Statement of RN BSc (Hons) Nursing
Cardiac Catheter Lab Manager
South Devon Healthcare (NHS) Trust

I am employed as a clinically focused cardiac catheter lab manager in a large district general hospital. My role involves ensuring a high standard of patient care from pre-assessment, throughout procedure, post procedure recovery and (in the future) post percutaneous coronary intervention (PCI) follow up of coronary artery disease (CAD) patients. I also manage a multi-disciplinary team and hold the budget for interventional materials, drugs and sundries.

The population of South Devon is predominantly elderly; this population can double during the tourist season increasing the number of hospital admissions of patients suffering with acute coronary syndrome requiring intervention.

As information givers my staff are often questioned by patients at pre-assessment about the benefits/risks of PCI and the use of drug eluting stents at our hospital (many patients have access to the internet and are well informed). The standard answer always given is that the cardiologist will, where clinically indicated follow government guidelines and the usage of drug eluting stents (DES) cannot be predicted prior to procedure.

Recently there has been a decline in the amount of bare metal stents used. With the advent of new technology and improved product design thus allowing manoeuvrability and deployment of DES into tortuous coronary arteries. I have also witnessed an increase in the number of high risk patient's under-going PCI especially those unsuitable for coronary artery bypass grafts (CABG), three vessel intervention is not uncommon amongst the elderly patient group.

In my experience, given the uncertainty of each procedure, it is difficult to predict and follow guidelines when faced with a critical/emergency situation. In these cases the cardiologist will require the most effective clinical outcome for his patient.
As a manager/budget holder I have been challenged by the hospital accountant on the increase of DES usage along with number of stents per patient and asked to present audit data on length of stent used and clinical indications for use. Accountants not fully appreciating the clinical decision making process.

In the last year the incidence of in-stent re-stenosis in bare metal stents (BMS) and DES has been 3% in our trust, ratio 4:3.

In my view, in the ideal world, all patients should receive evidence based best practice regardless of cost. If the initial technical outcome is successful then surely the long term prognosis for the CAD patient, with the use of DES and the recommended use of clopidogril, will be better.

However, I recognise that funding may not be adequate, especially for those patients requiring several DES. Inequalities will inevitably exist nationally as some NHS trusts may have financial overspends. The catheter lab in the past being viewed by financial auditors as a money making concern. It is my worry that payment by results will affect the care of patients requiring multiple lesion intervention as it will not be financially viable to perform multi-vessel PCI in one clinical episode. This would inevitably increase the risk to the patient, as no procedure carried out is without risk.