Abstract P5433 – Table 1. Description of the domains and categories

Physical		Psychological		Psychosocial		Environmental	
Barriers	Facilitators	Barriers	Facilitators	Barriers	Facilitators	Barriers	Facilitators
Limitation by the heart defect	Improved aerobic fitness	Lack of motivation	Having positive emotions	Lack of expectation from others	Stimulated to be active as a child	Lack of time	Structure
Presence of comorbidity	Medical intervention	Fear of movement	Having positive attitude	Impaired capacity compared to others	Encouragement from others	Limited by surroundings	Information and technical aids
Performance due to daily shape	Performance due to daily shape	Demand on performance	Being motivated	Restricted by others		Limited by climate	
			Feeling inner trust				

porting and promoting physical activity and thereby hopefully prevent long-term adverse outcomes. Barriers can potentially be transformed to facilitators through increased knowledge in both the adult with CHD and the healthcare provider.
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P5434
Evaluation of the determinant factors on the capacity for self-care in patients with acute myocardial infarction

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Background: In patients suffered from Acute Myocardial Infarction, Self-care capacity after their discharge including ability to recover fully from an illness, to regain as optimal a level of function as possible, and to maintain a healthy state, depends on numerous interrelated factors. The objective of this study was to investigate the factors associated with self-care in patients having history of percutaneous coronary intervention for acute myocardial infarction.
Methods: Between September 2017 and October 2017, 106 patients with history of PCI for acute myocardial infarction were enrolled in the study during their visit to the outpatient department. The capacity of Self-Care was assessed with the Self Care Agency Questionnaire (SCAQ) which consists of the scale of 29 items including 4 subscales: 1) ability to perform self-care operations, 2) ability to adjust one's own physical condition based on personal weaknesses, 3) ability to concentrate one's attention on self-care, and 4) ability to receive valid support. Each subscale score was calculated by summing the item scores, and score range is 29–145. We divided these patients into two groups according to the SCAQ score, namely high SCAQ group (n=58) or low SCAQ group (n=48), and evaluated its correlation with patient characteristics and social background including age, gender, number of PCI procedure after index procedure, income, education, smoking, job status, social activity, co-living families, support from others, and status of life worth living (ikigai). The concept of "life worth living (ikigai)" is as reported elsewhere, a proxy of quality of life (QOL), and was measured by the Ikigai-9 Questionnaire, which comprises 9 questions and score range is 9–45.
Results: Low SCAQ group was older than high SCAQ group (66.6 v.s. 72.9 years old, $p<0.001$). Low SCAQ group was more likely to be male, current smoker, no social activity, no support from other in daily life than high SCAQ group (91.7 v.s. 75.9%, $p<0.05$; 85.4 v.s. 63.8%, $p<0.05$, 14.6 v.s. 39.7%, $p<0.01$; 40.4 v.s. 53.8%, $p<0.01$, respectively). Conversely, high SCAQ group was more likely to be jobless than low SCAQ group (69.0 v.s. 39.6%, $p<0.01$). Ikigai-9 score was significant lower in low SCAQ group than high SCAQ group (24.7 v.s. 29.9, $p<0.001$). SCAQ score has strong correlation with Ikigai-9 score ($r=0.52$, $p<0.001$).
Conclusions: In patients with older age, male, smoking, current worker, no social support and no social activity were more likely to be low self-care capacity. Self-care capacity has significant correlation with the score of the Ikigai-9 Questionnaire. The issue for the self-care in patient with AMI is multifactorial. A comprehensive approach from medical professional, families, and local community are needed.

