

AUSTRALASIAN CARDIOVASCULAR NURSING COLLEGE

9th Annual Conference

ACNC 2015



Coogee Beach, Crowne Plaza

S y d n e y , A u s t r a l i a

Friday 13th March - Saturday 14th March, 2015

www.acnc.net.au





Attention. There will be photographs taken throughout the conference and at the social events. These may be used for promotional activities, including the ACNC website. If you do not want your photograph taken, or used, please notify the photographer at your earliest convenience.



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SPONSORS

We would like to thank our generous sponsors for their contribution to what will be a successful conference. Without them, we would not be able to provide you with a conference of this calibre at a reasonable registration rate. Please stop by their stands outside the meeting rooms.

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This year's clinical excellence award has been sponsored by the Heart Foundation and we are extremely proud to be working closely with this wonderful not for profit organisation.

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Oral presentations sponsor



This year's oral presentations has been sponsored by the Joanna Briggs Institute and we are pleased to announce our exciting new collaboration on the development of a Cardiovascular Nursing Care Node within JBI CO²NECT.

www.joannabriggs.org

PRESIDENT'S WELCOME 2015



On behalf of the ACNC executive, I would like to welcome you to our ninth conference, for nurses by nurses.

We are back in one of my favourite venues at Coogee Beach, Sydney. I am sure this year we will continue to showcase amazing professionals focused on cardiovascular health from Australasia. These people are involved in some fantastic work and I am humbled by the strength of the research, case studies and novel quality improvement initiatives we have received this year. I know how much hard work goes into preparing your work for this conference. All presenters, invited, academic and

clinical, from expert to novice, will present their work to you to stimulate discussion, improve your knowledge and skills, generate discussion amongst your networks and most of all, have a darn good time with us all in Sydney.

This year, we have an interesting and varied programme. We are especially pleased to welcome Professor Sabina De Geest, from the University of Basel in Switzerland. Sabina is a well-recognised and respected international researcher and her expertise lies in improving outcomes for transplant recipients. I am also very pleased to welcome home to Sydney a past president of the ACNC and one of Australia's well regarded cardiac nursing leaders. Professor Patricia Davidson left the shores of Sydney for the beauty of Baltimore Harbour in 2013. Trish is widely recognised as an influential nurse and I'm sure Sydney-siders will all welcome Trish home.

The ACNC committee have had a very busy time again this year we and will announce some new exciting initiatives. Please take the time to attend the AGM and be in to win one of the grand door prizes.

This year I am pleased to acknowledge the significant sponsorship the ACNC have received. Please take the time to visit the display stands, introduce yourself and welcome the sponsors. It is through the support of the sponsors and the extremely hard work of the committee that we can offer a quality conference experience with costs as low as possible for you, our members. You will recall from previous years, that ACNC do not use event organisers, which means your committee, give many hours of their leisure time to bring this high quality conference to you. This year we divided the event organisation between various sub-committees and each group have done a fantastic job producing an exciting event. We have attracted more sponsors than ever and have a scintillating social event that will have you dancing the light fandango to the wee small hours!

Thank you for your support and encouragement, the ACNC is nothing without your participation.

Enjoy ACNC 2015 and Sydney's spectacular coastline and we look forward to seeing you all again next year for ACNC 2016 in Melbourne.

Andy McLachlan
President
Australasian Cardiovascular Nursing College



ACKNOWLEDGEMENT OF COUNTRY

The Australasian Cardiovascular Nursing College acknowledge and pay respects to the traditional Aboriginal people of the Sydney, New South Wales and their descendants. We also acknowledge the many Aboriginal people from other regions as well as Torres Strait and South Sea Islander people who now live in the local area and have made an important contribution to the community. We thank the traditional custodians of the land upon which we meet, for providing access to this part of your country.



The Aboriginal people have always been a part of Sydney. The original Aboriginal inhabitants of the City of Sydney local area are the Gadigal people. The territory of the Gadi (gal) people stretched along the southern side of Port Jackson (Sydney Harbour) from South Head to around what is now known as Petersham. Their southern boundary is unclear.

There are about 29 clan groups of the Sydney metropolitan area referred to collectively as the Eora Nation. The 'Eora people' was the name given to the coastal Aboriginal peoples around Sydney. 'Eora' means 'here' or 'from this place'. The Gadigal are a clan of the Eora Nation.

Despite the destructive impact of first contact, Gadigal culture survived. As the town of Sydney developed into a city, the Gadigal were joined by other Aboriginal people from around NSW to live, work and forge relationships with the urban Aboriginal community.

Sydney's inner suburbs have long been a magnet for Aboriginal peoples seeking work opportunities, shelter and connections with community and family. The 'big smoke' provided work opportunities, shelter and reinforced community connections. **see page 53*



THE VENUE



The ACNC committee are pleased to host your ninth conference in the Crowne Plaza, Coogee Beach in Sydney.

Crowne Plaza Coogee Beach offers guests the best of both worlds with superior beachfront views and the city centre being just a short drive away.

The concierge at the hotel will happily provide you with assistance or recommendations for tours or sightseeing arrangements if you plan on having a holiday following the conference.

Wi-fi access

Code: ACNC

Car parking

Car parking is available for delegates attending the conference for \$18 per day and delegates staying overnight for \$25 per day. Contact the friendly concierge team.

Getting To & From

Hotel Address:

Crowne Plaza, Coogee Beach
242 Arden Street
Coogee, NSW, 2034

Phone [+61] 2 9315 7600

THERE ARE SEVERAL OPTIONS TO COOGEE BEACH, INCLUDING AND NOT LIMITED TO:

Directions from Sydney CBD via car

From the city, drive along Anzac Parade and turn left at Alison Road. Turn right when you reach Arden Street, and then turn right again when you reach Carr Street. Turn right into the hotel driveway. Drive directly into the undercover car park, collect a ticket and you will be greeted in the hotel foyer by the friendly concierge.

Directions from Sydney Airport via car

Drive towards the CBD on Southern Cross Drive, avoiding the Eastern Distributor. Turn right onto Alison Road (just past Moore Park Supa Centa). Continue on Alison Road and turn right onto Arden Street. Turn right again when you reach Carr Street, and then turn right into the hotel driveway.

Drive directly into our undercover car park, collect a ticket and you will be greeted in the hotel foyer by the friendly concierge.

By public transport from the city business district

State Transit Bus Services operate buses - number 372, 373, 374, M50 - regularly from Sydney Central Business District at regular intervals and terminate at Coogee Beach.

For more information on Sydney's Public Transport Systems visit <http://www.131500.info>

By public transport from the International & Domestic Airports

From Sydney Airport take the 400 service (Bondi Junction destination) and change to the 353 route at Eastgardens Shopping centre (7am to 7pm only). At other times an alternative is to take the 400 as above but change at Randwick shops to route 372 or 373 to Coogee.

For more information on Sydney's Public Transport Systems visit <http://www.131500.info>

From other major locations

From Bondi Junction Railway/Bus Exchange take the 353 (to Eastgardens) service.

Route 370 now in operation from Leichhardt to Coogee Beach – linking Coogee with the University of NSW, Sydney University, Prince of Wales Hospital & Sydney Children's Hospital Randwick, The Royal Prince Alfred Hospital Camperdown, and Green Square Railway Station (Airport to City Line).

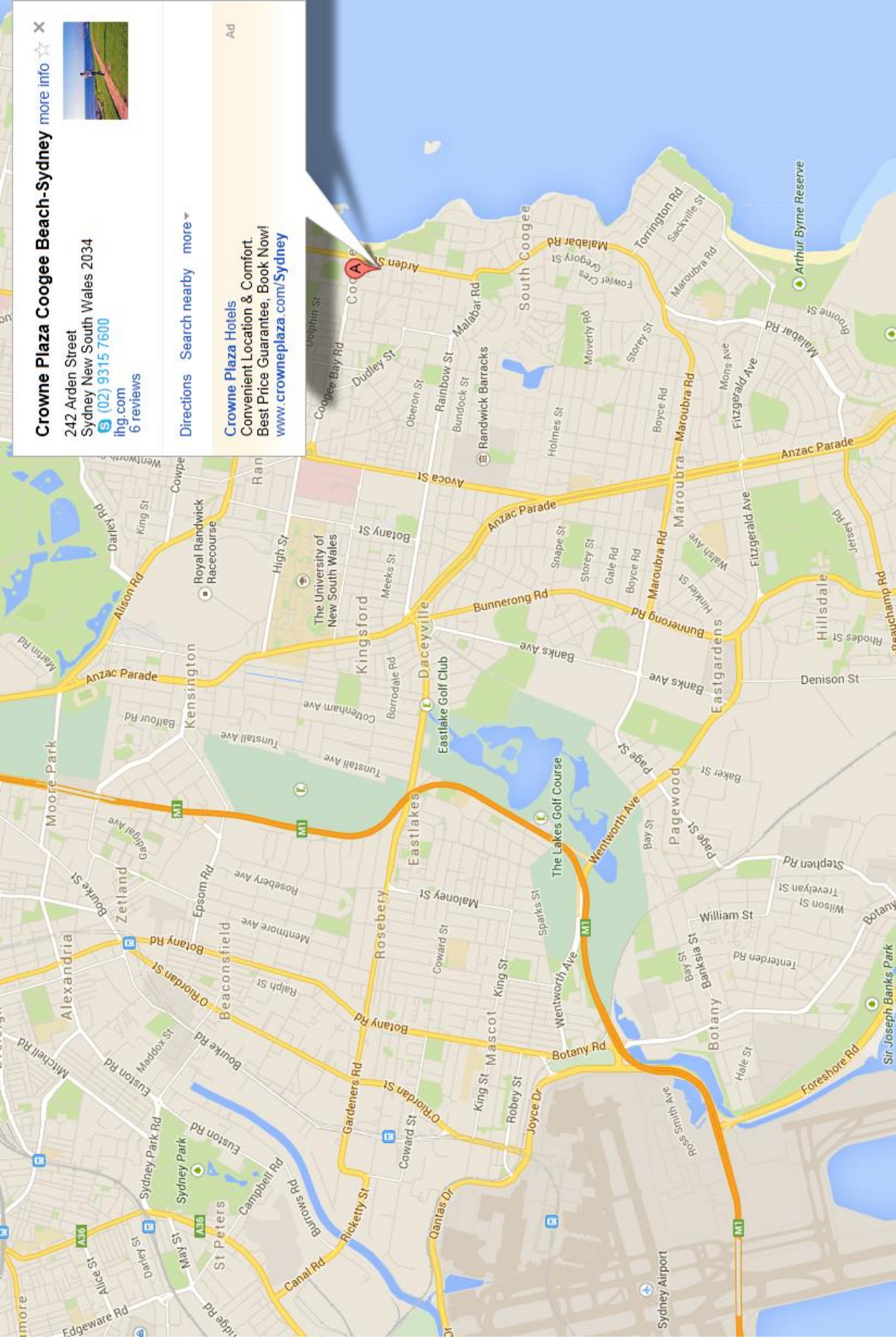
For more information on Sydney's Public Transport Systems visit <http://www.131500.info>

From Sydney International & Domestic Airport

Coogee is located 10 minutes by taxi from the airport domestic and international terminals or take the private shuttle bus services. There are many services provided by the various Hotels & Backpacker Hostels. The hotel concierge will advise you regarding travel times to destinations. Remember that peak hour traffic in Sydney will impact on travel times!

