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Research Article

Difficulties of Portuguese Patients Following Acute Myocardial Infarction: Predictors of Readmissions and Unchanged Lifestyles

Sofia Nunes, PhD, [1, 2, *] Guilhermina Rego, PhD, [1] Rui Nunes, PhD [1]

[1] Department of Social Sciences and Health, Faculty of Medicine of the University of Porto, Portugal
[2] Nursing School of Porto, Porto, Portugal

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SUMMARY

Purpose: Myocardial infarction can occur due to known risk factors and lifestyle choices. The difficulties that patients experience after discharge can lead to readmission and nonadherence to lifestyle change. The purpose of this study was to analyze the difficulties experienced by patients after hospitalization due to myocardial infarction and to identify the predictors of readmission and unchanged lifestyles.
Methods: The study used a mixed-methods design across 106 patients who had experienced a first episode of acute myocardial infarction. The data were collected from two patient interviews and the patients' medical records. A logistic regression was used to predict unchanged lifestyle and readmission.
Results: In the first interview, 74.5% of the patients reported receiving information prior to discharge. Six months after discharge, 80.2% mentioned that they had changed their lifestyles, but only 59.4% reported that their health had improved, and 75.5% continued to have concerns regarding their health. Patients described difficulties with regard to psychological problems, family dynamics, professional issues, problems with managing cardiovascular symptoms, and complications associated with hospital interventions. A follow-up assessment revealed that 12.3% of patients had been readmitted for cardiovascular disease.
Conclusions: The analysis revealed significant predictors of readmission amongst patients with hypertension and three-vessel disease. Specifically, the number of people in the household, per capita income, and a lack of information/education provided at discharge as well as problems related to mental health after discharge predicted unchanged lifestyle. An educational program might be advantageous to clarify doubts and involve patients in their own disease management.
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Introduction

Cardiovascular disease such as myocardial infarction (MI) is associated with patient lifestyle. Therefore, altering diets, sedentary lifestyles, and cigarette smoking habits is crucial [1] to avoiding the high mortality and morbidity rates of cardiovascular disease [2]. In Portugal, cardiovascular diseases are responsible for 31,421 deaths in a total of 106,554 deaths in 2013 [3].

Cardiovascular disease provokes losses at all levels; furthermore, the direct financial burden associated with these diseases is predicted to increase over the next decade. Despite current treatment success, it is necessary to improve primary care and promote the prevention of cardiovascular risk factors. Because of changes in sociodemographic features and the adoption of unhealthy lifestyles, risk factors can result in disease, productivity losses, and premature death [4].

The economic recession has engendered questions related to health expenditures and quality of care; however, financial restrictions in the healthcare sector should not adversely affect the quality or continuity of care. It is important to combine the use of economic resources and quality when providing care [5].

Nurses in the cardiovascular field have implemented many programs to improve the quality of care, with satisfactory results. Heart-failure management programs with improved results and reduced concerns for patients are included in some examples; these were achieved in a cost-effective manner [6].

* Correspondence to: Sofia Nunes, PhD, Department of Social Sciences and Health, Faculty of Medicine of the University of Porto, Alameda Prof. Hernâni Monteiro, 4200-319 Porto, Portugal.
E-mail address: sofiartnunes@gmail.com

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The problems and needs of patients with MI must be studied, and nurses must attempt to more effectively manage their disease and plan their discharge. Evaluating the perceptions of patients after their first MI episode and considering their needs via an educational program are essential [7].

The first hospitalization due to MI can have a large effect on a patient's life [8]; therefore, involving patients in care planning is the first step in achieving better results, patient satisfaction, and treatment outcomes. This goal implies a higher workload for nurses; nevertheless, additional efficient results in education can be accomplished [9]. The current literature concerning educational programs and cardiac rehabilitation is increasing. Nevertheless, the participation of patients in secondary prevention programs remains low. Current health costs might result in future cost savings, thereby enhancing patient outcomes [10].

In 2007, Portugal was second to last in cardiac rehabilitation in Europe. In 2007, Portugal had 16 cardiac rehabilitation centers (an increase of 14.0% since 2004), and in 2009 this number increased to 18 centers. In previous studies, significant differences favorable to cardiac rehabilitation programs after acute MI were found and, despite the benefits of cardiac rehabilitation and other educational programs, these programs continue to be underutilized in this country due to factors such as low referral rates, the lack of centers, low national health system funding, and poor patient adherence [11,12]. Nevertheless, recent data from 2014 shows that 10.0% of MI patients are being rehabilitated compared to 3.0% in 2009, according to the survey performed by the Portuguese Society of Cardiology [13].

