The Official Journal of the Canadian Council of Cardiovascular Nurses
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Conseil canadien
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cardiovasculaires

Canadian Cardiovascular Congress 2012—Toronto, ON

Jocelyn Reimer-Kent calls the AGM to order

The 2012 CCCN Annual General Meeting and Scientific Sessions took place in Toronto, October 27–31, 2012, as part of the Canadian Cardiovascular Congress (CCC), the premier annual cardiovascular event in Canada. Close to 450 CCCN members attended the Congress, which included 91 CCCN sessions showcasing a wide range of outstanding clinical and research work in the CV nursing field. Registration to the Congress also permitted nurses to attend a multitude of other sessions being offered through the other Congress partners.

CCCN's program started on Sunday, October 28 with three pre-Congress workshops followed by the Congress Opening Ceremonies. CCCN also held its Annual General Meeting that evening. Jocelyn Reimer-Kent, CCCN's President, called the AGM to order at 4:35 p.m. and welcomed everyone in attendance. CCCN's Board of Directors each took a turn reporting on the activities that took place over the past year.

Every year CCCN honours cardiovascular nurses with awards that celebrate nursing excellence. CCCN's 2012 Cardiovascular Nursing awards were presented to Carol Meade-Corkum (Clinical Excellence), Kelly Johnson (Leadership Excellence), Lyne Cloutier (Research Excellence) and Vanessa Morris (Student Award) during the AGM. Nomination guidelines are available on CCCN's website at **www.cccn.ca**.

Dr. S. Clarke speaks during the Opening Plenary session

Following the AGM, a cocktail reception was held and more than 100 CCCN members had the opportunity to network with fellow members from across the country over drinks and hors d'oeuvres.

CCCN's Opening Ceremonies took place on Monday, October 29 over a breakfast sponsored by CCCN's newest national sponsor, General Mills. There has been a longstanding relationship between the two organizations but, most recently, General Mills decided to expand its relationship with CCCN to encompass a year-long partnership. Dr. Sean Clarke followed the Opening Ceremonies and spoke on "Health Human Resources and Change in the Canadian Health Care System: Supply of and Demand for Cardiovascular Nurses in The Coming Decades".

The morning of Tuesday, October 30 had some members attending the Health Promotion Starts with Us Activity with Debbie Childerhose from Women's College Hospital in Toronto. Debbie conducted a session that included a morning stretch and review of the many benefits of walking. Light refreshments to go were provided with support from Bayer.

This activity was followed by the Health Promotion Educational Session with Dr. Milan Gupta who spoke on "Cardiovascular Risk in South Asians: The Thin-Fat Paradox?"

CCCN wrapped up its portion of congress on Tuesday afternoon with a closing panel discussion on "Perspectives on Maintaining Balance: Technology, Ethical Issues and the Financial Constraints of Cardiovascular Health Care". Panel members presented various perspectives on maintaining balance between expanding cardiovascular technology, ethical issues and financial constraints of providing cardiovascular health care.

CCCN would like to take this opportunity to thank its National Sponsors—General Mills, Edwards and Eli Lilly. CCCN would also like to thank all the members who were able to join us at Congress 2012.

Conference coverage continues on page 7…

Above, right and facing page: AGM 2012 Reception

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RUBRIQUE CLINIQUE

Le bon brassard pour mesurer la pression artérielle

Marie-Ève Leblanc, inf., M.Sc., Caroline Lemay, inf., B.Sc., et Lyne Cloutier, inf., Ph.D.

Résumé

La validité de la mesure de la pression artérielle est cruciale car de celle-ci découle la prévention, la détection et la décision d'initier ou non un traitement pour l'hypertension artérielle. Plusieurs facteurs sont à considérer afin d'obtenir une mesure de pression artérielle valide: le matériel utilisé, la technique de mesure et la préparation du patient. L'objectif de cette chronique est de conscientiser le professionnel de la santé à l'importance du choix du brassard lors de la mesure de la pression artérielle.

Mots clés: brassard, hypertension artérielle, lignes directrices, mesure de la pression artérielle

Abstract

Hypertension prevention, detection, follow-up and medication adjustment depend on valid blood pressure measurement. Many factors should be taken into consideration to get accurate blood pressure readings: the blood pressure measurement method, the equipment used and the patient preparation. This column will focus on the importance of the cuff for blood pressure measurement.

Key words: blood pressure measurements, cuff, guidelines, systemic hypertension

Au Canada, 20 % des adultes sont atteints d'hypertension artérielle (HTA) (Robitaille et al., 2011). Prévenir, détecter, traiter et assurer le suivi des patients hypertendus est possible grâce au geste routinier de la mesure de pression artérielle (PA). La validité de la mesure de la PA est cruciale: de celle-ci découle la décision d'initier ou non un traitement anti-hypertenseur (Cloutier, 2007). Plusieurs facteurs sont à considérer afin d'obtenir une mesure de la PA valide tels: le matériel utilisé, la technique de mesure et la préparation du patient. L'objectif de cette chronique est de conscientiser le professionnel de la santé à l'importance du choix du brassard lors de la mesure de la PA.

Que recommandent les lignes directrices canadiennes?

Le Programme éducatif canadien en hypertension artérielle (PECH) a émis les recommandations suivantes concernant les dimensions du brassard. La longueur du brassard doit encercler entre 80–100 % de la circonférence du bras et la largeur doit être entre 40–60 % de la circonférence du bras (Daskalopoulou et al., 2012). Le non-respect de ces recommandations peut fausser la de lecture des mesures de PA obtenues de ±5 mmHg (O'Brien, 1996). Utiliser un brassard trop petit surestime la valeur de la PA, ce qui peut entraîner un traitement pharmacologique non requis. Utiliser un brassard trop grand sous-estime la valeur de la PA, ce qui peut masquer la présence d'une PA élevée et priver de ce fait le patient d'un traitement nécessaire.

Qu'a-t-on de disponible en soins cliniques?

Les compagnies qui conçoivent les appareils de mesures rendent disponibles des brassards s'adaptant à différentes circonférences de bras. Le format des brassards varie sensiblement d'une compagnie à l'autre pour la même catégorie de brassard (*très petit, petit, régulier, large, extra-large)*. Peu importe l'endroit de la prise des mesures de la PA, que ce soit en milieu clinique ou hors du contexte clinique, le choix de la bonne grandeur de brassard reste un élément à considérer.

Choisir la bonne grandeur de brassard

En milieu clinique. La plupart des brassards comporte des démarcations à l'intérieur pour faciliter la sélection de la bonne grandeur. On peut donc facilement sélectionner celui qui convient en prenant le temps de refermer le brassard partiellement autour du bras pour déterminer rapidement, en un coup d'œil, si la grandeur est adéquate (Figure 1A).

Parfois, la grandeur choisie sera « limite » ou très juste pour le bras (Figure 1B). Dans ce cas, il est préférable de prendre un brassard plus grand car un brassard trop serré pourrait surestimer la lecture de pression artérielle obtenue. On pourrait utiliser dans ce cas-ci un brassard *large* pour un bras respectant la limite inférieure de cette grandeur (Ex : Bras de 32 cm de circonférence : utiliser le brassard *large* dont les limites inscrites sont entre 32–45 cm). À l'inverse, lorsque le bras est d'une circonférence très petite, même si il s'agit d'un adulte, un brassard habituellement employé pour des enfants, pouvant s'ajuster à des circonférences plus petites, sera utilisé. On peut donc évaluer la grandeur nécessaire en utilisant les marques des manufacturiers ou encore mesurer la circonférence du bras au préalable, ce qui facilitera le choix de la grandeur la plus appropriée. Cette mesure devrait être inscrite au dossier et l'information devrait être transmise au patient. La mesure de la circonférence du bras doit être réalisée à mi-chemin entre l'acromion et l'olécrane.

En milieu ambulatoire. Les mesures de la PA effectuées hors du contexte clinique sont effectuées avec des appareils de mesure dont les brassards comportent également des démarcations qui facilitent la sélection d'un brassard de taille appropriée comme pour les appareils utilisés en milieu clinique. Les mesures de pression artérielle obtenues en milieu ambulatoire permettent d'exclure le phénomène de sarrau blanc soit, l'augmentation transitoire de la PA en clinique en présence d'un professionnel de la santé (Angeli, Reboldi, & Verdecchia, 2010) ainsi que l'HTA masquée, caractérisée par des valeurs de PA plus basses en milieu clinique (Bobrie et al., 2004). La mesure ambulatoire de la PA (MAPA) et la mesure de la PA à domicile (MPAD) sont deux méthodes de mesure ambulatoire.