P5435
The instruction of sodium restriction by presented concrete objective of action and estimated sodium intake

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Introduction: Opinions are divided about the effect of sodium restriction for patients with heart failure. The average sodium intake among the Japanese population was reached nearly twice the cut off line in various guidelines. The same is true of patients with heart failure. Therefore, the instruction of sodium restriction is necessary for Japanese heart failure patients. However, little has been reported on the effect and method of sodium restriction instruction. So, we prospectively studied the change in dietary sodium intake and behavior change for patients with heart failure.
Purpose: The purpose of this study was examined the effect of sodium restriction instruction using estimated sodium intake and behavior changes for patients with chronic heart failure (CHF).
Methods: The subject of this study is outpatient who diagnosed CHF (NYHA I to II) in our hospital between May 2017 and January 2018. We surveyed understanding to the patient using the check-sheet which was marked on a maximum scale of 20 points. We instructed individually for patient using the result of check-sheet before they consult with a doctor. In the instruction, we actually showed the amount of dietary sodium which includes various foods, and instructed with emphasis on the score is low items. Finally we show estimated sodium intake for the patient, gave a brochure of sodium reduction. The cut off line of sodium intake is less than 7 grams a day for the patient with mild heart failure, provided the guideline in Japanese circulation society. When next visit we surveyed understanding to the patient using the check-sheet and calculated to estimated sodium intake again to investigate the effects of instruction. The estimated sodium intake is calculated from spot urine when they consult with a doctor. We collected the blood data and blood pressure and body weight.
Results: Score of check-sheet was significantly increasing after the instruction than the first time (15.9+2.8 vs. 13.9+3.1, $p<0.05$). Similarly the estimated sodium intake was significantly decrease after the instruction than the first time (8.2+3.1g vs. 9.4+3.4g, $P<0.05$). The patients who reduced estimate sodium intake were significantly reduced brain natriuretic peptide than patients who not reduced sodium intake (-40.0 vs. -7.7, $p<0.05$). Women were more reduced sodium intake than men after the instruction. The patients who less than cut off line of sodium intake was 29% in first time, it was improved 36% by the instruction. The patients who know the need of sodium restriction was 93%, but among them could recall the cut off line were a few. The patient who recalled the cut off line of sodium intake was increased by the instruction (25.7% vs.55.4%, $p<0.05$).
Conclusion: The present result suggested that the instruction using checksheet and estimation sodium intake was effective to motivation of sodium restriction and it was useful to determine effect of sodium restriction instruction.

P5436
Does cardiac rehabilitation improve functional, independence, frailty and emotional outcomes following trans catheter aortic valve replacement?

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Background: Transcatheter Aortic Valve Replacement (TAVI) is often undertaken in the oldest frailest cohort of patients undergoing cardiac interventions. There is currently insufficient evidence to support the routine recommendation of CR in this population.
Purpose: We undertook a pilot trial of CR following TAVI to inform the feasibility and design of a future fully powered randomised trial.
Method: We screened patients undergoing TAVI at our institution between June 2016 and February 2017 and randomised selected patients post-TAVI to either standard of care alone (control group) or standard of care plus exercise based CR (CR group). We assessed recruitment and attrition rates, uptake of CR and explored changes in the 6 minute walk test, the Nottingham Activities of Daily Living, Fried and Edmonton Frailty scores and Hospital Anxiety and Depression Score, from baseline (30 days post TAVI) to 3 and 6 months post randomisation.
Results: Of 82 patients screened undergoing TAVI, 52 met the inclusion criteria and 27 were recruited (3 patients/month) and randomised (14 control, 13 CR,). In the CR group, 10/13 (77%) patients completed the prescribed course of 6 sessions of CR. No significant differences were seen between SOC and CR at 3 or 6-months in 6 minute walk test, the Nottingham Activities of Daily Living, Fried and Edmonton Frailty scores and Hospital Anxiety and Depression Score.
Conclusions: We have demonstrated the feasibility of recruiting from this often frail and comorbid cohort of post TAVI patients into a randomised trial of CR within a single centre. Study participation and CR were acceptable to patients with a high rate of recruitment, retention and completion at six months.
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P5437
Lifestyle self-management experiences of south asians post myocardial infarction

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Background: Coronary heart disease is the biggest killer globally. South Asians