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An exploratory study of the subjective experience of patients who have had primary percutaneous coronary intervention (PPCI) following a heart attack (myocardial infarction): the personal journey to discharge

This is the Accepted Version of the final output.

AN EXPLORATORY STUDY OF THE SUBJECTIVE EXPERIENCE OF PATIENTS WHO HAVE HAD PRIMARY PERCUTANEOUS CORONARY INTERVENTION (PPCI) FOLLOWING A HEART ATTACK (MYOCARDIAL INFARCTION): THE PERSONAL JOURNEY TO DISCHARGE

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Abstract

The National Health Service (NHS) in England is changing, not only in terms of the technical aspects of care (such as that afforded by new technology), but also in the way in which care is delivered to patients. For example, due to the increasing pressures being placed upon health services, hospitals need to develop innovative ways to reduce the length of time patients actually spend in hospital. Whilst this improves capacity planning, bed management and patient flow, it also seeks to ensure improved patient safety by delivering care and ongoing treatment in the most appropriate setting.

However, discharging patients from hospital can be challenging and fraught with complexities. Therefore, the efficient and effective management of this process can have a considerable impact on subsequent clinical outcomes and readmission rates. As such, effective discharge planning and practice has become an integral part of health service policy and, in recent years, there has been an increased emphasis placed on the contribution nurses make to this process (Department of Health, 2002; 2005a; 2005b). New recommendations from the Kings Fund (Seale, 2016) suggest that a collaborative relationship between patients, carers, third sector parties and communities is central to the future of the NHS. This is because these perspectives are fundamental; indeed, patients are the reason the NHS exists. Since 2010, this has been the aim of my doctoral research — to explore a shared leadership approach in determining the principles of care.

The purpose of this study is to gain an insight into (and a greater understanding of) patient experiences during the discharge process following percutaneous coronary intervention (PCI) after myocardial infarction (MI) — commonly known as a heart

attack. PCI is a relatively new procedure; since its implementation it has resulted in patients staying in hospital for less than three days. Previous management would regularly result in patients remaining in hospital for longer than seven days. However, reducing the length of stay has potentially impacted how information and communication are both provided and understood by patients on discharge from acute hospital care. Previous research such as Hainsworth (2006), Department of Health (DoH) (2004) and Picker (2010) suggests that whilst there has been a great deal of emphasis placed on policy, there still remains scope for improvement in practice.

As qualitative research is a form of social enquiry that focuses on the way people make sense of their experiences and the world in which they live, this research focuses on individuals who have had a heart attack and have then undergone the same treatment. The aim is to understand, describe and interpret their experiences, behaviour and feelings by looking at social processes and interactions. This was based on undertaking three separate focus groups involving patients, clinicians and members of the management team from a local NHS acute hospital in West London. Furthermore, in-depth, semi-structured interviews with eight patients were conducted. The idea behind surveying patients', clinical staff and managers narratives/opinions, was to establish a holistic view of discharge planning and practice. Recommendations for change could then be made dependant on these findings, in order to improve the effectiveness and efficiency of this process, in addition to patients' experiences.

Following the completion of the focus groups and semi-structured interviews, analysis was undertaken to identify whether any common themes emerged across the three different groups. Although the narratives identified varying views, the most

significant of the emerging themes was that of communication and the attitude of staff. Indeed, further analysis confirmed that communication was a prevalent issue in all three focus groups. The findings suggest patients have specific individual needs; this would not be surprising given the treatment and care received. Communication was also noted to be a major theme for patients; whilst clearly the majority of patients were relatively happy with the care received, they remained keen to make suggestions for improvement. The attitude of staff also featured strongly; patients were keen to suggest the changes they required and their rationale for these suggestions. The clinicians' themes mirrored the patients' themes, whilst also incorporating resource and innovation. The managers' themes commonly focused on service and proposed new ways of working, which included 'joined-up' working across acute and community services. Furthermore, the clinicians' and managers' themes recognised that the attitudes of all groups of staff remained a challenge.

In conclusion, this study has demonstrated the requirement for and the importance of effective communication throughout the entire discharge process. The aims are as follows: to ensure that post-procedure patients are discharged home or into a community setting safely; that they receive the right care, treatment and information in the most appropriate setting; and that they find and use ways to facilitate their recovery. Furthermore, this study has validated the importance of empowering patients to live with their diagnosed condition/disease by enabling the provision of support post-discharge. To this end, there is a need to ensure that positive values (such as empathy and compassion) remain a core part of the discharge planning process. This can be achieved by recognising each patient as an individual who is trying to make sense of a daunting life-changing experience whilst maintaining their

own core belief and value systems. As a result, recommendations for improvements and change within this study have been based upon these findings.

Further research needs to be defined to ensure that discharging patients from an acute hospital to their home or community setting remains both safe and effective, whilst also being informative and empowering.

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1 Introduction

1.1 Introduction

This is an exploratory study to gain an insight and a greater understanding into the experiences of patients during the hospital discharge process following primary percutaneous coronary intervention (PPCI) after myocardial infarction (MI) — commonly known as a heart attack. PPCI is recommended as a first line and gold standard treatment for ST elevation myocardial infarction (STEMI) based on unequivocal mortality and morbidity benefits (Antman et al., 2004; Antman et al., 2008; Iles-Smith et al., 2014) Combined mortality and readmission to hospital due to cardiac ischaemia is reportedly 14% at 12 months post PPCI (Lambert et al., 2010) Although with less frequency, readmission due to causes other than ischaemic heart disease that have comparable symptoms would include physiological and psychological conditions (e.g. musculoskeletal, pulmonary, and anxiety and depression) (Grace et al., 2004). This study will describe a qualitative research design and will explore the patient's journey including his or her discharge experience. In conjunction with exploring patients' experiences, the researcher will also seek to explore the healthcare professional's perspective. The researcher will examine the views of both clinicians and managers, and their experiences of the discharge process. This will allow the researcher to provide supporting evidence to encourage service improvements/changes to the current discharge arrangements, promoting a process that is effective, efficient and safe for patients having a PCI procedure following MI. The researcher will analyse and utilise patient suggestions for improvements in order to make recommendations, which will inform any service improvement and change to the discharge process and practice. The researcher

seeks to examine issues of concern relating to communication surrounding the discharge process between healthcare professionals and patients.

Generally, patients who had PPCI reported feeling highly satisfied with their initial PPCI treatment (Radcliffe et al., 2009.) However, Astin et al. (2009) and Sampson et al. (2009) reported patients were shocked and found it difficult to comprehend that they had had a heart attack. Feelings of shock were exacerbated due to the speed of the treatment, which consequently acted as a barrier to absorbing information. Patients also reported receiving insufficient information related to symptom management post PPCI (Astin et al., 2008). Local discharge evidence suggests there is currently no consistent approach for the management of patients in the days leading up to and on the actual day of discharge; discharge planning and information remains vague. (Picker Institute Europe, 2015). Indeed, in light of the findings, it is clear that further study and exploration is justified. The patient has a right to know what has happened and how they can manage their disease; they have the right to receive up to date evidenced information and, further, they have the right to know who to go to if they have concerns. The aim of the study is to gain a better understanding of the experiences of patients in order to inform and improve discharge processes and practices.

1.2 The Researcher's Professional Career

The researcher works as a Lead Specialist Nurse in Cardiology in a National Health Service (NHS) acute trust, delivering hospital-based care. This remit encompasses acting as an expert in clinical and academic practice in areas of cardiology nursing. The role combines both inpatient and outpatient work, and involves the management of autonomous nurse-led clinics. The researcher has

had a particular interest in patient experience for a period spanning approximately 20 years. The researcher has previously undertaken 'discovery interviews' with patients who have cardiovascular disease (CVD) and has developed discharge policy procedures, including guidelines for nurse-led discharge for post-PCI patients.

