I PERCORSI APPROPRIATI ASSISTENZIALI E TERAPEUTICI IN PREVENZIONE SECONDARIA

Approccio al paziente ad alto rischio cardiovascolare

10 GIUGNO 2022

IL MINIMAL CARE IN CARDIOLOGIA RIABILITATIVA: E SE NON CI SONO TUTTE LE COMPONENTI?

Francesco Fattirolli

Dipartimento di Medicina Sperimentale e Clinica Università di Firenze

Azienda Ospedaliero Universitaria Careggi

2021 ESC Guidelines on cardiovascular disease prevention in clinical practice

4.11. Cardiac rehabilitation and prevention programmes

Cardiac Rehabilitation and Risk Reduction

Time to "Rebrand and Reinvigorate"

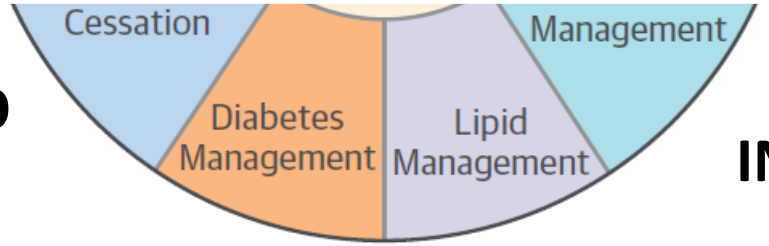
Sandesara, P.B. et al. J Am Coll Cardiol. 2015; 65(4):389-95.

Multidisciplinary Team in Cardiac Rehabilitation

CARDIOLOGO

CR is a comprehensive, multidisciplinary intervention not just including exercise training and PA counselling, but also education, risk factor modification, diet/nutritional counselling, and vocational and psychosocial support

PSICOLOGO



INFERMIERE

A multidisciplinary approach to prevention

Jenning C, Astin F

European Journal of Preventive Cardiology
2017, Vol. 24(3S) 77–87

Whilst it is acknowledged that 'multidisciplinary' relies on the use of knowledge and skills from different disciplines, it does not necessarily refer to an interaction between the disciplines.

"An interdisciplinary team aspires to a more profound level of collaboration (than a multidisciplinary team), in which constituents of different backgrounds combining their knowledge mutually complete different levels of planned care."

Il dietista sa cosa fa il fisioterapista?

L’infermiere sa cosa consiglia il dietista?

Il medico sa cosa dice lo psicologo?

Il Paziente percepisce l’ Interdisciplinarietà?

Il team multi-inter-trans disciplinare in Cardiologia Riabilitativa

Integrare le diverse componenti

Identificare ciò che è essenziale

Declinarne l'applicazione in ogni contesto

Rendere omogenei gli interventi in realtà organizzative differenti

European Journal of Preventive Cardiology
0(00) 1–12

DOI: 10.1177/2047487318789497
journals.sagepub.com/home/ejpc
SAGE

What constitutes the 'Minimal Care' interventions of the nurse, physiotherapist, dietician and psychologist in Cardiovascular Rehabilitation and secondary prevention: A position paper from the Italian Association for Cardiovascular Prevention, Rehabilitation and Epidemiology

Francesco Fattirolli[1], Ornella Bettinardi[2], Elisabetta Angelino[3], Letizia da Vico[4], Marina Ferrari[5], Antonia Pierobon[3], Daniele Temporelli[6], Susanna Agostini[7], Marco Ambrosetti[8], Barbara Biffi[9], Silvana Borghi[10], Silvia Brazzo[11], Pompilio Faggiano[12], Manuela Iannucci[13], Barbara Maffezzoni[14], Maria Luisa Masini[4], Antonio Mazza[15], Roberto Pedretti[15], Marinella Sommaruga[16], Sabrina Barro[17], Raffaele Griffo[18] and Massimo Piepoli[19]

Method used for the minimal care (MC) pathways description.