Sydney cabs – phone 13 33 00. *

Map of Crowne Plaza and Surrounds

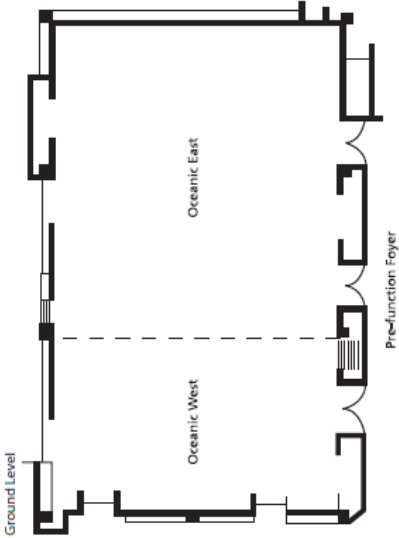


Crowne Plaza Meeting Rooms Plan

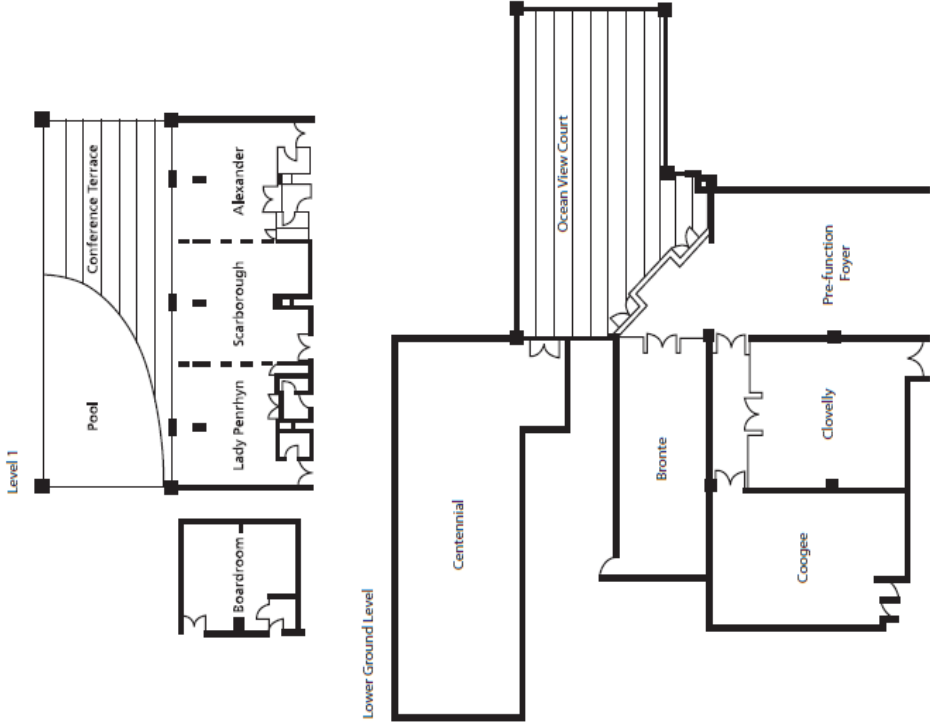
MEETING ROOM CONFIGURATIONS

ROOM	DIMENSIONS (m)	FLOOR AREA (m²)	DOOR (m)	CEILING HEIGHT (m)	CLASSROOM	THEATRE	BANQUET	BOARDROOM	COCKTAIL	U-SHAPE
Oceanic Ballroom	15 x 24	360	W 2.64 H 2.0	3.4	180	350	270	-	350	-
Oceanic East	15 x 15.2	228	W 2.64 H 2.0	3.4	120	180	150	60	180	60
Oceanic West	9 x 15	135	W 2.64 H 2.0	3.4	60	120	80	40	100	40
Centennial	7.5 x 15	112	W 1.8 H 2.3	3.5	50	100	80	40	100	40
Coogee	11 x 6.5	71.5	W 1.8 H 2.3	3.5	36	70	40	26	60	26
Clovelly	9 x 7.8	70.2	W 1.8 H 2.3	3.5	27	60	40	22	50	22
Bronte	12 x 5.5	66	W 1.8 H 2.3	3.5	36	50	40	27	50	27
Lady Penrhyn	8 x 7	56	W 1.6 H 2.0	2.4	18	30	30	16	30	15
Scarborough	8 x 7	56	W 1.6 H 2.0	2.4	21	30	30	16	30	15
Alexander	8 x 7	56	W 1.6 H 2.0	2.4	18	30	30	16	30	15
Lady Penrhyn + Scarborough + Alexander	23 x 8	184	W 1.6 H 2.0	2.4	70	100	100	45	100	45
Scarborough + Lady Penrhyn or Alexander	16 x 8	128	W 1.6 H 2.0	2.4	45	70	60	35	70	35
Boardroom	4.8 x 7.5	36	W 1.6 H 2.0	2.4	12	20	-	13	-	12

MEETING ROOM FLOOR PLANS



MEETING ROOM FLOOR PLANS



ACNC 2015



Day 1 | Friday 13th March 2015

0800 – 0900	Registration
0900 – 0915	Welcome to ACNC 2015: Mr Andy McLachlan (President ACNC) Welcome to Country: Uncle Chicka Madden
Plenary 1 0915 – 1045 Room: Oceanic East	Chairs: Mr Andy McLachlan and A/Professor Sally Inglis
0915 – 1000	Professor Sabina De Geest, University of Basel, Switzerland A multilevel perspective of health behaviour in transplantation: New insights into health care system and genomics research
1000 – 1045	Professor Jane Phillips, University of Technology, Sydney Integrating primary palliative care into cardiovascular care
1045 – 1115	Morning Tea
Plenary 2 1115 – 1240 Room: Oceanic East	Chairs: Dr Phillip Newton and Mr Ross Proctor
1115 – 1200	Professor Patricia Davidson, Johns Hopkins University, US Global perspectives of cardiovascular disease: the crucial role of nurses
1200 – 1230	Louise Moore and Sonya Cameron, Aboriginal Medical Service, Western Sydney Experiences and insights into the Aboriginal Medical Service Western Sydney
1230 – 1240	Opportunity for discussion and questions
1240 – 1330	Lunch
Plenary 3 1330 – 1355 Room: Oceanic East	Chairs: Ms Jacqueline (Jackie) Colgan and Ms Natasha Eaton
1330 – 1355	Ms Julie Parkinson, NUM Cardiac Angiography Unit, Gosford Hospital, NSW An evaluation of peripheral vascular access site complications following cardiac angiography and PCI

1400 – 1500	Submitted abstracts	
	Clinical case studies Chair: Jim McVeigh Room: Oceanic East	Acute care Chair: Jo Wu Room: Centennial (lower ground floor)
1400 – 1415	Elizabeth Fitzgerald & Elise Smith Exploring the patient experience and nursing challenges of a prolonged cardiac admission: a case study	Sarka Hartmannova Surgical site infection in a cardiothoracic perioperative environment
1415 – 1430	Melinda Davis & Rojina Chhetri An unusual presentation of Brugada Syndrome	Kyoungrim Kang Health-related quality of life in patients with myocardial infarction
1430 – 1445	Ross Proctor Methamphetamine associated cardiomyopathy	Lisa Kuhn Association of gender with decreased treatment and increased mortality for patients admitted with ST-segment elevation myocardial infarction in Victoria
1445 – 1500	Kathryn Tonini A heartless heart- the battle against giant cell myocarditis: A case study	Megan Higgs Computerised insulin dosing calculators for the management of continuous insulin infusions after cardiac surgery: a systematic review and meta-analysis
1500 – 1510	Opportunity for discussion and questions	
1510 – 1530	Afternoon tea	
Plenary 4 1530 – 1640 Room: Oceanic East	Chairs: Ms Maria Sheehan and Ms Snez Stolic	
1530 – 1600	Dr Sasha Bennett, Executive Officer, New South Wales Therapeutic Advisory Group Inc. The quality use of medicines in cardiovascular patients discharged from hospital: how are we doing?	
1600 – 1630	Professor Robyn Gallagher, University of Sydney Health literacy in cardiac patients – Do they hear what you say?	
1630 – 1640	Opportunity for discussion and questions	
1640 – 1715	AGM Room: Oceanic East	
1715 – 1800	Treat your heart – enjoy a beach walk. Meet Natasha in the lobby (optional activity)	
1900	CONFERENCE DINNER - SPONSORED BY NOVARTIS Location: Oceanic East	

ACNC 2015

Day 2 | Saturday 14th March 2015



0800 – 0900	Registration
Plenary 1 0845 – 1015 Room: Oceanic East	Chairs: Dr Phillip Newton and Ms Margaret Lucas
0845 – 0930	Professor Sabina De Geest, University of Basel, Switzerland Benchmarking Australian heart transplant patients' health behaviours and heart transplant centres practice patterns in an international context: The BRIGHT Study.
0930 – 1015	Professor Peter Macdonald, St Vincent's Hospital, Sydney & Victor Chang Cardiac Research Institute How do you mend a donor heart?
1015 – 1045	Morning Tea
Plenary 2 1045 – 1225 Room: Oceanic East	Chairs: Ms Karen Sanders and Ms Sophie Rayner
1045 – 1115	Ms Julie Parkinson, Gosford Hospital, NSW Reflections from the Cath Lab on pre-hospital thrombolysis for STEMI's
1115 – 1145	A/Professor Andrew Jabbour, St Vincent's Hospital, Sydney Cardiovascular imaging 2015 and beyond
1145 – 1215	Ms Natasha Eaton, Cardiac CNC Redcliffe Hospital ACS Clinical care standards
1215 – 1225	Opportunity for discussion and questions
1225 – 1315	Lunch
Plenary 3 1315 – 1425 Room: Oceanic East	Chairs: Dr Jo Wu and Mr Caleb Ferguson
1315 – 1345	Professor Patricia Davidson, Johns Hopkins University, Baltimore, US Perspectives on being Dean of the School of Nursing at Johns Hopkins University, Baltimore US
1345 – 1415	Dr Carolyn Astley, SA Cardiac Clinical Network and Flinders University, Adelaide Improving cardiovascular nurse-led health services: advocating for clinical advanced practice and nurse practitioner roles
1415 – 1425	Panel Discussion International perspectives on cardiovascular nursing into the future Professor Patricia Davidson, Professor Sabina De Geest and Dr Carolyn Astley

1430 – 1515	Submitted abstracts	
	Heart Failure Chair: Maria Sheehan Room: Oceanic East	Education & Practice Chair: Jackie Colgan Room: Centennial (lower ground level)
1430 – 1445	Louise Hickman Feasibility of the Montreal cognitive assessment tool as a rapid screening instrument for early identification of mild cognitive impairment in an older heart failure population group	Caleb Ferguson Education and practice gaps on atrial fibrillation and anticoagulation: A survey of cardiovascular nurses
1445 – 1500	Hiba Deek Family focused Approach to iMprove Heart Failure care In Lebanon Quality (FAMILY) Intervention: Block randomized controlled trial for implementing an education family session	Annabel Hickey What's new on HEART Online for cardiovascular nursing?
1500 – 1515	Aaron Conway Pilot testing a model of psychological care for heart transplant recipients	Narelle Berry Trends in the prevalence of sufficient physical activity among South Australian adults, stratified by income level: 1998-2010 Perceived
1515 – 1530	Afternoon Tea	
1530 – 1600	Award Presentations and Conference close Room: Oceanic East	

KEYNOTE SPEAKERS

Professor Sabina De Geest

Sabina De Geest is a Professor of Nursing and Director of the Institute of Nursing Science and Chair of the Department of Public Health of the Faculty of Medicine at the University of Basel, Switzerland. She has several adjunct appointments at Schools of Nursing in the US (e.g. Johns Hopkins University) as well as the University of Technology, Sydney, Australia. Sabina De Geest leads the Leuven Basel Adherence Research Group, an international, interdisciplinary research group focusing on behavioural and psychosocial issues, with the ultimate goal of improving clinical outcomes in chronically ill patient populations (e.g., solid organ & stem cell transplantation). Projects currently conducted in Europe, Australia and North- & South-America focus on the prevalence, determinants and consequences (both clinical and economic) of non-adherence to medication regimens, and on testing the efficacy of adherence enhancing interventions, recently also including interactive health technology. Over time, the research group has expanded her focus to include assessment of the predictive value of pre-transplant psychosocial and behavioural factors regarding post-transplant outcomes, and the development and testing of instruments to assess patient reported outcomes.



Currently the PI of three research projects, Sabina De Geest also chairs the Psychosocial Interest Group of the Swiss Transplant Cohort Study, a nation-wide cohort study which started in May 2008. She also heads the BRIGHT initiative, an international study exploring the practice patterns, health behaviours and the relationship between system factors and medication adherence in transplant recipients, which is conducted in 4 continents, 12 countries and 43 heart transplant centres. Her research has been published in leading interdisciplinary journals. She is co-editor of the Journal of Nursing Scholarship and serves on the editorial board of Paediatric Transplantation, Progress in Transplantation, BioMed Central – Nursing, the European Journal of Cardiovascular Nursing, International Journal of Care Coordination, Progress in Cardiovascular Nursing, and the International Journal of Health Policy. She was inducted as a Fellow of the Royal College of Nursing in 2004, as a Fellow of the American Academy of Nursing in 2006, as member of the Swiss Academy of Medical Sciences in 2008 and as fellow of the European Academy of Nursing Science in 2012.