The researcher was responsible for developing a clinical pathway for the Treat and Transfer service. This service essentially improved clinical outcomes between an NHS acute trust and an NHS acute trust tertiary centre in West London. The team showed enthusiasm along with tenacity in their approach to the new initiative, considering this to be central to change, as well as credible and authentic.

1.3 Search Strategies

In order to define the search an emphasis must be placed on search strategy. This process is important; indeed, Hart (1998, p.13) defines it as:

> *The selection of available documents (both published and unpublished)*
> *on the topic, which contain information, ideas, data and evidence written*
> *from a particular standpoint to fulfil certain views on the nature of the*
> *topic and how it is to be investigated, and the effective evaluation of*
> *these documents in relation to the research being proposed*.

Evans (2002) suggests the effectiveness of electronic database searches would be improved through the development of a qualitative research filter, its purpose being to retrieve only the studies most relevant to the review —and in my case qualitative methods.

For Clark and Oxman (2000), nurses, other health care providers, decision-makers, and consumers are inundated with exponentially increasing amounts of healthcare information. Systematic reviews can assist in managing this huge amount of information by synthesising valid data and demonstrating the effects of health care interventions. Systematic reviews reveal where the effects are consistent, and for which populations, in which settings, under what conditions and where the effects may differ significantly. More reliable results are provided by systematic reviews because of the explicit, systematic methods used that limit bias (systematic errors) and reduce chance effects.

Punch (2016) points out the specific importance of certain aspects:

(1) The identification of literature relevant to the topic

(2) The relationship of the literature to the proposed study

(3) The way the researcher uses the literature in the research

The purpose of the review is to explain and critically discuss the findings from the studies selected following a search of the relevant literature. The National Electronic Library for Health was used to gain access to some of the databases. All articles were required to be written in English. Key words were generated from the question being asked and synonyms were used. Databases were scanned for search and combination of terms. There were no exclusion criteria. Several databases were searched; studies were found, both in the UK and internationally, relating to the 'broader' term of discharge and they were inclusive of different medical conditions in different surroundings. It appears there is work being undertaken in developing nurse and healthcare professional discharge in small pockets across the country. Articles were found discussing the issue of nurse-led interventions and/or a description of

how some hospitals are taking this concept forward. However, there are a limited number of articles that have used research and published findings.

Fourteen relevant UK articles were found providing information relating to the researcher's investigation. Eight relevant international articles were found from Taiwan, Turkey, the United States, Australia and China.

1.4 Changes in the NHS

Change in the NHS is not a new phenomenon; there have been numerous white papers and policy directives seeking to make improvements. Over the last two decades, these changes have aimed to develop services and care systems, designing them around the needs, wants and expectations of the patients using the service. The commissioning of patient-centred services has further strengthened this. However, challenges to service delivery remain; these include an ageing population, changes to lifestyles with negative health implications, acute presentation of patients' medical conditions, increasing patient attendance, advances in medicines and technology, and reduced lengths of stays. DoH policy documents reflect these changes and challenges, and therefore place specific emphasis on areas of discharge practice — in particular the contribution that nurses make to this process (DoH, 2002; 2005a; 2005b).

1.5 Cardiovascular Disease (CVD): Treatment and Mortality

At the time of writing, there are 2.3 million people living with coronary heart disease in the UK. This results in a healthcare burden of 1% for all GP surgeries and 40% for all accident and emergency (A&E) units. It has been estimated that 20–40% of the

general population will experience chest pain during their life. Chest pain caused by coronary artery disease (CAD) has a potentially poor prognosis, emphasising the importance of prompt and accurate diagnosis. Treatments are available to improve symptoms and prolong life — hence the need to develop National Institute for Health and Care Excellence (NICE) guidelines for the diagnosis of chest pain (Liu et al., 2016).

CVD is one of the leading contributors to the global burden of disease (British Heart Foundation (BHF), 2014). Despite a reduction in deaths from CVD in England over recent years, it remains the most common cause of death and still causes a large proportion of ill health in this country. CHD is the biggest single cause of death in the UK. In 2014, 15% of male deaths and 10% of female deaths were from CHD — a total of around 69,000 deaths (BHF, 2014).

In addition, the BHF estimates that there are over one million males and over 840,000 females living in the UK who have or have had angina — heart-related chest pain (BHF, 2010). Mortality from CHD continues to decline. When the BHF first published figures for 1988 there were 175,793 deaths from CAD in the UK; the equivalent figure quoted for 2008 is 88,236 (BHF, 2014). Without effective treatment, the immediate mortality of MI approaches 40%, with a further 10% of patients dying in the subsequent year. For those who survive the initial post-MI period an increased risk of death from cardiovascular causes (5% per year) persists indefinitely. Reducing morbidity and mortality among this group requires effective secondary prevention measures.

Established in 1998, The Myocardial Ischaemia Audit Project (MINAP) is a national registry of patients admitted to all hospitals and ambulance services in England and Wales with Acute Coronary Syndromes (ACS). This national clinical audit is a

mechanism for participating hospitals and ambulance services to review audit data in relation to their management of ACS. This performance can then be compared against standards as previously defined within the National Service Framework (NSF) for CHD (NSF, 2000), and as defined in other nationally and internationally agreed standards. Participating hospitals and ambulance services can then compare performance against national aggregated data, encouraging and enabling both clinicians and managers to create sustainable improvements in clinical outcomes and quality. Evidence has demonstrated that prompt and appropriate treatment within the first 150 minutes of a suspected heart attack is important in order to reduce the likelihood of death and recurrent heart attacks. If coupled with good cardiac rehabilitation then this can improve the patient's chance of a better recovery (MINAP, 2014).

1.6 Revascularisation, Patient Benefits and Outcomes

Rapid changes in interventional cardiology services have evolved due to new research and changes in technology. Over the last 15 years, cardiac services have transformed considerably in this particular demographic area. Morgan et al. (2005) agree that the patient journey has changed considerably since the development of primary angioplasty. In the current era, the patient journey challenges the sick role for STEMI patients, as PPCI is timely with treatment initiated within 90 minutes of onset of pain. The treatment brings about a dramatic and almost immediate improvement in the patient's condition, with prompt resolution of pain and wellness (Astin et al., 2009).

PPCI has increased dramatically and has become one of the most common medical interventions performed. Before commencement of the PPCI procedure, patients are required to participate in the informed consent process. Informed consent seeks to

ensure that patients have been given the following: information on what the procedure involves; explanation of the benefits and risks (including information on reasonable alternatives); and the option of refusal. For consent to be valid, the patient must have the capacity to make a decision about whether they wish to continue with the procedure. It is also considered best practice for patients to be provided with a written information leaflet.

The technique for this procedure involves gaining arterial access via the femoral, radial or brachial arteries. Under fluoroscopy, a guide wire is passed into the coronary artery (which supplies the heart with blood) and across the stenosis; a balloon or stent catheter is passed over it and the lesion is dilated and/or stented. The technique dilates an area of arterial blockage with the help of a catheter that has an inflatable small sausage-shaped balloon at its tip. The balloon catheter is introduced percutaneously through the skin of the groin, and sometimes the arm. The catheter is placed within a blood vessel (known as transluminal, meaning in the channel or lumen of a blood vessel). In the treatment of coronary arteries, this technique is also called percutaneous transluminal coronary angioplasty (PTCA).

Percutaneous coronary intervention (PCI) is a rapidly evolving technique used to treat patients whose coronary arteries are narrowed or blocked. Patients who are admitted with an STEMI or a non-ST segment elevation myocardial infarct (NSTEMI) heart attack currently follow evidence-based pathways. General or local anaesthetic is not required for this procedure, although patients may be given a sedative (this will make the patient calm or sleepy). A few hours after the procedure, patients can usually mobilise and will be discharged home the same or next day.