The lack of patient knowledge with regard to disease management can lead to readmission. These readmissions might be associated with the absence of or gaps in patient discharge plans. Previous studies have shown that a nurse-led disease management program positively affect patient outcomes [14].

Establishing the predictors of patient's unchanged lifestyle and readmission is of unparalleled importance [15] because identifying these factors might decrease health costs and improve patient care.

Significant associations between patients' involvement and behavioural outcomes after MI have been described [9]. However, greater patient involvement is not consistently associated with desirable outcomes. Arnetz et al [9] found that fewer cardiovascular symptoms were associated with positive patient ratings of involvement after hospital discharge. In contrast, patients who attended cardiac rehabilitation programs were less satisfied with their involvement, although they had met their smoking cessation and systolic blood pressure goals.

Previous studies have not examined these issues together. Therefore, we hypothesized that patients would require individualized programs during the post MI period. One program should provide personalized assistance directed toward patients' holistic needs and considered people as bio-psycho-socio-cultural beings. Care should not only be based on physical conditions but also on individual needs; therefore, it is necessary to consider a holistic, patient-centered "total care" that allows for their involvement and encourages reflection and self-awareness [16]. We must improve our knowledge of these issues, explore and understand patients' needs during their recovery process after discharge. We also recognize that nurses play an important role in patient education and involvement.

Given previous investigations, this study aimed to (a) analyze the perceptions and difficulties of patients with regard to the disease/recovery process after discharge, considering who was included in cardiac rehabilitation programs, and (b) identify the predictors of patient readmission and unchanged lifestyle during the first 6 months after MI.

Methods

Study design

This study used a mixed-methods design within a broader longitudinal research project exploring topics such as the management of cardiovascular disease, its risk factors, patient perceptions regarding health costs, and nursing roles in healthcare.

The current design applied a multifaceted procedure by combining and linking research methods [17] to collect and analyze quantitative and qualitative data [18]. Because of our first objective, it was important to explore patients' perceptions of their diseases and recovery processes and provide them with the opportunity to express themselves via open-ended questions. The purpose of content analysis is to provide knowledge, new insights, and valid inferences via text interpretation, and the use of inductive content analysis allows us to approach inductive data in a way that moves from the specific to the general [19].

With regard to the second aim of this study (identifying the predictors of patient readmission and unchanged lifestyle), we converted patient opinions in qualitative data and the categories that emerged were transformed into quantitative variables. The combined use of quantitative and qualitative approaches promotes a better understanding of the research problem, thereby providing the most complete analysis. This methodology seeks to understand the complexity of the problem and offset the weaknesses of individual quantitative and qualitative research methods [17,18].

Settings and sample

Patients were recruited using convenience sampling from the cardiology department (including the coronary intensive care unit) at a central hospital in Oporto, northern Portugal. The sample was composed of 106 patients. This sampling method was selected because it included patients with defining characteristics in compliance with the aims of the study. Patients were included if (a) they had an acute MI based on changes to their electrocardiograph, cardiac biomarker values, or both [20]; (b) they were between 35 years and 64 years old; (c) they had no previous documented history of MI; (d) they had at least two recognized cardiovascular risk factors [21]; and (e) they were native Portuguese speakers.

We selected patients without a previous history of acute MI to focus on the initial effect of the disease; this age group restriction was justified given the low incidence of coronary disease before 35 years old and the possible unchanged lifestyle due to the Portuguese retirement age of 65 years old.

Patients were excluded due to:

(1) the presence of other chronic such as chronic renal failure, considering also the inclusion of cardiovascular risk factors, as well as immune diseases, with focus only in coronary disease;
(2) addictions, such as chronic alcoholism, or the use of psychoactive substances; or
(3) who reside outside of Portugal.

The exclusion criteria focused on patients who do not have diseases that might result in bias regarding disease management and, also patients who might be difficult to contact after discharge. Furthermore, Oporto is a tourist destination, and certain admitted patients might be foreign. Given the differences across nations in culture and lifestyle, foreign patients were excluded.

After applying the inclusion and exclusion criteria, patients were approached individually and invited to participate. The aims

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