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Psychosocial Screening and Assessment Practice within Cardiac Rehabilitation: A survey of Cardiac Rehabilitation Coordinators in Australia

Alun C Jackson^{a,b,c*}, Michael Le Grande^{a,c}, Rosemary O Higgins^{a,d,e}, Michelle Rogerson^{a,c}, Barbara M Murphy^{a,c,f,g}

^aAustralian Centre for Heart Health, Melbourne, Vic., Australia

^bCentre on Behavioural Health, University of Hong Kong, Pokfulam, Hong Kong

^cFaculty of Health, Deakin University, Melbourne, Vic., Australia

^dDepartment of Physiotherapy, University of Melbourne, Melbourne, Vic., Australia

^eSchool of Psychology, Deakin University, Melbourne, Vic., Australia

^fDepartment of Psychology, University of Melbourne, Melbourne, Vic., Australia

^gSchool of Medicine & Public Health, University of Newcastle, Newcastle, NSW, Australia

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Background

Many cardiac rehabilitation (CR) guidelines and position statements recommend screening for psychosocial risk factors, although there is wide variation in the recommended factors and recommended screening tools. Little is known about screening in CR in Australia.

Methods

Cardiac rehabilitation coordinators at the 314 CR programs operating across Australia, drawn from the 2014 Australian Directory of Cardiac Rehabilitation Services were invited to participate in an online survey.

Results

Of 165 complete responses, 157 (95%) CR coordinators indicated that they screened at entry with 132 (80%) screening on exit. At CR entry, programs screened for – depression (83%), anxiety (75%), stress (75%), and sleep disturbance (57%). The use of standardised instruments by those screening at entry varied from 89% for depression to only 9% for sleep disturbance. Organisational, resource and personal barriers inhibited the routine screening for many psychosocial factors.

Conclusions

Surveys such as this are useful for monitoring the rate of adoption of guideline recommendations and identifying barriers to implementation. Findings can also inform discussions about what should be included in minimum data sets for CR programs, and the identification of brief screening tools that have been validated not just in the general population but in cardiac patients.

Keywords

Cardiac rehabilitation • Screening • Assessment • Psychosocial

Introduction

Coronary Heart Disease (CHD) is the leading cause of death in Australia [1]. Patients who have had a cardiac event are at increased risk of a subsequent event and death [2] and are,

therefore, a priority for preventive cardiology [3]. As such, in Australia [4] and worldwide [5], it is recommended that cardiac rehabilitation (CR) be offered to all patients after an acute event. Cardiac rehabilitation is a multidisciplinary intervention, which improves functional capacity, recovery

*Corresponding author at: Australian Centre for Heart Health, Box 2137 Post Office, The Royal Melbourne Hospital, Victoria 3050, Australia.

Tel.: +(613) 9326 8544; fax: +(613) 9326 5066, Email: alun.jackson@heartresearchcentre.org

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and psychological well-being [5-7]. Cardiac rehabilitation has been shown to reduce the risk of further heart attack or death by 25-30% [8,9]. In addition, models of care that incorporate psychosocial and education-based CR [10,11] may improve the health-related quality of life [12]. As the European Association of Cardiovascular Prevention and Rehabilitation notes [13] CR is recommended (with the highest level of scientific evidence-class I) by the European Society of Cardiology, the American Heart Association and the American College of Cardiology in the treatment of patients with coronary artery disease (CAD) [14-16].

Centre-based group programs are the major systematic approach to CR currently available in Australia. Group CR typically comprises low or moderate intensity physical activity; and education and discussion, with programs usually running for six to eight weeks [4,6]. Cardiac rehabilitation aims to restore individuals to their optimal level of physical, psychological, social and vocational wellbeing and is considered 'an essential part of the contemporary care of heart disease' [17].

Current Guidelines for Psychosocial Screening in CR

According to the recently published core components of cardiac disease secondary prevention and rehabilitation [18,19] it is recommended that patients be formally assessed at entry to the program and a mutually agreed treatment plan devised, and assessed again at exit and at 6- and 12-month follow-up. It is recommended that the entry assessment include medical history; current medications; physical and functional status; risk factor profiles; health behaviours including, for example, diabetes management where relevant; employment status and plans for resuming work; and psychosocial issues, including the availability of social support. Traditionally, risk factor assessments have included clinical indicators such as blood pressure, cholesterol, waist girth, and family history, and behavioural indicators such as smoking status, physical activity and diet [6].

In addition to the standard physical and behavioural factors, psychosocial risk factors are now being incorporated into standard screening assessments. For example, specific depression screening guidelines were released by the Heart Foundation of Australia [20], following the 2008 recommendations of the American Heart Association [21]. The Australian guidelines state that routine screening for depression is indicated at first presentation and again at the next follow-up appointment and that a follow-up screen should occur two to three months after the event [20]. Cardiac rehabilitation provides the ideal opportunity for systematic assessment of depression in cardiac patients. It also provides an opportunity to assess lifestyle characteristics known to be associated with depression, such as social isolation, which is implicated in poorer recovery. Impaired social support is also considered an important predictor of adverse CHD outcomes [22-25] while good social support has been demonstrated to buffer

the impact of depression; such that the association between cardiac mortality and depression weakens with higher social support, and depressive symptoms decrease in patients with higher levels of social support [26].

Other emerging cardiovascular risk factors include sleep disturbance [27,28]. In the general population, both short and long sleep duration have been associated with cardiovascular and all-cause mortality [29-31]. In patients recovering from cardiac events such as acute myocardial infarction (AMI) or coronary artery bypass graft surgery (CABGS), the reported prevalence of sleep disorders is considerably higher than in the general population [32,33]. Sleep disorders are associated with anxiety and depression in hospital cardiac patients [34] and CR patients [32,35] and with treatment non-adherence [36] and reduced self-efficacy in cardiac patients [37,38]. It is therefore feasible that sleep disorders may directly or indirectly hamper CR objectives and patient recovery, suggesting that screening for sleep disturbance in CR patients is indicated.

Table 1 provides a summary of recommended psychosocial screening tools from a range of Australian, European and North American guidelines and position statements. Shen *et al.* [39] also propose a number of measures, but as they are not contained in formal guidelines they are not included in Table 1. The variation in recommended screening tools for depression and anxiety, and the relative paucity of recommendations for screening for sleep disorders and social isolation is evident.

Despite the availability of current guidelines and recommendations, very little is known about screening activities in CR in Australia. Approximately 314 CR programs currently operate in Australia, with programs in metropolitan, regional and rural areas. In the light of current screening guidelines, together with emerging evidence regarding new cardiac risk factors, it has become increasingly important that CR-based screening activities be documented as an indication of guideline adherence. It is important also to document the barriers to screening currently experienced in Australian CR programs.

The aim of the current study, therefore, was to investigate and document current practice in CR in screening and assessment for a range of cardiac psychosocial risk factors; and the perceived barriers to undertaking screening and assessment in CR.

Method

Participants

Eligible participants were coordinators of CR programs currently operating in Australia. Based on a 5% margin of error and 95% confidence intervals, a sample of 174 CR coordinators was required [40]. This represented a 50% response rate (of the full population of 314 CR programs).

Measures

An online survey was developed which asked about screening activities across a range of traditional and emerging

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