Assessment of Self-Care for Patients with Myocardial Infarction

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Abstract

Background: Self-care behaviors can start after passing the acute period of myocardial infarction and have special importance in health maintenance and its recurrence. **Aim of the study:** Was conducted to assess self-care for patients with myocardial infarction. **Research design:** Descriptive research design was used to conduct this study. **Setting:** The present study conducted at Cardiac Out Patient Clinics in Benha University Hospital & Benha Teaching Hospital. **Sample:** Simple random sample was used in this study. The total number of sample was 254 myocardial infarction patients. **Tools:** One tool was used to collected data **Part (I):** An interviewing questionnaire to assess patients' socio demographic characteristics. **Part (II):** About patients' medical history. **Part (III):** Patients' knowledge regarding myocardial infarction and self-care. **Part (IV):** Patients' self-care reported practices**. Results:** 63.8% of patients had total average knowledge regarding myocardial infarction and self-care, while 65% had unsatisfactory reported self-care practices. **Conclusion:** There were highly statistical significant relation between studied myocardial infarction patients' total knowledge and their socio demographic characteristic regarding educational level, while there were highly statistically significant relations between the total self-care practices of studied myocardial infarction patients and their total knowledge. **Recommendation:** Health educational program should be developed and implemented for patients with myocardial infarction to improve, and updated knowledge and self-care practices.

Key words: Myocardial infarction, Patients Self-care.

Introduction

Self-care behaviors is adapt to prevent or maintain the stability of an illness (self-care maintenance), to monitor signs and symptoms (self-care monitoring), and to respond to signs and symptoms of an illness exacerbation (self-care management). The self-care of chronic illness inventory, based on the theory of self-care of chronic illness, was developed for use in individuals with any number and type of chronic conditions. Although adherence to self-care programs in Myocardial Infarction patients leads to a higher quality of life, lower mortality, morbidity, medical costs, and prevent hospital readmission **(Riegel et al., 2019)**.

Self-care for patients and their families is currently seen as an important aspect of chronic disease treatment. The ability of an individual to cope with any chronic disease is defined as self-care. This encompasses coping with the physical and psychosocial repercussions of chronic disease, as well as controlling symptoms, treating sickness, making lifestyle adjustments, and managing

the physical and psychosocial consequences of chronic disease. Self-care attempts to reduce the negative effects of chronic conditions and preserve a good quality of life (**Sharma et al., 2018**).

Myocardial Infarction (MI) is a cardiovascular disease caused by myocardial insufficient blood supply or even myocardial necrosis due to coronary artery occlusion. MI is a subset of acute coronary syndrome, in which there is damage to the cardiac muscle as demonstrated by increased cardiac Troponin levels in the setting of acute ischemia. MI is a fatal disease caused by block in the oxygen supply of blood vessels of the heart muscles, leading to permanent heart muscle damage and death of its cells. This block is due to atherosclerosis in which plaque of fatty patches is precipitated on the inner wall of the coronary artery or one of its smaller branches. When the plaque is ruptured, the blood clot is formed inside the artery blocking the blood flow (**ALzahrani et al., 2018; Feng et al., 2019**).

The most popular form of Coronary Artery Disease (CAD) is myocardial infarction, that is in charge of over 15% of mortality each year throughout the world. The prevalence of MI approaches three million people worldwide, with more than one million deaths in the United States (US) annually. Risk factors are classified into causal, conditional and predisposing. The causative factors include cigarette smoking, diabetes, hypertension, and increased total cholesterol. Whereas, conditional risk factors involve increased triglycerides, lipoproteins, low-density lipoproteins, increased levels of homocysteine and coagulation factors. The group of predisposing factors includes obesity, lack of physical activity, male gender, family

history concerning early occurrence of coronary heart disease and psychosocial factors (**Peretti et al., 2020; Nascimento et al., 2019**).

