

Facilitation of the Heart Manual



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Self-Management

Cardiac rehabilitation is built on the foundation of promoting and facilitating self-management in patients. Self-management was defined by The Expert Patient Approach (National Health Service, UK, 2001) as:

“any formalised patient education programme aimed at providing the patient with the information and skills necessary to manage their condition within the parameters of the medical regime”.

This provides some insight into the concept of self-management but simplifies the complexity of facilitating and achieving self-management.

In addition to traditional patient education, self-management aims to build problem solving skills, confidence in health-related decision making and self-efficacy.

Supporting Self-Management

Health care professionals often consider themselves as advocates for their patients, but consideration needs to be given to how this works within the context of self-management as promoting self-advocacy is also part of self-management.

The role of health professionals in supporting effective self-management is to ensure that the most appropriate information and resources are being provided for the individual and their family (Scottish Government 2008). This should be an empowering approach in which the individual is the leading partner in managing their own life and condition.

According to Lorig et al (2002) self-management is problem based as it focuses on patient concerns and problems. Facilitation in cardiac rehabilitation therefore focuses not on solving these issues for patients but in supporting problem solving across all aspects of their health and wellbeing.

Problem solving:

- Patient identifies the problem/ area of concern (problem identification)
- Considers possible solutions (through various means- peers, healthcare professionals, reliable information (generation of solutions)
- Takes action (solution implementation)
- Evaluates if this action has worked (evaluate solution)

Facilitation

Hooser (2002) describes how the use of four facilitative strategies may be applied within clinical practice. She describes:

- The need to develop a 'trusting' relationship which encourages mutual respect and empathy within a safe environment, allowing learning to take place between both the practitioner and the patient.
- The need to become an 'advocate' acting on behalf of the individual to access appropriate resources and obtain additional support.
- The role of the practitioner as an 'information and resource provider' in-order to assist the individual to develop the appropriate skills to meet their on-going self-management needs.
- At the core of all of these strategies is the need for the practitioner to become a 'capacity builder' through the development of communication skills which are crucial to effective self-management support.

As noted earlier the role of the health professional in advocacy must be carefully considered in the context of self-management where the responsibility to act on certain issues may at times be shared.

The ability of the facilitator to communicate can have a profound effect on outcomes and the way in which people with CAD self-manage. Effective communication is often taken for granted as being a core aptitude of health care professionals. Supporting and facilitating lifestyle changes and providing self-management information does however require more advanced techniques such as motivational interviewing and solution-focused skills.

Communication is critical when looking to help develop effective self-care strategies with patients. The dynamics of these interactions in the context of cardiac rehabilitation can sometimes be difficult to clearly define, however, communication with health professionals can be one of the few opportunities' patients have to obtain information, make decisions and gain motivation (Thorne et al. 2004).

Facilitation contacts with patients can vary from an acute care brief intervention to intensive long term management support. Most cardiac rehabilitation intervention has some of these elements but generally sits somewhere in the middle of this continuum, beginning within the early post event or intervention period and continuing for several weeks post discharge. These interactions are often critical to the way in which the individual perceives their condition and gains an understanding

of the impact that it may have on their daily life, as well as their future well-being. It is therefore important when using a facilitative approach to make that initial connection with the patient, to engage them and help them find the best way forward. Past initial introductions and building a rapport, this includes looking for strengths to praise, introducing content gradually followed by questions which foster discussion, leading to decision making and plans for change over time.

Adult learning

A key contribution a practitioner may make when supporting an individual with CAD is to facilitate learning. Information should be contextualised and tailored to ensure that it is appropriate to the individual and their family, but must also be delivered in ways that promote accessibility. Facilitating the Heart Manual therefore requires not only an understanding of CAD, an awareness of adult learning theory and health behaviour change as well as effective communication skills.

Learning is not a static process but changes from child to adult, through formal education and life experiences, and fluctuates in association with the motivation to learn and obtain knowledge. Adult learners may resist learning when they sense that others are imposing information, ideas or actions on them (Queensland Occupational Therapy Fieldwork Collaborative 2007).

In the 1970's Malcolm Knowles established his theory to adult learning (Atherton 2012) which affirms that adults learn, and choose to learn differently. In essence, we have to want, or need to learn something new and be interested in the subject. Our motivation to learn will be influenced by our past learning and life experience.

