Cardiac Rehabilitation (CR) is an exercise and education program for people with cardiac disease. It is widely recognised as essential evidence-based therapy which can reduce patients’ morbidity and mortality by about 26% to 31% (NSW Department of Health, 2006). Community partnerships in the delivery of a exercise based chronic disease program for cardiac rehabilitation has helped establish this program as a sustainable service in a remote area of Hunter New England health (HNEH).

Quirindi is a remote rural area and the Health Service facility serves a population of approximately 7500. The hospital has 20 acute beds, a full time Emergency Department (ED) and a HealthOne NSW facility. Over the last fourteen years a Registered Nurse (RN) has run a weekly cardiac rehabilitation program consisting of counseling and exercise-based rehabilitation. This article describes the ongoing development of this program over fourteen years supported by a strong community partnership.

The National Heart Foundation and The Australian Cardiac Rehabilitation Association recommend that two skilled staff members should be available for a cardiac rehabilitation exercise class. This was a major problem for this remote rural site as there was only one RN available. Therefore, the initial provision of a second staff member to support the exercise sessions was ad hoc, and at times the role was performed by the Health Service Manager, the Administration Assistant or even the Speech Pathologist. Following on from this, a partnership with the hospital’s Aboriginal Liaison Officer was developed which worked well, as our Aboriginal clients were encouraged and felt comfortable to participate because of her involvement. It is recognised that the indigenous population are at higher risk of cardiovascular disease than the non-indigenous population (AIHW: Penm, 2008). However, for many years there was no cover for annual leave and as a consequence there was no service provision for clients during that time.

Over the last three years the exercise group has grown and adapted to become a Phase 2 / Maintenance group. This phase encourages clients to continue exercise once they have recovered from the acute phase of their illness in order to maintain optimum health outcomes. Initially the CR program was held on the hospital grounds but the group eventually outgrew the available space at this site. In 2006 program staff approached the local Liverpool Plains Shire Council and successful negotiations saw the exercise group relocate to the newly renovated gym that was at that time unstaffed. The sessions in the new site were still led by the Registered Nurse who coordinated the program. The Council agreed to subsidise the program fees, and the hospital provided some exercise equipment and morning tea for those who attended the program. However, the issue of safe staffing had not disappeared as there was still only one staff member dedicated to attend sessions.

The Health Service Manager and CR coordinator were forced to rethink how the exercise program could be maintained when the coordinator was diagnosed with a chronic disease and needed to have more regular time away from work. Council was again approached by the Health Service Manager to support the introduction of Heartmoves, a low to moderate intensity exercise program, designed for people living with health conditions (Heart Foundation, 2011) developed by the National Heart Foundation. In late 2008 the Council employed a Gym Manager, trained as a fitness leader And further negotiations have resulted in the gym manager being trained to lead the Heartmoves program. The CR coordinator continues to attend the sessions and introduces new clients to the program, so the previous issue of not being able to provide safe staffing levels has now been put to rest.

There is now a longstanding partnership with Liverpool Plains Shire Council that has seen our cardiac rehabilitation exercise component continue as a Phase 2 / Maintenance service that is now open as an exercise class to the general public. Patients new to cardiac rehabilitation exercise with the coordinator beside them for six weeks. They have the opportunity to chat with the “veterans” who are always willing to share their stories about managing their chronic illness. The new clients often know the “veterans”, who may be neighbours or friends. These people are reassured to know that life does go on, all be it a little differently.

The problems experienced in terms of staffing the program have been addressed and solved by forging a community partnership which will make it sustainable in the long term. When the CR coordinator takes leave, the program continues, but without any new clients. The Health Service is not required to provide staff for the maintenance group. Council is able to provide another fitness leader trained in Heartmoves for their staff relief.

There is a Heartmoves group three times each week now and some of the maintenance members are attending a second group as well. Fees have remained low, $3 per session, and participants are able to access other services at the gym for the reduced cost.

The success of this community based partnership has been exceptional. In 2010 the Council obtained a grant from BHP Billiton to provide upgraded equipment for use within the Heartmoves programs, acknowledging that an important service is being provided to the community. Participation in the supervised phase of exercise has increased and the previous maintenance group has grown from 16 to 28 participants. Heartmoves has become the second most popular group program at the gym.

Heartmoves continues to grow and is now being used for the maintenance phase for our Pulmonary Rehabilitation (exercise group for patients with lung disease) group program. The participants of that group are introduced to Heartmoves in the latter stages of their program and are supported by the Pulmonary Rehabilitation nurse at the first few sessions.

It was also recognised that intervention for newly diagnosed patients needs to be timely. This is a primary concern in a facility where there is only one staff member to provide the service. To accommodate leave requirements, an excellent solution has been implemented in the form of a telephone-based service. Hunter New England Local Health District has in place a telephone-based Cardiac Rehabilitation Service, Cardiac Coaching and Risk Reduction Program (CCARP). Any cardiac rehabilitation referrals received are sent electronically to the CCARP coordinator and a service is provided to patients by telephone. Patients are referred
back to Heartmoves on completion of the coaching intervention.

In developing a partnership with local government, community and other health service providers to suit our needs as a rural based Health Service, we believe that we are able to continue to provide an effective, sustainable Cardiac Rehabilitation service to the members of our community. The Cardiac Rehabilitation service and its providers are recognised as valuable assets by the community. Word of mouth buoys numbers of non-Cardiac Rehabilitation referred clients and clients feel safe when they join in for the first time knowing that their progress is being monitored by the Cardiac Rehabilitation coordinator.

REFERENCES


NSW Health Nursing and Midwifery Office and HNELHD Nursing and Midwifery Service are implementing the Essentials of Care program (EOC) across HNELHD facilities.

The program focuses on the patients’ experience, as well as what the patients’, their families and health professionals value about effective and relevant patient care, care that recognises all that’s essential for achieving the best outcomes.

EOC’s major focus is in the development of clinical environments that empower patients, their families and health professionals to work towards this together and to challenge the issues that compromise this.

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