Signs and symptoms of myocardial infarction patients are chest, arm, or jaw pain with descriptors of dull, heavy, tight, pressure, ache, squeezing, crushing, or gripping. Atypical pain was classified in patients reporting epigastric or back pain or pain that was burning, stabbing, indigestion-like, or any other pain description or presentation. Guidelines also state that radiation of pain and the presence of associated symptoms form part of a typical presentation; therefore the presence of radiation to right arm, left arm, neck, jaw, back and presence of any associated feature include nausea, vomiting, sweating, dyspnea, palpitations (**Ferry et al., 2019**).

Complication of MI; the most commonly encountered mechanical complications are acute mitral regurgitation secondary to papillary muscle rupture, ventricular septal defect, pseudo aneurysm, free wall rupture and heart failure; each complication is associated with a significant risk of morbidity, mortality, and hospital resource utilization. The care for patients with mechanical complications is complex and requires a multidisciplinary collaboration for prompt recognition, diagnosis (**Damluji et al., 2021**).

Community Health Nurse (CHN) plays an essential role in health promotion through disease management and prevention by providing support and required information to the patients with myocardial infarction. CNH can also facilitate and educate to self-care effectively, encourages patients to make healthy lifestyle choices, prevent further progression of disease and provide social and psychological support. In addition, the nurse should allow time for the patients to express concerns about

complaints and treatment modalities (**Zakeri et al., 2022**).

Significance of the study:

Worldwide, each year more than seven million people experience myocardial infarction, in which one year mortality rates are today in the range of 10% but differ with patient features. The significances are even more spectacular among patients who live, 20% hurt a second cardiovascular incident in the first year and around 50% ischemic heart disease. In developing countries, MI is appraised to consider for seven out of 10 deaths. Mortality owing to MI in Egypt is one of the maximum associated to other countries in the region and worldwide. About 75% of MI patients in Egypt can be accredited to the majority risks; high cholesterol, blood pressure, low fruit and vegetable intake, sedentary life style, and tobacco. Constant behavioral interventions have been exposed to be active in increasing population risk factors (**Chindy et al., 2020& Shaheen et al., 2020**).

Aim of the study

This study aimed to assess self-care for patients with myocardial infarction.

Research Questions:

1- What is the patients᾿ knowledge regarding myocardial infarction?
2- What is the patients᾿ reported self-care practices regarding myocardial infarction?
3- Is there a relation between patients᾿ socio demographic characteristics and their knowledge?
4- Is there a relation between patients᾿ total knowledge and their total practice?

Subject and Methods:

Research design:

A descriptive research design was utilized to conduct this study.

Setting:

The study was conducted at Cardiac Out Patient Clinics in Benha University Hospital & Benha Teaching Hospital.

Sampling:

Simple random sample was used in this study. The total number of sample 254 myocardial infarction patients.

Tools of data collection:

Structured interviewing questionnaires was designed by the investigator and revised by supervisor composed of four parts:

First part: Concerned with the socio-demographic characteristics of the patients which included 8 closed ended questions (age, sex, residence, number of floor, educational level, occupation, marital status, and monthly income.

Second Part: Concerned with the patients᾿ medical history which included 8 closed ended questions (previous heart surgery, type of operation, number of hospital admission, onset of myocardial infarction, other chronic disease, type of disease, family history for MI, and degree of kinship).

Third part: Concerned with: the patients᾿ knowledge; which consisted of 2 subparts:

(A): Knowledge about the myocardial infarction disease composed of 9 questions.

(B): Knowledge about the self-care composed of 4 questions.

Knowledge scoring system:

It was calculated as follows 2 points for correct and complete answer, while 1 point for correct and incomplete answer and 0 for wrong answer. These score converted into a percent and classified as the following:

Total scores of knowledge = 26 points

- **Good** when total score was 75% to 100% (19:26 points).

- **Average** when the total score was 50 to less than 75% (13- 19 points).
- **Poor** when the total score was less than 50% (<13 points).

Forth part: Concerned with assessment of patients' self-care reported practices and was included 9 categories classified as follow (movement and daily living activities, nutritional practices, treatment compliance, exercise practices, rest and sleep practices, healthy habits to prevent infection sick again, social care practices, psychological care, and management of pain and difficulty breathing).

