

# Charter for European Cardiovascular Disease Patients

## Annex

### 1. Skill-training lessons for young people

Lessons should include cardiopulmonary resuscitation (CPR), dealing with choking, serious bleeding, ambulance calling<sup>1</sup> and use of an external defibrillator.<sup>2</sup> The lessons should be given by trained teachers or healthcare professionals. In the longer term, children trained in CPR significantly contribute to the number of adults trained in CPR in a community. The expected direct benefit of increasing the number of people trained to perform CPR is to increase the likelihood that a victim of a cardiac event promptly receives CPR. This assumes that bystanders trained in CPR are more likely to take action than those who are not trained.<sup>3</sup>

### 2. Automated External Defibrillators (AED)

AED training should be encouraged to help improve the time for shock delivery and correct pad placement. The training sessions can be short video/computer self-instruction courses, with minimal or no instructor coaching, combined with hands-on practice.<sup>4</sup> Such sessions should also be given to local volunteers of heart foundations, who can then mobilise their communities.

It is recommended that a guide to basic life support and/or training by a healthcare professional should be provided with the devices. Any rescuer should be able to apply first aid techniques (such as cardiopulmonary resuscitation via a continuous chest compression over the middle of the chest<sup>5</sup>) where no AED is available or while the AED is arriving (after an ambulance call) or is switching on.<sup>6</sup>

The placement of defibrillators should be clearly indicated by signposting, such as the one developed by the International Liaison Committee on Resuscitation.<sup>7</sup>

### 3. Ambulance service

Staff operating in an ambulance should be trained according to national guidelines.

### 4. Necessary equipment to ensure optimal diagnosis

To ensure optimal diagnosis, it is recommended that hospitals and clinics possess appropriate equipment and appropriately trained staff to operate them as described in relevant guidelines. Such equipment includes echocardiograms, electrocardiographs (ECGs), and portable

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<sup>1</sup> European Resuscitation Council Guidelines for Resuscitation 2010, <http://www.cprguidelines.eu/2010/>.

<sup>2</sup> Many of EHN's members propose some examples of emergency life support courses for young people, here is a non-exhaustive list: the British Heart Foundation, UK, the Swiss Heart Foundation, CH, Irish Heart Foundation, IE.

<sup>3</sup> Importance and Implementation of Training in Cardiopulmonary Resuscitation and Automated External Defibrillation in Schools: A Science Advisory from the American Heart Association *Circulation*, 15 February 2011; 123: 691 – 706, <http://circ.ahajournals.org/cgi/content/full/123/6/691>, and Resuscitation Council UK, Adult Basic Life Support, 2010 Resuscitation Guidelines, <http://www.resus.org.uk/pages/bls.pdf>.

<sup>4</sup> European Resuscitation Council Guidelines for Resuscitation 2010, <http://www.cprguidelines.eu/2010/>.

<sup>5</sup> Ibidem.

<sup>6</sup> Ibidem.

<sup>7</sup> International Liaison Committee on Resuscitation (ILCOR), the universal ILCOR AED sign, <http://www.ilcor.org/data/letter-ILCOR-AED-sign.pdf>.

ultrasounds machines. The number of these devices should be sufficient to cover the need of the population living in the surrounding area of the hospital/medical centre.

#### 5. Tools for risk/benefit communication

When proposing a treatment to a patient, healthcare professionals should use terms that are easily understandable, avoiding technical jargon. Treatment options must be carefully explained and, if the treatment presents a degree of risk, the healthcare professional must explain the risk to the patient weighing it against the benefits and ensuring that the patient is allowed to make an informed choice about having the treatment.

#### 6. Waiting Times

Waiting times for non-acute cardiovascular intervention should meet the European Society of Cardiology guidelines and should never be more than 90 days.<sup>8</sup>

#### 7. Guidelines

The European Society of Cardiology has adopted a wide range of guidelines.<sup>9</sup> They present evidence on a particular clinical issue and aim to support health professionals in everyday clinical medical decision-making. Below a non-exhaustive list of guidelines:

- Atrial Fibrillation (Management of)
- Stable Angina Pectoris (Management of)
- Arterial Hypertension (Guidelines on Diagnosis and Treatment of)
- Acute and Chronic Heart Failure
- Prevention of CVD in clinical practice

In terms of the initial management of stroke, some guidelines have been published by the National Institute of Health and Clinical Excellence of the UK (NICE<sup>10</sup>), the European Stroke Organisation<sup>11</sup>, and the Irish Heart Foundation Council on Stroke.<sup>12</sup>

#### 8. Adherence and effectiveness

- a. In order to ensure adherence to treatment and medication, tools to assist healthcare professionals in improving compliance with treatment and medication are available. These tools consist of validated patients questionnaires, telephone reminders, education videos, etc.
- b. Healthcare professionals must ensure the treatment they have suggested is effective. To this end, they can use validated tools such as patients questionnaire or telephone follow-up, or e-Health tools, such as tele-monitoring via an electronic device installed in the patient's household<sup>13</sup>, smartphone applications controlling risk factors, 24/7 free telephone/email contact with nurse.