Professor Patricia Davidson

Patricia Davidson, PhD, MEd, RN, FAAN, is the Dean of Johns Hopkins University School of Nursing. A former Director of the Centre for Cardiovascular and Chronic Care at the University of Technology Sydney (Australia) and Professor of Cardiovascular Nursing Research at St. Vincent's Hospital, Sydney; Professor Davidson has an established program of research in supporting individuals living with chronic conditions and developing innovative models of transitional care. A primary objective of her work has been to improve the cardiovascular health of underserved populations through development of innovative, acceptable, and sustainable initiatives within Australia and beyond. She is a Fellow of the Australian College of Nursing, the American Heart Association, the Preventive Cardiovascular Nurses Association, and the American Academy of Nursing. She is Counsel General of the International Council on Women's Health Issues and actively involved in the international activities of Sigma Theta Tau International. Since 2003, Dr. Davidson has supervised and mentored more than 33 researchers and currently is an editor of *Collegian* and the *International Journal of Nursing Studies*, and is on the editorial boards of a number of other journals including the *European Journal of Cardiovascular Nursing*, *Circulation: Cardiovascular Quality and Outcomes*, *Heart Lung and Circulation*, and the *Journal of Cardiovascular Nursing*. She has secured over \$8 million in competitive research funding from national and international funding bodies, and co-authored 290-plus peer-reviewed journal articles, 18 book chapters, and more than 70 peer-reviewed abstracts.



Professor Peter Macdonald

Professor Peter Macdonald is Conjoint Professor of Medicine in the University of New South Wales, senior staff Cardiologist in the Cardiopulmonary Transplant Unit at St Vincent's Hospital, Sydney and co-head of the Transplantation Research Laboratory at the Victor Chang Cardiac Research Institute. Major research interests over the last 20 years have been in the areas of heart failure, pulmonary hypertension, transplant allograft rejection, donor management and organ preservation injury. Professor Macdonald has established a basic research laboratory at the Victor Chang Institute, which has developed a variety of in vitro and in vivo small and large animal models in order to investigate these areas. He has been involved in multiple clinical studies with the major focus being the translation of laboratory findings into clinical practice.



Professor Macdonald is a senior member of the cardiothoracic transplant program at St Vincent's Hospital, which is the largest cardiothoracic program in Australia and regarded as a leading transplant program internationally. His expertise in the management of critically ill patients undergoing cardiopulmonary transplantation has helped him to play a critical role in the development of a highly successful mechanical assistance program for patients with advanced heart failure.

Associate Professor Andrew Jabbour

Associate Professor Andrew Jabbour is a Consultant Cardiologist at St Vincent's Hospital, Sydney, and a conjoint Associate Professor of Medicine with the University of New South Wales. After completing cardiology training at St Vincent's, Dr Jabbour undertook a PhD at the Victor Chang Cardiac Research Institute before moving to the United Kingdom to work at The Royal Brompton Hospital and Imperial College London. In his years overseas Dr Jabbour gained further expertise in advanced cardiovascular imaging. At the world's largest and most established Cardiac MRI unit, he also conducted research with a particular focus on cardiomyopathy (from coronary artery disease and genetic causes), hypertension, valvular heart disease, and rarer infiltrative disorders such as cardiac amyloidosis and sarcoidosis. This work has been published in the highest ranking medical journals, including the Journal of the American College of Cardiology, The Lancet and JAMA. He has received numerous awards for his work including the University of New South Wales Foundation Year Graduates Medal, the Transplantation Society of Australia and New Zealand President's Prize, and a prestigious National Health and Medical Research Council of Australia Neil Hamilton-Fairley Postdoctoral Clinical Research Fellowship. Dr Jabbour is a member of the Heart Transplantation Team at St Vincent's Hospital. He also works as a general cardiologist, travelling with New South Wales Royal Flying Doctors Service (Rural Doctors Network). He has a keen interest in radiation-free cardiac imaging and runs a weekly Cardiac MRI session at St Vincent's Hospital.



Dr Sasha Bennett

Sasha Bennett is a pharmacist with experience in hospital and community clinical practice. Her PhD investigated the significance of a neurohormonal and multidisciplinary approach to the optimal management of heart failure. She currently holds a leadership role in NSW facilitating and advising on the quality use of medicines in NSW hospitals. She has a keen interest in the chronic management of cardiovascular diseases and is the pharmacist for the cardiac rehabilitation program at St Vincent's Hospital, Sydney. Sasha is also accredited to perform Home Medicines Reviews.



Ms Julie Parkinson

Julie Parkinson began her nursing career in 1986 at Kuring-gai College in Lindfield Sydney, the second year after nursing training moved from hospitals to Universities... a time where nurses found themselves having to defend the move into universities. Later upgrading to a degree at the University of Sydney, postgraduate qualifications in Cardiothoracic Nursing at UTS, an MPH at UNSW and returning to Sydney University to undertake a Masters in Philosophy (Nursing)... you could say the thirst for learning never ceases.



Julie's career has focused on a love for Cardiac Nursing originating at Gosford Hospital, with her last 12 years working in Cardiac Cath Labs – a career highlight included commissioning 3 new Cath Labs at a 1400 bed hospital in Riyadh, Saudi Arabia from 2005-7.

As part of the new Cath Lab service at Gosford Hospital in 2002, Julie commenced a QI project looking at what she thought was a higher incidence of complications following coronary angiography and PCI procedures. While the audit reassured the team that complication rates were within the normal rates published in the literature, the QI project eventually lead to a more formal study in 2007 and still goes on. The results of this study were presented at EuroPCR in Paris, in May 2014, and won the Nurses and Technicians Best Abstract Award, as well as Third Best Abstract overall. This was a huge achievement considering that there were 1052 submissions from 55 Countries of which 417 were selected as Oral Presentations.

Dr Carolyn Astley

Carolyn is the Network Development Manager for the SA Cardiac Clinical Network, Senior lecturer, School of Medicine, Flinders University and a director on the board of the Southern Adelaide, Fleurieu, Kangaroo Island Medicare Local (SAFKIML). She has research investigator roles in acute cardiac health services. Carolyn's work in cardiology has spanned more than 20 years ranging from clinical cardiac nursing, a research coordinator in cardiac clinical trials, manager of a Cardiovascular Outcomes research unit and Cardiac Clinical effectiveness manager at the Flinders Medical Centre. She has had previous professional leadership roles as a director on the Cardiac Society (CSANZ) board and inaugural chair of the CSANZ Cardiovascular nurses council.



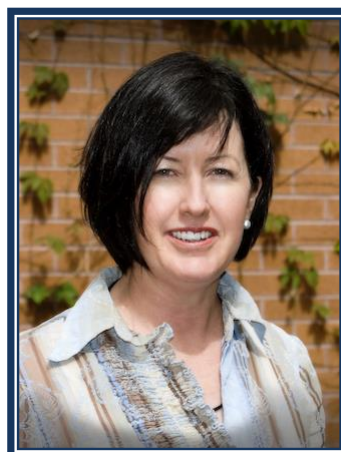
Professor Robyn Gallagher

Dr Robyn Gallagher is Professor of Nursing at the Charles Perkins Centre at the University of Sydney. The focus of Dr Gallagher's nursing career has been the support of cardiac patients as a clinician, educator, academic and researcher. Her PhD was completed in 2001 and involved testing a telephone intervention to support women recovering from cardiac events in a randomised controlled trial. Since this time her research focus has been self-management for cardiac events, including recovery and secondary risk factor prevention and more recently included nurses' health. In 2012, Robyn was awarded the Cardiac Society of Australia and New Zealand Nursing Affiliate Research Prize and the American Heart Association Council of Cardiovascular Nursing Research Article of the Year Award and the Australian Cardiovascular Health and Rehabilitation Association Award for Best Exercise and Physical Activity paper in 2013 and in 2014 she was made a Fellow of the American Heart Association. She has published nine book chapters, more than 70 peer-reviewed papers and presented her research at international conferences including the European Society of Cardiology, World Congress of Cardiology and American Heart Association Scientific Sessions. She has supervised 12 research students to completion and has been awarded a teaching and learning award for postgraduate research student supervision in 2011. Robyn is currently Chair of Cardiovascular Nursing Council of the Cardiac Society of Australia and New Zealand and on the Executive Committee of the Australian Cardiovascular Health and Rehabilitation Association



Professor Jane Phillips

Professor Jane Phillips is the Director of the Centre for Cardiovascular and Chronic Care and Professor Nursing (Palliative Care) at UTS. She has an in-depth understanding of palliative care and experience in delivering best-evidenced based palliative care across diverse settings, including rural and regional Australia and considerable expertise in leading and evaluating complex, health service reforms. Jane has led a number of major cancer and palliative care reform initiatives, at the local and national levels. She has the capacity to navigate the complex interplay between the clinical, research, policy and professional environments. Jane graduated from the University of Western Sydney with a PhD in 2008. She holds a Bachelor of Science – Nursing and a post-graduate Diploma in Health Promotion from Curtin University, Western Australia. In 2005, she completed the “Program in Palliative Care Education and Practice” at Harvard Medical School in Boston. She is currently an Editor of ‘Collegian’ the Australian Journal of Nursing and on the Editorial Board of the International Journal of Palliative Nursing. In late 2013, she co-edited a special issue on Geriatric Oncology for the ‘Cancer Forum’ Journal. She is a member of the Palliative Care Nurses Australia national committee and holds an honorary clinical appointment at Sacred Heart Hospice and St Vincent's Hospital, Sydney.



Ms Sonya Cameron and Ms Louise Moore**The Aboriginal Medical Service Western Sydney**

The Aboriginal Medical Service Western Sydney (AMSWS) was established in 1987 to provide wholistic comprehensive primary health care to the Aboriginal community of Western Sydney. AMSWS is approximately 40km from Sydney and is located within the Deerubbin Local Aboriginal Land Council area which covers 3,602 km from the east-west: Auburn/Lithgow to the north-south: Windsor/Liverpool. According to the 2006 ABS Census, this area has an Aboriginal and Torres Strait Islander population of 17,137, making it the highest urban population of Aboriginal and Torres Strait Islander people in Australia.

The Aboriginal Medical Service Western Sydney identifies its purpose as: 'Sovereign Aboriginal Peoples with a state of wellbeing, consistent with our wholistic concept of health, at least equal to that which existed prior to invasion and colonisation, enjoying all the rights and responsibilities inherent in our unceded sovereignty.'

Louise Moore is an Aboriginal Healthworker at the Aboriginal Medical Service Western Sydney.

Sonya Cameron is a Chronic Care nurse in the Chronic Care Team at the Aboriginal Medical Service Western Sydney.

ABSTRACTS – ORAL 1-14

1 Higgs, MH¹ & Fernandez, R²

1 St George Hospital, Sydney, Australia, 2 St George Hospital, Sydney, Australia and University of Wollongong, Wollongong, Australia

Computerised insulin dosing calculators for the management of continuous insulin infusions after cardiac surgery: a systematic review and meta-analysis

Background: Hyperglycaemia, a perioperative complication that occurs almost universally in cardiac surgery patients, can be detrimental during the post-operative period if untreated or treated inadequately (1, 2). Peak bodies therefore recommend the administration of continuous intravenous (IV) insulin infusions for the treatment of hyperglycaemia during the initial post-operative phase (3, 4).

Purpose: To determine the safety and efficiency of the use computerised insulin dosing calculators, after cardiac surgery, to manage continuous IV insulin infusions in comparison to the paper nomogram method.

Methods: A systematic review of clinical trials published in the English language up to March 2014 was undertaken as per a pre-determined protocol.

Results: Six clinical trials were included in the final review. Pooled data demonstrated significant improvements in mean blood glucose levels (MD -23.74, 95 % CI: -24.45, -23.02), $p < 0.00001$ and time (hours) to reach target blood glucose range (MD -1.00, 95% CI: -1.43,-0.57), $p < 0.00001$ among the computer calculator groups in comparison to the paper nomogram groups. Three out of four studies that reported on time spent within the target blood glucose range demonstrated a statistically significant higher percentage of time within the target range in the computer calculator groups, with one study reporting no difference between groups. Two studies that investigated the outcome hyperglycaemia had significantly lower reports of hyperglycaemia amongst the computer calculator groups. All six studies reported on hypoglycaemia. Pooled data from two studies demonstrated significantly lower rates of hypoglycaemia among the computer calculator groups (OR .038, 95% CI: 0.16-0.90), $p = 0.03$. Of the remaining studies, one had lower reports of hypoglycaemia in the computer calculator group while two had higher reports and one demonstrated no difference between groups.

Conclusion: The computerised insulin dosing calculator method for the management of continuous IV insulin infusions is both safe and efficient, achieving optimal glycaemic control without significantly increasing the risk for hypoglycaemia.