Le MAPA permet d'obtenir des mesures représentatives des fluctuations de PA de jour et de nuit grâce à un appareil installé par un professionnel de la santé qui est porté par le patient durant une journée complète (24 heures). La MPAD permet d'obtenir des mesures de PA effectuées au domicile par le patient le matin et le soir pendant une semaine. Lors de l'achat d'un appareil pour la MPAD, la taille du brassard doit correspondre à la circonférence du bras du patient. Les appareils de mesure sont souvent vendus en pharmacie ou dans les magasins à grandes surfaces. Le personnel de la pharmacie pourra vérifier avec la personne si la grandeur du brassard inclus avec l'appareil vendu lui convient.

Situations particulières

Dans certaines situations, l'infirmière peut se questionner quant au choix du bon brassard. Les enfants, les personnes âgées et les personnes atteintes d'obésité sont des exemples pouvant représenter un défi par rapport à ce choix. Voici des pistes de solution afin d'outiller les professionnels de la santé face aux situations énumérées.

Enfants. Les enfants ont des bras de circonférence plus petite que les adultes. Lorsqu'on mesure la PA chez un enfant il faut utiliser un brassard respectant les normes de mesures établies. Les règles de mesure de circonférence chez l'adulte s'appliquent également chez l'enfant (National High Blood Pressure Education Program Working Group on High Blood Pressure in Children and Adolescents, 2004). Lorsque le brassard adéquat semble tout de même trop petit et entraîne un inconfort marqué chez l'enfant, il est recommandé d'utiliser la grandeur supérieure même si celui-ci semble trop grand (National High Blood Pressure Education Program Working Group on High Blood Pressure in Children and Adolescents, 2004). Chez les adolescents, le brassard adulte convient généralement. Dans le cas contraire, l'infirmière sélectionnera plutôt le plus grand brassard pédiatrique pour les adolescents plus minces. Évidemment, il est préférable d'utiliser la méthode manuelle, ou auscultatoire, chez l'enfant tout comme chez l'adulte, surtout en cas de doute sur la valeur obtenue avec l'appareil automatique, ou oscillométrique (National High Blood Pressure Education Program Working Group on High Blood Pressure in Children and Adolescents, 2004).

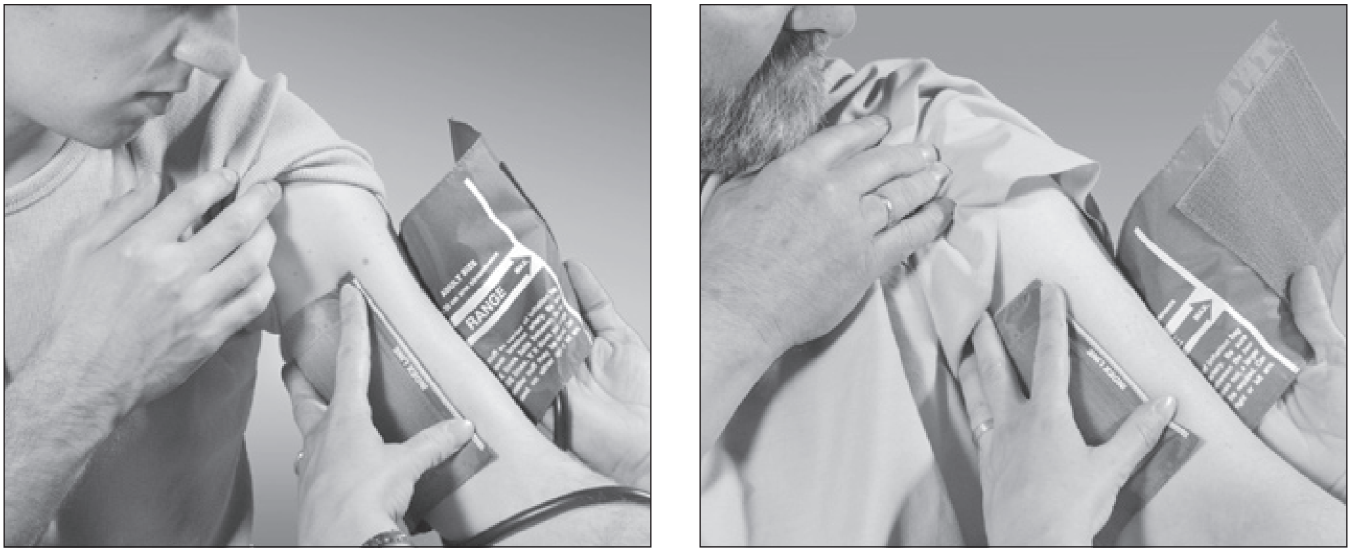

Figure 1. Ajustement du brassard. A. Grandeur adéquate. B. Grandeur inadéquate.

Personnes âgées. Les bras des personnes âgées sont parfois plus minces ou, à l'opposé, comportent un surplus de tissu adipeux sur la partie supérieure du bras donnant au bras une forme conique. L'utilisation d'un brassard adulte *régulier* pourrait ne pas convenir dans cette situation et se révéler trop grand ou trop petit. Si le brassard est trop grand, on peut utiliser un brassard adulte *petit* ou encore un brassard pédiatrique. Lorsque le bras est de forme conique, s'assurer que le brassard se referme bien lors de la prise de mesure.

Personnes atteintes d'obésité. Les personnes atteintes d'obésité, particulièrement celles atteintes d'obésité sévère, ont parfois un bras large, court et de forme conique. Dans ces situations, il faut évidemment respecter le plus possible les normes de mesures pour le choix du bon brassard en s'assurant que le brassard choisi se referme bien lorsqu'on l'installe sur le bras et qu'il reste en place lors de la réalisation de la mesure. Devant l'impossibilité d'adapter le brassard au bras du patient, on a constaté que plusieurs professionnels de la santé utilisaient la mesure de la PA à l'avant-bras comme alternative dans leur pratique. Cette alternative n'est pas documentée dans la littérature et ne figure pas dans les lignes directrices du PECH (Daskalopoulou, et al., 2012). En l'absence de recommandation sur la mesure de la PA à l'avant-bras, il faut demeurer vigilant dans l'adoption de cette technique car il n'est pas acquis que la valeur de PA obtenue soit valide, fiable et reproductible. Par ailleurs, si le professionnel de santé décide de mesurer la PA à l'avant-bras, celui-ci devrait décrire au dossier du patient la méthode de mesure de PA utilisée avec suffisamment de détails permettant de la reproduire en expliquant les raisons qui ont justifié ce choix (ex. brassards disponibles trop petits). Il est permis de penser que cette méthode pourrait éventuellement être adoptée lorsque les études de validation seront complétées et auront déterminé la procédure à suivre.

Conclusion

Déterminer la grandeur de brassard qui convient le mieux à la circonférence du bras d'un patient est nécessaire lors de chaque mesure de la PA. En pratique, on rencontre parfois des situations où le choix du brassard est problématique. Utiliser son jugement et respecter les recommandations déterminant le choix de la bonne grandeur de brassard permettent d'uniformiser les pratiques et d'obtenir des valeurs valides, fiables et reproductibles de la pression artérielle. ♥

Au Sujet des Auteures

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CCCN 2013 Membership Renewal

(Membership period from January 1 to December 31)

2012 was a very exciting year for the Canadian Council of Cardiovascular Nurses. Our membership grew by more than 480 members to an all-time high of **1,224 members**. Our annual spring 2012 conference "Updating your Cardiovascular Nursing Toolkit" in Regina saw 134 members enjoy a full day of education and networking, and 425 members attended the CCCN Annual General Meeting and Scientific Sessions in Toronto.

CCCN divisions hosted **free monthly webinars** on topics such as: Metabolic Syndrome, **Expanding the Horizons of Cardiovascular Therapies: New Antiplatelet and Anticoagulation Options, and Home and Community Care – Interpreting Signs and Symptoms of Heart Failure, as well as a variety of education and networking sessions**: Alberta Lunch Rounds, Manitoba education session entitled **"SADS: Sudden Arrhythmia Death Syndromes", Nova Scotia Annual Education Conference "Cardiac Nursing Update" and professional health advocacy challenges** just as the one hosted by the Ontario Division "Be First to Walk to the 2012 CCCN Conference!"

Through the **Cardiovascular Nursing Excellence Recognition Program**, four CCCN members were recognized and awarded Certificates of Excellence at the Annual General Meeting in Toronto and more than $5,000.00 was awarded in research grants. Our *Canadian Journal of Cardiovascular Nursing (CJCN)* got a new look and we introduced a monthly electronic newsletter.

We invite you to visit our website at **www.cccn.ca** for a complete list of member benefits, including a **new partnership** with The Personal Insurance Company that gives members like you exclusive rates on your home and auto insurance.

It is easy to renew. Simply visit our website at **www.cccn.ca** and login. If you have any trouble logging in, or wish to renew over the phone or pay by cheque, please contact our national office and they will be more than happy to help you.

Tell us what you want! We would love to hear from you and find out how we can improve our services. Please share your feedback with us by contacting Kathryn Cyr at the CCCN at **kathryn@cccn.ca** or by phone at 613-599-9210 ext. 2.

