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► [Improving lifestyle and risk perception through patient involvement in nurse-led cardiovascular risk management: a cluster-randomized controlled trial in primary care.](#)



Koelewijn-van Loon M.S., van der Weijden T., Ronda G. et al. Preventive Medicine: 2010, 50, p. 35–44.

If unable to obtain a copy by clicking on title above you could try asking the author for a reprint (normally free of charge) by adapting this [prepared e-mail](#) or by writing to Dr Koelewijn-van Loon at M.Koelewijn@HAG.unimaas.nl.

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Dutch general practice patients at risk of cardiovascular disease did not further reduce their risks (including drinking and smoking) in response to motivational counselling from the practice nurse. Why did a well worked out, multi-session intervention fail to better usual care? The probable answer is among the common factors which transcend therapies.

Summary Most patients at risk of cardiovascular diseases could benefit from various non-pharmacological risk-reduction options such as giving up smoking, exercising more, eating more healthily, and cutting their alcohol intake. However, it is not clear if programmes intended to foster these lifestyle changes are effective in the primary prevention of cardiovascular diseases. A systematic review of trials found no significant effects, though a recent trial showed that a nurse-coordinated programme achieved healthier lifestyle changes among patients at high risk.

The [IMPALA](#) study used a new intervention to reduce cardiovascular risk, in which general practice nurses play a central role. Key elements are risk assessment, risk communication, use of a patient decision support tool, and adapted motivational interviewing. Risk communication and the patient decision support tool inform patients about their risk of cardiovascular disease and options for risk reduction, and are also used to correct inappropriate risk perceptions. Motivational interviewing is used to help patients articulate their views and personal values regarding cardiovascular risk reduction and to build motivation for lifestyle change. In this study the intervention was delivered

by practice nurses trained over two days and occupied two 20-minute face-to-face consultations (intended to give patients time to reflect on the information received in the first consultation) plus a further 10-minute telephone or face-to-face consultation to initiate the follow-up.

An earlier study found no impact a year after intervention but it was thought there might have been some shorter-term impacts, a possibility tested by the featured study. The study randomly allocated 25 general practices to the IMPALA intervention or to a **control** group whose nurses were trained for just two hours in risk assessment and apart from this merely applied usual care. One practice had to leave the study leaving 13 allocated to the intervention and 11 to the control group. Altogether they recruited 615 adult patients to the study who were eligible for cardiovascular risk assessment due to their blood pressure, cholesterol level, smoking, diabetes, family history or obesity. All but 67 were followed up 12 weeks later. They averaged about 57 years of age and 45% were men.

Main findings

The study assessed whether trends in cardiovascular risk from baseline to 12 weeks differed for patients in practices implementing the IMPALA intervention compared those which did not. Though both sets of patients reduced their risk, no statistically significant differences between them were found on any primary outcome including fat, fruit and vegetable consumption, physical exercise, smoking and drinking. In particular, in both groups the proportions drinking within Dutch national guidelines remained virtually unchanged at around 90%.

The authors' conclusions

Patients in both intervention and control groups improved their lifestyles, but there were only a few small and non-relevant significant differences between them. Some relevant effects of the intervention were found on the secondary outcomes of the appropriateness of their perceptions of the risk they faced of cardiovascular disease and the appropriateness of their anxiety about their risk.

A possible explanation for the lack of added impact from the intervention is that nurses in both groups were highly motivated and gave high quality care, making it difficult to improve more after just one short course. More extended training and supervision seems needed for motivational interviewing. However, another analysis was confined to patients who actually received the intervention as planned, and yet again it found no extra risk reduction. The engagement of the nurse with the patient and their concern seem the key active ingredients, whether or not the nurse followed the structured advice stipulated by the IMPALA intervention.

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