

# Prompt to Care - Post ACS checklist

Welcome, the Prompt to Care – Post ACS checklist is a clinical collaborative tool developed to provide support to new and experienced clinicians enabling them to provide comprehensive care to clients in the year following an ACS event. The purpose is to promote a collaborative, caring conversation around life style and pharmacological interventions as part of shared decision making conversation. Available documents include

Prompt to care - POST ACS checklist

Prompt to care- Post ACS - Recommendations and Resources

# Prompt to Care – Post ACS checklist

| Name   |  |
|--|--|
| NHI  |  |
| Provider   |  |
| Date of event  |  |
|  |  |
| Coding   |  |
| Date / IHD   |  |
| Specific Event / Date (e.g MI, STEMI/ NSTEMI, Angina)                |  |
| Intervention / Date (Primary PCI / Angio / CABG/ Medication Therapy) |  |
|  |  |
| Plan   |  |
| Follow up appointments   |  |
| Targets (LDL / BP)   |  |
| Future Interventions / Plan  |  |
|  |  |
| Medications  |  |
| Aspirin  |  |
| Tiercuster (data of ecception on equipt)                             |  |
| Ticagrelor (date of cessation on script)                             |  |
| Clopidogrel  |  |
| ACEI/ARB   |  |
| Beta Blocker   |  |
| Statin   |  |
| Written information provided   |  |
| Patient has a list of Medications printed                            |  |
|  |  |
| Input from Clinical Pharmacist                                       |  |
|  |  |

# **Lifestyle Conversations**

| Physical Activity   |  |
|---|--|
| Nutrition / Healthy eating  |  |
| Healthy Weight  |  |
| Alcohol   |  |
| Smoking   |  |
| Diabetes screening  |  |
| Chest Pain Action Plan  |  |
| Anxiety / Depression Screening  |  |
| Return to work / Employment   |  |
| Driving   |  |
| Sexual Activity   |  |
| Social Support  WINZ / Social Worker / Home help / Green prescription / Meals on Wheels / Counselling / Pharmacist) |  |
| Cardiac Rehabilitation post event   |  |
| Phase One – In patient  |  |
| Phase Two - Attendance  |  |
| Phase Three -Cardiac Clubs / Support groups   |  |

**Secondary Prevention post event > 12 months** 

Follow up / Notes:

Developed by Dr Fraser Hamilton in collaboration with the nursing team at Northcare Hamilton, and with the support of the Clinical Support Team at the Heart Foundation, Please send correspondence to <a href="FraserH@heartfoundation.org.nz">FraserH@heartfoundation.org.nz</a>

# **Lifestyle Conversations & Prompts to Care**



# Post an Acute Coronary Syndrome event

A patient centred prompt to care tool - personalised to individual preferences whilst promoting self-management.

# **Physical Activity**

# Aim for minimum of 30 minutes of moderate intensity physical activity on most days of the week.

Build intensity over several weeks. Resume slowly, e.g. walking to the letter box and back, then two – three lamp posts, slow incremental increases.

What's available in the local region – leisure centre, walking group, cardiac club. Ensure able to hold a conversation throughout activity.

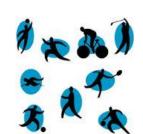
Sexual Activity – if you can walk up two flights of stairs without getting chest pain or feeling short of breath, you are probably well enough to have sex with your usual partner.

Sit less – Be active.

Recommend Cardiac Rehabilitation exercise programme or other structured exercise program e.g Green Prescription / local Gym / community programs.

http://www.health.govt.nz/your-health/healthy-living/food-and-physical-activity/physical-activity/how-much-activity-recommended http://www.health.govt.nz/your-health/healthy-living/food-an-physical-activity/green-prescriptions

http://www.heartfoundation.org.nz/healthy-living/exercise-and-fitness



### **Healthy Eating**

# See Heart Foundation recommended links for cook books, and visual food guide.

Visual Food Guide / swap portion table / suggested alternatives.

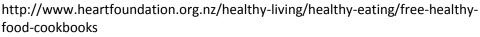
Portion control – downsize portions and plate sizes.

Low Salt Diet – reduces Hypertension.

Cook Books – suggestions/ ideas for healthy eating.

Avoid highly saturated foods, butter, deep fried and fatty foods.