There are evidence-based papers (such as Antman et al., 2004 and electronic documents in the National Electronic Library for Health) guiding clinicians to treat

patients from admission through to discharge (Appendix 1). The DoH (2000) NSF for Coronary Heart Disease, which upholds modern standards and service models, is a practical, evidence-based and flexible approach to tackling CHD. This framework defines national standards (clinical and organisational) in service models for preventing and treating CHD, establishing initial milestones, goals and performance indicators against which progress within agreed timescales is measured.

Local patient benefits and outcomes observed to date are as detailed below:

- Immediate treatment: this is usually with 45 minutes and involves a same-day transfer back to the local hospital.

- Shorter hospital stays: in total, including a day at the tertiary centre, treatment is three to four days.

- Reduced readmission rates (less readmission as whole treatment completed) and returning to work within weeks.

Prior to the introduction of the PCI programme, patients who had suffered a heart attack were thrombolysed (given clot-busting therapy). A thrombolytic drug breaks down the blood clot so that the blood flow to the heart muscle can be restored to prevent further damage. Therefore, the sooner the blood flow can be restored, the better the chances of limiting the damage to the heart. Early thrombolysis occurs when a thrombolytic drug is given as soon as possible after the heart attack starts. This drug can be given by injection into a vein (intravenous injection) or by infusion into a vein (intravenous infusion, often called a 'drip', which means that the liquid drug is slowly delivered to the body through a tube inserted into a vein). Thrombolytic drugs are routinely given in hospital as soon as possible after it has been confirmed that a patient has had a heart attack. Increasingly, ambulance paramedics are giving

thrombolytic drugs before the patient is brought into hospital. In some hospitals, this practice remains; however, the PCI programme is used in most of the larger cities.

Curry et al. (2009) confirm that over the last decade cardiovascular outcomes research has contributed to improvements in both practice and policy. However, there remains an important challenge: optimal outcomes require supporting principles of patient centredness and promotion of the patient experience. By focusing on the patient's experience, the concept and implementation of research and qualitative methods of enquiry can shed light on aspects of the patient's experience that have been ignored.

Gulanick et al. (1997) examined differences in the recovery experiences of representative groups of patients who had undergone a PTCA procedure, including their attitudes and behaviours related to lifestyle changes, and the ideas they may generate for creative rehabilitation treatments that nurses could administer. It was used to enrol subjects who could describe recovery experiences from a variety of perspectives. They used seven different focus groups. The sample consisted of 45 patients (26 males, 19 females). They felt the number of groups needed depended on how homogenous they were; they believe an ideal group would be between six and ten participants. Larger groups make it difficult for everyone to contribute, limiting collection of all the information that might be of interest; smaller groups can be less productive. Their study size ranged from four to nine, with six to eight person groups being the most stimulating. This study also suggested the role of the moderator was important for a successful focus group. In the groups studied, the focus groups produced clear messages. A wide range of themes emerged from the data. Positive themes included: contentment with comfort measures, satisfaction with supportive hospital care, and trust in medical competence. Negative themes

included: anger over unmet needs for comfort and support, feeling dehumanised, and frustration about a lack of control in decision-making. Although many participants described very positive experiences, many patients expressed bitter dissatisfaction regarding several aspects of their care. They concluded that healthcare professionals must be aware of these possible reactions so that they can anticipate, recognise, and intervene early and appropriately.

1.7 Risk-Assessment and Discharge

Recently, there have been new approaches to discharging patients who have had PTCA. For example, Jones et al. (2012) suggest that discharge of low-risk patients 2 days after successful primary PCI is feasible and safe. Over 40% of all patients with STEMI may be suitable for very early discharge based on simple clinical criteria, with important implications for healthcare costs; it is feasible to discharge low-risk patients who have had an uncomplicated, successful PPCI. Dawood et al. (2012) and Bertrand et al. (2006) concur that the radial approach virtually eliminates access site complications after PCI, which allows rapid mobilisation; they concur that same-day discharge after radial PCI is safe and feasible. However, they suggest early follow-up by advanced practice nurses. Clavijo et al suggest (2016) discharge after uncomplicated single and multivessel coronary stenting of patients with stable, low-risk ACS, via the femoral approach facilitated by a closure device, is associated with similar clinical outcomes, patient satisfaction, and cost savings compared to overnight hospital stay. Khouri et al (2012) propose newer advances in PCI have played a vital role in decreasing the incidence of acute complications following PCI. These advances, especially when utilised with proper risk stratification through validated criteria, can help identify low-risk PCI patients who can be discharged

safely on the same day of the procedure. Locally, in 2013, the senior cardiac nursing and medical team implemented a similar structure for patients who had had an uncomplicated procedure and were considered low risk. The operator who undertakes the procedure indicates on the catheter report documentation that discharge can be considered 'nurse-led'; in addition, the senior nurse assesses the patient using a risk algorithm. The patient is deemed appropriate for discharge if all safe parameters have been confirmed.

1.8 Evaluating Discharge Processes

The discharge process should aim to ensure patients are returned safely to their permanent or new place of residence. Clinicians are required to ensure that the patients' needs and concerns are addressed in terms of self-management at home. Across the NHS, patients have a care plan that indicates their expected discharge date and details of the arrangements for their discharge. However, patients routinely convey concerns about the discharge process (DoH, 2004). Similarly, this finding is echoed within the NHS acute trust in West London as not meeting patients' needs (Picker, 2010). This research highlights areas requiring improvement in relation to the patient experience — in particular, the need to improve communication with patients, which includes talking to them about their worries and fears, improving correspondence and the provision of information to their GP.

Picker (2010) also identifies the need to improve opportunities to ascertain patients' views on the quality of care received, reporting that patients:

- Did not always get enough help from staff to eat meals.

- Were not always involved in decisions around their care.

- Did not always have the opportunity to talk to a doctor.

- Were not always told about side effects of medication.

  Picker's (2015) patient survey noted that, whilst the results were not significantly worse compared to 2013 and 2014, the following areas for improvement were identified:

- Patients reported that information from the nursing team was insufficient, including: a lack of confidence; no contact details for advice; nurses talking in front of patients; and staff not giving information relating to discharge (including adaptions or equipment that may be required on discharge).

- There was not enough information on further health or social care services.

- Patients reported they did not always feel well looked after and there was not enough information about how to make a complaint.

1.8.1 Multidisciplinary Care/Nurse-Led Care

In a review paper, Shepherd et al. (2004) suggested that discharge planning was a routine feature of healthcare systems in many countries. The focus of the review was on discharge planning that occurred whilst a patient was in hospital, and was not inclusive of follow-up care. However, issues relating to problems with discharge from hospital have been documented in the literature over the last 20 years (Brown, 1990; Klop, 1991; Armitage, 1994; McBride, 1995; Goncalves-Bradley et al., 2016).

They have recognised potential barriers to patient discharges from hospital, including communication problems between the treating team and the patient or family with

regard discharge planning. They suggest that a bedside 'Leaving Hospital Information Sheet' can potentially improve communication between patients, families and their treating team.

Nicholson Thomas et al. (2017) suggest that only 59.9% of patients are able to accurately state their diagnosis and ongoing management after discharge. This places patients at a higher risk of complications. Educating patients by providing them with accurate and understandable information enables them to take greater control, potentially reducing readmission rates, and unplanned visits to secondary services whilst providing safer care and improving patient satisfaction. They wished to investigate whether a simple intervention could improve the understanding and retention of key pieces of clinical information in those patients recently admitted to hospital. A leaflet was designed to trigger patients to ask questions about key aspects of their stay. This was then given to inpatients who were interviewed two weeks later using a telephone follow-up to assess their understanding of their hospital admission. Patients were asked about their diagnosis, new medications, likely complications, follow-up arrangements and recommended points of contact in case of difficulty. Sequential modifications were made using PDSA cycles to maximise the impact and benefit of the process. Baseline data revealed that only 77% of patients could describe their diagnosis and only 27% of patients knew details about their new medications.