2 Kuhn, L¹, Page, K², Rahman, MA³ & Worrall-Carter, L⁴

1 Deakin University – Eastern Health Nursing & Midwifery Research Centre – Deakin University, Melbourne, Australia, 2 Heart Foundation of Australia, Melbourne, Australia, 3 St Vincent's Centre for Nursing Research – ACU, Melbourne, Australia, 4 St Vincent's Centre for Nursing Research – ACU, Melbourne, Australia

Association of gender with decreased treatment and increased mortality for patients admitted with ST- segment elevation myocardial infarction in Victoria

Background: Death from ST-segment elevation myocardial infarction (STEMI) is avoidable with early reperfusion therapy. International studies report inequity in treatment provision and mortality for women with STEMI compared to men. These differences have not been investigated in an Australian population.

Purpose: To determine whether patient sex and age were associated with variation in reperfusion therapy or increased inhospital mortality in patients with STEMI in Victorian emergency departments (EDs).

Methods: We undertook retrospective analyses on a government database for patients admitted to Victorian hospitals with STEMI during 2005-10. Patients were analysed according to sex and age (<65 or ≥65 years).

Results: Women were less likely to receive angioplasty with stent and were more likely to receive no reperfusion therapy than men in corresponding younger and older age groups ($p=0.006$ and $p<0.001$, respectively). Overall, women in both age groups were more likely to die inhospital than men from equivalent age groups with STEMI ($p<0.001$, both groups).

Conclusions: Maximising treatment for patients with STEMI saves lives. Consistent with findings from international studies, women in Victoria were less likely to receive treatment for STEMI and were more likely to die during admission than men. Further research needs to verify the findings and causes, and guide future research to ensure application of equitable treatment to both sexes.

3 Hickman LD¹, Phillips JL¹, Newton, P¹ & Davidson PM²

1 University of Technology, Sydney, 2 Johns Hopkins University, USA

Feasibility of the Montreal cognitive assessment tool as a rapid screening instrument for early identification of mild cognitive impairment in an older heart failure population group

Heart failure is associated with an increased risk of dementia and Alzheimer disease in older adults. The Montreal Cognitive Assessment Tool (MoCA) has been shown to be more sensitive than the Mini Mental State Examination for the detection of Mild cognitive impairment and mild Alzheimer's disease in the general population. Assessing cognitive competence and translation of this information into a tailored targeting person centred care package is essential for self-management and improvement of care. Significantly, many of the criticisms of patients and their families relate to the failure of individual clinicians and systems to translate and provide appropriate information and resources to communicate effectively. Currently there is minimal data supporting the use of cognitive assessment tools in the older HF population group. We are currently undertaking a study to explore the feasibility of using the Montreal Cognitive Assessment in a recently hospitalised older heart failure population. Early identification allows for strategies to put in place to avoid hospitalisation, promotes consumer choice and individual autonomy, decrease risk of falls, drug interactions and iatrogenesis. This presentation presents preliminary data ($n=180$) on the feasibility of cognitive screening and the implications for health care professionals.

4 Kang, K¹, Gholizadeh, L¹, Inglis, S¹ & Han, H²

1 University of Technology, Sydney, 2 Johns Hopkins University School of Nursing

Health-related quality of life in patients with myocardial infarction

Background: Health-related quality of life (HRQOL) is a multidimensional concept that encompasses self-reported measures of physical and mental health. It is often adversely affected in patients with chronic diseases including cardiovascular diseases. As a serious consequence of coronary artery disease, myocardial infarction (MI), is often associated with lower HRQOL.

Purpose: This study aimed to review the past evidence on the health-related quality of life (HRQOL) of patients with myocardial infarction (MI) and to identify strategies that have been reported to be effective in enhancing the quality of life in this patient population.

Methods: Online databases including CINAHL, Medline, and Google Scholar search engine were searched using terms 'health-related quality of life/quality of life/HRQOL/QOL' and 'myocardial infarction/heart attack/MI'. The search was limited to articles published in English between 1989 and May 2014. We screened title and abstract of the retrieved articles for studies that reported quality of life data and/or examined effectiveness of a particular intervention in patients with MI.

Results: A total of 65 articles met the criteria for inclusion in the review. The findings of the review suggest that patients with MI score their HRQOL lower in the short term after the event, although HRQOL is likely to recover over time if the patients do not have symptoms of fatigue and depression and their self-efficacy is high. Cardiac rehabilitation programmes, including home-based cardiac rehabilitation, a regular weekly aerobic training programme, and group counselling have shown promising results to improve HRQOL of patients with MI.

Conclusions: In conclusion, patients with MI should be encouraged to participate in programmes that can help promote their QOL. Future research is needed to examine factors that affect HRQOL in MI patients in the long-term.

5 Fitzgerald, EB¹ & Smith, E²

1 Clinical Nurse Specialist, Prince of Wales Hospital, 2 Registered Nurse, Prince of Wales Hospital

Exploring the patient experience and nursing challenges of a prolonged cardiac admission: a case study

In a busy cardiology ward with a high turnover of patients, the unique psychological and social needs of patients staying for a prolonged period are not always examined. This presentation investigates the patient experience of a lengthy admission in a cardiology unit and challenges in nursing this patient population. The case study explores the experience of a patient admitted for 73 days with a diagnosis of infective endocarditis. Further analysis of patients with prolonged cardiac admissions is obtained through a patient survey. The challenges of nursing this patient population are examined with the results from a staff survey. By presenting this case study and the results of our survey, we hope to gain insight from patient's perspective of hospitalization and reflect on our nursing practices.

6 Berry NM¹, Smith M² & Dollman J³

1 School of Nursing and Midwifery, Flinders University, South Australia, 2 National Heart Foundation, South Australia, Australia, 3 School of Health Sciences, University of South Australia, South Australia

Trends in the prevalence of sufficient physical activity among South Australian adults, stratified by income level: 1998-2010

Background: It is well established that increased physical activity participation has benefits for cardiovascular health. Lower levels of habitual physical activity are consistently seen among adults of low socioeconomic position, placing them at a greater burden of developing future chronic disease.

Purpose: This study examined trends in self-reported physical activity among South Australian adults from the highest and lowest categories of annual household income, between 1998 and 2010.

Methods: The South Australian Physical Activity Survey has been conducted every three years since 1998, with approximately 3000 respondents per survey. The questionnaire is administered by computer assisted telephone interview. Telephone numbers are randomly selected from the Adelaide metropolitan and country Electronic White Pages listings. Within households, the person ≥18 years with the most recent birthday was selected for interview. Respondents were defined as sufficiently active if they reports ≥150 minutes per week of walking, moderate or vigorous exercise, with vigorous activity doubled to account for its additional health benefits. Low and high annual household income categories were defined as <\$20,000 (20% of the sample in 1998 to 10% in 2010) and ≥\$60,000 (18% of sample in 1998 to 44% in 2010), respectively.

Results: in the whole sample, the prevalence of sufficient physical activity rose from 49.7% in 1998 to 60.1% in 2010. In the lowest income category, the prevalence fell from 46.1% in 1998 to 67.1% in 2010, with the trajectory steady at approximately 1.0-1.5% per year between 1998 and 2007, and little change between 2007 and 2010.

Conclusions: The widening socioeconomic disparity in regular physical activity among adult South Australians is an urgent public health concern. Interventions and policies designed to promote physical activity are not reaching those at highest risk of overweight and chronic disease.

7 Deek, H¹, Newton, PJ², Inglis, SC³, Nouredine, S⁴, Macdonald, PS⁵ & Davidson PM⁶

1 University of Technology Sydney- Centre for Cardiovascular and Chronic Care, 2 University of Technology Sydney- Centre for Cardiovascular and Chronic Care, 3 University of Technology Sydney- Centre for Cardiovascular and Chronic Care, 4 American University of Beirut- Hariri School of Nursing, 5 St Vincent Hospital/ University of New South Wales, 6 Johns Hopkins School of Nursing

Family focused Approach to iMprove Heart Failure care In Lebanon QualityY (FAMILY) Intervention: Block randomized controlled trial for implementing an education family session

Introduction: Heart failure is a complex condition with high demands for self-management and impacts on the family unit. Addressing family dynamics through a focussed caregiver intervention is a novel culturally tailored approach in the Lebanese context.

Aim: This study assessed the effect of a culturally appropriate, nurse-led educational conference on heart failure health-related outcomes through specifically involving the family in self-care.

Methods: The FAMILY project was a multi-site; block randomised controlled trial conducted over a 12-month period in Lebanon. The primary endpoint was 30 day readmission, and the secondary endpoints were emergency department presentation, quality of life, self-care, health care utilization

and major vascular events. Participants with limited life expectancy, pending major cardiac surgery with limited functionality, living alone or in nursing homes or aged less than 18 years were excluded. A total of 256 patients were randomised into a usual care (130 patients) and an intervention (126 patients) group.

Results: A total of 218 (85%) were available for analysis. Readmission rate was 13.76% (n=30) which was significantly different between the intervention and the usual care group [n=10 (33%) vs. n=20 (67%), $p<0.05$ respectively]. Self-care scores were low in both groups at baseline, self-care items improved across the three scores in the intervention group with significance in the maintenance and the confidence scales only.

Conclusion: Involving the family in self-care of heart failure is a novel approach. To our knowledge no one has studied this approach on this selected patient group. Further, this is the first trial conducted in Lebanon on patients with heart failure, which is appropriate in a collectivist culture where the family is involved in many aspects of patients' lives.

8 Conway, A¹, Sheridan, J², Maddicks-Law, J³, Fulbrook, P⁴ & Yates, P⁵

1 Queensland University of Technology, 2 Queensland University of Technology, 3 The Prince Charles Hospital, 4 The Prince Charles Hospital, 5 Queensland University of Technology

Pilot testing a model of psychological care for heart transplant recipients

Background: Insufficient evidence is available regarding the effectiveness of interventions in improving psychological well-being after heart transplant.

Aims: The aim of this study was to test the feasibility of nurse-led screening for anxiety and depression in heart transplant recipients followed by referral for a course of telephone-delivered cognitive behaviour therapy (CBT). A secondary aim was to determine the validity of screening tools.

Methods: A pilot randomised controlled trial was conducted. Participants first completed screening tools (PHQ-9, GAD-7 and K10) as well as a structured psychological interview. Participants who reported at least mild symptoms of anxiety, depression or psychological distress were randomised. The intervention group was offered a course of telephone-delivered CBT.

Results: A total of 129 heart transplant recipients were assessed. 124 (96%) met eligibility criteria. Of these, 89 (72%) provided consent for participation. At a cut-off score of 5, the GAD 7 had a sensitivity of 0.80 and specificity of 0.93 for detecting any anxiety disorder. At a cut-off score of 5, the PHQ-9 had a sensitivity of 0.88 and a specificity of 0.8 for detecting depression. 13 (15%) participants were randomized. Two (33%) completed the entire course of CBT and both were symptom free at 2 months. All participants who declined CBT (n=4; 67%) still had symptoms at 2 months. Four (57%) of the seven control group participants still experienced symptoms at 2 months.

Conclusion: The PHQ-9 and GAD-7 are valid screening tools to detect psychopathology in heart transplant recipients. Not all heart transplant recipients who might benefit from CBT will accept a telephone-delivered intervention. While a larger trial would be required for confirmation, it appears that in line with evidence from other populations, heart transplant recipients who are willing to take part in counselling over the telephone should expect that their psychological well-being will likely improve.

9 Ferguson, C¹, Inglis, SC², Newton, PJ³, Middleton, S⁴, Macdonald, PS⁵ & Davidson, PM^{6,7}

1 Centre for Cardiovascular & Chronic Care, University of Technology, Sydney, 2 Centre for Cardiovascular & Chronic Care, University of Technology, Sydney, 3 Centre for Cardiovascular & Chronic Care, University of Technology, Sydney, 4 Nursing Research Institute, Australian Catholic University & St Vincents Hospital, Sydney, St Vincents Health Sydney, Australia, 5 St Vincents Hospital, Sydney. Victor Chang Cardiac Research Institute, University of New South Wales, 6 Centre for Cardiovascular & Chronic Care, University of Technology, Sydney, 7 School of Nursing, Johns Hopkins University, Baltimore, Maryland, USA.

Education and practice gaps on atrial fibrillation and anticoagulation: A survey of cardiovascular nurses

Background: Patients' knowledge of their atrial fibrillation (AF) and anticoagulation therapy are determinants of the efficacy of thromboprophylaxis. Nurses are well-placed to provide counselling and education to patients on all aspects of anticoagulation, including self-management. Current practice and knowledge of cardiovascular nurses on AF and anticoagulation in the Australian and New Zealand (ANZ) context is not well reported.

