

BACR EXERCISE PROTOCOL FOR MANAGEMENT OF CHD PATIENTS

1. TRANSITION FROM PHASE III TO PHASE IV EXERCISE 2. GP CHD PATIENT EXERCISE REFERRAL PATHWAY

1. Transition from Phase III to Phase IV Exercise

- 1a. Before being accepted for exercise by BACR Phase IV instructor, all CHD patients in transition from Phase III to IV will require Phase III information and associated physician's assessment which will include:-

Index cardiac event and date

Subsequent complications and/or interventions

Relevant medical history

Cardiac risk stratification

Exercise prescription (with relevant summary of ETT)

Medication

Secondary prevention plan

The patient's consent should be obtained and the recommended BACR information sheet (see Appendix 1) completed by both the CR professional and the patient. The information sheet should either be given to the patient as a hand held document or (where local protocol permits) forwarded directly to the Phase IV exercise professional.

- 1b. If Phase IV professional is satisfied that the patient should be transferred to Phase IV and THERE HAVE BEEN NO NEW EVENTS OR SYMPTOMS in the interim, accept patient for Phase IV exercise. All patients should consider & consent to 'Conditions of Participation' in exercise. Agreed contraindications to exercise should be considered prior to each session & if necessary patient should be referred back to GP as appropriate.

2. GP CHD Patient Exercise Referral Pathway (See Appendix 2, 3 & 4).

If the CHD patient -

(a) has **not** been assessed by Phase III rehabilitation staff or Cardiologist or

(b) **> 6 months** has elapsed since event or Phase III completion, a referral from GP can be accepted if:

- identifying criteria & contraindications for exercise referral are appropriate
- a clinical assessment is completed
- where relevant - an associated Phase III cardiac rehabilitation review to complete the necessary documentation.

If the clinical assessment is insufficient/incomplete the patient should be referred back to GP and reviewed by Cardiologist as appropriate.

On-going evaluation of Phase IV exercise prescription should be undertaken to ensure appropriate continuation/progression of exercise. Phase IV physical activity measures may be sought/shared with the primary health care team in the required annual review of CHD risk factors/lifestyle.

BACR EXERCISE PROTOCOL FOR MANAGEMENT OF CHD PATIENTS

Appendix 1	BACR Phase III–IV Information sheet
Appendix 2	CHD Patient - Exercise Referral Pathway
Appendix 3	CHD Patient –Exercise Referral Criteria
Appendix 4	CHD Patient - Exercise Referral Form



PHASE IV

INFORMATION SHEET

Name _____	GP Dr _____
Address _____	Tel No _____
_____	Local 'contact' person for emergency _____
_____	_____
Tel No. _____	_____
Age _____ DOB _____	Tel No _____

CURRENT CARDIAC STATUS

Diagnosis _____	Angioplasty/Stent	Y/N	Date _____
Date _____	BP _____	Pulse _____	reg/irreg
Complications _____	Y/N	LV Function	Good/Moderate/Poor
_____	Assoc Heart Failure	Y/N	Mild/Mod
ETT PROTOCOL	Full/Modified Bruce	Current angina (post MI/CABG)	Y/N
Result -ve/+ve	Date _____	Rest	Y/N Exertion Y/N
Completed _____	mins _____	Incidence	_____
Stopped because _____	_____	GTN	Y/N _____
Angiogram	Y/N	Date	_____
_____	_____	Comments	_____

CURRENT DRUGS

TICK IF PRESCRIBED

Aspirin <input type="checkbox"/>	B Blocker <input type="checkbox"/>	ACE Inhib <input type="checkbox"/>	Nitrate <input type="checkbox"/>
Digoxin <input type="checkbox"/>	Warfarin <input type="checkbox"/>	Diuretic <input type="checkbox"/>	"Statin" <input type="checkbox"/>
Anti-arryth <input type="checkbox"/>	C C block <input type="checkbox"/>	Other _____	