Practices scoring system: it was calculated as follows 2 points for always done, while 1 point for some time done, and 0 for never done. These scores of the items were summed- up and converted into present score. As well as patients total reported practices score was classified as the following:

Total scores of practices = 114 points

- **Satisfactory** when the total score was > 80% (> 91 points).
- **Unsatisfactory** when the total score was < 80% (< 91 points).

Validity of the tools:

The tools validity was done by five Staff Nursing Experts from Community Health Nursing Specialties in Benha Faculty of Nursing who reviewed the tools for clarity, relevance, comprehensiveness, and applicability.

Reliability of the tools:

The reliability was done by Cronbach's Alpha coefficient test which revealed that each of the two tools consisted of relatively homogeneous items as indicated by the moderate to high reliability of each tool. The internal consistency of knowledge was 0.732 and the internal consistency of practices was 0.841.

Ethical considerations:

Permission has been obtained from ethical committee from Faculty of Nursing Benha Uniersity and orally from each patient before conducting the interview and given a brief orientation to the purpose of the study. They were also reassured that all information gathered would be confidential and used only for the purpose of the study. No names were required on the forms to ensure anonymity and confidentiality. They were also informed about their right to withdraw at any time from the study without giving any reasons.

Pilot Study:

The pilot study was carried out on 10% (25 patients) of the sample size who represented patients from total sample to test the applicability and clarity of the tool for further required modification, and time needed to fill each sheet, completing the sheet consumed about 15- 20 minutes. No modifications were done, so the pilot study sample was included in the total sample.

Field work:

The data collection phase from myocardial infarction patients who attended in Cardiac Out Patient Clinics in Benha University Hospital & Benha Teaching Hospital through interviewing with them at waiting area. Collected data was conducted at a period of 6 months which started from the beginning of August 2021 to end of January 2022. The investigator visited the selected patients from Cardiac Out Patients from 9 am to 12 PM two days/ week (Thursdays &Tuesdays) in University Hospital and (Wednesday, Sunday) in Benha Teaching Hospital to collect data from patients. The average time needed to fill tool was around 15-20 minutes, the average number of interviewed patients/day was between 3-5 patients depending on their understanding and responses to the investigator. The patient filled this questionnaire in the present of the investigator all time to clarify any

ambiguities and answer any queries and collect the questionnaire.

Statistical analysis:

Computerized data entry and statistical analysis were fulfilling scored using Statistical Package for Social Science (SPSS), version 22. Descriptive was used as frequency, percentage then other statistical test such as, Chi-square and using mean and stander deviation.

Results:

Table (1): Shows that; 44.5% of studied myocardial infarction patients aged from 45 years to less than 55years with mean ±SD 52.41±7.35, 77.6% of them male, 54.3% were lived in ruler areas, 37.4% were lived in middle floor, 41.3% had secondary education, 63% were worked, and 64.2% were married, while 64.2% had enough income per month.

Table (2): Shows that; 3.5% of studied myocardial infarction patients had previous heart surgery, 66.7% had open heart surgery, 55.5% were admitted once to hospital with myocardial infarction, 44.9 % had myocardial infarction from 3 month to less than 6 month, 71.7% suffering from chronic diseases, 60.4% had hypertension disease, and 12.2% had family history of myocardial infarction, while 48.4% their father had myocardial infarction.

Figure (1): Illustrates that; 63.8% of studied myocardial infarction patients had total average level of knowledge about myocardial infarction and self-care, and 20.5% had total poor level of knowledge about myocardial infarction and self-care, while only 15.7% had total good level of knowledge about myocardial infarction and self-

care.

Figure (2): Illustrates that; 65% had unsatisfactory reported self-care practices, while 35% of studied myocardial infarction patients had satisfactory reported self-care practices.

Table (3): Reveals that; there were highly statistical significant relation between studied myocardial infarction patients total knowledge level and their socio demographic characteristic regarding educational level, and there were statistical significant relations between studied myocardial infarction patients total knowledge level and their socio demographic characteristics regarding age, sex, residence, and occupation, while there were no statistically significant relation between studied myocardial infarction patients total knowledge level and their socio demographic characteristics regarding marital status and monthly income.