After the leaflet intervention, these figures improved to 100% and 71% respectively. Too often patients are unaware about what happens to them whilst in hospital and are discharged unsafely and dissatisfied as a result. A simple intervention such as a leaflet prompting patients to ask questions and take responsibility for their health can

make a difference in potentially increasing patient understanding — thereby reducing risk.

Rudd and Smith (2002) believe that nurses should proactively take a lead role in co-ordinating discharge planning. The researcher shares this view, Identification is given that, when considering the discharge planning process as part of the nursing scope/role, nurses should be writing discharge letters, making follow-up calls and advising patients' carers and other professionals (DoH, 2004; NMC, 20I5; DoH and RCN, 2003). The researcher considered the above suggestions in relation to her study enquiry, and a patient empowerment tool with a patient's enquiry was developed (Appendix 2). Following a patient's attendance at a nurse-led clinic, a detailed discharge letter is sent to the general practitioner with the suggested treatment plan; this is discussed and agreed with the patient, and the patient receives a copy. Patients discharged home from the hospital are called by the researcher in the first week to assess symptoms, discuss medication and discuss how they are managing. This conversation was documented and a letter was sent to both the GP and the patient.

Griffiths (2001) compares multidisciplinary care and discharge practice on a nurse-led Intermediate Care Unit; the findings from the study suggest that a wide range of professionals participate in care, with therapies being widely involved. The recommendations were that future research should use a qualitative description of the decision-making process; this should help clarify if there are true differences. Within this study there was exploration of the idea of nurse-led discharge in a traditional ward area, not a specific nurse-led unit. It is important to be reminded of the findings of Griffiths' (2001) study in particular, with its emphasis on qualitative enquiry. Qualitative enquiry is developmental and vigorous in character; the focus is

on outcomes and process. Lees (2004) argues that only fellow professionals have the requisite evaluation skills because of their adherence to a work ethic different to that of the rest of the society. Therefore, it can be argued that the bulk of evaluation studies sponsored or mentored by the nurses' associations (ANA, RCN) are actually carried out by fellow nurse professionals or nurses at postgraduate level, and not by independent agents who are acting on behalf of the consumer. The main conclusion from this research is that a major underlying reason for undertaking a quality of care evaluation is the measurement of costs, as the goal for every successful manager is to minimise costs whilst maintaining quality. This equates a nursing evaluation to undertaking an evaluation of a business model — a parallel that does not appeal to those within the caring profession of nursing. The researcher believes it is difficult for nurses to follow their moral compass and to focus on quality and care given the current climate's focus on a reduction of stay, a reduction in cost, and increased effectiveness.

However, what we do know is the NHS is also looked upon as a business. The NHS now encompasses a huge breadth of alternative services to hospital admission, including in reach and outreach services, and rapid-access clinics; these all aim to increase the pace of discharge or transfer. Furthermore, it is now recognised that each clinical area involved in the discharge of a patient, from the pharmacy to the transport services, must collaborate to reduce overlap, waste and frequent frustrations (Hindmarsh and Lees, 2012). The researcher's personal experience of cardiology care pathways informs they can be effective, particularly in understanding what treatment should happen next; indeed, guidelines for discharge may be a suitable fit in the discharge process.

1.8.2 Patients' Perspective of Discharge

In Turkey, Yilmaz and Emiroglu (2005) used questionnaires and interviews both in hospital and at home with patients and their family members. Study findings highlighted that most of the patients were not given sufficient information about their disease, treatment, care and activities related to their disease. Interestingly, this article suggested that within developed countries this problem was not replicated due to the development and availability of policies for discharge. Whilst there are national and local policies for discharge planning in more developed countries, there does remain scope for improvement. On review, most of the articles surveyed concurred with the viewpoint that there is still a need for improvement or further research. The perceived problem associated with discharge planning in practice is that, from the perspective of patients, healthcare professionals and managers, this process still seems to be fragmented and disjointed.

The UK articles highlighted the user's perspective of discharge care, as did those from Sweden, four from the United States, and one from Australia. All studies refer to the growing need for user involvement in discharge care. Atwal (2002) reports discharge care is a service that is provided for the patient when he or she is particularly vulnerable. This does draw assumptions that individual patients need carefully considered care pathways that will meet their needs. The need for the multidisciplinary team (MDT) to conform to the necessary documentation is acknowledged in the extant literature (Tierney, 1993; Roberts, 2002; Huby et al., 2007; Almborg et al., 2008). These four studies make specific reference to the needs of senior patients. Three studies discuss the effects on the patients and their carers' participation in the discharge process (Efraimsson et al., 2003; Yilmaz and Emiroglu, 2005; Carroll and Dowling, 2007). One study focuses on

some significant associations between involvement and health and behavioural outcomes after acute MI (Arnetz et al., 2010). This is in keeping with Condon and McCarthy's (2006) findings that survival was a major factor in motivating and empowering patients to undertake lifestyle changes in the early recovery period following an MI. In a qualitative study, Page, Jackman and Snowden (2008) focus on the experiences of patients undergoing PTCA. Driscoll (2000) undertook a small-scale study looking at patients' and carers' perceptions of information, adequacy of information and their utilisation of information concerning post-discharge care received from healthcare professionals during their stay in hospital. This was an exploratory study using a mixed methods approach.

Arnetz et al. (2010) investigated whether patient involvement during hospitalisation for acute MI was associated with a post-discharge treatment outcome. Patient involvement has been associated with improved health outcomes in chronic disease, but less research has focused on the effects of patient involvement in acute conditions such as MI. This study represents the first attempt to examine associations between patient involvement in the acute phase of illness and short-term health outcomes. Some significant associations between involvement, health and behavioural outcomes after acute MI have been found in this study. However, higher involvement ratings were not consistently associated with more desirable outcomes, and involvement during hospitalisation was not associated with MI patient health and behaviour six to ten weeks after hospital discharge to the extent hypothesised.

Engaging patients in their care has been discussed and debated for more than two decades. In 2000, the NHS plan was launched, including for the first time a promise to give patients a real say in shaping NHS services (DoH, 2000). This theme

continued with later documents, such as the 'National service frameworks for long-term conditions' (DoH, 2005b) and 'Our health, our care, our say' (DoH, 2006). Despite these policy developments, Hainsworth (2006) suggests that research highlights UK levels of engagement are not as high as in other countries. Evidence demonstrates that when patients engage in managing their care, health services are used appropriately. Wanless (2004) found that there is a large difference in expected cost to the NHS, depending upon the level of engagement patients have with their health, which in turn improves cost-effectiveness and outcomes. As early as 1994, the Picker Institute Europe (2006) and Bull (1994) highlighted the importance of effective communication in successful discharge planning.