Thank you for renewing your membership in CCCN

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**Conseil canadien
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infirmiers en soins
cardiovasculaires**

The 2013 CCCN Annual General Meeting and Scientific Sessions will take place in Montreal, October 17–20, 2013. This will be a truly unique event. Recognizing the opportunity for shared knowledge and community building, four organizations will come together for a one-time Canadian event: **Vascular 2013!**

For the first time in Canada, the Canadian Cardiovascular Society, the Canadian Diabetes Association, the Heart and Stroke Foundation of Canada, and the Canadian Stroke Network will join forces to coordinate their respective annual meetings/congresses in one venue. The meetings will be held in parallel from Thursday, October 17, 2013 until Sunday, October 20, 2013.

Upon registering, delegates will have full access to all sessions across all Congresses. Visit **www.cccn.ca** for more details.

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Congratulations to the CCCN 2012 Award Winners

Carol Meade-Corkum, Cardiovascular Nursing Clinical Excellence Award

Kelly Johnson, Cardiovascular Nursing Leadership Excellence Award

Lyne Cloutier, Cardiovascular Nursing Research Excellence Award

Vanessa Morris, Mae Gallant Cardiovascular Nursing Student Award

Every year, CCCN honours cardiovascular nurses with awards that celebrate nursing excellence. Awards are presented at the CCCN Annual General Meeting & Scientific Sessions. Deadline for application is August 31, 2013. For nomination guidelines and additional information, please visit our website at **www.cccn.ca**

Please consider nominating a nurse you feel exemplifies the best in cardiovascular nursing.

Student Oral & Poster Presenter Awards 2012

John Kayser, Canadian Cardiovascular Congress 2012 Student Oral Presenter Award

Sheila O'Keefe-McCarthy, Canadian Cardiovascular Congress 2012 Student Poster Presenter Award

The purpose of the student oral/poster presenter awards is to recognize excellence in clinical or research presentations based on work completed as a student and related to the student's program of study. The presentation must be made within a year of graduation and the student must be the lead or co-author, and the presenting author at the CCCN National Scientific Sessions.

ERRATUM

In the Fall 2012 issue of *The Canadian Journal of Cardiovascular Nursing*, the French abstracts for the two articles were printed with errors. Please see the corrected abstracts here. Our apologies to our readers.

Les infirmières praticiennes en soins post-opératoires de chirurgie cardiaque: sont-elles efficaces?

Résumé

Introduction *: Au Canada, les résultats des recherches scientifiques évaluant la pertinence du rôle des infirmières praticiennes spécialisées (IPS) dans les unités de soins post-opératoires de chirurgie cardiaque ont été dépassés par une demande accrue de ces ressources dans les milieux.*

But *: Comparer l'efficacité des soins post-opératoires de chirurgie cardiaque prodigués par l'IPS, aux soins prodigués par le médecin responsable du patient sur une unité de chirurgie cardiaque d'un centre hospitalier universitaire affilié, de niveau tertiaire.*

Méthodes *: Les patients en attente d'une chirurgie cardiaque élective ou urgente (pontages coronariens ou chirurgie valvulaire) ont été aléatoirement assignés dans l'un des deux groupes soit celui de l'IPS (*$n = 22$*) ou médecin responsable du patient (*$n = 81$*) pour le suivi post-opératoire. L'IPS et le médecin responsable ont travaillé en collaboration avec le chirurgien cardiaque. Les variables qui ont été mesurées dans les deux groupes sont la durée du séjour hospitalier, le taux de réadmission, les complications post-opératoires, l'observance aux rendez-vous de suivis, l'inscription à un centre de réadaptation cardiaque ainsi que la satisfaction des patients et de l'équipe de soins.*

Résultats *: Au départ, les caractéristiques démographiques se sont révélées similaires entre les deux groupes à l'exception que : le groupe suivi par l'IPS ont eu des interventions chirurgicales urgentes (*$p \leq 0.01$*) et ont eu davantage des procédures chirurgicales compliquées* $p \leq 0.01$*). Lors du congé médical, plus de patients dans le groupe sous les soins du médecin responsable de l'unité ont eu un rendez-vous avec leur médecin de famille durant la semaine suivant leur congé (*$p \leq 0.02$*). Les mesures de satisfaction concernant l'enseignement, la réponse aux questions, l'écoute et la gestion de la douleur ont été plus élevées dans le groupe de l'IPS.*

Conclusion/Implications *: Cette étude a contribué à optimiser l'importance du rôle de l'IPS auprès des patients en soins post-opératoires de chirurgie cardiaque. Malgré une participation moindre qu'escomptée initialement, nos constats permettent de clarifier le rôle de l'IPS dans le cadre des soins post-opératoires de chirurgie cardiaque. En effet, les patients ayant bénéficiés des soins de l'IPS en période post-opératoire de chirurgie cardiaque ont présenté des résultats similaires aux patients recevant des soins du médecin responsable de l'unité de soins en regard des variables à l'étude mais, pour certaines mesures de soins, un niveau de satisfaction supérieure a été observé.*

Étude pilote randomisée évaluant les effets d'un programme de cessation tabagique par une infirmière chez des patients cardiaques après leur congé de l'hôpital

Résumé

Introduction *: Un Canadien sur cinq est fumeur, malgré la disponibilité de programmes en cessation tabagique dans la communauté. Une hypothèse a été émise: la mise en place d'un programme d'intervention en cessation tabagique chez des patients cardiaques après leur congé de l'hôpital diminuera le taux de fumeurs à 6 mois.*

Méthodes *: Cette étude pilote randomisée a exploré la faisabilité, l'acceptabilité et l'efficacité d'un programme en cessation tabagique prodigué par une infirmière spécialisée en cessation tabagique chez des patients cardiaques après leur congé de l'hôpital.*

Échantillon *: À leur sortie de l'hôpital, les participants (*$N = 40$*) ont été aléatoirement attribués à une intervention téléphonique à raison d'un appel par semaine durant le premier mois suivant le congé de l'hôpital, puis un appel à chaque mois jusqu'au* 3^e *mois (Groupe expérimental [GE]), ou référés aux soins usuels habituellement offerts en communauté (Groupe contrôle [GC]).*

Résultats *: Les chercheurs confirment la faisabilité du recrutement et l'acceptabilité de l'intervention mais le suivi est difficile. Il a été démontré, selon l'« intention-to-treat », des taux de cessation tabagique à 6 mois similaires entre les deux groupes (25 % GE vs 30 % GC;* $p = 0.72$*).*

Conclusion *: Un protocole de suivi soutenu ou encore un programme d'interventions multidisciplinaires plus intensif et adapté aux fumeurs semble nécessaire, compte tenu de leurs caractéristiques.* ♥

Another recertified nurse in CV nursing:

Pauline Fletcher,
Toronto, ON

Pauline's name was accidentally missed from the list of newly-certified and recertified nurses in cardiovascular nursing in 2012.

Annual Spring Conference: “Update Your Nursing Toolkit”

Saturday May 25, 2013, Sheraton Hotel, St. John’s, Newfoundland

Come out and enjoy this premiere annual conference. This conference is designed for nurses (including students) in urban, rural and remote settings, practising in acute care, community, or public health, in roles that span front-line to advanced practice and any other health care professionals interested in updating their knowledge of cardiovascular disease prevention and management.

It will also provide education needed for nurses in either obtaining or retaining cardiovascular certification with the Canadian Nurses Association.

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Thank you to our recent peer reviewers and volunteer translators

We would like to express our sincere appreciation to our peer reviewers who assisted the Associate Editors by reviewing manuscripts for the Canadian Journal of Cardiovascular Nursing during 2012.

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CCCN SCIENTIFIC SESSIONS CALL FOR ABSTRACTS

in conjunction with the Canadian Cardiovascular Congress in Montreal, QC, October 17–20, 2013

CCCN is announcing a Call for Abstracts related to any aspect of cardiovascular and/or cerebrovascular nursing for presentation at the Scientific Sessions of the Canadian Council of Cardiovascular Nurses in Montreal, Quebec, October 17–20, 2013.

Submissions are invited for presentation in English or French. Please indicate on the abstract form the language in which you would like to present. Abstracts are invited in **four** presentation options.

Workshop: Workshop presenters will offer an interactive discussion and analysis of a clinical topic or clinical practice issue in a forum lasting 50–60 minutes. The abstracts for the workshop sessions must meet the same criteria as the other submissions, and must outline the educational objectives, proposed content area and method of presentation (i.e., case study, multiple choice questions) for attendees to interact with one another and the presenters.

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Submissions will be peer reviewed in one of two broad categories: research and non-research. An abstract submission will be reviewed in the "research" category if it describes some aspect of an original piece of research, either as "completed research" or "research in progress".

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Abstract submissions will be considered under one of the following themes: ACS/AMI, stroke, paediatrics and congenital heart disease, arrhythmia management, health promotion, nursing education, health services, patient safety, heart failure/transplant, cardiac surgery and other.