Table (4): Shows that; there were highly statistically significant relation between the total self-care practices level of studied myocardial infarction patients and their total knowledge level.

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Table (1): Frequency distribution of studied myocardial infarction patients regarding their socio demographic characteristics (n=254).

Socio demographic characteristics	No	%
Age		
35<45	35	13.8
45<55	113	44.5
< 55	106	41.7
Mean ±SD	**52.41±7.35**	
Sex		
Male	197	77.6
Female	57	22.4
Residence		
Rural	138	54.3
Urban	116	45.7
Number of floor		
Ground floor	93	36.6
Middle floor	95	37.4
Up stairs	66	26.0
Education level		
Primary education	98	38.6
Secondary education	105	41.3
High education	51	20.1
Occupation		
Work	160	63.0
Not work	94	37.0
Marital status		
Married	163	64.2
Divorced	45	17.7
Widowed	46	18.1
Monthly income		
Enough	163	64.2
Not enough	91	35.8

Table (2): Frequency distribution of studied myocardial infarction patients regarding their medical history (n=254).

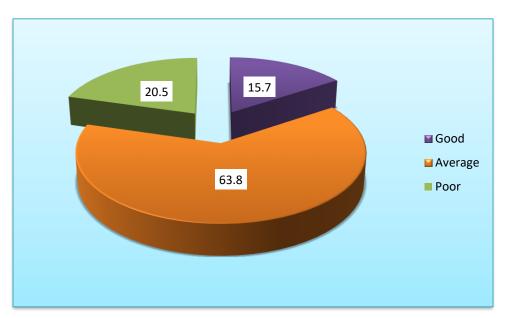| Past medical history	No	%
Previous heart surgery	9	3.5
Type of the operation (n= 9)		
Cardiac catheterization	3	33.3
Open heart	6	66.7
Number of hospital admissions with myocardial infarction		
Once	141	55.5
No previous admission	113	44.5
Present medical history		
Onset of myocardial infarction		
>3 months	81	31.9
3> 6 months	114	44.9
6 >1 year	59	23.2
Other chronic diseases	182	71.7
Type of disease (n=182).		
Diabetes	42	23.1
Hypertension	110	60.4
Chest diseases	30	16.5
Family history of myocardial infarction	31	12.2
Degree of kinship (n=31)		
Brother	5	16.1
Father	15	48.4
Uncle	11	35.5

Figure (1): Percentage distrubtuion of stuied myocardial infarction patients regarding their total knowledge level regarding myocardial infarction and self care (n=254).
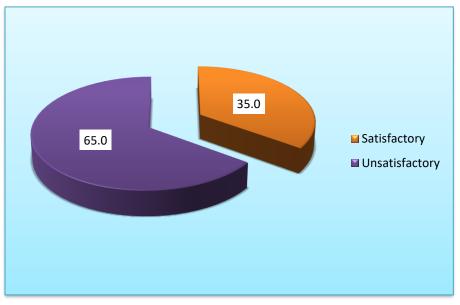

Figure (2): Percentage distrubtuion of stuied myocardial infarction patients regarding their total reported self care practices level (n=254).

Table (3): Statistically relation between total studied myocardial infarction patient's knowledge level and their socio demographic characteristics (n=254)

Socio demographic characteristics	Total knowledge						X^2	p-value
	Poor (n=52)		Average (n=162)		Good (n=40)			
	No	%	No	%	N	%		
Age								
35<45	10	19.2	18	11.1	7	17.5		
45<55	15	28.8	71	43.8	7	17.5	12.15	016*
< 55	27	51.9	73	45.1	26	65.0		
Sex								
Male	42	80.8	132	81.5	23	57.5	10.98	004*
Female	10	19.2	30	18.5	17	42.5		
Residence								
Rural area	19	36.5	97	59.9	22	55.0	8.65	013*
Urban area	33	63.5	65	40.1	18	45.0		
Educational level								
Primary education	16	30.8	67	41.4	15	37.5	2021	
Secondary education	15	28.8	75	46.3	15	37.5		000**
High education	21	40.4	20	12.3	10	25.0		
Occupation								
Work	42	80.8	93	57.4	25	62.5	9.221	010*
Not work	10	19.2	69	42.6	15	37.5		
Marital status								
Married	29	55.8	108	66.7	26	65.0		
Divorced	13	25.0	27	16.7	5	12.5	3.654	0.455
Widowed	10	19.2	27	16.7	9	22.5		
Monthly income								
Enough	30	57.7	106	65.4	27	67.5	1.254	0.534
Not enough	22	42.3	56	34.6	13	32.5		

Table (3): Statistically relation between total studied myocardial infarction patient's self-care practices level and their total knowledge level (n= 254).