Patient power is a pertinent component in discharge planning as they can tell us what they need when we (the nurses) ask. Qualitative research by Efraimsson et al. (2003) reveals patients frequently experience feelings of powerlessness and being treated like an object in the discharge process. The focus tends to be on the medical condition and the administrative protocols; this drowns the voice of the patients, who should be able to exercise legitimate authority over their own lives. It is suggested that staff should use reflection as a corrective tool for combating patient's powerlessness in discharge planning; for example, staff could reflect on the language they use in discharge planning meetings, or whether the patient is 'meaningfully involved' rather than a 'tolerated guest'. In the study in question, as suggested above, a focus on conditions and administrative policies seems to resonate. Indeed, as demonstrated in the findings, the participants in this study did not always feel included in the discharge planning process. Radcliffe et al. (2009) found that patients felt let down by primary care after hospital discharge or were unsure if it had any role to play; they surmised this needed to be addressed. The

researcher suspects that a patient passport shared between secondary and primary care health professionals and the patient could aid in sharing relevant information. They might relate to reaching goals (including exercise, healthy eating and relaxation) and include an account of medicines with a place for amendments i.e. doses.

Although patient engagement is deemed to be a key feature of good practice in discharge planning, it is evident that there are variances in levels of patient engagement (Atwal, 2002; Salter, 2002; Hainsworth, 2006), suggest using a 'systems approach' which recognises the contribution that all partners make to the delivery of high quality care. Both in the literature and anecdotal accounts, it has been demonstrated that healthcare professionals do not communicate effectively when it comes to discharge. On a broader scale, the literature enquiry undertaken for this proposal indicates that, although there have been attempts over the last 20 years to involve patients in their care, there is still infinite room for improvement. In an earlier study, King and MacMillan (1994) concluded that a lack of information and poor communication can make the discharge process a stressful experience for patients and their families. When analysing the data and findings of this thesis, the researcher of this study found that King et al.'s conclusion is correct for some participants — in particular, there is a lack of and poor communication surrounding medicines, and a conflict of advice from health professionals. It is true to say that not one process or method will suit all; however, there may be shared themes about discharge that need attention — such as psychological, emotional, practical and physiological issues.

The patient empowerment tool developed during this study enquiry by the researcher picked out the most pertinent suggestions from patients (Appendix 2).

Bate and Robert (2006) argued it is equally important to empathise with patients by imagining yourself in their position, and to be receptive to what they are feeling. Developing a meaningful discharge plan requires time and discussion with the patient or family/carers. The patient's perception of what they need may not always be sustainable, however, health professionals need to be honest and clear about what can be delivered and by whom and when. The House of Commons Committee (2007) Third health report recognises that the directness and rawness of using patient stories gives real power in influencing change in health service delivery. The researcher chose to use a narrative enquiry for this study; indeed, hearing a patient's story provides credence to their experience.

1.9 Summary

Despite efforts on behalf of government bodies and health professionals to positively affect and alter the patient's experience of discharge, inadequacies do remain. Gaps in the service demonstrated by surveys of patient's experiences confirm that health professionals are not consistently meeting the needs and expectations of patients and their support networks. Further research is required to explore factors associated with a meaningful discharge process as experienced by the patients themselves. The important issues for patients resonate with communication. For the researcher, a meaningful discharge will always include the patient and, where necessary, others allied to the patient. A structured discharge plan has to be seen as important as an admission plan; this should be built into the individualised care plan with an emphasis placed on allocated time and discussion. There should be a written account of needs with a plan for action along with reasons why resources are or are not available. A designated health

professional should take decisions and document plans with the patient/family/carers.

2 Research Methodology and Overview

2.1 Research Questions

The four specific research questions for this study are as follows:

- How do patients feel about the discharge process?

- What issues concern them about the discharge process?

- What is their overall experience of the discharge process?

- How might these views inform a patient-centred discharge process?

2.2 Research Aims

The aim of this study is to explore and illuminate narratives from patients and healthcare professionals (including clinicians and health service managers), in order to ascertain factors that may impact on a safe and meaningful discharge. Patients' reports of their experiences indicate that healthcare providers are still not meeting their needs, despite recommendations and government policies. This study may help to improve discharge for patients who have had a PCI following an MI.

2.2.1 Rationale for Chosen Research Design

There is limited information relating to measuring patient experience and it is a commonly held view that the quality of health services can have a big effect (Bowling and Ebrahim, 2005). This includes cardiology patients and discharge in particular. There is acknowledgement in the literature that the most effective use of patients' viewpoints has not always been made. Greco, Brownlea, and McGovern (2001) suggested that the process of undertaking patient surveys alone might not be

sufficient. This would be dependent on what method was chosen; for example, if a questionnaire, tick box closed question approach was taken, rich data may not be extracted and meaningful insights may be lost. A grounded theory method would generate theory directly from the data, focusing on interaction and interviewing, and participant engagement. Hankins et al. (2007) further suggests that the measurement of patient satisfaction is problematic in they believe that before questionnaires are promoted for widespread use they require formal testing to demonstrate their ability to measure what they purport to measure (validity) and the precision, or reproducibility, of that measurement (reliability). Whilst not straightforward, the design of a reliable and valid questionnaire is a piece of empirical work that should precede its adoption for research or survey purposes.

Quantitative research is considered useful and valuable but can be seen as limiting as it neglects the participants' perspectives within the context of their lives; the controlled conditions of traditional approaches sometimes limit practical applications. This research does not always answer complex questions about the nature of the human condition; indeed, works of research are not inherently concerned about human interactions or the feelings, thoughts and perceptions of people in their research, but with facts, measurable behaviour, and cause and effect. However, both types of research are considered necessary (Holloway and Galvin, 2017). Qualitative research is a form of scientific enquiry that spans many different disciplines and has varied approaches. Qualitative methods can be used to understand complex social processes, to capture essential aspects of phenomena from the perspective of study participants, and to uncover the beliefs, values and motivations that underlie individual health behaviours. Curry et al. (2009) and Silverman (2015) state that theory provides a framework for critically understanding phenomena, whilst Creswell

(2014) ascribes a place to theory and calls it a general 'orientating lens' through which the research can be seen. It helps researchers to formulate the research question and eventually locate their own research inside or outside a framework. Equally, qualitative research can be difficult as there may be a lack of methodological knowledge — for instance, information about interview procedures. There is often a huge amount of data that needs time for data analysis and reflection (Richards 2015). Each interview in this study was tape recorded and verbatim transcribed. The researcher recognised that the considerable amount of data that resulted required good organisation and data management in line with ethical approval; consequently the evaluation of the literature suggests there are currently gaps in available research. Further research is required to explore what measures can be used to expand and improve the discharge process for this group of patients. This study will include a review of the current status quo after consulting with staff members, managers and patients. Following this enquiry, it is anticipated that the information gathered will assist in identifying improvements to discharge services that meets the needs of patients. Whilst there is some evidence of user involvement in the NHS, there is clearly scope for further improvement. (Picker 2015) This thesis will therefore offer suggestions and recommendations in how to change current service delivery.

2.3 Qualitative Research

A qualitative method was chosen by the researcher to explore a constructivist approach, which would fit with the idea of exploring human nature. Qualitative research is a form of social inquiry that focuses on the way people make sense of their experiences and the world in which they live. A number of different approaches

exist within a wider framework of this type of research, and many of these share the same aim to understand, describe and interpret social phenomena as perceived by individuals, groups and cultures. Researchers use qualitative approaches to explore behaviour, feelings and experiences of people, and what lies at the core of their lives. In this type of inquiry, the data collected by the researcher has priority over hypothesis and theories, and the research is initially inductive (discovery orientated). Further, context and contextualisation are of major importance. Researchers have continual and prolonged engagement necessary to immerse themselves. The relationships of power between the researcher and participants are based on equality, as the persons and the approach chosen should 'fit' the research question and the epistemological stance of the researcher. The basis of qualitative research lies in its interpretive approach of social reality and in a description of the lived experience of human beings (Holloway and Galvin, 2017)

For over 20 years, the researcher has been involved with people living with heart disease and has heard their views regarding their experiences following a heart attack. The researcher's first study looked at the experiences that the partners of patients had following the patient's heart attack, as there was a lack of data in this area and many studies were dated (Shotter, 1999). The experience of suffering a heart attack is always frightening and painful, arousing intense distress in the patient and the family, especially the spouse. Negative emotions after a cardiac event are clinically relevant for three reasons. First, symptoms of depression and anxiety have been shown to predict quality of life 12 months post Mil; and second, major depression adversely influences recovery, in particular adherence to recommended behaviour and life style changes intended to reduce coronary risk. Astin et al. (2005) suggest that their findings lend support for closer surveillance of the emotional status

of people in this population. Specialist nurses have the potential to play a greater role in identifying those at risk of developing anxiety and depression. However, this unmet need will remain unmet until specialist nurses who spend the most face-to-face time with the patients are equipped with the skills and resources to systematically identify those 'at risk'.