Aims: This study aimed to; 1) Explore the nurse's role in clinical decision making in anticoagulation in the setting of AF; 2) Describe perceived barriers and enablers to anticoagulation in AF; 3) Investigate practice patterns in the management of anticoagulation in the ANZ setting; 4) Assess cardiovascular nurses' knowledge of anticoagulation.

Methods: A paper-based survey on current practices and knowledge of AF and anticoagulation was distributed during the Australian Cardiovascular Nursing College (ACNC) Annual Scientific Meeting, February 2014. This survey was also emailed to nursing members of the Cardiac Society of Australia and New Zealand (CSANZ) and Cardiovascular Trials Nurses throughout New South Wales, Australia.

Results: There were 42/73 (58%) respondents to the paper-based survey. A further 13 surveys were completed online via nurse members of the CSANZ, and via an investigator developed NSW cardiovascular trials nurse email distribution list. A total of 55 surveys were completed and included in analyses. Prior education levels on AF, stroke risk, anticoagulation and health behaviour modification were mixed. The CHA₂DS₂-VASc and HAS-BLED risk stratification tools were reported to be underused by this group of clinicians. Reported key barriers to anticoagulation included; fears of patients falling, fears of poor adherence to medication taking and routine monitoring. Patient self-monitoring and self-management were reported as underutilised. ANZ cardiovascular nurses reported their key role to be counselling and advising patients on therapy regimens. Anticoagulant-drug interaction knowledge was generally poor.

Conclusion: This study identified poor knowledge and practice in the areas of AF and anticoagulation. There is scope for improvement for cardiovascular nurses in ANZ in relation to AF and anticoagulation knowledge and practice.

10 Davis MA¹ & Chetri R¹

1 Royal North Shore Hospital Sydney

An unusual presentation of Brugada Syndrome

Since Brugada Syndrome was first described in 1992 its recognition has increased significantly. However it remains a rare presentation that is not well understood by many clinicians. This case study of a young male with an atypical presentation will be used to explore the pathophysiology, ECG findings and management of Brugada Syndrome. A 32 year male two days after arrival to Australia from China presented to the emergency department with marked tachycardia requiring electrical cardioversion. The clinical challenge was to gather the patient's medical history from China to piece together a differential diagnosis in the setting of equivocal ECGs.

11 Hickey, A¹, Adsett, J², Foreman, R³ & Page, K⁴

1 The Prince Charles Hospital, Queensland, 2 Royal Brisbane and Women's Hospital, Queensland,
3 The National Heart Foundation of Australia, 4 The National Heart Foundation of Australia

What's new on HEART Online for cardiovascular nursing?

Background: Health care clinicians find it difficult to easily access evidence based resources to support the management of patients with cardiovascular disease. Nurses providing post discharge management within a multidisciplinary environment are often challenged to find resources in a relevant time-frame.

Purpose: Heart Education Assessment Rehabilitation Toolkit (HEART) Online provides tools for nurses and other members of the multidisciplinary team to enable the assessment, planning, implementation and evaluation of care for patients with coronary artery disease and heart failure.

Methods: HEART Online was launched in May 2013 and has since been continuously evaluated through periodic targeted surveys and expert reviewers. Ongoing feedback is also provided through Google Analytics and the "contact us" pages.

Results: HEART Online has an average of 3,100 visits to the site per month. The site is widely used in every state and territory of Australia and international visitors are growing. Between January and September 2014, visitors were mainly from English speaking countries: Australia (68%) followed by USA (12%), UK (6.5%) then Canada, India and New Zealand. Feedback has resulted in: new pages on medications for acute coronary syndromes; sleep and heart failure; implantable devices; and revised sections on sexual activity and smoking. The 33 downloadable resources (such as clinical forms and letters, clinical management algorithms and tables, and patients handouts) have been revised to improve presentation and the ease of reading. Further enhancements suggested by evaluation are dependant on funding and include: developing a mobile-enabled site, creating a patient portal; and linking materials to clinical training.

Conclusion: HEART Online has the potential to improve standards of evidence-based practice in cardiovascular care. The popularity of the site suggests that it is meeting an unmet need. Updates to content demonstrate the benefits of the web in being responsive to current and future needs of clinical practice.

12 Proctor, R¹

1 Royal North Shore Hospital

Methamphetamine Associated Cardiomyopathy

Methamphetamine use has risen dramatically in the last decade to be second only to cannabis use worldwide. Methamphetamine associated cardiomyopathy is reported to be increasing as a result. There is limited evidence available to guide our care of these patients. This presentation will present a case study of one such patient and discuss the management. A review of the current evidence base will be discussed to provide an update on the care of patients with Methamphetamine Associated Cardiomyopathy.

13 Hartmannova, S¹, Jain, S¹ & Pine, P¹

1 Prince Of Wales Hospital Randwick NSW

Surgical Site Infection In Cardiothoracic Perioperative Environment

Surgical site infection (SSI) represents an adverse complication in post-surgery patients' recovery and accounts for a substantial number of healthcare associated infections. Sternal wound infection affects a relatively small portion of cardiac surgery patients. Nonetheless, the increased mortality associated with the SSI, the prolonged length of hospital stay, and the emotional and physical distress to patients all pose an acute impediment to the already involved patient journey. Healthcare associated Infection (HAI) surveillance and other risk assessments suggested that there are ongoing opportunities for improvement. The above norm SSI rates in the specialty Unit led to a review of the department's clinical practices, and ultimately, change of practice. Indirectly, we started looking for evidence, leading to an establishment of a multidisciplinary Focus Group to engage clinicians and other stakeholders. In the engagement phase, we realised that there is a need for clear and effective communication pertaining to the reasons why the SSI implementation strategies are important for patient care. The focus was on implementation of strategies to reduce barriers and improve adherence with evidence-based practices and reduce the risk of SSIs, including standardization of care processes, and creating redundancy or independent checks. During this practice development process we learned that accountability is an essential principle for preventing HAIs. It provided the necessary translational link between science and implementation. Professional autonomy involves critical thinking, efficient decision-making and social interaction. In such, clinicians are actively engaged in the new process and reflection, whilst the initiator's role is to support and guide the practice change journey. Traditional approaches and practices were challenged and we encountered resistance and monetary issues; nonetheless, we believe the outcome, due to the collective efforts in this challenging work contributed to significantly reduced infection rates. In the end, we celebrated the combined effort and collaborative clinical leadership influencing positive patient outcomes.

14 Tonini, K¹

1 St Vincent's Hospital, Sydney

A heartless heart- the battle against giant cell myocarditis: A case study

Introduction: Giant cell myocarditis is an aggressive autoimmune disease causing heart failure and can ultimately lead to multi-organ failure and likely death in patients. It is an uncommon diagnosis in patients admitted to the coronary care unit, however those that do present may require aggressive management and urgent listing for heart transplantation. In some cases the implantation of a bi-ventricular assist device (BiVAD) may be required as a bridge to transplantation.

Case Study: A 40-year-old women presented with a two day history of intermittent chest pain, diagnosed with giant cell myocarditis. During investigation to obtain a diagnosis she developed signs of congestive heart failure, deteriorating further with cardiogenic shock requiring veno-arterial extra corporeal membrane oxygenation (VA-ECMO) and continuous veno-venous haemodialysis CVVHD. Decision was made to implant left and right ventricular assist devices, or BiVADs as a bridge to transplant, in order to maintain effective cardiac output. The patient had a long intensive care unit (ICU) and coronary care unit (CCU) admission with significant improvement before transfer to the rehabilitation unit. However she was soon readmitted to the CCU with acute kidney injury and fluid overload. While awaiting heart transplantation her condition deteriorated, despite aggressive diuretic and inotropic support. The patient endured many complications including heparin induced thrombotic thrombocytopenia (HITTS), suspected beta lactam skin rash and multi-organ failure. It was also noted that she had no underlying cardiac rhythm and cardiac output totally dependent on BiVADs. Despite treatment the patient developed end stage renal failure, making her unsuitable for heart transplantation. A decision was made for palliation and the patient died, five months after initial presentation.

Conclusion: As this diagnosis is rarely seen, it raises a number of issues that, with further understanding and reflection may assist nursing staff in considering nursing actions when faced with a variety of challenges.

ABSTRACTS – POSTER 1-15

P1 Crittenden, J¹, Leslie, G², Hood, SD³ & Davidson, PM⁴

1 Sir Charles Gairdner Hospital, Nedlands, WA, 2 School of Nursing and Midwifery, Curtin University, WA, 3 School of Psychiatry, University of Western Australia, WA, 4 School of Nursing, Johns Hopkins University, Baltimore, MD, USA

Identifying ACS patients at risk of depression: Preliminary development of a questionnaire for use in the acute clinical setting

Background: Depression is an important comorbid diagnosis in Acute Coronary Syndrome (ACS). Early detection of depression risk will allow psychological support to be directed to those who may benefit the most. This research project aimed to develop a brief depression risk assessment instrument for use by nurses in hospital.

Methods: The Depression Risk Assessment Questionnaire (DRAQ) was developed using a four step approach. 1 Literature were searched for studies identifying risk factors for depression in ACS samples then graded for quality of evidence. 2. Comprehensiveness and content validity of the DRAQ was assessed by a panel of eight experts 3. The refined DRAQ was tested for internal consistency, reliability and temporal stability in a sample of 220 ACS patients. 4. Qualitative acceptability of the DRAQ was established in a small survey of study participants.

Results: Thirteen risk factors were initially identified as highly relevant to developing depression. Following assessment of the comprehensiveness and content validity, nine questions were retained. The internal consistency of the DRAQ was calculated using the Cronbach's coefficient alpha based on raw (0.71) and standardized (0.68) variables. Temporal stability was assessed using the kappa statistic with results indicating 'fair agreement' (0.47) to 'excellent agreement' (1.00). Eleven patient participants reviewed the acceptability of the DRAQ and reported questions were clear, relevant and appropriate.

Conclusion: This project has developed a preliminary tool with acceptable psychometric properties which could be used by nurses to help screen for the potential development of depression amongst ACS patients.

P2 Crittenden, J¹, Leslie, G², Hood, SD³ & Davidson, PM⁴

1 Sir Charles Gairdner Hospital, Nedlands, WA, 2 School of Nursing and Midwifery, Curtin University, WA, 3 School of Psychiatry, University of Western Australia, WA, 4 School of Nursing, Johns Hopkins University, Baltimore, MD, USA

Risk factors for depression following an episode of acute coronary syndrome: A systematic literature review

Background: The risk factors for the development of depression in patients following an episode of ACS have not been fully described. The objective of this review was to identify risk factors from the literature and critically evaluate the evidence base in order to develop a risk assessment tool.

Methods: A search of the literature was conducted dating from January 1990 to January 2010 using established medical databases and manual searching methods. To be included in the review, articles needed to be published in English, be a primary research article using quantitative methodology and report results of risk factors for depression obtained from prospective data or correlations obtained

from cross-sectional data. The Oxford Centre for Evidence-based Medicine Levels of Evidence (2009) was used to critically appraise the articles.

Results: A total of 1,887 full-text papers were assessed and 1,860 were excluded on eligibility and methodological grounds. Twenty-seven articles, describing 24 studies, met the inclusion criteria. In total 50 risk factors were described in the literature. Following grading 13 risk factors were found to be highly relevant to the development of depression post ACS. The strongest evidence was found for a past history of depression, the presence of depressive symptoms during admission, and recent negative life events prior to ACS episode.

Conclusion: Identifying the presence of risk factors for depression is a novel approach which allows high risk groups to be supported appropriately throughout their recovery period.

P3 Sanchez, P¹, George, A², Everett, B³, Salamonson, Y⁴ & Ajwani, S⁵

1 University of Western Sydney, Centre for Applied Nursing Research, 2 Centre for Applied Nursing Research, University of Western Sydney, 3 Centre for Applied Nursing Research, University of Western Sydney, 4 Centre for Applied Nursing Research, University of Western Sydney, 5 Sydney Local Health District, Sydney Dental Hospital, University of Sydney

Developing a Cardiovascular Oral Health (CARDIOH) promotion program for the cardiac rehabilitation setting: Findings from a scoping review

Background: Cardiovascular disease (CVD), a leading cause of death in Australia, is also the leading cause of chronic morbidity and mortality in industrialised countries. In the last two decades an increasing body of evidence has found significant correlation between poor oral health (OH) and CVD, including coronary heart disease and cerebral-vascular accidents. Inflammatory markers linked to pathological changes in periodontitis are risk factors for atherosclerosis. Therefore the international consensus is that all cardiac care providers should advise patients of the risks associated with poor OH and CVD, and provide dental assessments and referrals for comprehensive periodontal therapy. The aim of this review was to (i) identify programs with embedded OH education or OH promotion implemented by clinicians practising in the cardiovascular settings; (ii) assess cardiovascular clinicians' and patients' knowledge of OH and its association with CVD, and (iii) identify validated OH assessment tools suitable for use by clinicians in the cardiac rehabilitation setting.