Theory of Adult Learning

- Adults have a need to know why they should learn.
 - Learning needs to be relevant and important.
- Adults prefer to be self-directed.
 - Deciding for themselves what they want to learn.
- Adults have a broad range of life and learning experiences.
 - This may influence new learning in both a positive and negative way.
- Adults can become ready to learn when they experience a life situation where they want to or need to develop understanding.
- Adults enter into the learning process with a task orientated aspect to learning.

As a facilitator it is essential that the resources and support being offered reflect these principles. This can be achieved by considering the patient and family perspective and finding out what matters to them. It is also important for the facilitator to check understanding and share appropriate knowledge in a way that makes sense to the patient. By identifying appropriate and meaningful goals in partnership with the patient, potential barriers and support mechanisms/resources can be explored. Positive reinforcement and feedback are also important motivators which can support adult learning and lifestyle change.

Perceptions of Healthcare

Responses to illness and its management are influenced in many ways and for some patients they don't want to lead the management of their condition (Kings Fund 2005). They may see this as the role of the health service, will happily attend appointments and take their medications, but feel they have no contribution to make to longer term management. Similarly, there may be other life priorities at the fore or a refusal to allow their condition to dominate their time or thinking. These are all natural responses that can impact on engagement, and where they exist can be key barriers to progress. Dealing with such issues will require careful facilitation, but asking the patient initially to consider some of the following may help open the door to the idea that there are things they can do to manage their condition moving forward:

“How do you think what has happened will change things for you?”

“What would **you** like to get out of cardiac rehabilitation?”

“Is there anything you would like to change?”

Alternatively, some patients may already be aware of their own health and daily activities that influence their well-being. Many will have already made changes and may have found them difficult to initiate and even harder to maintain. As a result, they may feel change is too difficult for them.

As facilitators we come from varied health professional backgrounds. With us we bring personal experience of illness and health, as well as the experiences of those we have cared for. These experiences influence our practice and our own perceptions of health and wellbeing. To be an effective facilitator you must not only

be aware of the patient's circumstances but your own perceptions of health and how this affects how you facilitate and interact with your patients.

The Role of the Facilitator

At the core of the Heart Manual programme is the patient - facilitator interaction, and the programme will only reach its full potential if the facilitator understands and can apply the key elements of the cognitive behavioural model in clinical practice. This is what makes the Heart Manual programme so effective.

A key consideration when initiating the Heart Manual is patient safety. It is the responsibility of the Heart Manual facilitator to assess the patient's clinical and psychological condition before broaching the subject of behavioural change and self-management strategies. This may mean delaying the intervention until issues have been addressed or the patient's condition is clinically stable.

It is the role of the facilitator to assess the suitability of the Heart Manual Programme for each patient.

The role of the facilitator is to:

- Monitor current clinical symptoms, referring on as appropriate
- Support the patient and family to take control of the condition and identify their educational needs
- Identify and clarify misconceptions
- Provide on-going education
- Provide informal psychological assessment and support
- Facilitate the adoption of self-management strategies such as goal setting and pacing
- Encourage the patient to adopt appropriate strategies to self-monitor and manage clinical symptoms
- Promote the return to normal activity
- Facilitate the process of lifestyle change

Using the 5 Steps to Success

To facilitate means to ease, make possible, help or assist. This can be done by working in partnership with the patient and their family, building a rapport, expressing respect, and directing rather than persuading lifestyle change.

The 5 steps to success is a suggested method of facilitating the Heart Manual. You will recognise this from the training slides. These 5 steps provide a framework on which to build and develop your practice whilst you gain more confidence in facilitating. Over time it will become second nature and you will develop your own techniques that you find work well for you. Depending on your existing level of expertise it may be useful to observe another Heart Manual facilitator initially. It is also worthwhile to have a trained facilitator sit in with your session until you feel more confident.

Self-reflection can also be used to aid facilitation. It also gives you an opportunity to reflect on what went well during the consultation with the patient and what you may change another time? This type of reflection of practice can be used for the NMC Revalidation process for nursing practitioners.

Following the 5 steps during each interaction with the patient (and family members) will allow you to continue to build a relationship with the patient over time. This may create opportunities to address aspects that initially the patient may not have been comfortable to discuss. So, this pathway is not linear, but each step is applicable during all facilitation sessions.