Submission of an abstract constitutes a commitment by the author(s) to attend the meeting and present their abstract. All presenting authors must register for the meeting and are responsible for their own transportation and accommodation. Abstract grading will be performed by blind review and notification of acceptance or rejection of abstracts will be by email in May–June 2013.

Students are invited to submit their abstract to be considered for either an oral or poster presentation award at the CCCN Scientific Annual Meeting. Each award recognizes excellence in a clinical or research presentation. Successful candidates will be awarded a free membership and a certificate of achievement. To be eligible for either an oral or a poster presentation award:

1. The presentation has to be based on work completed as a student and related to the student's program of study.
2. The presentation must be made within a year of graduation.
3. The student must be either the lead or co-author, and also must be the presenting author at the CCCN National Scientific Session.
4. The student must be a current member of CCCN.

Please note: CCCN has an online submission process and all abstracts **must** be submitted on the CCCN website at **www.cccn.ca**. Online submission will open February 15, submission deadline is April 1, 2013 at 2400 hours. For more information, visit **www.cccn.ca** or contact **info@cccn.ca**.

Please note: *Abstracts that have been previously presented at CCCN Scientific Sessions will not be accepted. Should an abstract be accepted for presentation at CCCN Scientific Sessions in Montreal, it may not be presented in duplicate at another national conference before or within three months following presentation at CCCN.* ♥

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APPEL DE RÉSUMÉS POUR LES SÉANCES SCIENTIFIQUES DU CCIISC

en conjonction avec le Congrès canadien sur la santé cardiovasculaire à Montréal, QC, du 17 au 20 octobre 2013

Le Conseil canadien des infirmières et infirmiers en soins cardiovasculaires (CCIISC) lance un appel de résumés portant sur des aspects particuliers des soins cardiovasculaires, ou cérébrovasculaires, ou les deux, pour être présentés dans le cadre des Séances scientifiques du Congrès canadien sur la santé cardiovasculaire qui aura lieu à Montréal, QC, du 17 au 20 octobre 2013.

Vous pouvez proposer des résumés en vue des présentations en français ou en anglais. Veuillez indiquer sur le formulaire de proposition de résumé la langue dans laquelle vous aimeriez offrir votre présentation. Vous pouvez nous proposer un résumé pour les **quatre** options de présentation suivantes :

Présentation en atelier : Les présentatrices et présentateurs en atelier offriront une discussion et une analyse interactives d'un sujet clinique ou d'une question de pratique clinique dans un format de tribune d'une durée de 50 à 60 minutes. Les résumés proposés pour les séances d'atelier doivent respecter les mêmes critères que pour les autres propositions. Ils doivent énoncer les objectifs d'apprentissage, le contenu proposé et la méthode de présentation (étude de cas, questions à choix multiple) pour permettre aux participantes et aux participants d'interagir ensemble et avec les présentatrices et les présentateurs.

Présentation orale : La présentation orale du contenu sur papier devra durer 15 minutes, et elle sera suivie d'une période de questions et réponses de cinq minutes.

Présentation sur affiche : Les affiches seront exposées pendant deux jours à la conférence du CCIISC. Les présentatrices et les présentateurs devront être présents près de leur affiche pendant 30 minutes au cours de l'une ou l'autre des deux journées. Les présentatrices et les présentateurs sur affiche **peuvent** être choisis par le comité d'examen des résumés afin de présenter leur affiche dans une séance orale d'affiche qui sera animée.

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Les résumés proposés seront examinés par les pairs selon l'une des deux grandes catégories suivantes : « travail lié à la recherche » et « travail non lié à la recherche ». Un résumé proposé sera examiné dans la catégorie « travail lié à la recherche » s'il décrit un aspect d'un travail de recherche original, soit à titre de « travail de recherche achevé » ou de « travail de recherche en cours ».

La catégorie « travail non lié à la recherche » comprend les travaux théoriques, les travaux qui portent sur des applications cliniques, les analyses documentaires, etc. (c'est-à-dire qu'il ne s'agit pas de la description d'un travail de recherche original). Les sujets cliniques sont fortement encouragés.

Les résumés proposés seront considérés aussi selon l'un des thèmes suivants : Syndrome coronarien aigu (SCA) et Infarctus aigu du myocarde (IAM); Accident vasculaire cérébral; Pédiatrie et Cardiopathie congénitale; Gestion de l'arythmie; Promotion de la santé; Enseignement infirmier; Services de santé; Sécurité du patient; Insuffisance cardiaque et Transplantation; Chirurgie cardiaque; et autre.

Il est entendu que les auteures et auteurs qui proposent un résumé s'engagent à participer à la rencontre et à y faire une présentation de leur résumé. Toutes les auteures et tous les auteurs qui font une présentation doivent s'inscrire à la rencontre et sont responsables de leur déplacement et de leur hébergement. Les résumés proposés seront classés par examen aveugle et les avis d'acceptation ou de refus seront envoyés par courriel en mai ou en juin 2013.

Les étudiantes et les étudiants sont invités à proposer un résumé devant être présenté en format oral ou sur affiche pour être admissibles à un prix à la Réunion scientifique annuelle du CCIISC. Chaque prix reconnaît l'excellence d'une présentation clinique ou liée à la recherche. Les lauréates et les lauréats obtiendront une adhésion gratuite et un certificat de mérite. Critères d'admissibilité à un prix pour une présentation en format oral ou sur affiche :

1. La présentation doit être basée sur un travail achevé à titre d'étudiante ou d'étudiant et elle doit porter sur le programme d'études de l'étudiante ou de l'étudiant.
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4. L'étudiante ou l'étudiant doit être membre courant(e) du CCIISC.

Veuillez noter que le CCIISC utilise un processus de proposition en ligne et que tous les résumés **doivent** être proposés sur le site Web du CCIISC à **www.cccn.ca**. Le processus de proposition en ligne ouvrira le 15 février 2013, et la date limite de proposition sera le 1er avril 2013 à 24 h. Pour en savoir plus, allez à **www.cccn.ca** ou contactez **info@cccn.ca**

Veuillez noter *que les résumés qui ont déjà été présentés aux Séances scientifiques du CCIISC ne seront pas acceptés. Advenant qu'un résumé soit accepté en vue d'une présentation aux Séances scientifiques du CCIISC à Toronto, il ne pourra pas être présenté en double à une autre conférence nationale avant sa présentation au séances du CCIISC, ou dans les trois mois qui suivront les séances du CCIISC.* ♥

Exposing Barriers to End-of-Life Communication in Heart Failure: An Integrative Review

Ella L. Garland, RN, MN, CHPCN(C), Anne Bruce, RN, PhD, Kelli Stajduhar, RN, PhD

Abstract

Background: *End-of-life (EOL) communication is lacking despite patients with heart failure (HF) and their caregivers desiring it.*

Aim: *To review the existing literature to identify barriers that inhibit EOL communication in the HF population.*

Method: *We chose an integrative literature review method and began by searching CINAHL, Medline, PsychInfo, Web of Science, Health Source Nursing Academic, Evidence-Based Medicine Reviews (EBMR), dissertations and theses searches through the University of Victoria and through Proquest from 1995 to 2011.*

Data evaluation: *EOL communication regarding wishes, prognosis and options for care rarely happen. We noted that patients lacked understanding of HF, feared engaging health care professionals (HCP), did not wish to talk about EOL, or waited for HCPs to initiate the conversation. HCPs lacked communication skills, focused on curative therapies and found diagnosing and prognosticating HF difficult. Limited time and space for conversations played a role.*

Conclusion: *The challenge of diagnosing and prognosticating HF, its unpredictable trajectory, HCP inexperience in recognizing nearing EOL and lack of communication skills lead to HCPs avoiding EOL conversations. Four categories of barriers to communication were identified: patient/caregiver, HCP, disease-specific and organizational challenges.*

Key words: palliative care, heart failure, communication barriers, communication

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Exploration des obstacles à la communication en fin de vie dans l'insuffisance cardiaque : Une revue intégrative

Résumé

Fondement *: La communication en fin de vie est déficiente malgré que les personnes atteintes d'insuffisance cardiaque et leurs proches aidants la souhaitent.*

But *: Réviser la littérature pour identifier les obstacles qui empêchent la communication en fin de vie auprès des personnes atteintes d'insuffisance cardiaque.*

Méthode *: Une revue intégrative de la littérature a été choisie en commençant par une recherche sur CINAHL, Medline, PsychInfo, Web of Science, Health Source Nursing Academic, Evidence-Based Medicine Reviews, les mémoires et les thèses de recherche de l'Université de Victoria et Proquest publiés entre 1995 et 2011.*

