

## **Guidance Notes**

### **Suggestions on how to facilitate the Heart Manual**

Please note, there is no right or wrong way to facilitate the Manual. You will find your own way of doing it, and remember, every facilitation will be unique as you will be responding to the individual needs of your patient. **Digital HM:** “Getting started” guides for facilitators and patients can be found in facilitator login area, but it is essentially the same process after getting patient logged in to the resource.

This is just a suggestion of how to do basic signposting when facilitating the Manual. You can also refer to the Navigation tool in your training pack which is much more detailed, particularly when you are finding your own way around the resource.

- I suggest having a “working” copy of the Heart Manual which you can tab up to help you facilitate the resource, and then you give the patient their own copy.
  
- You may also want to print off the colour diagrams from the online training folder (resources section) which you can laminate and use to illustrate when teaching patients about CAD, MI and stenting. Many people learn visually so it is important to use a variety of teaching tools. The audio discs, (relaxation and information disc) is another example of this.
  
- Consider the **5 steps to success** as a general framework: you do not need to follow the steps in that particular order, but it can act as an aide-memoir when you are starting out and feel as if you have a lot to cover.

#### **Steps 1 and 2**

- Allow enough time for the consultation. A very important part of building rapport is to allow the patient to “tell their story”. It is also a very important way of uncovering possible misconceptions. Use visual aids and Part 1 of the Manual to check understanding. Make sure you have the facts and if you don’t have the answer, find out and get back to the patient.

- Where applicable try to involve the family member or carer. This is important as it can make a huge difference to adherence with the programme, and may reduce over protection if they have all the facts. The family member can also benefit by taking part in the exercises and relaxation where appropriate.

### **Step 3**

Ask the patient what they think the cause of their MI was. Many will blame smoking or there may be a strong genetic element. Advise the patient that there is information within the Manual which can help. If the patient is keen to stop smoking, refer to specialist services if they are available. You can support this positive behaviour change throughout the time of the intervention and can assist the patient with setting any other relevant goals.

### **Introducing the resources: (Incorporating Step 4)**

1. Explain what the essence of the Manual is all about. Reinforce that it has been backed by research and is proven to work. It is a powerful tool, but should not be given to other patients with cardiac problems. It needs to be prescribed after an assessment has been carried out by a trained facilitator/experienced cardiac nurse.
2. **3 key elements** or “pieces of the jigsaw” : Information, Exercise, Relaxation and stress management. All are equally important. Although the patient may not feel he/she is an anxious person, learning some techniques may help with other subtle signs of stress e.g. poor memory, sleep problems, bad temper or frustration
3. Explain that the Manual is split into 3 parts.  
**Introduce Part 1.** Ensure the patient is clear about their diagnosis and treatment. Briefly discuss driving restrictions and getting back to work. This can be discussed in more detail in subsequent weeks.
4. **Go to Part 3.** Explain that this is a “reference” section which can be dipped into whenever required. Point out sections which you recommend they look at early on, mainly for reinforcement:

5. **Go to Part 2.** Explain that it is split up into 6 weekly sections. Each week will focus on a particular risk factor or topic e.g. returning to work. There is always something to be looked at, however, so no weeks should be skipped, although they don't need to read about smoking for example if not relevant.

**6. Week 1.**

- Remind them that it is normal to have good and bad days and they are likely to be emotional at times. Be positive and reassure that they are on the road to recovery, but at this early stage there are some definite **“Do’s and “Don’ts” p.23**

- **Setting initial activity goal**

It is important to find out what the patient's previous level of activity was prior to assisting setting an activity goal. You are particularly interested in what the patient did on a regular basis prior to the cardiac event. Playing rugby as a teenager or previously being a ballroom dance champion, while interesting, is unlikely to be relevant now. In addition if the patient swam every day normally, you might be inclined to consider swimming as an intermediate goal, however, if they have not swum regularly for some time, it is not likely to feature in the early weeks due to the amount of exertion expended and the lack of normal “body cues” alerting to this. Once you have established previous levels of exercise, it is worth considering how the patient could take a step back from this in order to set a new baseline. Here it is useful to **ask the patient** what they think they would be able to manage “fairly easily” or what they think a realistic start would look like. It is also useful to discuss the current guidelines for exercise and see where there may be room for progress. It is also important to discuss what the patient understands “moderate intensity” to be. Moderate intensity exercise should make you feel warmer, and breathe faster. Ideally you are aiming for a period

of sustained activity at this level in addition to a warm up and a cool down. A walking goal for example, may be 5 minutes at a comfortable pace, 5 minutes at a quicker pace and 5 minutes back down at a comfortable pace. **Remember the HM is flexible and you can tailor the resource to the patient.** You can combine home based exercise with walking, or the patient may only focus on one area depending on their existing level of fitness and needs.