Facilitation and self-management topics

Some helpful hints when using the Heart Manual:

- Become familiar and use the terminology and language used within the Heart Manual during your facilitation discussion.
- Using examples of the case studies or the analogies within the Heart Manual can help the patient focus on areas in the Heart Manual to reference and read after your facilitation session.
- Use the digital bookmarking facility or reference specific pages for patients to review at a later stage.
- Highlight the quizzes that are dotted throughout the manual; these aid understanding and help address misconceptions.

This approach can support the natural flow of discussion during consultations whilst providing structure and content where necessary.

The key aspects facilitation within a cardiac rehabilitation setting should address (in the context of the Heart Manual) are detailed below:

Dealing with denial or rejection

There is a small group of patients in whom a diagnosis of coronary artery disease appears to cause little, if any, psychological distress; some may even refuse to believe that they have heart disease. Early research suggested that denial can be a healthy coping strategy in the short term but people adopting such a strategy may do less well in the longer term (Levine et al. 1987). Further research indicates that people may try to disguise or 'repress' their distress and that a spouse or partner may give a more accurate picture of the patient's distress levels (Smith et al. 2008).

With the well-documented association between psychological distress and recovery in coronary artery disease there is an implicit assumption that those who display less distress are at lower risk for medication non-compliance and re-infarction. However, this may not apply to those who adopt a repressive coping style and try to conceal their distress (Smith et al. 2008). Those who are already depressed may also have difficulty in articulating their emotions. Inclusion of spouses or close family members in facilitation of the Heart Manual can support the sharing of issues that may be privately concerning the patient.

Some people will reject rehabilitation, but efforts should still be made to engage them in cardiac rehabilitation. A discussion around reasons for not engaging can prove useful and often the Heart Manual as a home-based programme can address some of these issues such as travel, time away from work, dislike of group activities etc.

The Heart Manual given early in the recovery process can also help patients to understand how they feel and allay some initial fears. So, leaving the Heart Manual with them and returning later often bears results, or returning when the patients' next of kin is present. Experience also shows that many of these patients will subsequently become more open to cardiac rehabilitation, especially if they return home after an event and feel weaker than they expected. It is helpful to leave the door open to those not ready to engage, or arrange to give a call in a few days just to see how they are doing.

Patient:

'I don't need any help'

Facilitator:

'I know your family are worried about you and it might help them to understand and be less upset about what has happened, would you mind if I give it to them?'

Patient information needs

Patients rate prognostic and preventative information in the most important category of need. In other words, the questions they most want answered are:

'Will I have another heart attack or need another procedure?' and

'How can I avoid it?'

It is important that you have all the relevant facts regarding your patient's situation e.g. PMH and whether any further interventions are planned.

Consider responses to simple open ended questions such as:

'Tell me what has happened'

'How are you feeling now?'

These will give an indication as to the patients understanding and any misconceptions they may have around what has happened and why. Referencing sections within the Heart Manual for further reading can be helpful as it presents information in such a way as to correct misconceptions and aid understanding.

Many patients want to do practical things which will help them improve or maintain their health. The amount of reassurance and emotional support required will vary from person to person. Work with patients should concentrate on solving the problems which they identify as being likely to prevent them having a good quality of life or making progress.

Encouraging feelings of control over illness

Psychological research, in many illnesses, has shown that the more control the patient believes he/she has over the illness the better their recovery will be. Too often patients are made to feel that the answer lies with pills or surgery, making them feel powerless and dependent on the 'miracles of modern medicine'.

It is important to stress how much the patient can do to help him or herself. Facilitation can support this by:

- Helping patients understand risk factors and causes of CAD, supporting the idea there are changes they can make.
- Helping the patient identify their risk factors and supporting them to consider changes they may feel they can /want to make.
- Throughout the programme regularly remind the patient of the positive steps they are taking to reduce the chance of further heart problems, e.g. changing their diet, stopping smoking, doing exercise.

Perceived need

Foster et al (2021) identified that perceived need for cardiac rehabilitation was a key factor in attendance. In considering engagement in physical activity, self-efficacy was seen as a positive facilitator and lack of willpower as a barrier to engagement.

