITH THE PATIENT AND FAMILY DEPENDANT ON NEED AND RISK STRATIFICATION.

Patient proceeds to ‘Phase 3’
**CARDIAC REHABILITATION PHASE 3**
(Structured Programme)

ON TRANSITION FROM PHASE 2 THE PATIENT RECEIVES A COMPREHENSIVE ‘PRE- PHASE 3 ASSESSMENT’ TO IDENTIFY ON-GOING CARDIAC REHABILITATION GOALS, PSYCHOLOGICAL AND BEHAVIOURAL EXPECTATIONS, AND RISK STRATIFICATION FOR EXERCISE IN ACCORDANCE WITH ‘BACR’, ‘SIGN’ AND ‘A.C.P.I.C.R.’ STANDARDS.

### PATIENT ASSESSMENT (Pre-Phase 3)

- **Assessment of Symptoms & Risk Stratification to include:**
  - Exercise History
  - Functional Capacity Assessment (e.g. 6 Minute Walk Test / Chester Step Test / Shuttle Walk / ETT)
- **Assessment of Psychological/Quality of Life Status**
- **Assessment of Functional Status**

### ‘Hospital or Community Based’
- ‘high risk’.
- (Estimated 20% of classes)

### ‘Community Based’
- ‘low and moderate risk’
- Leisure Services, local health & treatment centres, community halls, etc.
- (Estimated 60% of classes)

### ‘Home based’
- (Estimated 20% of classes)

‘PHASE 3’ ACCESS

Programmes are provided as near to patients home as possible and allocated on the basis of individual ‘patient risk’.

If appropriate, ‘fast-track’ to Phase 4 – ‘National Exercise Referral Scheme’.

### ‘PHASE 3’ PROVISION [NSF QR 149 & 155]
- Programmes provide for a minimum of 8 weeks participation (twice weekly) depending on need;
- Programmes are delivered by an appropriately trained team consisting of: nurses, occupational therapists, physiotherapists, exercise physiologists, BACR instructors, dieticians, pharmacists, clinical psychologists, etc;
- Programmes provide the option of a ‘structured supervised exercise session’ or supported ‘home-based exercise programme’ as appropriate;
- Programmes provide patients with access to health education & secondary prevention / risk factor management with relevant supporting literature as appropriate;
- Programmes provide patients with feedback and on-going support with goal setting and support with social / vocational / leisure / occupational issues;
- Programmes provide access to psychological support and stress management;
- Programmes provide the option of family support / engagement;
- Updating Patient Held Record Card.

### PATIENT ASSESSMENT (Post-Phase 3)

ON COMPLETION OF ‘PHASE 3’ PROGRAMME EACH PATIENT IS OFFERED AN ASSESSMENT OF THEIR PROGRESS AND ARE SUPPORTED IN DEVELOPING A PLAN FOR ONGOING MAINTAINANCE WITH REFERRAL TO ‘PHASE 4’ IF DESIRED. A COPY IS ISSUED TO MEDICAL NOTES IN SECONDARY CARE AND GENERAL PRACTITIONER / PRACTICE NURSE IN PRIMARY CARE. THE ‘PATIENT HELD RECORD CARD’ IS UPDATED TO REFLECT PROGRESS AND FUTURE PLAN WHICH CAN BE RE-ASSESSED IN PRIMARY CARE AS PART OF THEIR FOLLOW UP [NSF QR 156].

Patient proceeds to ‘Phase 4’
‘CARDIAC REHABILITATION PHASE 4’
(Long-Term Maintenance)

A menu of options exist for Phase 4 - ‘Long-Term Maintenance’

- Individualised ‘self-directed’ programme
- Supervised ‘BACR’ ‘Phase 4’ Programme (Other than ‘NERS’)
- ‘NERS’ (National Exercise Referral Scheme)

Long-Term Review and Maintenance with Primary Care is suggested at:
6 months, 12 months and annually thereafter to re-assess goals of psychological and behavioural changes as set in Phase 3

- Provision of Community Support Group / ‘Expert Patient Programme’

A facility exists for patient to ‘self-refer’ / contact Cardiac Rehabilitation Team for further advice if needed