Method: This systematic scoping review examined all published English literature on OH promotion in the cardiac setting, clinicians' and patients' knowledge and current OH practices. It also included OH programs and promotion in other non-cardiac inpatient and outpatient settings.

Findings: In Australia, cardiac rehabilitation clinicians do not provide OH education, assessments and referrals to patients during the rehabilitation period. There is also limited research examining the role of nurses and allied health cardiac rehabilitation clinicians in promoting OH of their patients. No studies were identified that described the inclusion of OH education, assessment tools or referral systems in the cardiac rehabilitation setting to promote and improve OH for CVD patients.

Conclusion: Findings from this scoping review will be used to further explore the implementation of an OH assessment component within existing cardiac rehabilitation programs.

P4 Alyasin, N¹

1 Coronary Care Unit, The Canberra Hospital, ACT

Cardiac Based Handover: Precise and Informative

Clinical handover is transfer of professional responsibility and accountability for some or all aspects of care for a patient or group of patients and therefore implementing written and verbal handover is essential. As such, a minimum data set (minimum content) must be contained and transferred during clinical handover. The clinical handover in the Coronary Care Unit (CCU) at The Canberra Hospital (TCH) consists of a group handover and a bedside handover. During the group handover, team leaders provide relevant patients' information to the incoming nursing staff using a cardiac based clinical handover sheet. A new handover sheet was designed for team leaders and was put in trial for a period of six months prior to its formal approval. The new handover sheet focuses mainly on relevant cardiac history including previous diagnosed coronary artery disease, cardiac arrhythmias, implantable devices, hypertension, high cholesterol and heart failure. Moreover, two separate sections were designed to have the angiogram and echocardiogram result briefly documented, highlighting occluded vessel and left ventricular function respectively. In addition to the new handover sheet are a "required" and a "notified" section for social worker, physiotherapy, dietician, CT scan and ultrasound, NFR, precautions and non-English speaking background. A retrospective study was initiated in which senior nursing staff in team leading role were asked to complete a questionnaire. The following five questions were asked: 1-Does the new document flow well for handover? 2-Are the relevant information abbreviations sufficient and appropriate? 3-Is the layout of the document easy to follow? 4-Do we need more space to write in results of procedures? 5-Is the shift update sheet functional? Questionnaires were done anonymously as hard copies. Staff were welcome to add comments at the end of questionnaires. At the end of data collection period, 12 handover documents questionnaires were completed (app%80). Some limitations of the project includes the number of nursing staff in team leading roles and having non-cardiac admissions into CCU including patients with TIA/CVA and COPD. The new handover sheet has been put in practice since September 2014 with possible further development in 2015.

P5 Crittenden, J¹, Leslie, G², Hood, SD³ & Davidson, PM⁴

1 Sir Charles Gairdner Hospital, Nedlands, WA, 2 School of Nursing and Midwifery, Curtin University, WA, 3 School of Psychiatry, University of Western Australia, WA, 4 School of Nursing, Johns Hopkins University, Baltimore, MD, USA

Perceived barriers and facilitators related to screening for depression in a coronary care unit

Background: Although it is recommended that formal screening procedures for depression be integrated into clinical practice this remains a challenge with little guidance available on how to translate the evidence into practice. This qualitative research study explored the barriers and facilitators to depression screening in a CCU as perceived by medical and nursing staff.

Methods: Ten members of clinical staff with varying professional roles and experience were recruited to the study. Data were obtained from ten semi-structured, individual interviews. A Thematic Framework was used to analyse the qualitative data.

Results: In total 23 themes and sub-themes were identified from the data. Interpretation of the data resulted in the identification of 12 major issues related to depression screening in the CCU. Issues

related to current practice included a lack of a systematic approach to identifying depression and poor access to specialized psychiatric support services. Major barriers to screening included perceived time constraints, staff's lack of mental health related skills and lack of specific knowledge related to depression in cardiac patients. Staff identified four requirements for change: that screening must lead to improved patient outcomes and a management plan; that a strong evidence base was required to underpin change; further staff education was required; a change facilitator was essential.

Conclusion: Important insights into the context of practice can be gained from qualitative data collected at individual hospitals. The findings from this study have informed further qualitative research being conducted in the department leading to an integrated model of depression screening and management.

P6 Anuruang, S¹, Davidson, PM^{1,2}, Jackson, D¹ & Hickman, LD¹

1 University of Technology, Sydney, 2 Johns Hopkins University

Strategies to enhance recruitment of rural dwelling older people with hypertension into community-based randomised controlled trials study

Aim: To describe strategies that can enhance recruitment of rural dwelling older individuals into community-based randomised controlled trials.

Background: Recruiting older, community-based participants into randomised controlled trials (RCTs) can be challenging. RCTs need adequate sample sizes to demonstrate an intervention effect. Therefore it is essential that studies seeking to recruit complex population groups consider the best strategies and approaches to use.

Data Sources: In this paper we draw on the available literature and our personal successful experiences, to present a range of flexible and inclusive strategies that have been successful in enhancing the participation of rural dwelling older people in a community-based RCT.

Results: For this study, the researchers spent 3 months recruiting 156 rural dwelling older people with hypertension into the community-based RCT. Three important strategies from the researcher experiences contribute to enhancing recruitment: 1) understanding the culture of the research setting; 2) identifying the key gatekeepers in the setting; and 3) building trust with the key gatekeepers.

Discussion: Though it can be difficult to recruit people into a community-based RCT project, this study shows that thoughtful preparation and utilising a range of strategies aimed at gaining gatekeepers support can improve the recruitment of older people.

Conclusion: The most important finding from the literature and our own experiences in undertaking this study is the need to understand the nature of participants and the nature of the setting. These understandings were crucial in the recruitment process and enabled recruitment of a sufficient number of participants within a reasonable timeframe. These strategies may also be of use beyond the rural setting, with different communities including urban communities.

Implications for practice/research: These strategies may provide guidance for future researchers seeking to recruit older people into RCT studies.

P7 Tongpeth, J¹, Du, HY² & Clark, RA³

1 Flinders University, 2 Flinders University, 3 Flinders University

Development and evaluation of an Avatar-based intervention for improving knowledge on symptom recognition and management in patients with Acute Coronary Syndrome

Background: Patients' ability to recognise and manage the symptoms of acute coronary syndrome (ACS) is imperative to timely medical attention. Numerous studies have demonstrated that information technology plays an important role in improving patients' knowledge and self-management ability.

Aim: This study aims to develop and evaluate an avatar-based education app for improving patient's knowledge on ACS symptoms recognition and management.

Methods: This study will be conducted using mixed methods. Cochrane systematic review method will be used to review current evidence of Interactive Health Communication Applications for people with chronic disease. Secondly, an avatar-based education app will be developed through action research, and the app will be evaluated in a Randomised Controlled Trial for its effectiveness.

Proposed outcomes: The avatar-based intervention is an innovative approach for patient education. An engaging and interactive education intervention is likely to improve ACS patients' knowledge on symptom recognition and management, minimise pre-hospital delay and lead to better clinical outcomes.

Conclusion: This project will be one of the first to address the issues of low literacy and low health literacy in ACS patient education. This study may suggest further new, culturally-based implementation and designs.

P8 Clark, RA¹, McCarthy, A², Chowdhury, MH³, Berry, N⁴, Koczwara, B⁵ & Roder, D⁶

1 School of Nursing & Midwifery, Flinders University, South Australia, 2 School of Nursing, Queensland University of Technology (QUT), Brisbane School of Nursing, Queensland University of Technology (QUT), Brisbane, 3 School of Nursing & Midwifery, Flinders University, South Australia, 4 School of Nursing & Midwifery, Flinders University, South Australia, 5 Medical Oncology Units, Flinders Medical Centre, South Australia, 6 Cancer Epidemiology and Population Health Unit, School of Population Health, University of South Australia, South Australia

Cardiotoxicity following Cancer Treatment: a Linked Health Data Analysis

Background: Cardiotoxicity resulting in heart failure is a devastating complication of cancer therapy. It is possible that a patient may survive cancer only to develop heart failure (HF), which ultimately has a higher mortality than cancer.

Purpose: The aim of this project was to profile the characteristics of patients at risk of cancer treatment induced heart failure.

Methods: Linked Health Data Analysis of Queensland Cancer Registry (QCR) from 1996-2009, Death Registry and Hospital Administration records for HF and chemotherapy admissions were reviewed. Index heart failure admission must have occurred after cancer registry entry.

Results: A total of 15,987 patients were included in this analysis; 1,062 (6.6%) had chemotherapy+HF admission (51.4% Female) and 14,925 (93.4%) chemotherapy_no HF admission. Median age of chemotherapy+HF patients was 67 years (IQR 58 to 75) vs. 54 years (IQR 44 to 64) for chemotherapy_no HF admission. Chemotherapy+HF patients had increased risk of all cause

mortality (HR 2.79 [95% CI 2.58-3.02] and 1.67 [95% CI, 1.54 to 1.81] after adjusting for age, sex, marital status, country of birth, cancer site and chemotherapy dose). Index HF admission occurred within one year of cancer diagnosis in 47% of patients. Increase in the number of chemotherapy cycles was associated with significant reduction in survival time in chemotherapy+HF patients. Mean survival for heart failure patients was 4.96 years (95% CI 4.65 - 5.27) vs. 9.08 years (95% CI 8.99-9.18) for chemotherapy_no HF admission patients.

Conclusion: All-cause mortality was 67% higher in patients diagnosed with HF following chemotherapy in adjusted analysis for covariates. Methods to improve and better coordinate of the interdisciplinary care for cancer patients with HF involving cardiologists and oncologists are required, including evidence-based guidelines for the comprehensive assessment, monitoring and management of this cohort.

P9 Clark, RA¹, Fredericks, B², Howie-Esquivel, J³, Dracup, K⁴, Atherton, J⁵ & Berry, N⁶

1 School of Nursing and Midwifery, Flinders University, South Australia, 2 Central Queensland University Australia, Rockhampton, Queensland, 3 University of California, San Francisco, CA, United States of America, 4 University of California, San Francisco, CA, United States of America, 5 School of Medicine, University of Queensland, Brisbane, QLD, 6 School of Nursing and Midwifery, Flinders University, South Australia

A collaborative approach to developing culturally appropriate heart failure self-care tools for Indigenous Australians using multi-media technology

Introduction: Indigenous Australians have a 70% higher incidence of heart failure (HF), and twice as many deaths as non-Indigenous people. Patient education that is consistent with the values of Indigenous communities is needed to improve self-care.

Purpose: To design, in collaboration with the local Indigenous community, culturally appropriate tools for teaching self-care.

Methods: A mixed methods study was conducted in two phases. Phase 1 used action research to engage a HF expert panel to adapt the existing resource to be evidence-based, reflect Indigenous Australian culture and be suitable to delivery on a tablet-computer. The resource was then reviewed by a stakeholder group (Indigenous staff and HF patients, researchers and clinicians). Phase 2, the resource was evaluated in Indigenous HF patients to assess feasibility and acceptability. Knowledge, satisfaction and self-care behaviours were measured with validated questionnaires.

Results: Results of the stakeholder consultation indicated that the resource needed to accurately reflect the local Indigenous community, with the appropriate clothing, skin tone and voice. This included voiceovers from members of the local community, images and converting text to the first person and using plain language. This was a small pilot test statistical comparisons were not appropriate. Five Indigenous Australians (aged 61.6±10.0 years) with HF participated in feasibility testing. Participants reported a high level of satisfaction with the resource (83.0%) and expressed intentions to weigh themselves daily following education. HF knowledge score increased by 20.8% (9.6±1.3 to 11.6±2.0), and the self-care index indicated a 95% increase in confidence score (46.7±16.0 to 91.1±11.5).

Conclusion: By working collaboratively, engaging Indigenous researchers and patients, capacity-building, and being responsive to local systems, a culturally appropriate HF resource has been developed for Indigenous Australian patients. Positive participant feedback shows that the methodology used in this study was appropriate and acceptable; participants were able to engage with willingness and confidence.