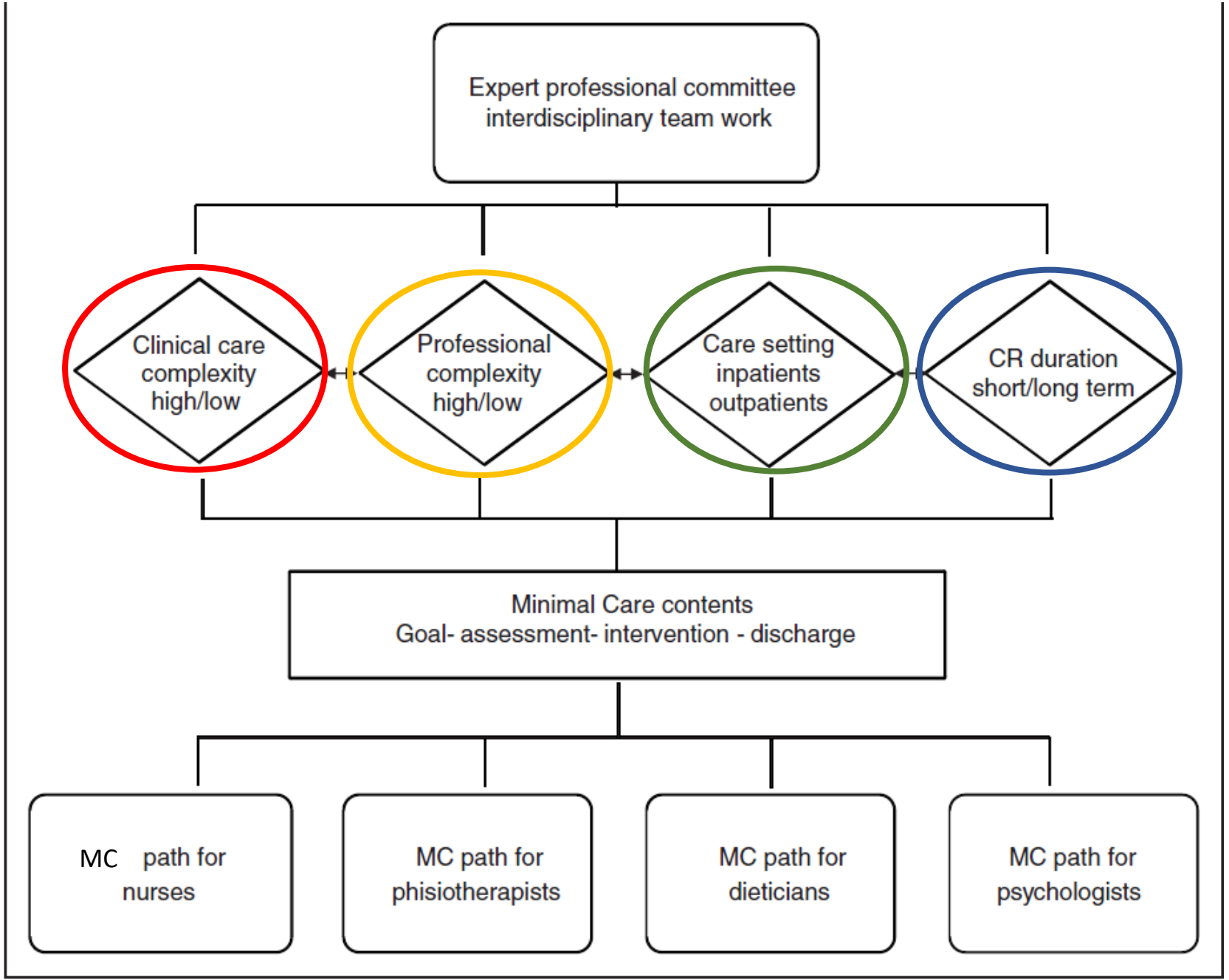


Table 8. High 'area' complexity.