Review lifestyle eating habits – encourage options/alternatives.



http://www.heartfoundation.org.nz/healthy-living/healthy-eating/healthy-heart-visual-food-guide

http://www.health.govt.nz/publication/eating-and-activity-guidelines-new-zealand-adults

http://www.health.govt.nz/system/files/documents/publications/eating-activity-guidelines-for-new-zealand-adults-oct15 0.pdf



### Weight

# Reaching a healthy weight

If you are overweight, losing even small amounts of weight will be good for your health. Steps to drop your weight will improve your:

- Blood pressure
- Cholesterol levels
- Blood sugar levels
- Reduce your risk of heart disease and diabetes.

http://www.heartfoundation.org.nz/healthy-living/losing-weight

http://www.heartfoundation.org.nz/order-resources/product\_view/891/a-guide-to-heart-healthy-eating-booklet

http://www.heartfoundation.org.nz/order-resources/product\_list/category/healthyeating-resources



#### Alcohol



#### Reduce excessive alcohol intake

Drinking excessive amounts of alcohol contributes to hypertension, weight gain, and stroke.

- < 2-3 pub measures daily for men
- < 1 -2 pub measures daily for women

Aim for 2 alcohol free days per week

Alcohol & Drug helpline 0800 787 797 for free confidential advice. http://alcoholdrughelp.org.nz/?gclid=CN7uiJG3z80CFVEIvAodtawCnw

http://alcohol.org.nz/

https://www.heartfoundation.org.nz/know-the-facts/food-and-drink/alcohol

# **Smoking**



# For those still smoking – offer cessation support.

Quitline - 0800 778 778

NRT therapy.

Counselling - Face to Face.

Telephone support – weekly support, encouragement.

Behaviour support face to face and written materials.

See Heart Foundation online eLearning module

See Heart Foundation resources: Smoking resource

http://www.quit.org.nz/94/helping-others-quit/health-professionals

http://www.smokefreecontacts.org.nz/

http://www.health.govt.nz/your-health/healthy-living/addictions/smoking/stop-smoking

#### **Diabetes**



#### Aim for HBA1c 50 - 55mmol/L

Hba1c between 41-49 mmol – Pre Diabetes – Lifestyle Interventions necessary to prevent progression to Diabetes.

2 x HbA1c results > 50 mmol = Diabetes – lifestyle interventions, medications, regular reviews, annual review.

Consider micro and macrovascular complications such as retinal screening (retinopathy), microalbumin (kidney disease), podiatry/nerve checks for (neuropathy), Cardiovascular risk assessment (cardiac disease).

See Heart Foundation Resource: Diabetes

http://www.heartfoundation.org.nz/know-the-facts/conditions/diabetes http://www.diabetes.org.nz

#### **Anxiety & Depression**



#### Can be common after a cardiac event but returns to normal as time passes.

Due to the high incidence of anxiety and depression in people with a cardiac event It is important to screen individuals.

Using the PHQ screening tool - if the answer to both of these questions is Yes, then refer person to the GP for a more comprehensive screening test.

- Kessler Screening tool
- PHQ9 Depression Screening tool

Encourage patients to check out the HF web site and listen to the psychologist interview.

Consider and discuss strategies to regain balance.

http://firststeps.hearthelp.org.nz/home/the-early-days/depression-and-anxiety/http://www.bpac.org.nz/BPJ/2009/adultdep/assessment.aspx#assess

http://www.mentalhealth.org.nz/

http://www.depression.org.nz/

#### **Return to Work**



# Ease into work – light duties initially, then progressively increase.

Inquire about the nature of work and tailor advice around safely returning to work Refer to following section on Resuming Driving

If necessary, contact the local WINZ support office as soon as possible either pre cardiac admission or as soon as possible to process claims, and receive financial support.

Phone the 0800 778 008 number, Ministry of Social Development for advice.

http://www.workandincome.govt.nz/online-services/apply/ http://www.workandincome.govt.nz/eligibility/lost-job/health-condition.html#null

# **Resuming Driving**



# Following a heart attack, the person cannot drive for 2 weeks

(as car insurance may not be valid)

Clarify if driving on a private license or a commercial license.

If the individual has a **commercial license**, e.g. heavy truck, bus, and taxi, patients must have an Exercise Treadmill Test and Echocardiogram completed. The Ejection Fraction must be over >40%, these patients are unable to drive for 4 weeks, and must be cleared by Medical Practitioner.

Refer to NZTA - Medical Aspects of Cardiovascular conditions. https://www.nzta.govt.nz/resources/medical-aspects/3.html#31https://www.nzta.govt.nz/driver-licences/getting-a-licence/medical-requirements/

### **Pharmacy Input**

# Seen by Clinical Pharmacist if available or liaise with local pharmacist.

Select one pharmacy only so they are able to keep an accurate record of meds, and keep Special Authority codes loaded and up to date.

If on a number of medications there are various methods that pharmacist have available to support medication e.g. Blister Packs

## **Medication Adherence**



# Check person understands why the medications have been prescribed for them

Provide medication information leaflet

Ensure patients have not stopped medications and encourage discussions with GP if prescriptions are interfering with activities of daily life

The attainment of treatment targets such as blood pressure and low-density lipoprotein (LDL) levels or outcomes such as 1-year mortality after hospitalization for conditions like acute myocardial infarction reinforces the importance of long term medication adherence.