PAST MEDICAL HISTORY

When affirmative, please supply details and dates of events

Angina <input type="checkbox"/>	Diabetes <input type="checkbox"/>	Epilepsy <input type="checkbox"/>
MI <input type="checkbox"/>	CVA/Neuro <input type="checkbox"/>	COAD/Asthma <input type="checkbox"/>
Angioplasty <input type="checkbox"/>	Ortho/musc. skel prob <input type="checkbox"/>	_____
CABGS <input type="checkbox"/>		
Other cardiac surgery <input type="checkbox"/>		
Hypertension <input type="checkbox"/>		
Claudication <input type="checkbox"/>		

OTHER CONSIDERATIONS



SECONDARY PREVENTION PLAN

TICK IF APPLICABLE

Known: FH IDDM/NIDDM CHD History

Risk Factors	Pre MI/CABG	Comp phase III	Risk Factors	Pre MI/CABG	Comp phase III
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	Excess alcohol	<input type="checkbox"/>	<input type="checkbox"/>
Raised Chol	<input type="checkbox"/>	<input type="checkbox"/>	Sedentary	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Stress	<input type="checkbox"/>	<input type="checkbox"/>
Overweight	<input type="checkbox"/>	<input type="checkbox"/>			

Agreed rehab goals Y/N Compliant with medication Y/N

PHASE III GRADUATION INFORMATION

Date of entry to phase III _____ Coped well Phase III ex sessions Y/N _____
 Date of discharge to phase IV _____ Symptomatic Y/N _____
 No. of exercise sessions attended _____ Phase III indiv. prescription detail attached Y/N _____
 Pre ex HR reg/irreg _____ bpm
 Training HR reg/irreg _____ bpm Regular walk Y/N Dist Time
 Working @ METs/RPE _____ Other activities _____
 BP on completion prog. _____
 Exercise assessment on completion of Phase III _____
 Y/N Date _____ Resumed work Y/N Rtd
 Result _____ Occupation _____

IMPORTANT NOTICE

Please identify if patient is awaiting further medical/surgical treatment *after* completion of Phase III in which case transition to phase IV may need to be *delayed or exercise limited* pending

e.g.

- Angiogram
- Angioplasty
- Surgery
- Cardiology review/Investigations

Date of Phase III completion _____

I AGREE FOR THE ABOVE INFORMATION TO BE PASSED ONTO THE PHASE IV EXERCISE INSTRUCTOR. I UNDERSTAND THAT I AM RESPONSIBLE FOR MONITORING MY OWN RESPONSES DURING EXERCISE AND WILL INFORM THE INSTRUCTOR OF ANY NEW OR UNUSUAL SYMPTOMS. I WILL ALSO INFORM THE INSTRUCTOR OF ANY CHANGES IN MY MEDICATION, THE RESULTS OF ANY INVESTIGATIONS OR TREATMENT.

