

0.67[strong positive ($p < 0.01$)]. The ISWT change was similar to the minimum important difference (MID) 70m in the CHD population. There is no MID for the DASI

Abstract 26 Table 1

Variable	Pre mean (SD)	Post mean (SD)	Change mean (95% CI)	Significance p value
DASI METs	6.0 (1.8)	7.2 (1.7)	1.2 (0.8-1.6)	$P < 0.001$
ISWT (m)	397.3 (154.7)	467.0 (173.2)	69.7 (54.5-84.8)	$P < 0.001$

Conclusions Patients attending CR post-pandemic made significant improvements in both the DASI and ISWT. Correlations became stronger post programme, indicating patients may better self-evaluate physical performance after taking part in CR. DASI questionnaire may be a useful alternative outcome measure when F2F exercise testing is not an option. Future work could explore how to prescribe an exercise programme from this and what might represent a meaningful change in this outcome following CR

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THE EFFECTIVENESS OF A TARGETED PROTEIN EDUCATION INTERVENTION TO INCREASE PROTEIN INTAKE IN PATIENTS WITH CORONARY HEART DISEASE AND LOW PROTEIN INTAKE: A PILOT RANDOMISED CONTROLLED TRIAL

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Background Low protein intake is prevalent in, and detrimental to, patients with coronary heart disease (CHD). We have shown that protein education in UK cardiac rehabilitation (CR) needs improvement. Evidence-based targeted protein education may increase protein intake in patients with CHD.

Aim To identify whether targeted education increases protein intake in patients with CHD and low protein intake, compared with standard CR dietary education.

Methods Patients referred to CR with CHD (≥ 50 years) will complete a three-day food diary, five repetition sit-to-stand test and three questionnaires (Physical Activity Vital Signs, SARC-F, and a researcher-developed nutrition knowledge questionnaire). Stature, mass, waist circumference and medical history will be assessed. Patients with low protein intake (≤ 1.2 g/kg/day) will be randomised to receive a pre-recorded education session, either promoting increased protein intake and improved quality of protein sources (intervention) or reiterating standard CR dietary education (control). At 6-weeks and 12-weeks, patients will repeat the food diary, sit-to-stand test, questionnaires, and anthropometric measures.

Results Preliminary findings will be presented at the conference. Mean difference with 95% confidence intervals and effect sizes will be reported between groups for primary

(change in protein intake) and secondary (sit to stand time, questionnaire scores, change in waist circumference) outcomes at study timepoints. Significance testing will not be performed due to inadequate statistical power. Pilot studies require $n \geq 24$; we aim to recruit 30 participants (15 per group) to account for an estimated 20% attrition at 12-weeks, between October 2021 and September 2023.

Conclusion Insufficient protein intake contributes to muscle mass loss and impaired healing. Dietary education in CR traditionally focuses on weight loss and lipid management over protein intake. If protein intake can be increased using targeted education sessions, this method may be more easily and cost-effectively integrated into standard CR, compared to alternative dietary interventions such as supplementation.

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PROVISION OF DIETARY EDUCATION IN UK-BASED CARDIAC REHABILITATION: A CROSS-SECTIONAL SURVEY

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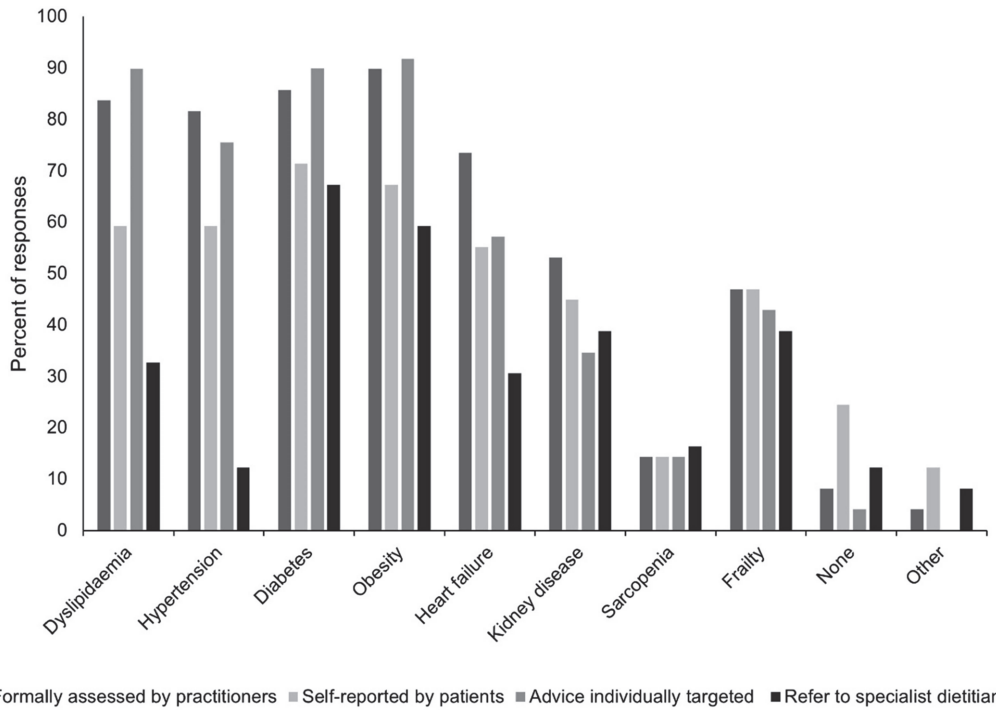
Background The cardioprotective diet is effective in reducing risk of mortality and morbidity in patients with heart disease. Therefore, high-quality dietary education in UK cardiac rehabilitation (CR) is needed. However, little is known about its provision in UK CR.

Aim Understand dietary education provision in UK-based CR: (1) Who delivers it? (2) How is it delivered? and (3) What does it include?

Methods A voluntary, electronic survey (Online Surveys, Jisc, UK) was disseminated in conjunction with the BACPR, between July and October 2021. Providers of dietary education in UK-based CR were eligible to participate. Survey questions related to the profession and qualifications of education providers, and the resources used, content and delivery method of dietary education sessions.

Results There were 49 eligible responses from CR centres, delivering early CR (77.6%), maintenance CR (6.1%) or both (16.3%). Dietary educators included; dietitians (55.1%), specialist nurses (65.3%), and exercise professionals (16.3%). 46.9% of educators had no formal nutrition-related qualifications.

A median of two (Range, 1 to 12) diet sessions was provided per CR programme. Most had a cardioprotective diet focus. Resources include British Heart Foundation booklets (93.9%) and the Eatwell Guide (69.4%). Diet history assessment methods varied between centres, with one fifth performing no assessment at the start of the programme; citing lack of time (70.0%), staff (20.0%) or knowledge (30.0%). Frequently, no specific amount of carbohydrate (75.5%), fat (63.3%) or protein (75.5%) was recommended. Comorbidities were used to tailor individual advice or referred to a specialist (figure 1). 87.3% of centres followed up whether advice was implemented by patients.



Abstract 28 Figure 1 Methods of identifying common comorbidities among patients attending cardiac rehabilitation, and whether the delivery of dietary education is targeted for each condition by the practitioner or referred to a specialist dietitian

Conclusion CR programmes consistently include key components of a cardioprotective diet and account for known risk factors in dietary advice. However, many failed to assess diet

at baseline. Increased training of practitioners, and time allocated to dietary education in CR, programmes is needed.