### **Anti-platelet therapy**



### Antiplatelet therapy is critical to prevent recurrent cardiac events

Current recommendations are for dual antiplatelet therapy for 12 months – usually Aspirin and Ticagrelor (although some patients may be on Clopidogrel). These medications can cause gastric irritation, easy bruising or more serious bleeding. If symptoms are mild patients should be encouraged to persist as the benefit outweighs the risk.

Ticagrelor may cause some SOB, which again may be transient and mild and patients should be encouraged to persist if possible to see if the side effects lessen.

The benefits of medications outweighs the risk.

Highlight medication should not be stopped suddenly without clinical input, If experiencing side effects, please discuss with GP about alternative options

Reference Parodi G, Storey RF. Eur Heart J: Acute Cardiovasc Care. 2014, published online 29 September 2014.

# **BP Management** (Hypertension)



# Monitoring BP every 3 – 6 months until blood pressure is stable.

Lifestyle management

BP lowering medications

Current Target BP <130/80 (with or without Diabetes)

High Falls Risk in the elderly/ apply caution

See Heart Foundation Resource: Blood Pressure

http://www.heartfoundation.org.nz/know-the-facts/conditions/high-blood-pressure http://www.heartfoundation.org.nz/know-the-facts/managing-your-risk/managing-your-blood-pressure

https://www.health.govt.nz/system/files/documents/publications/cardiovascular-disease-risk-assessment-updated-2013-dec13.pdf

# **Cholesterol Management** (Statins and lifestyle)



# Statins are lifelong medications— not short term as Statins are cardioprotective.

Atorvastatin is the preferred statin (80 mg is the gold standard).

Monitoring non fasting lipids every 3 - 6 months until the person is stable on their treatment regime and then annually.

Refer to local guidelines and discharge summary on targets for Cholesterol.

See Heart Foundation link: Cholesterol

http://www.heartfoundation.org.nz/know-the-facts/managing-your-risk/taking-medication/statins

http://www.heartfoundation.org.nz/know-the-facts/conditions/high-cholesterol

#### **Chest Pain Action Plan**



# Confirm GTN spray has been prescribed and provide clear instructions on use of GTN spray and when to call 111 for an ambulance.

Explain the need to carry the GTN spray and only use it once sitting down to avoid the risk of falls.

Highlight certain performance enhancing medication e.g. Sildenafil (Viagra) and GTN spray combined can cause profound hypotension.

Encourage the use of the Heart Foundation Emergency details Wallet Card – which outlines an Action Plan within the Wallet card



# Cardiac Rehabilitation



# Promote and encourage engagement with Cardiac Rehabilitation and Healthy Hearts / Heart Recovery programmes in the local community.

Check invitation to local rehabilitation program.

Liaise with local cardiac rehabilitation nurse specialists.

Discuss local options for community based education.

Heart Foundation - Heart Help Directory (Cardiac Rehab in NZ locations)

http://www.heartfoundation.org.nz/hearthelp/hearthelp-directory

# **Be Mindful of Inequities**



# Consider social determinants affecting self-management and the influence of social determinants on health outcomes in New Zealand

Engage with person and family to identify issues causing additional stress and determine support needed i.e

- Access to health services
- Transport
- Food security
- Housing
- Work
- Finance
- Drug and Alcohol
- Impending law and order
- Family Violence

### Support agencies i.e

| WINZ                           | Salvation Army                           |
|--------------------------------|--|
| Cardiac Rehab Nurse Specialist | Practice Nurse                           |
| Whanau Ora                     | Heart Health Advocate , Heart Foundation |
| Health Navigator               | Transport services                       |
| Meals on Wheels                | Counselling / Psychosocial support       |
| Pharmacist                     | Physio / Local Gym                       |
| Green Script                   | Home help                                |
| Social Worker                  |  |

# Local Contacts and Local support agencies



### Local considerations, local contacts, local referrals....

# Heart Foundation Journeys

#### You are not alone

There are more than 172,000 people living with some form of heart disease in New Zealand. Read and watch some of their stories, learn from others' life experiences, and find tips to help you and your family/whānau on your journey.

Recently we asked people who had experienced a heart event how the Heart Foundation could support them. One of the key things that people talked about was having opportunities to share their experiences and learn from others, so that they did not feel alone. This is how the Journeys programme started. It provides an opportunity for people to share their story, read the stories of others and feel supported. Often it is other people's stories that resonate and provide understanding to a patient starting out on the road to recovery.

http://www.heartfoundation.org.nz/journeys/

#### **Resources**



Health Professionals Support, resources, training and To Order Heart Foundation resources please visit our website and download the order form

https://www.heartfoundation.org.nz/resources/resource-order-form Or e.mail shop@heartfoundation.org.nz or fax 09 571 9190.