	NURSES	PHYSIOTHERAPISTS	DIETICIANS	PSYCHOLOGISTS
GOALS	Prevention of infections and treatment of surgical wounds or decubitus sores Pain reduction Prevention of risk of malnutrition Identification and management of dysphagia Management and reduction of functional and cognitive dysautonomia	Recovery/improvement of functional autonomy Improvement of respiratory function and joint mobility Correction of postural defects (due to sternotomy and/or saphenectomy) Achievement of self-management capacity of home physical activity	Prevention or treatment of malnutrition with the aim of improving nutritional status	Management/reduction of anxiety-depression symptoms and psychomotor agitation Management/reduction of refusal of self-care and hostility towards the team Management/reduction of smoking, alcohol, and substance abuse behaviours Management/reduction of socioeconomic and family issues
ASSESSMENT	Assessment and monitoring of surgical wounds Assessment and monitoring of pressure sores Assessment and monitoring of: pain, nutritional status, dysphagia, cognitive disability, functional disability	Assessment and monitoring of autonomy, postural movements, balance/gait, falls, fatigue/dyspnoea	Assessment of nutritional risk; nutritional and dietary history Inadvertent loss of weight prior to the index event Assessment and monitoring of biochemical and physical examination aimed at evaluating the nutritional status	Assessment and monitoring of severity and progression of anxiety-depression syndrome, cognitive disability, opposition to care plan Assessment and monitoring of smoking, alcohol, and substance abuse behaviours Assessment of social resources and available community services
INTERVENTION	Management of surgical wounds by advanced dressings Falls risk interventions Implementation of educational activity aimed at patient and caregiver to ensure a correct hydration and nutrition Help or assistance with meals for dysphagia Identification and monitoring	Active-assisted mobilisation exercises Controlled breathing exercises, if necessary with incentive spirometer and lung re-expansion Exercises of segmental-postural gymnastics Muscle strengthening exercises of upper and lower limbs	Nutritional prescription through oral nutritional supplements/enteral nutrition In the case of dysphagia, change in consistency of foods and/or beverages Weaning from artificial nutrition with definition of the gradual shift to oral nutrition	Clinical interview with patient and caregiver Neuropsychological investigation Relaxation exercises and stress management techniques Psychiatric counselling for appropriate psycho-pharmacological support Indications to the team and caregiver on relational

Obiettivi terapeutici

Valutazioni

Interventi

Standardization and quality improvement of secondary prevention through cardiovascular rehabilitation programmes in Europe: The avenue towards EAPC accreditation programme: A position statement of the Secondary Prevention and Rehabilitation Section of the European Association of Preventive Cardiology (EAPC)

European Journal of Preventive Cardiology (2021)

Table 2 **Minimal and optimal structure-based CR metrics, as defined in the European Association of Preventive Cardiology (EAPC) SP/CR accreditation programme.**

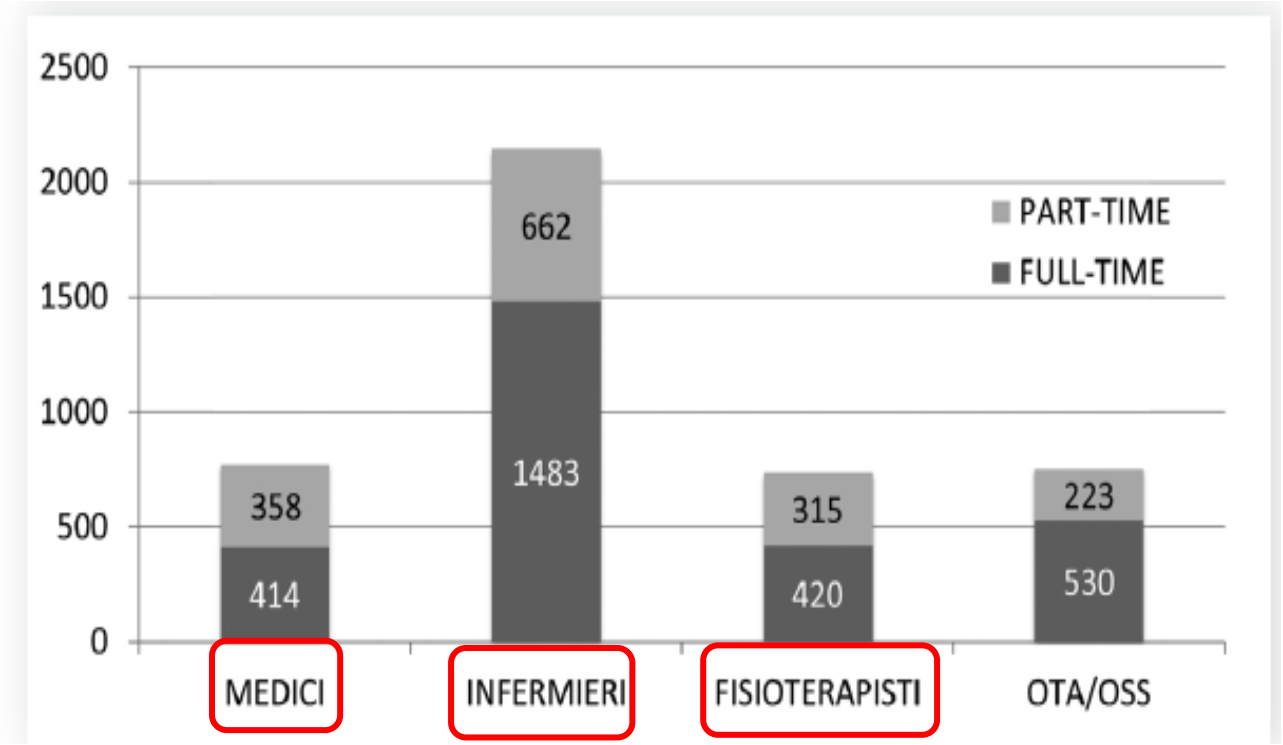
Human resources
Minimal
Multidisciplinary team: cardiologist, nurse, exercise specialist, nutritionist
Optimal
Multidisciplinary disciplinary team includes psychologist
Multidisciplinary team includes additional healthcare professionals: diabetologist, psychiatrist, social worker