- Introduce the **home based exercises**. (Found on back page of the Manual) Demonstrate the exercises and if possible ask the patient to try some with you. These exercises can be set at a low level (5 repetitions is usual but can be as low as 2-3 if frail) and should be done 2 times a day. **Goal should be “fairly easy”**. Ask patient to record daily his overall impression of the exercises once in the day. **(Exercise record p. 27)**
- If “fairly easy” 2 days in a row, the number of exercises can be increased by 1-2 times. If not so easy on one of the days, they should continue on that level until 2 clear days have passed where it was “fairly easy”. If exercises or walking are recorded as “fairly hard” or “hard” the patient should not progress. Ask what is hard about the exercise/walking. It may be a misunderstanding, or the level needs to be set lower.
- The home based exercises can be used to build confidence before someone starts the walking programme, or they can be done in conjunction with walking. (Some patients may wish to only progress with the walking programme and that is also fine.) The home based exercises are always useful in the winter months when walking outside can be limited.
- **Introduce the walking programme:** Point out the pages which discuss exercise and the plan for progression and show them where to record their daily walk. **(Walking record p.26)** Talk about what would be a reasonable starting point for walking (if appropriate) and where possible encourage the patient to verbalise what they think they could do quite easily. This can be their baseline. (Refer back to information on goal setting and pacing from the training.) Remind them of the importance of dressing for the weather, taking a GTN spray and mobile phone if

- **Daily activity record p. 28** can be used to record general activities and how they feel in general. It is important to be able to plan “up” activities to keep positive and can be an important mark of progress. If there is evidence of social avoidance there may be other underlying fears or concerns which need to be addressed before the patient can progress.
- Talk about the importance of relaxation and introduce the relaxation CD p. 31
- **Top tips for using the relaxation CD:**
  - Don't lie down on the bed. If you are tired, you will fall asleep
  - Find a comfortable chair or sofa which will support your head and arms
  - Try listening when you are feeling alert, e.g. after your morning walk. Less likely to fall asleep
  - If you continue to fall asleep, try the rapid relaxation track which is only 7 mins long. You can continue to listen to tracks 2 and 3 beyond week 1 if you are enjoying them and finding them helpful, but it's useful to try everything on the CD at least once. There are a variety of techniques including Visualisation which can be useful if your “mind is racing”
  - Do NOT listen while driving
  - Don't get stressed about it! If it's not for you, try something else e.g. yoga, Tai-Chi, Pilates
  - Point out p.34 which is all about **positive thinking** and can help to tackle misconceptions
- **Emergency information p. 35:** Make sure the patient and family member are clear about what to do if there is further chest pain. Encourage them to tear out the information sheet and put it on the fridge or somewhere else prominent. Go over what angina is (and isn't) and how to use the GTN spray. Make sure they know when to call for an ambulance: 10 mins of unrelieved chest pain/tightness/associated symptoms despite treatment with rest and GTN spray.

Explain that each week has the same format with a daily diary, walking record and exercise record and information on various topics. They can look at the detailed contents list for more information

#### **Step 5**

- **Summing Up:** Briefly sum up what you have discussed. Are they clear about what their goals are? I don't advise that they set too many. A physical activity goal, relaxation goal and e.g. preparing for/stopping smoking is enough. These can be revised as the patient progresses. Do they have a contact number? When will your next follow up be?

**Subsequent visits/contacts** will involve review of progress and revising goals. How many contacts will depend on your patient. You should aim to encourage greater self management and self efficacy. As confidence increases, the patient will be able to make plans for long term maintenance and be able to deal with setbacks.