P10

Driscoll, A¹, Barnes, EH², Blankenberg, S³, West, MJ⁴, White, H⁵ & Tonkin, AM⁶

1 Deakin University, 2 University of Sydney, 3 Department of General and Interventional Cardiology, Hamburg, 4 University of Queensland, 5 Auckland City hospital, New Zealand, 6 Monash University

Predictors of incident heart failure in patients with stable coronary heart disease

Aim: The aim of the study was to develop a heart failure (HF) risk prediction model in patients with stable coronary heart disease (CHD). CHD is a major cause of HF. Availability of risk prediction models for HF in CHD patients that include both clinical parameters and biomarkers is limited.

Method: The LIPID study recruited 9014 patients with myocardial infarction or hospitalisation for unstable angina 3-36 months previously. They were randomised to receive pravastatin 40mg daily or placebo and had a median of 6 years follow-up. All patients with a NYHA class>1 at baseline were excluded (n=858). A Cox proportional hazards model was used to determine independent predictors of a first HF event (HF hospitalisation or death). The c-statistic and net reclassification improvement (NRI) were used to assess the predictive usefulness of models containing only clinical parameters and after addition of novel biomarkers.

Results: Among the 8156 patients, median age was 62 years (IQR 55-67 years) and 84% were male. Overall 653 (8%) patients experienced a heart failure event during follow-up. Older age, history of claudication or diabetes mellitus, LDL>100mg/dl, heart rate >70bpm and several baseline medications (ACEI, digoxin, nitrates, and diuretics) were associated with increased risk of HF. However aspirin reduced the risk by 22% (HR 0.78, 95%CI 0.63-0.96). Among 7017 patients with biomarkers there was an increased risk of developing HF with higher troponin I (>0.018 v 0.006 ng/ml) (HR 1.91, 95% CI 1.52-2.38), higher cystatin C (>0.93 v < 0.7) ng/ml (HR 1.56, 95%CI 1.16-2.11), BNP>50.29 pg/ml (HR 1.94, 95%CI 1.61-2.32), higher hsCRP (>4.8 v <1.2) mg/L (HR 1.56, 95%CI 1.23-2.07), and higher D-dimer (>273 v <112) ng/ml (HR 1.48, 95%CI 1.13-1.94). The addition of all of these biomarkers to the clinical risk model improved the model c-statistic from 0.74 to 0.78 and NRI was 19.5% using predicted 5-year risk categories of <5, 5-10, 10-20 and >20%.

Conclusion: Incident heart failure was predicted by age, diabetes, history of claudication, elevated LDL-C and heart rate>70 per minute. The addition of a multi-biomarker panel markedly improved discrimination and risk classification for heart failure, which may significantly enhance clinical management of patients with stable CHD.

P11

Murray, PE¹

1 Prince of Wales Hospital, Sydney NSW

A Quick Reference Guide for Post-Cardiac Catheterisation Nursing Care

The standard of care for diagnosis and treatment of coronary artery disease (CAD) and acute coronary syndrome (ACS) is cardiac catheterisation and percutaneous coronary intervention (PCI) (Cosman, Arthur, & Natarjan, 2011). New Graduates, novice casual pool staff, and student nurses on the coronary care unit are generally inexperienced in the area of post cardiac catheterisation and PCI nursing care, and are often faced with patient questions to which they are unsure of the answer. The Quick Reference Guide aims to provide new graduate, novice, and student nurses working in the Coronary Care Unit, and acute cardiology settings with the knowledge and evidence based practice guidelines for post cardiac catheterization and PCI nursing care. The quick reference guide outlines a timeframe for observations, patient positioning, mobilisation, ambulation, eating and drinking, for

post interventional cardiac patients. The guide is specific to the patient situation, outlining the specific care for patients with an arterial sheath insitu, patients post haemostasis, patients who have had a vascular closure device, and patients who underwent a radial approach. The proposed outcomes include improved knowledge and confidence in the care of post interventional patients, improved patient safety and quality of care through minimization of potential vascular access site complications, and therefore improved patient outcomes.

P12

Burns, E¹, Martin, L¹, Johnston, R¹ & Naismith, C¹

1 Austin Health

Evaluation of procedural cancellations in a Melbourne metropolitan cardiac catheterisation laboratory

Introduction: Procedural cancellations are an unfortunate occurrence. The inconvenience and anxiety associated with rescheduling not only impacts the patient and their families, but disrupts the efficiency and productivity of the department. Therefore it is essential to identify and evaluate the reasons for procedural cancellations in order to reduce the effects.

Methodology: Data was retrospectively collected from the hospital's patient management system (PMS) for a period of 12 months. Inclusion criteria were all elective cardiac procedures booked on PMS then subsequently cancelled. Procedures included were coronary and electrophysiology cases. Cancellations were separated into 5 common groups; initiated by patient, doctor, hospital, administration, or for undocumented reasons.

Results: From a total of 2131 procedures, 375 patients had procedural cancellations. Patient initiated cancellations accounted for 25% (n=95). Reasons identified were; patient's health/condition changed 49% (n=46), unprepared for the procedure 41% (n=39) and patient indecisiveness regarding procedure 10% (n=10). Doctor initiated cancellations accounted for 23% (n=85). Reasons identified were; change of management 46% (n=39), rebooked 38% (n=32) and cardiologist not available 16% (n=14). Hospital initiated cancellations accounted for 12% (n=46). Reasons identified were; no bed available 76% (n=35), emergency priority 21% (n=10), equipment failure 2% (n=1). Administrative cancellations accounted for 10% (n=37). Reasons identified were; patient opted for a private procedure 46% (n=17), anaesthetist unavailable 35% (n=13), procedure already completed 16% (n=6), and inadequate paperwork sent 3% (n=1). There was no documentation for 30% (n=113) of procedural cancellations.

Conclusion: Identifying the reasons for procedural cancellations has provided opportunity to improve productivity of the cardiac catheterisation laboratory. It has also highlighted the need to maintain accuracy of the booking system so it can be used as an effective tool for evaluating the booking process, which would ideally lead to an increase in patient satisfaction.

P13

Bassett-Smith, M¹, Zgoznic, E¹, Martin, L¹ & Naismith, C¹

1 Austin Health

“Quantifying work flow for elective day cases in the Cardiac Catheterisation Department”

Introduction: Excessive patient waiting times are an important issue for productivity, impacting on flow and ultimately patient satisfaction in the Cardiac Catheterisation Laboratory. Currently there is no existing standard to measure efficiency and identify delay in wait times at Austin Health.

Aim: Evaluate current patient flow for elective day patients and describe potential variants, establishing an internal benchmark for performance and productivity.

Methodology: Consecutive data was collected over six months. Time specific data was retrospectively collected for three months. Three months of prospective data was collected documenting the same timeframes and quantifying reasons for delay. Inclusion criteria were all elective day cases. Exclusion criteria were non-elective patients. Patient journey was measured over five timeframes (TF). TF 1: Arrival in Reception to Recovery, TF 2: Recovery to initial contact with nurse, TF 3: Nurse to Cath Lab Time-out, TF 4: Cath Lab Time-out to start time of procedure, TF 5: Start time to end time of procedure.

Results: From 1st October 2013 to 31st March 2014, 479 patients were analysed. The total time from patient arrival to procedure completion was 172 mins (median). Timeframes and delay in minutes were as follows; TF1: 23 mins (median); TF 2: 12 mins (median) TF 3: 75 mins (median) TF4: 14 mins (median) TF 5: 26 mins (median). 19% (n=92) had documented delay to patient flow. Causes of delay were categorised: 1) Staff 51% (n=47); 2) Clinical 24% (n=22); 3) Equipment 6% (n=6); 4) Patient 4% (n=4); 5) Other (STEMI, PPM check, consent, interpreter) 15% (n=13).

Conclusion: Evaluation of patient flow has identified multiple variables play a part in the day to day flow of the Cath Lab. Reducing these variants whilst maintaining flexibility for unforeseen medical emergency or scheduling variability could have a significant impact on efficiency and staffing resource management at Austin Cath Lab.

P14

Alyasin, N¹

1 Coronary Care Unit, The Canberra Hospital, ACT

Assessment and Management of chest pain in patients with Acute Coronary Syndrome: Nurses' role

Nurses have a significant role in assessment and management of chest pain in patients with ACS. Hence, it is important that nurses have the appropriate knowledge and expertise to distinguish the aetiology of the chest pain. The focus of this review article is on the assessment and management of chest pain in patients with ACS. Chest pain as a symptom is most commonly associated with heart conditions and require cardiac investigations. This article provides an overview of chest pain assessment, diagnostic procedures, nursing assessment, patient education and discharge plan in patients with ACS. Patient education is also an important aspect of nursing care in patients with ACS. Having an action plan of how to manage chest pain at home is strongly recommended.

P15

McLachlan, A¹, McLean, K¹ & Kerr, A¹

1 Counties Manukau Health, New Zealand

The development and implementation of a cardiac rehabilitation tracking system

Background: Cardiac rehabilitation (CR) has an important impact on recovery and outcomes post cardiac event. However, uptake remains suboptimal despite significant effort, locally, to provide comprehensive hospital and community programmes. Attempts to audit our program identified that the existing hospital data base was impractical to guide and inform our strategies to improve access.

Purpose: To develop a simple, user friendly system to track CR referrals and attendance to inform ongoing quality improvement. **Methods:** As part of the ANZAC-QI system, a small group of clinicians and software engineers developed an electronic process to track, in real time, the referral and attendance of patients attending cardiac rehabilitation and provide a user generated report.

Results: Between 1/8/12-1/1/14, 1362 patients were enrolled on the CR programme. The majority (68%) were men, ethnicity was reported as Euro/other 46%, Maori 12%, Indian 11% and Pacific 27%. 42% were <60yrs old and 83% were referred from the CCU/ cardiology ward, primarily post ACS/PCI. 76% of patients opted for a group based programme, 12% for a community programme and 12% for a clinic based assessment (mainly reserved for non-English language). 68% attended one or more CR sessions. 140 patients were referred to the exercise programme and 70% attended at least one session. Current smokers (60% vs. ex/non-smokers, 76%), Women (68% vs. Men, 75%) and Pacific (55% vs. non Pacific, 78%) were least likely to attend, following enrolment.

Conclusion: Almost 2/3rds of patients invited to the CR programme, attend, ethnicity and gender differences in engagement, remain. The CR tracking system has facilitated a greater understanding of referral patterns and uptake of CR and will support the targeting of resources to close the identified gaps in our process.

THE 2015 ACNC EXECUTIVE

President | **Andy McLachlan** Auckland, New Zealand

Andy is a Nurse Practitioner with prescribing rights and has led the local development of advanced nursing roles in Cardiology for the last 5 years. He has a keen interest in methods to support patient self-management, health literacy, clinical audit, research and nurse led clinics. His aim as President is to establish ACNC as an organisation that represents the views and communicates the needs of cardiovascular nurses across Australasia. To ensure our voices are heard we need to work closely with like-minded organisations, seek out opportunities to influence decision making and find many and novel ways to communicate with our members. If you are not already a member, come and join us.



President Elect | **Maria Sheehan** Sydney, Australia

Maria has been a registered nurse in Cardiac Nursing more than 20 years, with 5 of those as a Nurse Practitioner. Maria completed a Masters in Nursing Practice (NP) in 2008. She was part of the working party writing the Heart Failure Model of Care in WA and collaborated in NSW in developing the Guidelines for the Deactivation of ICDs at the End of Life. Maria is passionate about maintaining and improving the role for cardiac nurses in the holistic management of chronic & complex cardiac patients. She is excited and nervous about stepping into the big shoes of her New Zealand counterpart Andy McLachlan, (both displaced from their birth land by choice, and both Kiwis). When Maria is not at work she enjoys being in New Zealand, being active outdoors & riding her Ducati Monster!



Treasurer | **Margaret Lucas** Brisbane, Australia

Margaret is a Nurse Practitioner with the Advanced Heart Failure and Cardiac Transplant Unit at The Prince Charles Hospital in Brisbane. Margaret has been cardiac nursing since 1996 and helped establish the initial Heart Failure Service at The Prince Charles Hospital. In 2003 she was appointed Nurse Co-ordinator of the Advanced Heart Failure Unit and in 2004 selected for the demonstration site for a Heart Failure Nurse Practitioner role. Masters in Nursing, Nurse Practitioner was completed and Margaret was appointed Nurse Practitioner in 2009. Margaret has been a member of ACNC since its inception and has served as Treasurer since 2007. Margaret has undertaken a study monitoring uptake of Fish Oil in heart failure patients and reported on the usefulness of Acetazolamide in those heart failure patients with refractory oedema. Outside interests are golf, travel and her grandchildren.



