



**IRISH ASSOCIATION OF CARDIAC REHABILITATION**

Submission to Joint Oireachtas Committee  
on Health & Children  
in respect of the importance of protecting  
Cardiac Rehabilitation Services in Ireland.

March 2010

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*Participation in cardiac rehabilitation should be available to all cardiac patients who require it.*

*(IACR Guidelines 2007)*

## **Introduction**

The Irish Association of Cardiac Rehabilitation (IACR) is grateful to the Chair and its members for taking the time to consider this submission highlighting issues relating to services in Ireland's 38 cardiac rehabilitation centres.

## **Who are the IACR ?**

The IACR was established in 1995. It is a multidisciplinary group under the auspices of the Irish Heart Foundation. It endeavors to promote a greater awareness and understanding of Cardiac Rehabilitation in Ireland and to facilitate communication and support between multi-disciplinary groups involved in the area.

## **What does the IACR do?**

The IACR works to:

Advocate on behalf of Cardiac Rehabilitation in Ireland to ensure the service is protected, developed and available to all who require it.

Co-operate and fully collaborate with existing international organisations working in this field to promote an evidence based approach to client care with cardiac rehabilitation.

Improve the standard of professional education within cardiovascular rehabilitation through the promotion of conferences, scientific meetings, publications and contact with appropriate international agencies.

Encourage support and communication support between cardiac rehabilitation multidisciplinary professionals who wish to promote a greater awareness and understanding of cardiac rehabilitation throughout the healthcare system.



## What is Cardiac Rehabilitation ?

Cardiac rehabilitation is a medically supervised program to help heart patients recover quickly and improve their overall physical, mental and social functioning.

The goals of cardiac rehabilitation are to promote secondary prevention and to enhance quality of life among cardiac patients (WHO, 1993). The following specific medical, psychological, behavioural, social and health service goals have been identified:

### *a) Medical Goals*

- To improve cardiac function
- To reduce the risk of sudden death and re-infarction
- To relieve symptoms such as breathlessness and angina
- To increase work capacity
- To prevent progression of the underlying atherosclerotic process

### *b) Psychological Goals*

- To restore self confidence
- To relieve anxiety and depression in participants and their carers
- To improve stress management
- To restore good sexual health

### *c) Behavioural Goals*

- To not smoke tobacco
- To make heart-healthy dietary choices
- To be physically active
- To adhere to medication regimes

### *d) Social Goals*

- To return to work if appropriate and /or previous functional capacity
- To promote independence in activities of daily living for those who are compromised

### *e) Health Service Goals*

- To reduce direct medical cost
- To promote early mobilisation and early discharge
- To reduce cardiac-related re-admissions

## Cardiac Rehabilitation in Ireland.

Cardiac Rehabilitation services have been in development in Ireland since the mid-1970's. Following the implementation of the Building Healthier Hearts programme (launched by DOHC 1999), the growth in CR services was dramatic. In 1998, CR was available in 29% of relevant hospitals. This had increased to 95% in 2005. Full time equivalent staff numbers went from 46 to 135 and there was a 6-fold increase in patients receiving a CR service (from 696 in 1996 to 4210 in 2005). (Delaney et al 2006). Unfortunately, cutbacks in recent years has meant the undermining of some of these positive developments.

## How a Cardiac Rehabilitation Programme Works ?

Cardiac Rehabilitation is a continuous process commencing in hospital following an acute event and continuing on discharge into the community (AHA1994). It can be divided into four distinct phases.