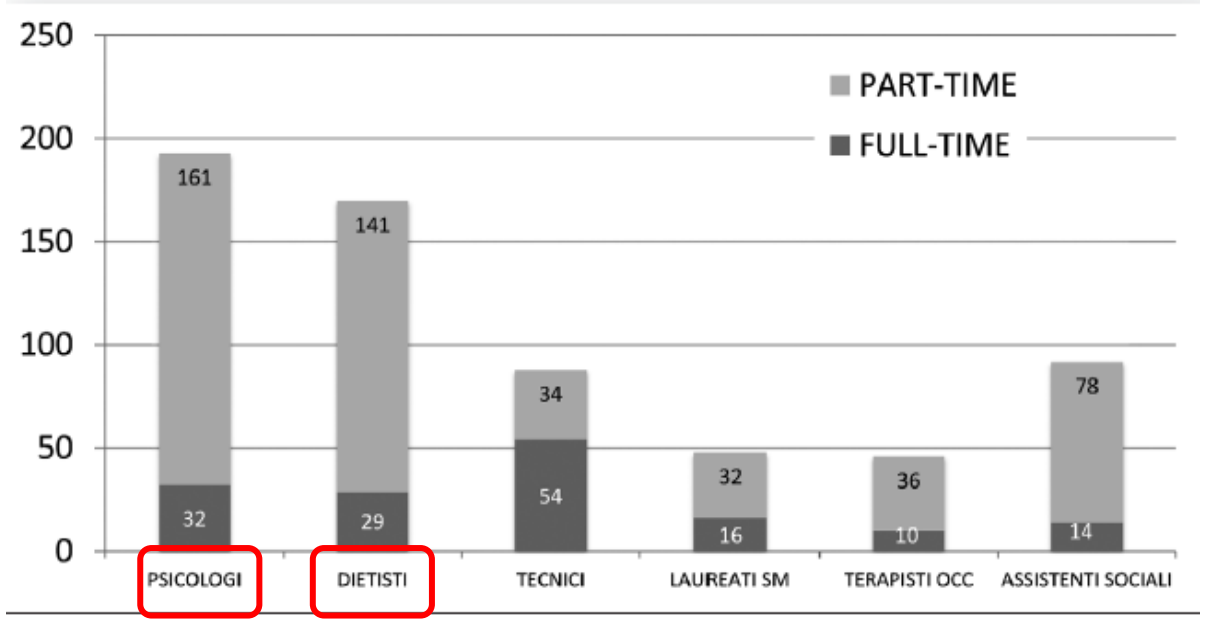
Staffing profile for CR programmes across the UK

2016

CATEGORY	UK TOTAL	
	N	%
NURSE	247	97
PHYSIOTHERAPIST	173	68
DIETITIAN	132	52
PSYCHOLOGIST	36	14
SOCIAL WORKER	2	1
COUNSELLOR	18	7
DOCTOR	23	9
HEALTH CARE ASSISTANT	35	15
SECRETARY	154	60
ADMINISTRATOR	19	7
EXERCISE SPECIALIST	131	51
OCCUPATIONAL THERAPIST	89	35
PHARMACIST	102	40
PHYSIOTHERAPY ASSISTANT	64	25

Italian Survey on Cardiac Rehabilitation (ISYDE.13-Directory): report su strutture, organizzazione e programmi di cardiologia riabilitativa in Italia