Résultats *: La communication concernant les désirs, le pronostic et les opinions en regard des soins en fin de vie surviennent rarement. Nous avons constaté que les patients manquaient de compréhension sur l'insuffisance cardiaque, que les professionnels de la santé craignaient de s'engager, ne souhaitent pas parler de la fin de vie ou attendaient que les professionnels de la santé initient la conversation. Les professionnels de la santé manquaient d'habiletés de communication, axaient sur les thérapies curatives et la difficulté à identifier le diagnostic et le pronostic de l'insuffisance cardiaque. Des limites de temps et d'espace empêchent les conversations de jouer un rôle.*

Conclusion *: Le défi du diagnostic et du pronostic de l'insuffisance cardiaque, sa trajectoire imprévisible, l'inexpérience des professionnels de la santé pour reconnaitre la fin de vie imminente et le manque d'habilités de communication empêchent les professionnels de santé d'entreprendre des conversations sur la fin de vie.*

Heart failure (HF) is a life-threatening illness that is predicted to escalate as the population in Canada ages (Strachan, Ross, Rocker, Dodek, & Heyland, 2009). Perhaps surprising to some health care professionals (HCPs) is that the mortality rate of HF is similar to that of some cancers (O'Leary, 2009). The unpredictable trajectory of HF challenges HCPs in identifying when patients are approaching end of life (EOL) and, consequently, palliative and EOL care are often not considered as options for care in a timely manner (Murray et al., 2002). However, research shows that while patients with HF and their families have similar needs as those with cancer, such as prognostic information, coordination of care, psychosocial care and symptom management needs, they receive less palliative and EOL care (Boyd et al., 2004; Murray et al., 2002). Using a palliative approach for patients with HF and their families has the potential to reduce these inequities.

The World Health Organization (n.d.) defines a palliative approach as one that improves quality of life (QOL) and relieves suffering for patients and their families living with life-threatening illnesses. Far from just care of the dying, palliative care can be implemented early in the trajectory of HF and can augment life-prolonging therapies (Selman, Beattie, Murtagh, & Higginson, 2009). Patient- and family-centred communication is a core tenet of the palliative approach (Kirk & Kirk, 2006) and influences emotional well-being, functional ability, physiological status and pain and symptom management (Stewart, 1995). Poor communication can negatively impact QOL, leading to anxiety or anger (Harding et al., 2008), undesired treatments at EOL (Strachan et al., 2009) and affect place of death (Murray et al., 2002).

The Canadian Cardiovascular Society (Arnold et al., 2006) guidelines explicate the need to communicate with patients about their prognosis to promote informed decision-making and to gain clarity around preferences for EOL care. Despite this, research indicates that EOL communication for patients with HF is lacking (Davidson, 2007). Davidson (2007) describes the limited communication in HF as a "conspiracy of silence" (p. 274). The term conspiracy, while provocative, implies a conscious decision by the parties involved to evade EOL communication. While this may have a base in truth, we argue that the complexities inherent in the care of patients with HF conspire to inhibit communication. Thus, the question to be answered by this integrated literature review is: What is the current state of knowledge about the barriers that interfere with EOL communications with patients with HF, their caregivers and HCPs?

Method

An integrative review includes all pertinent literature, regardless of method, ensuring a comprehensive perspective of the topic with which to inform nursing practice, policy and research (Whittemore & Knafl, 2005). There are five stages to the integrative review process including problem formation, literature review, data evaluation and analysis and, finally, presentation of findings (Whittemore & Knafl, 2005).

With the problem stated above, the next stage is the literature search, which employed the following databases in research retrieval: CINAHL, Medline, PsychInfo, Web of Science, Health Source Nursing Academic, Evidence-Based Medicine Reviews (EBMR), and dissertations and theses at the University of Victoria and through Proquest. Search terms included palliative care, hospice, end-of-life, supportive care, palliative treatment and palliative approach along with heart failure, cardiac failure, chronic heart failure, congestive heart failure and advanced heart failure and finally, the terms communication, communication barrier and conversation. Initial search limitations were identified as English, peer-reviewed articles from the 1995 to 2011.

This initial search yielded 164 articles whose titles were screened for relevance to the research topic, thus narrowing the field to 50 articles. In addition to the search limitations above, inclusion criteria were established to identify articles focusing on HF in context of life-threatening illness, communication or communication barriers in end-of-life care, non-research reports from experts, communication between HCPs and patients and their families, and primary research or systematic reviews. Exclusion criteria included research focusing solely on patients with cancer, research not clearly defining communication barriers specific to the HF population, communication education of professionals, pediatric population, communication between professionals, family communication, understanding treatment, symptom management communication, and systematic reviews including research not matching inclusion criteria.

Article abstracts were examined using the criteria resulting in 13 articles receiving further scrutiny. These were critically analyzed using the inclusion and exclusion criteria resulting in eight articles. Reference and citation searches of included papers netted an additional 13 articles. Hand searches were undertaken on *The Canadian Journal of Cardiology, Journal of Cardiovascular Nursing, Journal of Hospice & Palliative Nursing, Journal of Palliative Medicine, Journal of Palliative Care and Palliative Medicine* from 2005 to 2011 and yielded no new articles. In total, 21 research articles were included in this review. Each study was evaluated using tools adapted from the Rapid Appraisal Protocol Internet Database (Joanna Briggs Institute, 2006) and LoBiondo-Wood, Haber and Singh (2009).

Data Evaluation

The evaluation section begins with an overview of the included research focusing on the methodologies, participants and practice settings studied. A review of the state of EOL communication in patients with HF will pave the way to discuss the current knowledge about barriers to effective EOL communication in the HF population.

Of the 21 studies, 76% were generated in Europe while 14% came from North America and 10% from Australia. The articles were predominantly qualitative research (n=18) with only three using quantitative methodologies. Perspectives were sought from patients, their caregivers and HCPs working in the fields of cardiology, gerontology, general practice, internal medicine, hospice palliative care, as well as residential and community care. Practice settings represented included home and residential care, in-patient acute care hospitals, and out-patient clinics, as well as urban and rural settings. The majority of the researchers considered patient and family understanding and needs regarding prognostic information, attitudes toward medical information, preferences for cardiopulmonary resuscitation (CPR) and EOL information and communication needs vital for decision-making such as place of death. From a HCP perspective, the researchers considered the perceived information and communication needs of HF patients and the perspectives on the challenges of transitioning to a palliative approach for patients with HF.

Current State of End-of-Life Communication

Having a good understanding of one's illness is the basis for EOL communication and without which goals-of-care and decision-making discussions cannot be truly informed. Yet, many studies indicated that patients' understanding of HF was lacking (Agard, Hermeren, & Herlitz, 2004; Aldred, Gott, & Gariballa, 2005; Barnes et al., 2006; Boyd et al., 2004; Harding et al., 2008). For example, Agard et al. (2004) found that 34 of the 40 participants in their qualitative study had limited knowledge of the meaning of chronic heart failure. Further, some patients believed their health problems to be related to their lungs (Aldred et al., 2005) or the aging process (Agard et al., 2004; Barnes et al., 2006; Gott, Small, Barnes, Payne, & Seamark, 2008). Meanwhile, some physicians expressed difficulty informing patients of the life-threatening nature of HF given the public perception that HF can be cured (Barnes et al., 2006). Interestingly, Formiga et al. (2004) found that 64% of study participants had a good understanding of HF and their prognosis; the researchers attributed this to increased public HF education.

Perhaps not surprising then, the researchers reported that most HF patients had not had discussions about prognosis (Barnes et al., 2006; Boyd et al., 2004; Gott et al., 2008; Murray et al., 2002; Strachan et al., 2009). For example, Strachan et al. (2009) found that only 11.3% of participants had discussed prognosis with physicians while 46.2% wanted to know about disease progression and their prognosis. Poor communication contributed to many patients coming to the realization themselves that they were dying (Caldwell, Arthur, & Demers, 2007; McCarthy, Addington-Hall, & Ley, 1997). For instance, 82% of patients and 45% of the caregivers in McCarthy et al.'s (1997) retrospective study had figured out independently that death was imminent. Conversations regarding preferences for CPR (Formiga et al., 2004), advance care planning (Gott et al., 2008; Rodriguez, Appelt, Switzer, Sonel, & Arnold, 2008; Willems, Hak, Visser, & Van der Wal, 2004) or EOL care (Formiga et al., 2004; Green, Gardiner, Gott, & Ingleton, 2011; Harding et al., 2008; Selman et al., 2007) seldom took place. For example, Formiga et al. (2004) reported that only two of the 80 study participants discussed their wishes for life-sustaining therapies with their physicians. This is supported by Green et al.'s (2011) qualitative study where HCPs agreed that EOL discussions seldom happened. Clearly, poor communication can have a detrimental impact, as Strachan et al. (2009) found when patients received more aggressive care than they desired and lost the opportunity to plan for the future.