Qualitative researchers adopt a person-centred approach and holistic perspective. This approach develops understanding of human experiences, which is significant for health professionals who focus on caring, communication and interaction. Through this perspective, nurses and other healthcare researchers gain knowledge and insight about human beings — be it their patients, colleagues or other professionals. Researchers generate in-depth accounts that present a lively picture of a participant's reality. They focus on human beings within their social and cultural context, not just on specific conditions or professional and educational tasks. Qualitative health research is in tune with the nature of phenomena examined. Emotions, perceptions and actions are qualitative experiences (Holloway and Galvin, 2017, p.12). The researcher was incentivised to use this approach as rich knowledge and insights into human beings can be gained. Evidence-based practice demands that nursing maintains a closer compatibility between caring beliefs and caring actions "The" use of narratives in nursing research encourages the researcher/practitioner not only to consider individuals as unique but also to promote caring for the whole person rather than having a fragmented view which concentrates on a symptom or disease." (Capasso, 1998; Freshwater, 2004; Freshwater and Stickley, 2003)

The following elements are common to most qualitative methods:

1) Qualitative research can contain both emic and etic perspectives, in that it puts all the data elicited and its analysis into context. Qualitative research takes the 'emic' perspective, the insiders' point of view i.e. the patient's experience. The researcher attempts to examine their experiences, feelings and perceptions, and to uncover the meanings people give to their experiences.

2) Researchers immerse and involve themselves in the setting and the culture under study; they must be context sensitive to interpret what they observe and hear. The researcher is an instrumental part of the data collection process.

3) The data has primacy; the theoretical framework is not predetermined by the data but derives from it. Researchers do not impose assumptions but give analytical accounts of reality.

4) The method includes 'thick description': rich information given by the patients relaying their experience. In-depth collection of information leads to rich descriptions, details of a participant's experiences, listening too, interpreting, uncovering feelings and meanings develops from the data and context.

(5) The relationship between the researcher and the researched is close and based on a position of equality as human beings.

6) Data collection and analysis always interact. In qualitative research, data collected is analysed straight away and that part of the analysis is then compared to and related contextually to previous and later data collection. Qualitative implies a direct concern with experience as it is lived, felt or undergone.

2.4 Qualitative Content Analysis

Qualitative research is based on the belief that knowledge is socially constructed; it is a form of social enquiry that focuses on how people make sense of their

experience and the world around them. Koro-Ljungberg (2008) states that, in addition to having personal values and beliefs, participants are also connected with their environment; this influences their interactions with the researcher. If researchers understand the context, they can locate the actions and perceptions of individuals and grasp the meanings that they communicate. The interest in context and contextualisation goes beyond that which influences the research: it also effects the applications and use in the clinical situation. The researcher gleans the information in the participant's narratives to possibly make or affirm clinical change. The researcher of this thesis believes this could prove beneficial, as local audit (i.e. looking at communication on discharges) suggests the patient pathway from admission to discharge is not managed in a manner that is meaningful to patients.

Sociologists and anthropologists maintain that qualitative researchers study people in their natural settings Koro-Ljungberg 2008; Guba and Lincoln, 1989). Qualitative research is especially useful when little is known about the area of study and the particular problem; the research can reveal processes that go beyond surface appearances to provide fresh and new perspectives on known ideas (Strauss and Corbin, 1990). Glaser and Strauss (1995) suggest there is a third approach to the analysis of qualitative data, one that combines an analytic procedure of constant comparison, the explicit coding procedure of the first approach, and the style and theory of the second.

Research undertaken by Vygotsky (1978) offers a way of understanding mental processes through disclosure of their emergence and subsequent growth; he points out that all phenomena should be studied as a process in motion and change. Every phenomenon has a history and this is characterised by qualitative and quantative

changes. This research indicates that life experiences affect and influence our development and learning. For Vygotsky (1978), the human mind is both the product of human history, or phylogeny, and a person's individual history, or ontogeny. Heideggerian interpretive phenomenology is a popular research approach in nursing, as this form of research looks at what it means to be a person in the world. Rather than suspending presumptions, researchers examine them and make them explicit. Heidegger (1962) declares nothing can be encountered without reference to a person's background and understanding, and that every encounter entails an interpretation based on the person's background in its 'historicality'. The framework that we use is the fore-conception in which we grasp something in advance.

2.5 Constructivist Theory

Constructionists view knowledge and truth as created by the mind, rather than discovered (Schwandt, 2003). Berger and Luckmann (1991), and Hammersley (1992) believe that this idea is consistent with the view that reality is socially defined, but this reality refers to the subjective experience of everyday life — how the world is understood — rather than to the objective reality of the natural world. Steedman (2000) notes most of what is known and most of the knowing that is done is concerned with trying to make sense of what it is to be human, as opposed to scientific knowledge. Kelly's theory is called the fundamental postulate; it states that: "a person's processes are psychologically channelised by the ways in which he anticipates events" (Kelly, 1955, p.46). In other words, people act in a manner congruent with how they expect the world to be — based on their interpretations of past events. For example, if a person perceives people as friendly and helpful they are much more likely to engage others and seek advice. If a person perceives

people to be selfish and cruel, then it would only be logical to avoid interpersonal relationships and to solely rely on their own abilities.

Kelly (1955) states that the term 'construct' is particularly well-chosen because it reflects the concept's dual role; constructs represent the views a person has constructed about the world based on their personal experience, whilst they can also indicate how a person is likely to construe the world as they continue to experience it. Charmaz (2006) suggests that this helps to enhance the reflexivity of qualitative researchers. Indeed, the innovative approach taken in this thesis aims to empower the patient by asking them relevant questions such as: why do we need to do it this way? How could we do this differently? What looks like it would work and why? What are the benefits? Who benefits?

A person's construct system is both their history and predisposition to perceive. This is particularly relevant when looking at the experiences of the patients that the researcher has chosen to study. All the participants have had a heart attack and revascularisation, but the difference at this juncture is that their experiences will be different. As they all had different constructs, their history and predisposition to perceive would make their experiences very different. Therefore, the narratives expressed will be varied. By way of example, one of the participants had previous history, knowledge and insight into chest pain and treatment, as one of their relatives was a cardiac patient. Therefore, this patient's perception of what happened appeared heightened; they expressed how this personal experience was 'unbelievable'. This patient expressed information about the effect on their relative and how this had personally impacted them.