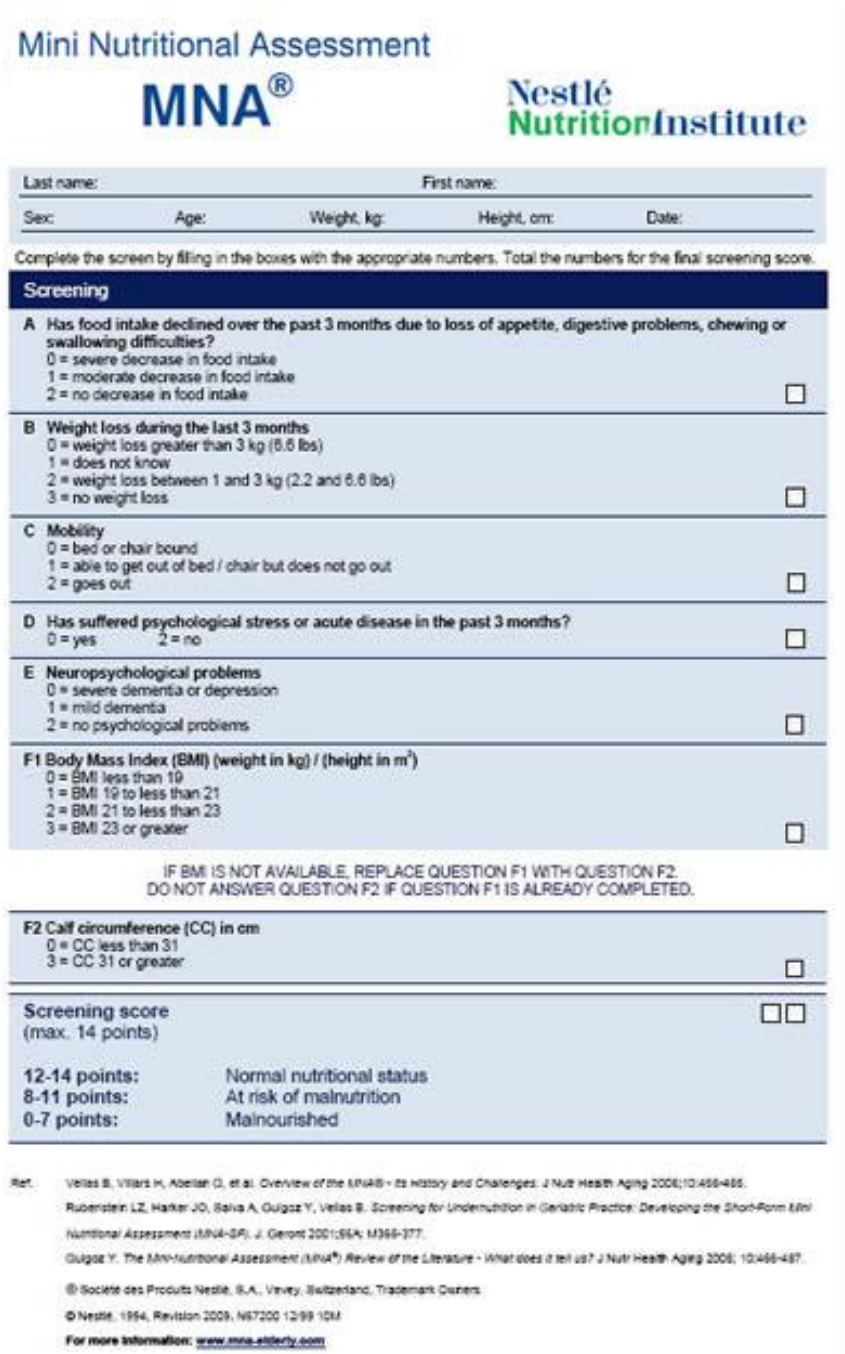


SE NON CI SONO TUTTE LE COMPONENTI PROFESSIONALI

?

ESEMPIO:
SETTING DEGENZIALE
SCREENING PER LA VALUTAZIONE DEL RISCHIO NUTRIZIONALE

Selezione pazienti per consulenza dietetica



Mini Nutritional Assessment

MNA®

Nestlé Nutrition Institute

Last name: First name:

Sex: Age: Weight, kg: Height, cm: Date:

Complete the screen by filling in the boxes with the appropriate numbers. Total the numbers for the final screening score.