As service providers we must give consideration to aspects we can influence. **ALL medical treatments can be made either more, or less, effective by the enthusiasm and beliefs of the staff administering them.** If you appear confident and positive about the Heart Manual and the benefits of cardiac rehabilitation, your patients are much more likely to feel the same. It is well established that cardiac rehabilitation can save lives across all CHD groups, including MI and revascularisation (Heran et al. 2011). Let the patient see and feel how important you think it is that they take up cardiac rehabilitation, this includes consistent messaging, quick referral and contact from the rehabilitation team.

Facilitating recovery and lifestyle change

Your role is not to prescribe but to guide and support the patient through their chosen targets to reach their health goals. This does not mean that we should only tackle the risk factors identified by the patient, but that we should allow the patient to prioritise their goals, working on those of greatest importance while asking the patient to consider other aspects of health risk. This may mean asking the patient to think about risk factors which they consider as less important, or to think about issues that they may have avoided or found difficult in the past. Encouraging patients to participate in this requires a non-judgemental and non-threatening approach.

Talking about changing personal behaviour can be delicate and takes time to learn. As health professionals we have a tendency towards taking control and making things 'right' or telling patients how to 'fix' the problem. Unfortunately when discussing behavioural change this can lead to coercion, which can be ineffective and in some cases will lead to behavioural resistance, nor does it help the patient to develop self-management strategies and build confidence in their own abilities.

Facilitation as an approach indicates a partnership, a more co-operative and empowering style of working. This can appear unnatural and difficult if we have historically been used to directing patient education in our clinical practice. So what can we do to avoid the 'righting response' to behavioural change? Often simply being aware of our own beliefs and values towards a particular behaviour is enough to reduce our desire to 'tell' the patient what we feel they 'should do'. Respecting the individual's point of view or circumstances can be a challenge, but building trust can reap rewards over time and may result in a shift in views at a later date, opening the door to revisiting that particular conversation. Remember motivational interviewing techniques, we should be "dancing not wrestling".

[More in-depth information on behaviour change can be found in the Health Behaviour Change chapter.](#)

Helping partners, carers and families

Hospital visiting times and GP consultations are often very short and busy, and partners may receive very little specific advice. Some will not want to bother health care staff. Even if they do ask for or receive information they may be too anxious or worried to take much of it in, or in some cases the information provided may be

misinterpreted. For this reason there is specific information within the Heart Manual package which is directed towards the partner's or carer's needs

- Q&A audio provides answers to the most common questions and encourages the family to participate.
- Many relatives do take up the relaxation and exercise programme, and report that it helps them to deal with the stress of what is happening.

Some relatives may need encouragement to attend to their own needs and to be helped to feel confident enough to allow their partner/relative to exercise or spend time alone. Many are unsure how to treat the person, especially if they become irritable or tearful. The information in the Heart Manual can help them normalise and understand these feelings, and find ways of dealing with them.

Marriage and relationship issues

Marriages and relationships high in intimacy appear to have a 'buffering effect', protecting the patient from anxiety and depression, but poor marriages may be further weakened. Generally such marital tension pre-dates the condition.

A diagnosis of coronary artery disease can lead to long-lasting changes in the partner's role and the [power dynamics of the relationship](#). These changes are often initiated during the immediate recovery period and with the risk of can becoming permanent, causing resentment in the overworked or newly dominant partner. As the individual recovers, both partners should be encouraged to discuss handing responsibilities back.

[Irritability](#) is so common as to be normal. Partners often report feeling that dealing with the patient is like 'walking on eggshells'. In most cases this problem will slowly improve. At the time many spouses take it to mean that they are not looking after the person well enough. They often fear bringing on another event by doing or saying something that might cause the patient to worry or be upset. They should be reassured and advised to try to be their usual self. If they start trying to be 'extra nice' it is likely to increase the irritability.

Some patients become [insecure](#) about their marriage and future. They may become very demanding, constantly looking for reassurance that the spouse won't leave them now that they are 'useless'. They should be re-assured that emotional upset should

pass and they still have a valuable contribution to make to their relationship. Reading about some of the common misconceptions may also help allay some of these anxieties.

Overprotection

The patient may be surrounded by friends and relatives 'wrapping them in cotton wool', trying to do everything for them or constantly keeping an eye on them. This type of overprotection can cause tension, increased family rows and is counterproductive to a successful recovery.