Berger and Luckmann (1991) maintain that conversation is the most important means of maintaining, modifying and reconstructing subjective reality. Subjective

reality is comprised of concepts that can be shared unproblematically with others. Using a social constructionist framework has been criticised due to its inability to change things, because there is nothing against which to judge the findings of research (Bury, 1986). Burningham and Cooper (1999) maintain this arises because of a misreading of the processes. They state that researchers adopting this approach, by comparing them unfavourably with objective reality, do not ground their arguments in, or discredit, opposing arguments. Dunne (2011) sees grounded theory as an ever-evolving approach subject to multiple definitions and interpretations. Charmaz (ibid.) suggests researchers can make up their own minds as to which specific way they want to take when using grounded theory — as long as they are knowledgeable about it and can explain why they have adopted a particular stance or followed specific processes. In any case, many researchers adapt methods during the process of research or use elements that they might find useful. Constructivist grounded theory adopts the inductive, comparative, emergent and open-ended approach of Glaser and Strauss's (1967) original statement. Viewing the research as constructed rather than discovered fosters a researcher's reflexivity with regard their actions and decisions (Charmaz, 2014). A constructivist grounded theory approach places priority on the studied phenomena and sees both data and analysis as created from shared experiences, and relationships with participants and other sources of data. Using a constructivist approach means to be vigilant of conditions under which such differences and distinctions arise and are preserved. Attaining sufficient material to anchor the experience takes rich and ample data, and involves having sufficient knowledge in order that differences and distinctions can be articulated.

For a study to be based on grounded theory, it must include the major features of this theory — most importantly the researcher must develop a theory, grounded in the data and with 'explanatory power' (Charmaz, 2006). Social constructionists do not present their findings in objective terms; instead they rely on the plausibility of their findings, suggesting findings are accepted by presenting a convincing argument — rather than by arguing that the results are definitive. Andrews (2012) proposes this is consistent with the idea that the research findings are part of many discourses; therefore, creating opportunity for a real debate that may lead to change. The researcher believes that the information gleaned is valuable because these are real patient experiences and narratives. Indeed, resonates well with Burr (1995), who suggests there are four foundational assumptions:

(1) A critical stance taken for granted knowledge.

Invites critical awareness of ideas that our observations of the world unproblematically yield its nature to human beings*.*

(2) Historical and cultural specificity.

The way in which the world is commonly understood — the categories and concepts used — are historically and culturally specific. People who are the subject of research have their own values and realities; therefore, multiple realities exist. Such research tends to believe that knowledge is interpreted and constructed rather than discovered or uncovered. It has frequently been used in nursing and social work, as well as in sociology, anthropology and psychology. This emanated from the work of researchers who developed scientific ways of uncovering meaning from the interpretation of patient's stories whilst they were terminally ill — in addition to interpreting the data within these stories (Glaser and Strauss, 1967).

(3) Knowledge is sustained by social processes.

People construct their knowledge of the world through their daily interactions with each other in the course of social life. Our current understanding of the world is a product of these interactions.

(4) Knowledge and social action go together.

There are numerous social constraints within the world; each different construction invites a different kind of action from human beings. These constructions sustain some patterns of social action and exclude others.

Lees (2011) suggests that an integrated approach with the use of surveys and more narrative methods, such as patient stories, will effectively define quality and how it should be measured, ensuring the focus is always on what matters to the patient. Curry et al. (2009) confirm that over the last decade research into cardiovascular outcomes has contributed to improvements in both practice and policy. However, there remain important challenges; in order to achieve optimal outcomes we require the supportive principles of patient centeredness and the promotion of patient experience. By focusing on the patient's experience, and the concept and implementation of research, qualitative methods of enquiry can shed light on aspects of the patient's experience that have hitherto been ignored.

Gulanick et al. (1997) examined differences in the recovery experiences of representative groups of patients who had undergone a PTCA procedure, including their attitudes and behaviours related to lifestyle changes and ideas they might generate for creative rehabilitation treatments that nurses could administer. Purposive sampling was used to enrol subjects who could describe recovery experiences from a variety of perspectives.

Sampling Methods

Purposive sampling represents a group of different non-probability sampling techniques; it relies on the judgement of the researcher when it comes to selecting the units (e.g. people, cases/organisations, events, and pieces of data) that are to be studied. Usually, the sample being investigated is quite small, especially when compared with probability sampling techniques. Purposive sampling is known as judgemental selective or subjective sampling, it is a type of non-probability sampling technique. Whilst the various purposive sampling techniques each have different goals, they can provide researchers with the justification to make generalisations from the sample that is being studied, whether such generalisations are theoretical, analytic and/or logical in nature. Gulanick et al. (1997) used seven different focus groups. The sample consisted of 45 patients (26 males and 19 females). They felt the number of groups needed depended on how homogenous they were, and that an ideal group would be between six and ten participants. Larger groups make it more difficult for everyone to contribute; however smaller groups can be less productive. Their study size ranged from four to nine, with six to eight person groups being the most stimulating. This study also suggested that the role of the moderator was advantageous to a successful focus group. In the groups studied, the focus groups produced clear messages. A wide range of themes emerged from the data. Positive themes included: contentment with comfort measures, satisfaction with supportive hospital care, and trust in medical competence. Negative themes included: anger over unmet needs for comfort and support, feeling dehumanised, and frustration with a lack of control in decision-making. Although many participants described very positive experiences, many patients expressed bitter dissatisfaction regarding several aspects of their care. They concluded that healthcare professionals must be

aware of these possible reactions so that they can anticipate them, recognise them, and intervene early and appropriately.

2.6 Research Methods

Researchers within personal constructivism seek to understand and explore how people construe their personal world. They believe that:

> Experience… is a set of personally construed events. To study a man's experience, then, is to have a look at that upon which, rightly or wrongly, he has placed some of his construction. (Kelly, 1955, 1991)

Research using constructivist methodologies stress the importance of listening and attempting to understand other people's frame of reference and the experiential context within which constructs can often be found. As such, emphasis is placed on creating a non-restricting framework within which the person has the opportunity to express such contextual elements.

The researcher recognises that qualitative and quantitative methodologies in research are equally important. For the purposes of this study, the researcher selected a qualitative research method as the experiences of the participants were thought to be a valuable indicator for discussion and analysis. It can be seen that, in some form, qualitative research can be involved in a variety of different approaches. However, it usually includes in-depth ways of exploring the world and the perspectives of the participants, and the investigation and description of a phenomenon seen from a viewpoint of a group of individuals (Ormston et al., 2014). As a result of these insights, this thesis investigated the views of the patient, clinicians and managers by way of focus groups and semi-structured interviews.

2.6.1 Focus Groups

Focus groups have been used in clinical nursing research for at least the last 20 years. Similar to a researcher's enquiry, they are often one source of data used in a specific qualitative approach. Focus groups in the social sciences and health professions have become more popular since the growth of qualitative research methods in the 1980s. The rigour of this approach is its ability to unearth emotions and feelings that other methods cannot; indeed, powerful narratives are often shared, which provide insight into the experience of individuals. The group interaction can act as a medium to generate unique insights into understanding shared experiences.

The focus group for this study comprised of eight participants, two of whom were female, with an age range of 62 to 89 years of age.

Focus groups in cardiology have been used in several ways to explore experience, change behaviour, reduce risk and increase motivation. They allow in-depth, open-ended discussion and exploration into an individual's experience and insights (Gerrish and Lacey, 2006). Bruseberg and McDonagh-Philp (2001) suggest that they are also an efficient way of obtaining opinions that contain a reasonable level of detail. Qualitative methods offer unique opportunities to contribute to empirical literature on key aspects of cardiovascular outcomes.

In qualitative research, a focus group involves a number of people who have had a 'similar experience or characteristics, the group are interviewed as a participative group by a researcher (can be assisted by a moderator) to elicit ideas, thoughts, perceptions, ideas, agreement or controversy about a specific topic' (Holloway et al. 2017), as was the case in this thesis. Hubbling et al. (2014) clearly state that focus

groups are a very efficient mechanism for generating rich data about a shared experience. In general, the advantages and limitations of this approach are the same as of all qualitative interviews, but there are a number of strengths and weaknesses specific to focus groups (Stewart and Shamdasani, 2014). The main strength is the production of data through social interaction. Through dynamic interactions, participants stimulate thoughts and feelings about the topic. Secondly, when discussion takes place, participants will respond to each other and may generate new ideas that have not been considered. Thirdly, all participants and the interviewer have an opportunity to ask questions, which may produce more ideas than individual interviews.

