Conclusion: Patients admitted under a cardiology unit received a higher rate of medical therapy and invasive management. A combined cardio-geriatric unit may help stratify a larger proportion of patients who may benefit from aggressive management of NSTE MI.

Impact of Gender on Meeting Secondary Prevention Targets and Depression Post Acute Coronary Syndromes: Insights from the SMART-REHAB Trial

A. Murphy,* O. Farouque, D. Clark, J. Ramchand, M. Yudi

Austin Health, Melbourne, Australia

Introduction: It is well publicised that women receive less aggressive secondary preventive therapy post acute coronary syndromes (ACS). Less is known about the cardiovascular risk profile and psychological well-being of females post ACS.

Methods: SMART-REHAB was a randomised controlled trial assessing the impact of a smartphone-based cardiac rehabilitation programme post ACS. In this study, we stratified the cohort by gender. We assessed whether there was a gender difference in the use of optimal medical therapy, achievement of secondary prevention target in blood pressure, cholesterol and diabetes, and prevalence of depression (assessed by Car diac Depression Scale, CDS) at 8-weeks post ACS.

Results: Only 26 (15%) of the 165 patients with complete follow-up were females. There was no different in the use of aspirin, statin, beta-blocker, ACE inhibitor or a P2-Y12 inhibitor between the groups (all p = NS). Women had similar rates to men of LDL-cholesterol <1.8mmol/L (69% vs 77%, p = 0.5) and HbA1c<7% (100% vs 92%). Women were more likely to have depression (31% vs. 14%, p = 0.04) as evidenced by a CDS score >95.

Conclusion: In this analysis from a contemporary randomised trial, women received guideline-directed medical therapy to the same extent as men. This translated to a similar proportion of patients achieving secondary prevention targets. However, women had significantly higher rates of depression highlighting the need for widespread screening and management of depression post ACS.

Increasing the Uptake of Cardiopulmonary Resuscitation Training Within Australian Cardiac Rehabilitation Programmes

S. Cartledge,1,2,3,* J. Bray,2,4, B. Abell5, D. Stub,1,2,3,6,7, J. Finn1,7, L. Neubeck3

1 Department of Epidemiology and Preventive Medicine, Monash University, Melbourne, Australia
2 Institute for Physical Activity and Nutrition, Deakin University, Geelong, Australia
3 Alfred Health, Melbourne, Australia
4 School of Nursing, Midwifery and Paramedic, Curtin University, Bentley, Australia
5 School of Public Health and Social Work, Queensland University of Technology, Brisbane, Australia
6 Cabrini Health, Melbourne, Australia
7 Baker Institute, Melbourne, Australia
8 Western Health, Melbourne, Australia
9 School of Health and Social Care, Edinburgh Napier University, Sighthill, United Kingdom

Background: People attending Cardiac Rehabilitation (CRehab) are at increased risk of cardiac arrest. We have demonstrated that people attending CR would like to be taught cardiopulmonary resuscitation (CPR) yet provision of CPR training in Australian CRehab programmes is 24%.

Aim: This study aimed to identify the best strategy to implement CPR training into CR programmes.

Methods: A two-arm randomised controlled implementation study is being conducted across Australia. One CRehab coordinator per programme are eligible to participate. Coordinators are randomised 1:1 and receive an information pack (control & intervention) and a face-to-face education session (intervention).

Results: To date 36 programmes (61% metropolitan, 39% rural) have been randomised. Few programmes had (14%) offered past CPR training and only 17% currently include CPR information. Baseline data identified common barriers to incorporating CPR training were time (69%), resources (69%) and a lack of awareness (19%). Coordinators are motivated to include CPR training as they believe that participants are interested in learning CPR (78%). Of the 12 programmes to complete the study to date, 70% have incorporated CPR training into their programmes (80% intervention, 60% control). Time was the most common barrier (67%) to implementation. Brief qualitative interviews with coordinators revealed that staffing, the responsibility of conducting CPR training and a reluctance to change were additional barriers.

Conclusions: CR represents a logical location to provide targeted CPR training to high-risk cardiac groups at scale nationally. This study will aid understanding of how CR coordinators can be supported to enable more programmes to incorporate CPR training.

http://dx.doi.org/10.1016/j.hlc.2019.06.543
http://dx.doi.org/10.1016/j.hlc.2019.06.544
http://dx.doi.org/10.1016/j.hlc.2019.06.545