Although some patients will be irritated by these restrictions, others may enjoy the attention and be only too willing to become invalids. Those close to the patient need to be educated too. It is important that the spouse and family understand the content of the manual and its self-management approach. This will help them to understand that the aim is for the patient to return to a normal life.

If the partner is highly anxious then their anxiety must be addressed before the problem will get better. This may mean suggesting an assessment by their GP or other support services.

Family demands

Sometimes patients will return home to be met with 'You must be OK now because they've let you out. Where's my tea? You'll need to do the garden'. You may identify these patients when they read you their activity diaries in the first weeks. Often this is due to a lack of the partner's knowledge and understanding about the patient's condition and their needs at this time. Encouraging them to read the manual and speaking with the partner will help raise awareness of the individual's need for support.

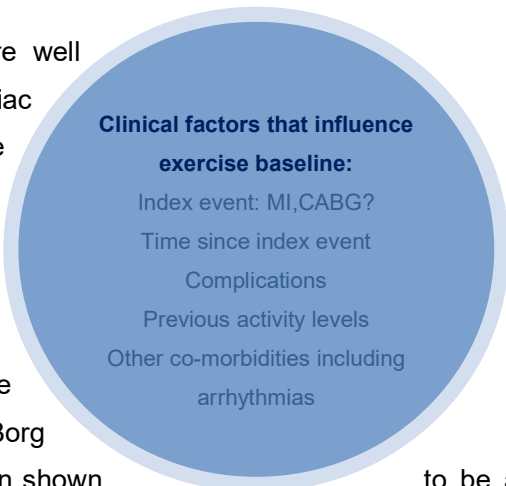
Some patients may have been carers for family members prior to their own diagnosis or event. In these situations it is important that the patient has time to discuss their concerns and is given the opportunity to consider if additional services or support may be required in the short term or in the future.

Avoidance of activity

A common reaction following an acute event or revascularisation procedure, but often an unhelpful one, is to overly reduce activity levels. This is based on the mistaken belief that 'doing too much' wears out the heart and that doing less will be protective of the heart. For the majority of patients the opposite is true. Such a misconception means patients remain or become unfit and have a poor long-term outlook as well as a poor quality of life. If these thoughts and anxieties can be addressed and reversed, patients encouraged to take appropriate levels of exercise, especially walking, then much of this fear will abate.

Returning to activity

The benefits of exercise and activity are well established as a core component of cardiac rehabilitation. It should be noted that the exercise programme within the Heart Manual is self-pacing. Patients increase the number of repetitions of each movement and the distance and pace walked when they find it has become 'quite easy'. This is an adapted form of the Borg self-perceived exertion scale that has been shown



Clinical factors that influence exercise baseline:

Index event: MI, CABG?

Time since index event

Complications

Previous activity levels

Other co-morbidities including arrhythmias

to be a safe way of increasing exercise. No two patients will be the same and each will have their own level of activity they will be able to achieve from their enrolment to the completion of their rehabilitation programme.

Exercise capacity varies from individual to individual, as such the facilitators role will be to assist the patient to identify their own safe level of activity while aiming to participate and build to moderate activity on a daily basis. Patients who do not progress very far with the exercise may still gain benefit from the other elements of the package. For this reason there is no age limit and physical disability is not an exclusion criterion.

[More in-depth information on returning to activity can be found in the Physical Activity and Exercise chapter.](#)

Returning to work

If patients regard their work as a cause of stress and understand that stress is likely to affect their health, they may feel hopelessly trapped. Work gives most people a sense of identity and worth and therefore when their work is impacted by illness patients may experience feelings of loss of self-worth, loss of position in the family, financial stress and may feel increasingly inadequate and guilty.

Patients often feel getting back to a busy working life makes it harder to adopt healthier behaviours, for example the lorry driver that has to be sedentary in their job. It is important to identify these beliefs and work with the patient to help them establish what they can realistically do to reduce or avoid this risky behaviour.

[More in-depth information on vocational issues can be found in the Work chapter.](#)

Information on the structure of the Heart Manual resource and hints on how the manual can aid facilitation can be found in the Heart Manual Programme chapter.

Please note: if you have questions or concerns about facilitation you can contact us at the Heart Manual dept either by phone or e –mail for advice.

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Steve Leslie Reasons for non-attendance etc