Screening

A Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties?
0 = severe decrease in food intake
1 = moderate decrease in food intake
2 = no decrease in food intake ☐

B Weight loss during the last 3 months
0 = weight loss greater than 3 kg (6.6 lbs)
1 = does not know
2 = weight loss between 1 and 3 kg (2.2 and 6.6 lbs)
3 = no weight loss ☐

C Mobility
0 = bed or chair bound
1 = able to get out of bed / chair but does not go out
2 = goes out ☐

D Has suffered psychological stress or acute disease in the past 3 months?
0 = yes 2 = no ☐

E Neuropsychological problems
0 = severe dementia or depression
1 = mild dementia
2 = no psychological problems ☐

F1 Body Mass Index (BMI) (weight in kg) / (height in m^2)
0 = BMI less than 19
1 = BMI 19 to less than 21
2 = BMI 21 to less than 23
3 = BMI 23 or greater ☐

IF BMI IS NOT AVAILABLE, REPLACE QUESTION F1 WITH QUESTION F2.
DO NOT ANSWER QUESTION F2 IF QUESTION F1 IS ALREADY COMPLETED.

F2 Calf circumference (CC) in cm
0 = CC less than 31
3 = CC 31 or greater ☐

Screening score ☐☐
(max. 14 points)

12-14 points: Normal nutritional status
8-11 points: At risk of malnutrition
0-7 points: Malnourished

Ref. Vellas B, Villars H, Abellan G, et al. *Overview of the MNA® - Its History and Challenges.* J Nutr Health Aging 2006;10:456-465.
Rubenstein LZ, Harker JO, Salva A, Guigoz Y, Vellas B. *Screening for Undernutrition in Geriatric Practice: Developing the Short-Form Mini Nutritional Assessment (MNA-SF).* J. Geront 2001;56A: M366-377.
Guigoz Y. *The Mini-Nutritional Assessment (MNA®) Review of the Literature - What does it tell us?* J Nutr Health Aging 2006; 10:466-487.

For more information: www.mna-elderly.com

ESEMPIO:
SCREENING PER LA VALUTAZIONE DEL DISAGIO PSICOLOGICO

Selezione pazienti per consulenza psicologica

Check list *(comprende)*

Pazienti con insonnia, ansia e irritabilità

Pazienti con sofferenza psicologica rilevata dagli altri membri dello staff

Pazienti con storia di disturbi psichiatrici

Pazienti con terapie psicoattive precedenti il ricovero

Competenze professionali del Dietista e del Nutrizionista

Il Dietista è l'operatore sanitario in possesso del diploma universitario abilitante. Ambiti di intervento: Nutrizione clinica, Dietetica applicata al soggetto sano e malato, Prevenzione, Sorveglianza nutrizionale, Educazione alimentare, Ristorazione collettiva.

Non esistono normative che definiscono le competenze del Biologo in ambito Nutrizionale se non il riferimento alla "valutazione dei bisogni nutritivi ed energetici dell'uomo, degli animali e delle piante" (legge n. 396/1967 art. 3 lettera b).

Ambiti di intervento: sorveglianza nutrizionale, educazione alimentare, dietetica preventiva, nutrizione collettiva. Nessuna competenza in Nutrizione Clinica né in Dietetica applicata alle Patologie.

Competenze professionali del Fisioterapista e del Laureato in Scienze Motorie

Il fisioterapista è l'operatore sanitario in possesso del diploma universitario abilitante che svolge in via autonoma, o in collaborazione con altre figure sanitarie, gli interventi di prevenzione cura e riabilitazione nelle aree della motricità, delle funzioni corticali superiori, e di quelle viscerali conseguenti a eventi patologici a eziologia congenita od acquisita.

Il laureato in Scienze Motorie possiede contenuti culturali, scientifici, professionali in:
area didattico-educativa , finalizzata all'insegnamento nelle scuole di ogni ordine e grado;
area della prevenzione e dell'educazione motoria adattata , finalizzata a soggetti di diversa età e a soggetti disabili;
area tecnico-sportiva , finalizzata alla formazione nelle diverse discipline;
area manageriale , finalizzata all'organizzazione e alla gestione delle attività e strutture sportive.

Può essere necessario SELEZIONARE i pazienti se manca la figura professionale ma non è appropriato SOSTITUIRLA

Professionista	**Post-acuto –Cronico**	
MEDICO	Non sostituibile	
INFERMIERE	Non sostituibile	
FISIOTERAPISTA	Non sostituibile	
DIETISTA	*Non sostituibile*	Selezione pazienti
PSICOLOGO	*Non sostituibile*	Selezione pazienti