Total knowledge	Total self-care practices				X^2	p-value
	Unsatisfactory (n=165).		Satisfactory (n=89).			
	No	%	No	%		
Poor (n=52)	44	26.7	8	9.0		
Average (n=162)	117	70.9	45	50.6	65.66	.000**
Good (n=40)	4	2.4	36	40.4		

Discussion

Self-care is fundamental to maintenance of health, and prevention and management of chronic illnesses. Self-care is a process whereby individuals and their families maintain health through health-promoting practices and managing illness. This definition captures the idea that self-care encompasses a variety of behaviors, general and disease specific, in which persons suffering from a chronic illness engage to maintain their physical and emotional stability. These behaviors e.g. assure sufficient sleep, take prescribed medications, manage stress and physically activity are referred to as self-care maintenance **(Zaben & Khalil 2019& Riegel et al., 2019)**.

Regarding to medical history; the present study revealed that less than three quarters of studied myocardial infarction patients had other chronic disease, more than three fifth of them had hypertension disease and less than three fifths of patients had once admission to hospital with MI. This finding is supported with **Hartikainen et al., (2020)**, who studied "Clinical application of the 4th universal definition of myocardial infarction" Medical

Center Hamburg-Eppendorf, Germany (n=2302), reported that more than three fifths (67%) of myocardial infarction patients had hypertension disease and disagreed with present result due to reported that of less than fifth of myocardial infarction patients had medical history of myocardial infarction (15.9%). This might be due to patients with hypertension cause difficulty in supplying blood to the heart, which causes an irregular heartbeat and leads to a heart attack, and inability of patients to apply healthy self-care lead to vulnerable to recurrence of the disease.

Regarding myocardial infarction patients' total knowledge level; the present study revealed that more than three fifths of myocardial infarction patients had average knowledge about myocardial infarction and self-care. This finding is supported by **Ibrahim (2017)**, who reported that more than three fifth of patients had average knowledge (71.1%), while this finding disagreed with **Liu et al., (2022),** who studied "Latent class cluster analysis of knowledge on acute myocardial infarction in community residents: a cross-sectional study in Tianjin, China" (n=4200), reported that slightly less than two fifths of

myocardial infarction patients had high level of knowledge (39.5%), (39.4%) had low level of knowledge, and more than one fifth of them had average of knowledge (21.15%). This might be due to insufficient health education for patients and the patients were not able to access information or attend programs related to their cases, and the inability to participate in the treatment program during hospitalization.

Regarding myocardial infarction patients' total practice level; the present study revealed that almost more than two thirds had unsatisfactory reported practices, while more than one third of myocardial infarction patients had satisfactory reported practices regarding self-care,. This finding is disagreed with **Adhikari & Bhandari (2017)**, who studied" Awareness and practice of prevention of myocardial infarction among hypertensive patients: cross sectional study in a tertiary cardiac center of Nepal" in South Asia (n= 96), reported that less than three fifths of myocardial infarction patients had good reported practices regarding self-care (57.3%), while more than two fifths of them had poor reported practices (42.7%). This might be due to lack of programs offered on social networking sites and lack of rehabilitation centers to help patients practice self-care in a correct manner.

Regarding to relation between total studied myocardial infarction patient's knowledge and socio demographic characteristics; the present study revealed that highly statistical significant relation between total knowledge among studied myocardial infarction patients and their socio demographic characteristic regarding educational level, and there were statistical significant relations between total knowledge among studied myocardial infarction patients

and their socio demographic characteristic regarding age, sex, residence, and occupation, while there were no statistically significant relation between total knowledge among studied myocardial infarction patients and their socio demographic characteristic regarding marital status and monthly income. This finding supported by **Adhikari & Bhandari (2017)**, who reported that highly statistical significant relation regarding educational level.