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<sup>8</sup> EuroHeartIndex, 2008, HealthConsumerPowerhouse, <http://www.healthpowerhouse.com/files/euro-heart-index-2008.pdf>.

<sup>9</sup> For a complete list of the ESC guidelines: <http://www.escardio.org/guidelines-surveys/esc-guidelines/Pages/GuidelinesList.aspx>.

<sup>10</sup> Diagnosis and initial management of acute stroke and transient ischaemic attack (TIA), July 2008, <http://www.nice.org.uk/CG68>.

<sup>11</sup> Guidelines for Management of Ischaemic Stroke and Transient Ischaemic Attack 2008, European Stroke Organisation, January 2009, <http://www.eso-stroke.org/recommendations.php?cid=9&sid=1>.

<sup>12</sup> National Clinical Guidelines and Recommendations for the Care of People with Stroke and Transient Ischaemic Attack, Irish Heart Foundation Council on Stroke, March 2010, <http://www.stroke.ie/media/pub/strokeie/Strokeguidelinesfinal.pdf>.

<sup>13</sup> Telemonitoring or structured telephone support for people with chronic heart failure reduces CHF-related hospital admissions; J. Riley, Cochrane Review, 10.1136/ebn1116.

## 9. Patients eligible for rehabilitation programmes

Rehabilitation programmes should be proposed to patients who have had a: heart attack, coronary angioplasty, coronary bypass surgery or another type of cardiovascular surgery, implantable cardioverter defibrillator, stable heart failure or stroke. Rehabilitation can also be helpful for people who have other conditions such as stable angina, cardiomyopathy or congenital heart disease.<sup>14</sup>

## 10. Components of a rehabilitation team

### a. Cardiac rehabilitation team

A rehabilitation team should be composed of: a cardiologist, specialist cardiac nurse, or a cardiac rehabilitation specialist, physiotherapist, exercise specialist, occupational therapist, dietician and psychologist.<sup>15</sup>

### b. Stroke rehabilitation team

A stroke unit should be staffed by a specialist multidisciplinary team of stroke physicians, nursing staff, physiotherapists, occupational therapists, and speech and language therapists.<sup>16</sup>

## 11. Components of a 'cardiac' rehabilitation programme

### a. Cardiac rehabilitation programme

Acknowledging that every patient is different and cardiac rehabilitation should be suited to the condition of the patient, core cardiac rehabilitation components common to all clinical conditions<sup>17</sup> are:

- Patient assessment (clinical history, symptoms, physical examination, exercise test, etc.)
- Physical activity counselling
- Exercise training
- Diet/nutritional counselling
- Weight control management
- Lipid management
- Blood pressure monitoring
- Smoking cessation
- Psychosocial management

### b. Stroke rehabilitation programme

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<sup>14</sup> Secondary prevention through cardiac rehabilitation: from knowledge to implementation. Piepoli et al, European Journal of Cardiovascular Prevention and Rehabilitation 2010, 17:1–17.

<sup>15</sup> Wood DA, et al., on behalf of EUROACTION Study Group. Nurse-coordinated multidisciplinary, family-based cardiovascular disease prevention programme (EUROACTION) for patients with coronary heart disease and asymptomatic individuals at high risk of cardiovascular disease: a paired, cluster randomized controlled trial. Lancet 2008; 371:1999–2012.

<sup>16</sup> Guidelines for Management of Ischaemic Stroke and Transient Ischaemic Attack 2008, European Stroke Organisation, ESO.

<sup>17</sup> Secondary prevention through cardiac rehabilitation: from knowledge to implementation. Piepoli et al, European Journal of Cardiovascular Prevention and Rehabilitation 2010, 17:1–17.

Acknowledging that every patient is different and stroke rehabilitation should be suited to the condition of the patient, stroke rehabilitation elements are<sup>18</sup>:

- Physiotherapy
- Occupational therapy
- Treatments for communication deficits
- Treatments for cognitive deficits
- Depression monitoring.

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<sup>18</sup> Guidelines for Management of Ischaemic Stroke and Transient Ischaemic Attack 2008, European Stroke Organisation, ESO.