Patient and Caregiver Barriers

Attitudes toward end-of-life communications. Researchers indicate that patients and caregivers have varying attitudes towards EOL conversations. For example, many patients with HF want to discuss their prognosis (Aldred et al., 2005; Caldwell et al., 2007; Harding et al., 2008; Strachan et al., 2009; Rodriguez et al., 2008). Many patients expressed a desire to be informed, to participate in their health care decisions (Boyd et al., 2004; Caldwell et al., 2007) and wanted truthful, but hopeful information (Caldwell et al., 2007; Harding et al., 2008; Strachan et al., 2009). For instance, one patient in Caldwell et al.'s (2007) study said she would feel resentful if others knew that she was nearing EOL but had not informed her. However, not all patients wanted this level of knowledge and were ambivalent, indifferent or avoided prognostic information (Agard et al., 2004; Boyd et al., 2004; Caldwell et al, 2007; Gott et al., 2008; Rogers et al., 2000). For some patients, the knowledge of their prognosis was viewed as too distressing for their families (Gott et al., 2008; Horne & Payne, 2004) or themselves (Agard et al., 2004; Barnes et al., 2006; Gott et al., 2008), creating uncertainty (Rodriguez et al., 2008) or removing hope (Agard et al., 2004; Boyd et al., 2004). Still others had unrealistic expectations of continuing medical therapy and denied that EOL was approaching (Agard et al., 2004; Borbasi, Wotton, Redden, & Chapman, 2005).

Patient fears as barriers. Further compromising communication were patients' fears of being seen as demanding of HCPs time (Aldred et al., 2005) or of talking about 'taboo' subjects and making the physician uncomfortable (Caldwell et al., 2007). Many patients, especially elders, did not feel comfortable raising questions (Barnes et al., 2006; Harding et al., 2008), finding physicians unapproachable and thus waited for HCPs to initiate EOL conversations (Boyd et al., 2004). Caldwell et al. (2007) suggested that some patients preferred the HCP to initiate discussions about prognosis. Similarly, some patients, believing their physicians would provide the required information, seldom asked questions and deferred to HCPs for decision-making (Agard et al., 2004; Caldwell et al., 2007; Rogers et al., 2000). In contrast, Rogers et al. (2000) reported that some patients believed physicians limited their information perhaps thinking patients were "…

stupid …or else not interested" (p. 606). Not surprising, then, is that some patients felt removed from their health care decisions (Boyd et al., 2004), disempowered (Harding et al., 2008), or doubted their opinions would impact care (Caldwell et al., 2007). For example, Harding et al. (2008) found that patients often did not know what questions to ask or did not have the opportunity to ask questions. Meanwhile, Boyd et al. (2004) found that when conversations did take place, a patient-centred approach was lacking.

Preferred timing of end-of-life communication. Conflicting information about preferred timing of EOL discussions adds another challenge. Caldwell et al. (2007) found that some patient's desired prognostic conversations early in the disease process, so they could control EOL decision-making, yet their findings also suggested that the better patients feel, the less likely they want to discuss EOL. In addition, some patients had the perception that HF is benign (Caldwell et al., 2007; Rogers et al., 2000; Selman et al., 2007) and never thought about dying (Agard et al., 2004; Gott et al., 2008), or, if they did, only when hospitalized for HF exacerbations (Willems et al., 2004). For example, participants in Willems et al.'s (2004) qualitative study reported that thoughts of death left once their life was no longer threatened. Conversely, participants in Horne and Payne's (2004) study revealed they thought about death on a daily basis with some fearing the dying process or worrying about their families. Short-term memory loss and confusion inhibited clear communication (Caldwell et al., 2007; Harding et al., 2008; Rogers et al., 2000) while mobility and fatigue issues challenged some patients' ability to attend medical appointments (Caldwell et al., 2007; Rogers et al., 2000).

Caregiver-specific communication barriers. Similar communication barriers existed for caregivers of patients with advancing HF. Caregivers reported being uncomfortable raising questions to physicians (Boyd et al., 2004) and found EOL discussions anxiety-provoking and, thus, avoided them (Selman et al., 2007). When they did desire information, caregivers reported being unable to obtain it (McCarthy et al., 1997). Alarmingly, Harding et al. (2008) found that some caregivers were provided the actual prognosis while the patient received a more hopeful prognosis. The physician participant reported that he asked the family to refrain from sharing the actual prognosis with the patient stating that he, the cardiologist, had "…to have that aspect of hope from the patient" (Harding et al., 2008, p. 153).

Disease-Specific Barriers

Researchers highlighted disease-specific barriers that impact EOL communication in HF care. To start, physicians identified that EOL communication problems were, in part, related to challenges in diagnosing HF (Barnes et al., 2006). For instance, Barnes et al. (2006) reported that some general practitioners believed presenting symptoms to be related to co-morbid disease rather than a new diagnosis of HF, thus delaying the communication of the diagnosis and prognosis. Further, one primary care physician, believing that the patient would die of a co-morbid disease, felt less obliged to discuss the HF diagnosis (Barnes et al., 2006). The unpredictable trajectory and fluctuating nature of HF make it challenging for HCPs to prognosticate (Barnes et al., 2006; Brännström, Brulin, Norberg, Boman, & Strandberg, 2005; Hanratty et al., 2002; Harding et al., 2008; Selman et al., 2007; Wotton, Borbasi & Redden, 2005). For example, patients assessed as being near death can unexpectedly recover (Hanratty et al., 2002; Wotton et al., 2005), thus challenging the recognition of nearing EOL resulting in deferred EOL discussions (Selman et al., 2007). Nurses in Brännström et al.'s (2005) qualitative study found the unpredictable trajectory of HF challenged their ability to prepare patients and families for impending death in the manner they would for a patient dying with cancer and with a linear dying phase. Given these challenges, it is perhaps not surprising that HCPs often wait for patients to initiate conversations about prognosis or EOL care (Barnes et al., 2006; Selman et al., 2007).

Health Care Professional Barriers

Poor or lacking communication skills. A significant barrier identified by HCPs who avoid EOL discussions was lack of communication skills (Brännström et al., 2005; Green et al., 2011; Harding et al., 2008; Selman et al., 2007) or difficulty finding the right words (Boyd et al., 2004). For example, in Selman et al.'s (2007) qualitative study, palliative physicians compared the EOL communication skills of oncologists to those of cardiologists and found the latter to be lacking the skill to recognize the need for and the ability to initiate EOL communication. Fears of needing to deal with emotions (Selman et al., 2007) and of removing hope (Harding et al., 2008) were added inhibitors. In particular, nurses in Barnes et al.'s (2006) study reported postponing discussions about the life-limiting nature of HF with patients for fear of causing them distress or depression. Significantly, patients' perceived poor interpersonal and communication skills of the HCPs to be barriers to these discussions (Caldwell et al., 2007) with many feeling that the style of communication was paternalistic (Boyd et al, 2004; Caldwell et al., 2007).

Complex terminology and euphemisms. Terminology was a barrier to communication with many patients either not understanding the term HF (Aldred et al., 2005; Rodriguez et al., 2008) or believing the term to sound too fatal (Rogers et al., 2000). HCPs often preferred to use euphemisms deemed to be less anxiety producing or, alternatively, choose complex terminology (Barnes et al., 2006; Boyd et al., 2004). Interestingly, Barnes et al. (2006) linked the idea of complex terminology with patients' disinterest in their heath care when, for example, one participant expressed that "… the fancy words…don't mean a damn thing does it, not to me…" (p. 485). Meanwhile, euphemisms, such as using the word deteriorating rather than saying more explicitly that a patient was dying, were seen as helpful if patients assessed their HCP as possessing good communication skills. Otherwise, euphemisms were viewed as the HCP's way of avoiding the truth (Caldwell et al., 2007). Complex terminology and euphemisms often led to a poor understanding of HF and, as such, many patients were confused about how their symptoms related to HF (Barnes et al., 2006). For example, one patient did not connect his breathlessness with HF and was stunned to hear, during a hospital admission, that he had HF. Interestingly, some patients believed HF was only present during periods of exacerbations (Rodriguez et al., 2008), as often it was on a hospital admission for an exacerbation of HF when they first heard the term used (Barnes et al., 2006).

Specialty-specific barriers. Medical specialties conceptualized here as 'specialty-specific barriers' were also identified. Barriers included a focus on curative and technological interventions such as implanted cardioverter-defibrillators and left ventricular assist devices in the care of HF patients (Green et al., 2011; Harding et al., 2008; Selman et al., 2007). Perhaps most telling was a comment by one cardiologist in Selman et al.'s (2007) study who expressed that his fellow cardiologists were interested in "…the ritzy things…so actually, when you're at the termination of life they're not so interested…" (p. 966). Death may be viewed as a professional failure (Barnes et al., 2006) and the EOL needs of patients may be neglected in favour of life-prolonging interventions (Green et al., 2011). Importantly, cardiology staff reported a lack of knowledge about alternatives for future care in HF (Selman et al., 2007), the appropriateness of palliative care services for patients with HF (Green et al., 2011) and when to engage palliative services (Harding et al., 2008), thus potentially having a major impact on the direction of care.