Regarding relation between total studied myocardial infarction patient's self-care practices and their total knowledge; the present study revealed that there were highly statistically significant relation between total self-care practices and total knowledge among studied myocardial infarction patients. This result is supported by **Dahal & Karki, (2017)**, who studied " Knowledge and practice regarding prevention of myocardial infarction among visitors of Sahid Gangalal national heart center, Kathmandu, Nepal" (n=101), reported that there were highly statistically significant relation between total self-care practices level and total knowledge level among studied myocardial infarction patients. This might be due to if the studied myocardial infarction patients total knowledge increases their total practice also increase and become better.

Conclusion

More than three fifths of studied myocardial infarction patients had total average level of knowledge about myocardial infarction and self-care, and almost two thirds of patients had unsatisfactory reported self-care practices, and there were highly statistical significant relation between studied myocardial infarction patients total knowledge and their socio demographic characteristic regarding educational level, while

there were highly statistical significant relation between the total self-care practices of studied myocardial infarction patients and their total knowledge.

Recommendation

1- Health educational program should be developed and implemented for patients with myocardial infarction to improve, and updated knowledge and self-care practices.

2- Disseminate booklet with illustrated pictures included all information and self-care measures towards myocardial infarction at Outpatient Clinic to enhance self-care practice to be available for patients to enhance self-care practice.

3-Regular follow up for myocardial infarction patients to ensure effectiveness of medication, and avoiding complications.

4- Further studies needed to be applied the same study in large sample size in different setting in Egypt.

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تقييم الرعاية الذاتية لمرضي احتشاء عضلة القلب

دعاء عبد الحميد مصطفي- هناء عبد الجواد عبد المجيد – شيماء جمال الدين ابراهيم

تعتبر الرعاية الذاتية أساسية لجميع جوانب الصحة ، وعلى جميع مستويات الرعاية ، وباعتبارها المفتاح لجميع الاشخاص ليعيشوا حياة متوازنة ، فإن ممارسات الرعاية الذاتية المطلوبة لإدارة عوامل الخطر متسقة بشكل عام عبر جميع الأنواع من الأمراض المزمنة مثل احتشاء عضلة القلب، ومن سلوكيات الرعاية الذاتية: يُنصح باتباع نظام غذائي صحي ، والنشاط البدني ، والإقلاع عن التدخين ، وتجنب تعاطي الكحول أو غيره من المخدرات. لذلك هدفت الدراسة الي تقييم الرعاية الذاتية للمرضى الذين يعانون من احتشاء عضلة القلب. وقد أجريت الدراسة في العيادات الخارجية بمستشفي بنها الجامعي ومستشفي بنها التعليمي علي عينة عشوائية بسيطة من مرضي احتشاء عضلة القلب بلغ عددهم 254 مريضا. وقد كشفت النتائج ان أكثر من ثلاثة أخماس مرضى احتشاء عضلة القلب الخاضعين للدراسة لديهم متوسط إجمالي من المعرفة حول احتشاء عضلة القلب والرعاية الذاتية ، وأن ما يقرب من ثلثي المرضى لديهم ممارسات رعاية ذاتية غير مرضية ، وكانت هناك علاقة ذات دلالة إحصائية عالية بين مستوى المعرفة الكلي لمرضى احتشاء عضلة القلب وخصائصهم الاجتماعية الديموغرافية فيما يتعلق بالمستوى التعليمي ، بينما كانت هناك علاقة ذات دلالة إحصائية عالية بين مستوى ممارسات الرعاية الذاتية الإجمالية لمرضى احتشاء عضلة القلب الخاضعين للدراسة ومستوى المعرفة الكلي لديهم. كما أوصت الدراسة بتطوير وتنفيذ برنامج تثقيف صحي للمرضى الذين يعانون من احتشاء عضلة القلب لتحسين وتحديث المعرفة وممارسات الرعاية الذاتية.