Acute Myocardial Infarction

North Trent CHD Collaborative

NHS Modernisation Agency

Patient Flow

Before

- Following an Acute Myocardial Infarction, patients were discharged home and would receive via the post, two separate out-patients appointments for exercise test and follow-up clinic.
- After the exercise test patients would not receive any information as to the results, nor would they know the next steps in their care.
- Following these appointments, if the exercise test was positive they would then await a third appointment possibly several weeks later to see a Cardiologist, for placement on the Angiography waiting list. Patients with a negative exercise test would be put on the waiting list for Phase III Cardiac Rehabilitation.

After

- Whilst still in hospital following an Acute Myocardial Infarction the patient agrees a convenient date for follow up investigations. Investigations are organised in a one-stop clinic.
- All eligible AMI patients have the opportunity to be referred to an AMI Cardiologist clinic. The Cardiologist provides the patient with the results of tests and informs them of the next steps in their care.
- Patients with positive exercise tests will be placed immediately on the list for Angiography. Those with negative exercise tests will be seen in the same appointment by the Cardiac Rehabilitation Sister, they will be assessed and given a date for phase III Cardiac Rehabilitation.

"When you have any tests you want to know the results - like on the TV they go away and come back with the results"

The updated MEST form acts as an easy referral route for all clinicians and has displays the following referral criteria:
The service will be open to all medical referring clinicians subject to the following referral criteria:

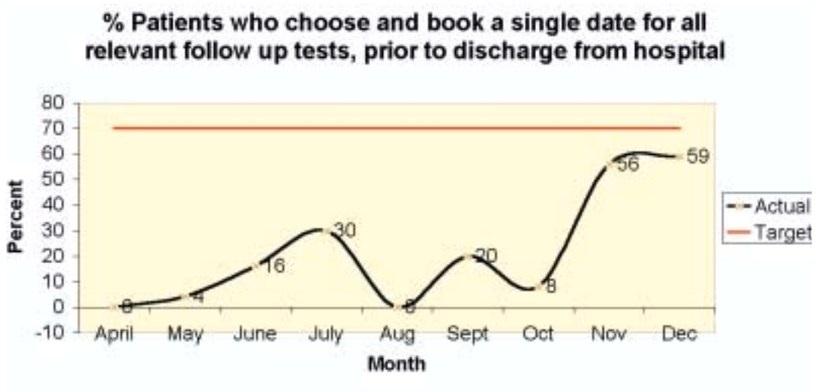
1. Patient must be physically fit enough to exercise.
2. Must have no concomitant illness, which would prevent further intervention, or would make it unnecessary. i.e. terminal illness severe COPD FEV1 <1 litre.
3. No contraindications to a technician lead exercise test (LBBB, LVH, VT, AS).
4. Age should be taken into account, as there is no doubt
   Intervention is increasingly risky as you get older and symptoms rather than silent/prognostic disease should lead the decision to intervene.

5. Definite MI/ Acute coronary syndrome i.e. A diagnostic Troponin rise.

Adapting this form has avoided form duplication and allows ward clerks an easy way of identifying patients for this clinic.

Changes brought about by the CHD Collaborative

Dr Gillian Payne Consultant Cardiologist Doncaster Royal Infirmary innovated the idea for this new clinic session, undertaking PDSA cycles and following enthusiasm from the 3rd Learning Workshop.



The main improvements have occurred since November 2001, this has occurred since the service has been extended to all eligible post AMI patients.
Prior to this some improvement has been shown during the pilot phase, when the service was restricted to patients under the care of a Cardiologist, however, small sample sizes inhibited the results.

Working for the patient

Before

- Patients were discharged from hospital with minimal Coronary Heart Disease information faxed to Primary Care.

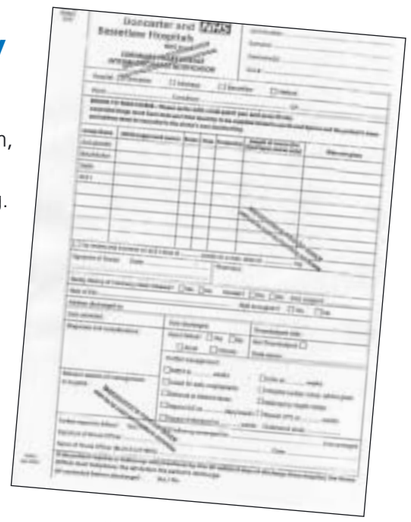
After

- Patients with Coronary Heart Disease are discharged from hospital to Primary Care, with a comprehensive CHD discharge summary which is both hand held by the patient and received in Primary Care within 24 hours.

"When I got home the GP couldn't understand why I was on so much medication "

Changes brought about by the CHD Collaborative

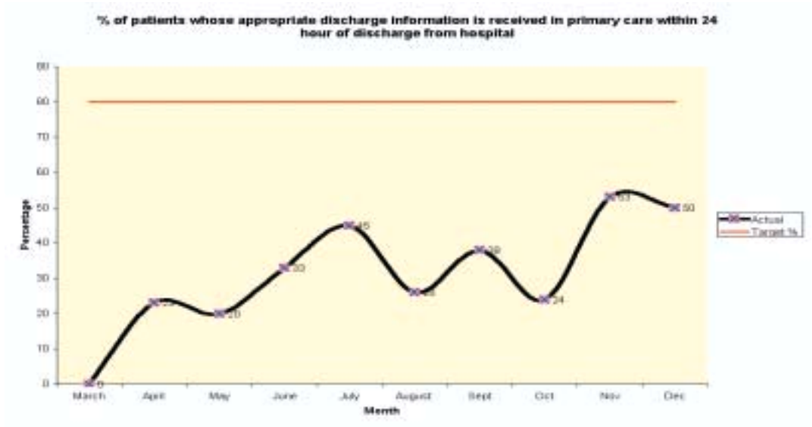
The new CHD interim discharge summary has been developed from the existing form, adapting it to include CHD information. This has avoided duplication of form filling. It has been developed to be user friendly, with tick boxes and acts as an "aide memoir" to help doctors ensure that patients are discharged on the recommended NSF Secondary Prevention medication.



The completed summary is typed into an existing electronic system, which is automatically faxed to Primary Care, if this is not received with 4 hours then it is automatically re-sent. The Trusts standard is 24 hours post discharge, this is audited on a regular basis. The summary is received in primary care in a free text format.

Although we have seen some progress this has been inhibited in slow processes in getting the form through the documentation committee and obtaining a costing due to its extra hand held copy for the patient. To date we are awaiting supplies from the printers however, continue to collect the data on a temporary A4 data collection sheet.

Marked improvement is anticipated on arrival of the new forms January 2002.



Patient and Carer Experience

Before

- Carers accompanying patients into the A&E department or CCU were requested to wait in the visitor's room. This was until Thrombolysis was initiated and the patient was stable.

After

- At the patient's choice, carers can remain with the patient, throughout their treatment and care.

Carer: "I was asked to wait in the waiting room, I was there for a long time, I imagined all sort of things"

Patient: "My wife had got up in the night to get indigestion pills, she held my hand and reassured me, I got really upset when they asked her to wait outside"

Dedicated teams of nurses both in CCU and the A&E department, are keen to make changes to meet the needs of both patients and carers, this for some individuals has required a complete change in practice. However, there has been a great understanding that the service, which is delivered, is under-pinned by the need of patients and carers.