Organizational Barriers

Organizational barriers such as poor communication between HCPs (Aldred et al., 2005; Hanratty et al., 2002; Harding et al., 2008) and role confusion (Barnes et al., 2006; Caldwell et al., 2007; Green et al., 2011; Hanratty et al., 2002) added further complexity. For example, Barnes et al. (2006) found that the addition of more HCPs confounded the communication process, as it was unclear who was to initiate EOL communication. Green et al.'s (2011) research strengthens this assertion by reporting professional discord on the topic, as some HCPs believed the cardiologist to be responsible for communicating diagnosis and prognosis while others thought the primary care physician or whoever had the strongest relationship with the patient should be the bearer of this news. Even if EOL communications had taken place, HCPs often did not relay this information to their colleagues (Harding et al., 2008). Finally, a lack of HCPs' time (Aldred et al., 2005; Caldwell et al., 2007; Harding et al., 2008) and an appropriate, quiet setting (Caldwell et al., 2007) for these conversations created additional barriers.

Discussion

The question posed by the authors of this integrative review was: What is the current state of knowledge about the barriers that interfere with EOL communications with patients with HF, their caregivers and HCPs? The findings provide a comprehensive view on the barriers to EOL communication with HF patients and their caregivers. Based on the 21 articles reviewed, barriers were identified in relation to patient/caregivers, HCP, disease-specific and organizational considerations that inhibit EOL communication in the HF population.

Perhaps the most pivotal obstacles are the disease-specific barriers such as the difficulty diagnosing and prognosticating HF and the uncertainty of the dying trajectory. These barriers were often identified by the HCP as the main reasons for not discussing EOL. However, the Canadian Cardiovascular Society (Arnold et al., 2006) guideline points to the importance of early communication and the role this plays in decision-making and identifying patient preferences. Palliative care physicians, while acknowledging the challenges of prognostication in HF, propose that it is possible to provide patients and families with this information in a sensitive manner (Green et al., 2011). Further, specialty-specific barriers such as the dominant curative focus in HF care and lack of knowledge about other options for care, such as focusing on comfort and quality of life over life-prolonging therapies, contribute to poor EOL communication. When contrasted with the more certain dying trajectory and prognosis of patients with cancer, as well as a clearer end-point for curative options, these communication barriers could be seen as the most challenging to remedy. However, education for primary physicians about the diagnosis of HF, sound prognostic indicators and HF communication guidelines for HCPs would help to point HCPs in the right direction.

Findings from this literature review identify a wide spectrum of patient/caregivers preferences for information regarding the diagnosis and prognosis. Contradictions abound in the literature with some patients being fearful of engaging HCPs while others welcomed the opportunity to discuss EOL options. In addition, there was uncertainty about the timing of these conversations, as patients preferred to be well during these talks, but then did not wish to think about EOL when well. Not thinking about death is, perhaps, an indication of acceptance of nearing EOL or, on the other hand, could be a coping mechanism. Conversely, frequent thoughts about dying could reflect poor, or no EOL communication. The research findings clearly demonstrated that many patients wanted to discuss their prognosis and EOL preferences while others left these decisions to their physicians. Given this variation in preferences for information and timing, communication must remain patient-centred and be sensitive to how much and what information the patient/caregivers desire at any given time.

Multiple HCP and organizational-centred barriers contributed to poor communication in EOL HF care. For example, HCPs reported a lack of communication skills and fear of upsetting patients, dealing with emotions or making them lose hope resulting in avoiding EOL conversations or focusing on a curative agenda. Complex terminology, paternalistic communication, and difficulty in identifying nearing EOL were additional barriers. HCPs-centred issues do pose significant barriers to EOL communication. However, when compared to cancer care, the concept of a palliative approach in the care of HF patients is relatively new (Green et al., 2011) and it will take time to educate the public and HCPs and to integrate a palliative approach into HF care. Furthermore, there are underlying assumptions that HCPs have the required communication skills to initiate EOL conversations and have a clear understanding of what palliative care is. Clearly, this review exposes these inaccurate assumptions. Finally, organizational barriers such as lack of time and appropriate spaces for EOL communications, in addition to poor role clarity and lack of inter-professional communication, all work against the HCP who may be attempting to have these vital conversations with patients and families. A collaborative effort aimed at having HCPs identify the barriers to these communications in their settings would go a long way in ameliorating these barriers.

Recommendations

This literature review contributes to existing knowledge by providing information that can be used to target educational, research and practice initiatives aimed at improving EOL communication. Patient and caregiver education sessions and written information about HF as a life-threatening disease have the potential to improve their knowledge and empower them to engage with HCPs. Meanwhile, multidisciplinary and multispecialty EOL communication skills training would benefit HCPs and provide mentorship possibilities (Selman et al., 2007). These skills are especially important for nurses, as patients often expressed being most comfortable discussing EOL with their nurse (Barnes et al., 2006). The creation of multidisciplinary guidelines that provide more direction as to when and how to convene EOL communications would be beneficial. Given the small body of research on this subject and, in particular, the role that culture plays in EOL conversations, additional studies of this topic would be of benefit. Finally, fear and discomfort of discussing death and dying is a major societal concern that will take time to reverse.

Limitations

There are numerous limitations identified within the literature findings beginning with the currency of the research; that is, two-thirds of the studies are more than five years old. However, while it is possible that the practices of EOL communication in HF are better than the literature suggests, even the more recent research, unfortunately, does not lead to this conclusion. Other limitations include the predominant Eurocentric perspective and the largely qualitative methodology, which limit the generalizability of these findings. Selection bias is a threat because the majority of studies had HCPs identify potential study participants. Additional biases may have occurred due to inability for some patients with New York Heart Association (NYHA) level IV to participate due to illness, thus limiting the perspectives of those potentially nearest to EOL (Aldred et al., 2005; Caldwell et al., 2007).

Conclusion

With a rapidly aging population comes an increased incidence of HF with its associated morbidity and mortality (Arnold et al., 2006). The importance of EOL communication in this burgeoning population cannot be underestimated, as it has ramifications for the quality of EOL care. Poor communication could potentially lead to unwanted treatments and psychological morbidity in patients, to moral distress for HCPs and to increased health care costs for society. Knowing that these conversations seldom take place while many patients desire them makes it imperative that HCPs improve this gap in care. In identifying the complex interplay of multiple barriers to EOL communications in HF, this integrative literature review simultaneously provides multiple viewpoints from which to tackle this problem. Altering just one barrier, such as improving the communication skills of HCPs, could open the door for EOL communications and potentially empower patients and their caregivers to ask questions, as they may feel safer to do so. As nurses, we have the opportunity and responsibility to advocate for and lead the way to improved EOL communications in the HF population. ♥

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RESEARCH COLUMN

Writing Competitive Scientific and Clinical Abstracts: Tips for Success

Sheila O'Keefe-McCarthy, RN, PhD candidate, and Monica Parry, NP-Adult, PhD

There are many research and clinical abstracts submitted to the Canadian Council of Cardiovascular Nurses (CCCN) Scientific Sessions each year. Of those submitted, only the highest ranked abstracts are accepted and presented as a workshop, oral or poster presentation. What is it that makes an abstract stand out from all the rest? How can you increase your chances of getting your research study or a clinical case accepted for the Canadian Cardiovascular Congress (Vascular–2013) in Montreal this year? We offer a few practical tips and suggestions to facilitate your future successful abstract submission(s).

What is an Abstract?

Excellent quality requires much thought, planning and preparation in order to write an impressive abstract. As you know, an abstract is a condensed version of the whole study or project, succinctly and clearly written. It highlights the most important data or salient information that is contained in the background, aim/purpose, design, results, and conclusion/implication sections. An abstract is the bare, or pertinent, information for the reader of the clinical issue or study under discussion. The quality of the contents included and the ability to convey the essential message of your work will determine if you are successful.

Preparation

To communicate complex information clearly and concisely is always a challenge, but not one that you are not up to! First tip: Know when the abstract is due and do not wait until the last minute to write your abstract—a sure way to fall short of your goal (getting your abstract accepted). Read carefully the instructions or guidelines provided by the professional society to which you are submitting. Paying close attention to the required specifications could mean an acceptance rather than receiving a negative response.

The Abstract Title

The abstract title should reflect the context and aim of the study or clinical problem. Try to have the title capture the main important message. It should be easy to understand and not contain any unfamiliar acronyms or professional jargon (Pierson, 2004).

Introduction /Background

Generally, the background section lets the reader know why your topic is important to present. Include information that would build a convincing argument that this research or clinical issue merits attention by the reader. This is a difficult section to write because there is limited space. This section provides the background information that typically is a summary of current knowledge in your topic area, what knowledge is missing, and how your research or clinical issue addresses the knowledge gap. Conclude the background section with the aim/purpose or questions of your research or clinical presentation.