PATIENT SIGNATURE _____

PLEASE PRINT NAME AND TITLE

CR PROFESSIONAL SIGNATURE _____

PLEASE PRINT NAME AND TITLE



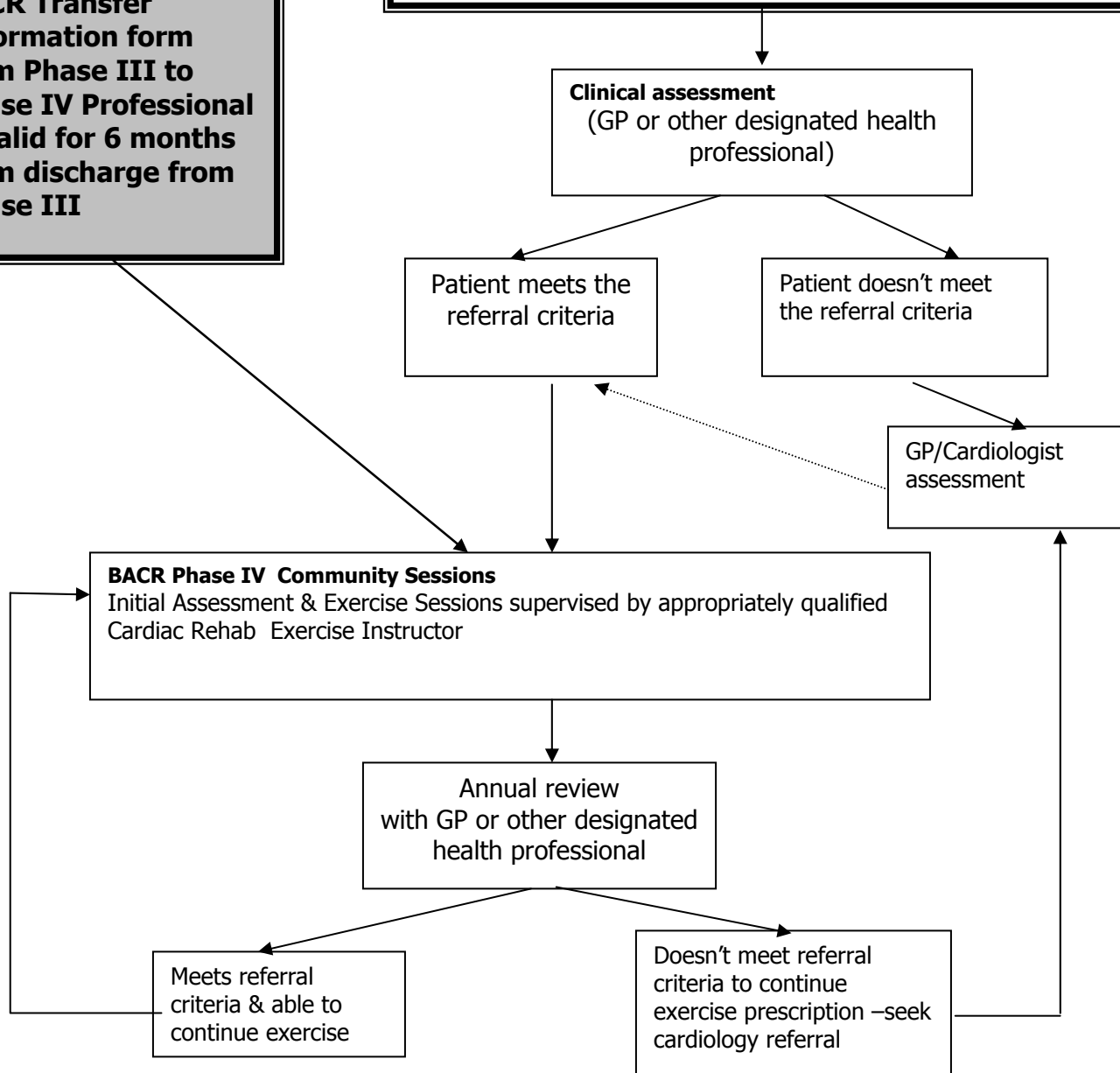
CHD PATIENT – EXERCISE REFERRAL PATHWAY

PHASE III – IV PATHWAY

CHD GP REFERRAL PATHWAY

CHD patient following Phase III Cardiac Rehabilitation as per existing protocol
IMPORTANT NOTE: BACR Transfer Information form from Phase III to Phase IV Professional is valid for 6 months from discharge from Phase III

The CHD Patient
 (i) > 6/12 elapsed since acute cardiac event, *or*
 (ii) > 6/12 since discharge from Phase III, *or*
 (iii) CHD history but no recent acute event
IMPORTANT NOTE – If <6/12 since acute event without clinical assessment or participation in Phase III redirect patient via Phase III



CHD PATIENT – EXERCISE REFERRAL CRITERIA

In recognition of the National Quality Assurance Framework Document (DoH, 2001) and the requirements of the Register for Exercise Professionals, patients can be referred on to an appropriate Exercise Referral scheme as long as the exercise instructor is appropriately qualified (eg BACR Phase IV instructor).