Secretary | **Natasha Eaton**

Brisbane, Australia

Natasha's cardiovascular nursing career began by accident 16 years ago in a busy cardiothoracic surgical ward, and led to an RN job in the CCU of a tertiary hospital. Curiosity got the better of her; ECG courses were attended, books were read and lots of questions were asked. She progressed to a Clinical Nurse role and then jumped in the deep end as Clinical Nurse Teacher of the CCU. This role whets her appetite for education, training and facilitation. Her love of clinical care and the opportunities of education led to her current role as Cardiac Clinical Nurse Consultant. This role has added the challenge of workforce management to the mix and provides the opportunity to wear many hats (often simultaneously!) When she is not nursing Natasha enjoys sweating it out in a cycle class, watching the simplistic life of her chickens, experiencing live music and indulging in wine and cheese.

Committee Member | **Carolyn Astley** Adelaide, Australia

Carolyn is the Network Development Manager for the SA Cardiac Clinical Network, Senior lecturer, School of Medicine, Flinders University and a director on the board of the Southern Adelaide, Fleurieu, Kangaroo Island Medicare Local (SAFKIML). She has research investigator roles in acute cardiac health services. Carolyn's work in cardiology has spanned more than 20 years ranging from clinical cardiac nursing, a research coordinator in cardiac clinical trials, manager of a Cardiovascular Outcomes research unit and Cardiac Clinical effectiveness manager at the Flinders Medical Centre. She has had previous professional leadership roles as a director on the Cardiac Society (CSANZ) board and inaugural chair of the CSANZ Cardiovascular nurses council.

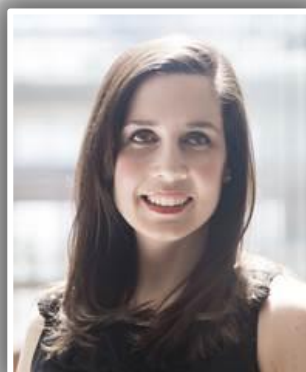
Committee Member | **Jackie Colgan** Gosford, Australia

Jacqueline (Jackie) Colgan hails from Birmingham, England, and qualified as a Registered General Nurse in 1991 at Dudley Road Hospital. Jackie has worked in cardiology for several years in various roles including Clinical Nurse Educator and is currently Clinical Nurse Consultant Cardiac Services at Central Coast Local Health District. Jackie has previously been a marker for the Cardiac Nursing Grad Cert at the NSWCN. Jackie is a casual academic at the University of Tasmania. She teaches into the Cardiovascular Nursing subjects.



Committee Member | **Sally Inglis** Sydney, Australia

A/Prof Sally Inglis, is a Cardiovascular Research Network Life Science Research Fellow, supported by the Heart Foundation and the NSW Office for Medical Research. She is an Associate Professor in the Centre for Cardiovascular and Chronic Care in the Faculty of Health at the University of Technology, Sydney. Sally's research interests include nurse management of chronic heart failure and peripheral arterial disease; remote monitoring using telephone support and telemonitoring and technology-based education for self-management. Her research also examines the epidemiology, management and outcomes of peripheral arterial disease. In 2008-2013 Sally was an NHMRC and Heart Foundation Sidney Sax Overseas Public Health Post-Doctoral Research Fellow and spent two years at the University of Glasgow examining the epidemiology and burden of peripheral arterial disease in Scotland. Sally is a Nurse Fellow of the European Society of Cardiology and a Fellow of the American Heart Association.



Committee Member | **Phillip Newton** Sydney, Australia

Dr Phillip Newton is a Senior Research Fellow at the Centre for Cardiovascular and Chronic Care at the University of Technology, Sydney and has an established record of cardiovascular research. His primary area of research is the development and testing of interventions to improve breathlessness in people with advanced heart failure. Dr Newton currently serves on the Executive Committee of the Cardiovascular Nursing Council of the Cardiac Society of Australia and New Zealand and the Australasian Cardiovascular Nursing Council. He is a member of the Editorial Board of the International Journal of Palliative Care and Contemporary Nurse. He holds a Bachelor of Nursing with First Class Honours and a PhD from the University of Western Sydney. In 2013 he was elected as a Fellow of the American Heart Association.



Committee Member | **Ross Proctor** Sydney, Australia

Ross works as Cardiology Clinical Nurse Consultant at Royal North Shore Hospital. He has more than 25 years experience in cardiac nursing in a variety of tertiary hospitals. Ross was employed as Nurse Educator for six years co-ordinating the post grad cardiac nursing course at The Australian College of Nursing. Ross lectures for the ACN, University of Technology, Sydney and Ausmed Conferences and he works with the Australian Resuscitation Council facilitating basic and advanced life support education within New South Wales. Ross is a founding member and past President of the ACNC.



Committee Member | **Sophie Rayner** Sydney, Australia

Sophie has worked in cardiac nursing for more than 20 years, commencing in Western Australia before moving to Sydney where she has worked as a registered nurse and clinical nurse specialist in Coronary Care before becoming a Nurse Educator in Cardiology. She is currently employed as the Clinical Nurse Consultant for Cardiology at Prince of Wales Hospital, Sydney. Sophie holds a Graduate Certificate in Coronary Care Nursing and a Masters of Clinical Education. She was a founding member and former Vice President of the Cardiac Nurses' Network of Australia and New Zealand. Sophie's special areas of interest include enhancing patient safety, developing guidelines and nursing education.



Committee Member | **Karen Sanders** Melbourne, Australia

Karen is an acute Cardiac Nurse Practitioner at Austin Health. After completing a Coronary Care certificate Karen has consolidated her cardiac nursing experience in various clinical, managerial, educational and project roles at Royal Melbourne Hospital, The Alfred and The Austin. Membership of several nursing and cardiac organisations includes the ACNC since its inaugural meeting in 2007, and committee membership since 2009. Karen is the nursing rep on the ACS subcommittee of the Victorian Department of Health Cardiac Clinical Network and appreciates this opportunity to help improve the delivery of care and outcomes for cardiac patients across Victoria.



Committee Member | **Snezana Stolic** Brisbane, Australia

Snez Stolic is a PhD candidate at Griffith University and lecturer at Queensland University of Technology. These role incorporate clinical research and teaching in the undergraduate nursing degree. Ms Stolic's research focuses on symptom management education for people with Acute Coronary Syndrome, pain management for cardiac surgical patients and medication education strategies for student nurses. Ms Stolic peer reviews for international journals and is a recipient of the Centaur Memorial Scholarship for nurses.



Committee Member | **Jo Wu** Brisbane, Australia

Dr Wu is a nurse academic, member Institute of Health and Biomedical Innovation, QUT, Fellow of the Australian College of Nursing, Honorary Research Fellow with the Mater Medical Research Institute and Royal Brisbane and Women's Hospital. She has over 16 years' clinical working experience in intensive care unit/coronary care units and as a diabetes educator.

Dr Wu has made significant contributions to the field of self-management for cardiac patients with diabetes, incorporating tele-health and testing in different delivery modes. Dr Wu has



disseminated findings on several refereed journals, including systematic reviews, and national/international conferences, has been awarded several research grants (approx. AUD 1.5 million). She is a reviewer of referred journals, textbook chapters and grant applications, on Editorial Board of *International Nursing Review* (official Journal of International Council of Nurses, ICN). Jo supervises higher degree research students.

Past Presidents

Simon Stewart 2006-09 | **Patricia Davidson** 2009-11 | **Ross Proctor** 2011-13
Life Member



ACNC Awards & Scholarships

In 2011 The ACNC instituted an awards and scholarship program. We are very proud of the calibre of Cardiovascular Nurses throughout Australia and New Zealand applying for the Travel Scholarships (TS), as well as those being nominated/self-nominating for the Clinical Excellence Awards (CEA). A huge congratulations for those who have received these.

We know there are many more of you out there and the ACNC executive encourages you to take time to visit our website, where you will find all you need to know about eligibility and the requirements for application submission. It is a simple process, and can be submitted online.

Visit www.acnc.net.au and locate the Membership tab >> Awards & Scholarships. They open five months prior to the conference and the closing date will be announced on the website.

The ACNC executive allocate up to five travel scholarships per year to help you attend the conference, and one clinical excellence award for a nurse who shows consistent excellence in the clinical area. There are some requirements and you will find the website outlines these. They are not onerous and if you are unsure if you can apply once you have browsed the page, we welcome your contact. Go to the website Contact Us page and send a message to the ACNC Secretary.

**Come visit, submit an application and let YOUR College, The
ACNC recognise and support you!**

ACNC 2014 Awards & Scholarship Recipients

2014 Gold Coast Conference

Life membership

For outstanding leadership and contribution to the development of the ACNC -
Professor Simon Stewart.

Clinical Excellence Award

Mr James McVeigh. Nurse Practitioner. Prince of Wales Hospital, Sydney.

Travel Scholarships

1. Caleb Ferguson. PhD Candidate, University of Technology, Sydney
2. Nicole Prentice. Clinical Nurse Specialist, Royal North Shore Hospital
3. Shauna Byrnes. Registered Nurse, Royal North Shore Hospital
4. Christine Wright. Research Assistant, St Vincent's Centre for Nursing Research and the Cardiovascular Care Centre

Congratulations!

WHO ARE THE ACNC?

The Australasian Cardiovascular Nursing College supports the vital role of cardiovascular nurses within Australasia. The ACNC is committed to equip and advance nursing practice, education and research.

We welcome and value collaboration with other health professionals as we strive to improve outcomes for cardiovascular patients across the spectrum of home to hospital.

The annual Australasian Cardiovascular Nursing College conference is produced entirely by the voluntary work of your executive committee. In order to bring you a professional, inspiring and informative meeting at a cost that is not prohibitive, we do not engage event management companies.

We hope you take the opportunity to meet new people while you are networking with those you already know. The executive sincerely wish you enjoy the conference and above all have a great time. Please approach any one of us if you have any queries, we are a friendly bunch!

Mission Statement

Leading nurses in cardiovascular care.

Vision Statement

To be the leading cardiovascular nursing college throughout Australasia.

The ACNC is committed to collaborating and promoting the advancement of cardiovascular nursing practice, research and education. Our passion is cardiovascular nursing. We aim to ensure cardiovascular nurses in Australasia are at the peak of their practice in all locations, from remote to metropolitan and within any across the spectrum of practice including home, clinics or hospitals.

We embrace the continuum of cardiovascular nursing and like-minded professionals. We aim to set the standards for cardiovascular nursing by championing research into practice and providing an open, supportive and collegial environment to foster, support and promote all cardiovascular nurses.

ACNC Affiliations & Associations

- Member of the **Coalition of National Nursing Organisations**
- Reciprocal benefits by affiliation with the **Australian College of Nursing**
- Affiliation with **College of Nurses Aotearoa (NZ) Inc**
- Affiliation with **Cardiac Nurses Council** – a nursing council within the CSANZ
- Collaboration with **Joanna Briggs Institute**

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Joanna Briggs Institute Collaboration

The ACNC executive is pleased to announce an exciting new collaboration with the Joanna Briggs Institute (JBI) on the development of a Cardiovascular Nursing Care Node within JBI COOnNECT+ that includes evidence on the key nursing care practices. Through this collaboration JBI and ACNC have established an expert reference group of a mixture of expert clinicians and clinical academics from Australia and New Zealand who have volunteered to review and provide expert guidance into the development of evidence based resources. These resources will be used to assist hospitals and nurses to use and integrate the evidence into their practice, and to evaluate the impact on patient health outcomes.

Dr Jo Wu is the nominated Chair of the ERG. Members of the expert reference group will participate in regular teleconferences, read and provide comments on documents and provide expert advice on JBI outputs.

- The development of evidence summaries based on the topics nominated by the ERG;
- The development of recommended practices based on the topics nominated by the ERG;
- The development of audit indicators and criteria for clinical audits based on the evidence identified;
- The outline of a multi-site audit, and topics are agreed to by the ERG; and
- The discussion of outcome measures specific to the monitoring and benchmark requirements



www.joannabriggs.org



www.acnc.net.au

Melbourne, Australia

Australasian Cardiovascular Nursing College
Conference **4 & 5 March 2016**
SAVE THE DATE



References

Aboriginal History

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The Three Sister's image

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Crowne Plaza, Coogee beach image

<http://www.crowneplazacoogee.com.au/coogee-beach/>

Sydney Harbour Bridge & Opera House image

http://www.sydneyoperahouse.com/about/media/photo_gallery.aspx

Sydney Beach image

<http://www.nswtravel.com.au/sydney-beaches.html>

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SEE YOU IN MELBOURNE – ACNC 2016



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