- **Phase 1:** This phase relates to the period of hospitalisation following an acute cardiac event. The duration of this phase may vary depending on the initial diagnosis, the severity of the event and individual institutions. During this phase, individuals typically undergo a risk factor assessment and risk stratification as well as receiving information regarding their diagnosis, risk factors, medications and work/social issues. Involvement and support of the partner and family is facilitated and encouraged. This phase also includes early mobilisation and adequate discharge planning.
- **Phase 2:** This phase encompasses the immediate post discharge period, which is typically a period of four to six weeks. It focuses on health education and resumption of physical activity, however the structure of this phase may vary dramatically from centre to centre. It may take the format of telephone follow up, home visits, or individual or group education sessions. Either way, some form of contact is maintained with the patient, facilitating ongoing education and exchange of information.
- **Phase 3:** This phase is sometimes erroneously referred to as the 'exercise' phase, however it incorporates exercise training in combination with ongoing education and psychosocial and vocational interventions. The duration of Phase 3 may vary from six to 12 weeks, with patients required to attend a CR unit two to three times weekly for structured exercise and other lifestyle interventions.
- **Phase 4:** This phase constitutes the components of long-term maintenance of lifestyle changes and professional monitoring of clinical status. It is when patients leave the structured Phase 3 programme and continue exercise and other lifestyle modifications indefinitely. This may be facilitated in the CR unit itself or in a local leisure centre. Alternatively, individuals may prefer to exercise independently and Phase 4 may involve helping them set a safe and realistic maintenance programme.

(Coats et al 1995, Brodie 2000)

## Evidence

There is robust clinical trial evidence demonstrating the benefits of Cardiac Rehabilitation, which include

- Reduction in overall cardiovascular mortality (Oldridge 1988, O'Connor 1989, Joliffe 2001, Taylor 2003.)
- Slowing of atherosclerosis process (Ornish 1990, Schuler 1992, Haskell 1994, Wenger 1995, Niebaer 1997.)
- Decrease of rates of subsequent coronary events and rehospitalisation (Haskell 1994, Ornish 1999,)
- Increased quality of life.

## What issues are the IACR looking to highlight to the Joint Oireachtas Committee on Health & Children ?

Recent cutbacks have hit Cardiac Rehabilitation hard and the quality of the service is under threat. The IACR would like to highlight the following issues.

### The need to protect cardiac rehabilitation from cutbacks in healthcare system.

Less than 50% of eligible patients have access to cardiac rehabilitation. Furthermore, increased demand for cardiac rehabilitation due to an aging population and an increase in the numbers of people surviving a cardiac event, means that demand for cardiac rehabilitation looks set to increase into the future. In spite of this, staff cuts have been imposed over the last year in 13 out of the country's 38 (34%) cardiac rehabilitation centres.

### The need to ensure availability of a multi-disciplinary team in each cardiac rehab centre.

Cardiac Rehabilitation in Ireland is managed by a Cardiac Rehab Co-ordinator in each of the 38 centres who direct patients to services needed and harness resources of the wider hospital and community system. The cardiac rehabilitation co-ordinator works with and is supported by Cardiologists, Physiotherapists, Nurses, Occupational Therapists, Dieticians, Pharmacists, Psychologists and Social Workers. It is well documented that this multidisciplinary approach is a key success factor in cardiac rehabilitation. Resources must be allocated for the appointment of staff, particularly multi-disciplinary staff, to ensure a thorough rehab service is offered to patients. The importance of the role of cardiac rehabilitation co-ordinator must also be recognised and supported.

### The need to streamline approach and structure of cardiac rehabilitation in different centres.

Cardiac rehabilitation centres offer different services depending on their resources and staffing levels. This means that not all patients receive the optimal cardiac rehabilitation to which they are entitled and deserve.

## [Need for the development of Phase 3 in the community and the introduction of Phase 4 nationwide.](#)

*Phase 3* cardiac rehabilitation incorporates exercise training in combination with ongoing education and psychosocial and vocational interventions. *Phase 4* constitutes the components of long-term maintenance of lifestyle changes and professional monitoring of clinical status.

Patients who receive both Phase 3 and Phase 4 cardiac rehabilitation are less likely to suffer subsequent coronary events than those that don't. These phases play a major preventative role, reducing the burden on acute hospital services. They need to be supported and developed.

## **CONCLUSION**

Cardiac Rehabilitation Programmes are a very effective way to help individuals who experience a cardiac event to deal with the consequences of their illness and support and facilitate them on the road to recovery. It is a cost effective programme with great scope for development. It is imperative that cardiac rehabilitation is prioritised to ensure the necessary resources are available to this service into the future.

The IACR would welcome the opportunity to appear before the committee to discuss in more detail the issues raised in this submission.

## **Further Information / Contact Details**

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