THE PATIENT WILL BE CLINICALLY ASSESSED BY THE REFERRER & the decision to be referred should be made in accordance with published UK guidelines (BACR Guidelines for Cardiac Rehabilitation, 2000; Scottish Intercollegiate Guidelines Network, 2002; BACR Phase IV Exercise Instructor Training Manual, 2002):

- ✓ clinically stable & without any of the contraindications to exercise (as listed below)

Contraindications to referral for exercise:

- ✗ Unstable angina
- ✗ Systolic blood pressure ≥ 180 mmHg & / or diastolic blood pressure ≥ 100 mmHg
- ✗ BP drop > 20 mmHg demonstrated during ETT
- ✗ Resting tachycardia > 100bpm
- ✗ Uncontrolled atrial or ventricular arrhythmias
- ✗ Unstable or acute heart failure
- ✗ Unstable diabetes
- ✗ Febrile illness

Referral for supervised long term exercise should include the following information (with consent):

- ✓ Date of diagnosis of CHD
- ✓ Details of the cardiac event(s) eg. MI, CABG & dates
- ✓ Subsequent progress, complications & / or interventions
- ✓ Results of investigations, eg ECG Exercise Treadmill Test, Echocardiogram
 - i.e. a) Left Ventricular function:
Ejection Fraction - <35% poor; 35-50% moderate; >50% good
 - b) Ischaemic status:
patient symptoms i.e. exertional or 'at rest angina';
ETT result – e.g. ST depression
- ✓ Other relevant medical history
- ✓ Details of medication

The Cardiac Rehab Exercise Instructor in receipt of clinical assessment via the Referral form will undertake fitness assessment screening prior to exercise prescription (NQAF,2001), which may include identification of functional capacity eg. walking at 3-4mph, prior to acceptance onto scheme. If patient is not accepted by the exercise instructor they will be referred back to GP / Phase III as appropriate.

To be completed by the Referring Doctor or designated health professional

Please print clearly

Patient Details

Name: _____
 Address: _____

 Postcode: _____ D.O.B. _____
 Telephone Home: _____
 Telephone Work: _____

Referrer's Details

Name & Profession: _____
 Surgery / Department: _____
 Address: _____

 Postcode: _____
 Telephone: _____

Cardiac History

MI: Yes No Date: _____ CABG: Yes No Date: _____
 Angioplasty / Stent: Yes No Date: _____ Other: _____ Date: _____
 Current Angina: Yes No GTN: Yes No Arrhythmias: Yes No
 At rest: Yes No On exertion: Yes No Details: _____
 Comments _____

✓ if prescribed

Current Medication

(attach prescription list if available)

Aspirin <input type="checkbox"/>	Warfarin <input type="checkbox"/>	Diuretic <input type="checkbox"/>	Statin <input type="checkbox"/>
Clopidogrel <input type="checkbox"/>	Calcium channel blocker <input type="checkbox"/>	GTN <input type="checkbox"/>	Nitrate <input type="checkbox"/>
Anti-arrhythmic <input type="checkbox"/>		Other: _____	

Investigations (if available)

ETT: Yes No Date: _____ LV Function: _____
 Result: _____ Good Moderate Poor

Current Status - CHD Risk Factors

Resting BP _____ Resting Heart Rate _____ Stable Type 1 / Type 2 Diabetes
 BMI _____ Chol _____ Physically Inactive Smoker Excess Alcohol Stress

Past Medical History

✓ if applicable, please supply dates & details as far as possible

COAD / Asthma Epilepsy Hypertension Claudication
 CVA / Neuro. Problems Ortho/musc. skeletal problems Details: _____
 Other considerations: _____

IMPORTANT NOTICE

- The patient exhibits no contraindication to exercise (as indicated on the protocol)
- The patient is clinically stable
- The patient is compliant with medication
- The patient is awaiting / not awaiting further medical or surgical treatment (see protocol)

REFERRER'S SIGNATURE: _____

Print Name: _____ Date: _____

GP's signature (if different from above): _____

Print Name: _____ Date: _____

PATIENT INFORMED CONSENT

I agree for the above information to be passed onto the Exercise Instructor. I understand that I am responsible for monitoring my own responses during exercise and will inform the instructor of any new or unusual symptoms. I will also inform the instructor of any changes in my medication, the results of any investigations or treatment.

PATIENT SIGNATURE: _____

Print Name: _____ Date: _____