Methods

This is an important section to pay attention to as it is often found deficient by reviewers (Bryne, 1998). In this part of an abstract you tell the reader what you actually did. In the space allotted, include a concise description of the design, the setting, your sample population and the inclusion and exclusion criteria. Moreover, provide the reader with a description of the intervention (if appropriate), the outcome variables and how they were measured, and the data analysis used in the study.

Results

In this section you will discuss the findings of your study or clinical case (Pierson, 2004). Reviewers often see statements that are vague or too general. Remember, if you do not have results, submit your abstract as *"research in progress"*. Do not surrender to *"this presentation will highlight";* this is not sufficient, nor is it an effective use of limited space. Present results that are related to your aim/purpose, questions or clinical problem. In as much clear detail, include data that support your conclusions and implications. If you are presenting numerical results, include standard deviations or 95% confidence intervals, as well as the level of statistical significance (e.g., $p < 0.05$). When possible, make your point with data (quantitative and/or qualitative), and not speculation or opinion (Alexandrov & Hennerici, 2007).

Conclusions and Implications

Clearly and concisely tell the reader why this research or clinical case is important. A common mistake is to overstate the significance of the data (Pierson, 2004). The conclusions must be supported by your results. Ensure you include implications for *nursing* practice and, if you have space, address the generalizability of your results to other populations.

Added Tips for Success

Tip: Use simple, clear language with an active voice. For example: "We studied 25 patients with congestive heart failure and normal diastolic function", rather than, "Twenty-five patients with congestive heart failure and normal diastolic function were studied".

Tip: Try to use minimal abbreviations. The most common acronyms should be spelled out the first time they appear in the abstract. Local expressions and professional jargon should be avoided.

Tip: Ensure there are no grammatical errors, misspelled words or typographical errors. Have a fresh pair of eyes review your abstract *before* you submit it!

An example of a research abstract is found in Figure 1 with comments highlighting the important aspects to consider when writing your abstract for submission.

Summary

Successful writing of a research or clinical abstract requires meticulous adherence to the professional society's call for abstracts and its particular specifications. The abstract must clearly answer why this research was carried out, how did you do it, what did you find, and what are the important nursing implications for clinical practice, education and research.

♥

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Figure 1: Research Abstract Example

Title: Content Validity of the Toronto Pain Management Inventory-Acute Coronary Syndrome (ACS) Version

Clear, concise, no jargon or acronyms

Authored by: Anonymous

Abstract:

Background: *Pain arising from acute coronary syndromes (ACS) is severe and anxiety-provoking, which can potentiate myocardial damage. In rural settings, rapid access to cardiac catheterization (CATH) is problematic; ACS patients wait as long as 32 hours. In lieu of rapid CATH access, pain management should be optimal to prevent risk of deterioration and preserve vulnerable myocardial muscle. Evidence suggests that once ACS patients are stabilized, health care professionals (HCPs) do not adequately assess their cardiac pain. Clinicians lack of knowledge and problematic beliefs about pain may contribute to this problem. To date, no standardized tools are available to examine HCPs specific knowledge and beliefs about ACS pain that could inform future educational initiatives. The Toronto Pain Management Inventory was recently adapted to examine nurses' knowledge about ACS pain assessment and management.*

Lets the reader know why this topic is important

Objectives /Research Questions: *To examine content validity of the Toronto Pain Management Inventory-ACS version (TPMI-ACS), a measure designed to assess HCPs knowledge and beliefs of ACS pain assessment and management.*

This can be included as the last few statements of the Background, or it can be included in a separate paragraph, immediately after the Background section

Methods: *A survey design was implemented to determine the content validity index (CVI) of the TPMI-ACS version. Eight clinical and scientific experts rated the relevance of each item using a four-point rating scale. A content validity index was computed for each item (CVI-I) as well as the overall scale using the Scale CVI Item Average approach (S-CVI/AVE); items with CVI-I ≥ 0.7 were retained, items with CVI-I between 0.5–0.7 were revised/clarified, and those with CVI-I ≤ 0.5 were discarded.*

Results: *All eight experts returned completed surveys yielding a 100% response rate. The CVI-I range across all items was 0.5–1.0. For 22 items, rated 3 or 4 only, the range was 0.75–1.0. Data indicated that the content of 22 of 25 items were deemed most relevant. One item was discarded based on consistent low relevancy ratings (i.e., 1 or 2). S-CVI/AVE was calculated for the 25-item TPMI-ACS draft as well as the revised 24-item scale, scores were 0.895 and 0.901 respectively, reflecting high inter-rater agreement across items.*

Conclusions: *Preliminary content validity was established on the TPMI-ACS version. All items retained in the TPMI-ACS version met requirements for content validity. Further evaluation of the psychometric properties of the TPMI-ACS is needed to establish criterion and construct validity, as well as reliability indicators.*

This is the "so what". Tell the reader why your work is important. Include here the implications for nurses, this will be important in the CCCN abstract review process

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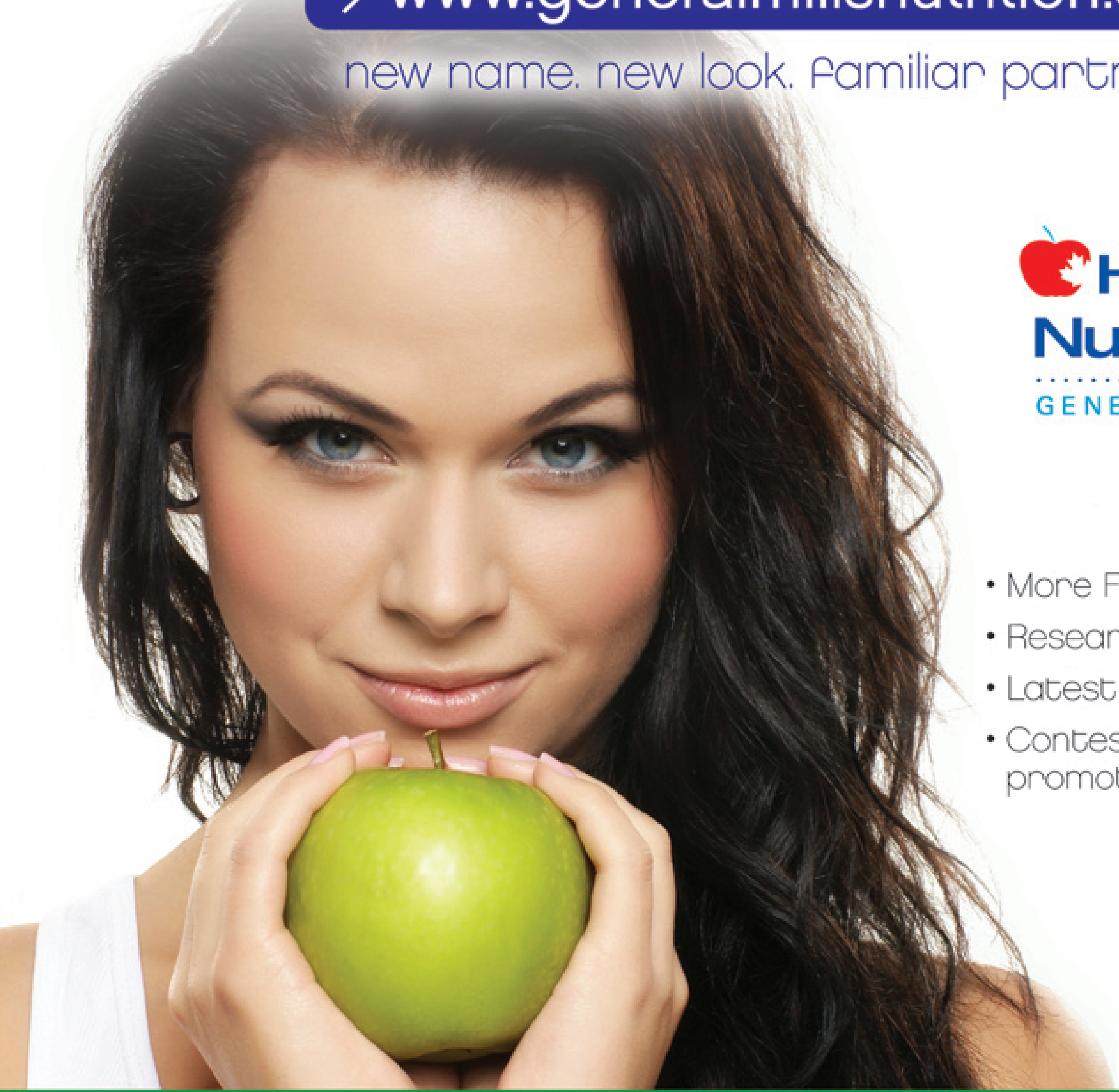

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