This method of research is valuable; focus groups are particularly suited to the collection of qualitative data, since they have the advantages of being inexpensive, flexible, stimulating, cumulative, elaborative, assistive in information recall, and capable of producing rich data (Fontana et al., 1994). However, a major disadvantage is 'groupthink' — a process that occurs when stronger members of a group or segments of the group have major control or influence over the verbalisations of other group members (Carey and Smith, 1994). Notwithstanding this disadvantage, the recognised advantages of focus groups as a data collection strategy outweigh any perceived weaknesses they may have.

2.6.2 Semi-Structured Interviews

This study used semi-structured interviews. Semi-structured interviews were preferred as the researcher has knowledge of the subject and can ask questions but cannot predict the answers; the interview provides the participants with the freedom to explain a situation in their own words. Interviewing is the most common way to

gather data. In particular, healthcare professionals are familiar with this approach (Holloway and Wheeler, 1996). Rubin and Rubin (2012) believe that researcher and informant become 'conversational partners,' but the interview has only some of the characteristics of a conversation. Ordinary conversations differ because the rules in the interview process are clearly defined. Burgess (1984, p.53) maintains that qualitative interviews are "conversations with a purpose"; however, recognition is given that questions are set to elicit information and an interview guide with prompts is used as an aide memoire. The purpose of the interview is the discovery of an informant's feelings, perceptions and thoughts. Marshall and Rossman (2015) state that interviews focus on the past and present, with a particular focal point on essential experiences. The sequencing of patients is not the same for every participant, as it depends on the answers of the individuals. An interview guide is helpful as it ensures the researcher collects similar types of data from all participants; questions are non-directive but are still guided towards the topic that the researcher is interested in.

The length and time of the interviews depends on the participants and the topic of the interview; an approximate time can be suggested by the researcher that acknowledges that participants may need to plan their day and that they may need a break. The other consideration is some participants may be willing to exceed the time allocated. Patton (1990) lists particular types of questions — for example experience, feeling and knowledge questions. The researcher chose to use this form of questioning as these types of questions were in keeping with the patient narratives. To support this, it was imperative that the researcher took an opportunity to become familiar with the background of the participant's journey and the literature that was reflective of the patient's conditions. The researcher was aware that, during

these sessions, those being interviewed may know and consider the researcher as an expert; therefore, it was important to ask that the participants spelled things out, so as to avoid leaving any gaps. Further, the researcher recognised that there was a need to put aside professional socialisation. Clough (2002) explains that narrative is useful only to the extent that it opens up (to its audience) a deeper view of life in familiar contexts. It can make the familiar strange; this potential to deepen a view of life is one of the characteristics that makes narratives a unique means of lived life and helps to ensure the strange becomes familiar. It was important to the researcher that the topic was covered, providing justice to the participant's views whilst recognising that direct prompting may be required to explore topic areas.

Of the eight patients interviewed, one was female and seven were male. Patient ages ranged from 41 years to 69 years. Two female patients initially agreed to take part in the study, but declined participation before giving consent.

The questions cited below were developed from the themes that were generated as a result of the data attained from the focus groups. The researcher sought to ascertain specific information that would inform and could be linked to experience. These specific questions were asked to enable the researcher to obtain specific information in order to be able to understand the 'whole' experience. From the semi-structured interviews, preliminary themes surfaced, which assisted the researcher to structure the questions. In particular, experience, knowledge and feeling emerged as themes — as indicated below:

- **Experience questions**: These would contain prompts to find out about the patients' experience of their admission, transfer, procedure and discharge.

- **Feeling questions:** What/how did the patient feel? Why did they feel as described — was this due to attitude, communication, environment, threat, fear, or anxiety?

- **Knowledge questions:** Did the patient feel prepared? Were they told about their treatment choices? Did they have prior knowledge? Did they know what to do when they got home? Did they understand their medications? Did they know who to call in an emergency?

2.7 Procedure

Patients were given a written letter advising them of the date and time of the focus groups and semi-structured interviews. A five pound voucher was offered as a refund for parking or travel. A meeting room was booked to provide privacy for participants and refreshments were made available. Participants were informed that the researcher and a moderator would be present at these sessions. For both the focus and semi-structured interviews, participants sat around a table. The focus groups were two hours in length and took place in the afternoon. A tape recorder was used at the focus groups and semi-structured interviews, allowing for subsequent transcribing of discussions, followed by analysis and interpretation of results in order to reach conclusions.

2.8 Selection

An interview guide in the form of a document was used to assist the researcher with practical steps. This included where the interview would be held, who was present, the positioning of participants in the room, and a list of questions.

In summary, the researcher's aim was to discover the actual experiences of the patients. The motive for asking questions under the three specific topics was to enable the researcher to obtain rich 'lived' information-based on individual stories. Interviews with patients can be considered as partnerships; indeed, it is important to recognise that the work is a process presenting a representation of reality — telling a story, remembering there are different techniques that may be used. Research occurs through the medium of a person; the researcher is always and inevitably present in the research. Through her work, the researcher noticed issues relating to changes in services and problems; this observance encouraged her to investigate, as there was a knowledge and understanding of issues, but further exploration was necessary. Indeed, clinical and practical research can be seen as 'actions in response to problems' (a term used by Jacobs, 2013). The researcher chose a topic that was relevant and appropriate for people who use the services along with the possible clinical improvement and advance of practice. Stanley and Wise (1983) mentioned hiding themselves away in the wings as the story belonged to the participants; the researcher is the interpreter followed by the narrator.

Recognition was given to the fact that people are different, as are their stories, whilst remembering their accounts would also have a similarity. All the patients wanted to be informed; some had different views in terms of attitude and understanding, and most were amazed at the technology. All were happy to be discharged at the time they were, but information about when they were to be discharged could have been better. Some patients wanted to share their experience to assist others; one participant found obtaining a yearly prescription certificate was useful and shared this with the group.

Purposeful selection was chosen for both the focus groups and semi-structured interviews, as this would appropriately fit the study enquiry. Qualitative research is the chosen paradigm. The researcher needed to interview patients who had experienced similar treatment and those who were diagnosed with the same problem. All data collection derives from sampling decisions, in this case with careful deliberation. The researcher was required to understand the experiences of these specific individuals who had had the procedure and were discharged home. The purpose was to select patients chosen from the ward who were admitted to hospital, had had a percutaneous intervention, and were discharged home. The participants' experiences were important as they provided information about the procedure and service from both trusts and ambulance services, including discharge. Morse (2000) advised that sampling should be appropriate and adequate; appropriateness means the sampling fits with the aim of the study and helps with an understanding of the research problem.

The selection sample was obtained through the researcher attending the ward round and identifying patients until the set number was achieved. The focus group took place on 2nd March 2011. The same process was followed for the semi-structured interviews. There was no dropout from agreeing consent to attending the focus group.

➤ Patient group: one female, seven males aged between 62 years and 89 years who had had an MI and subsequent PTCA.

➤ Manager group: eight in total, a mix of managers ranging from the chief executive to middle managers of medical, surgical and care of the elderly services and a ward manager.

➢ Clinician group: four in total, including different staff groups, consultants, nurses, and a pharmacist.

2.9 Ethical Considerations

Ethics for health professionals and researchers is concerned with guiding professionals to protect and safeguard the interest of clients. Nurse researchers have a responsibility to design research that upholds sound ethical principles and protects human rights. Ethical issues must be considered in all research methods. In nursing the researcher will apply principles that protect the participants in the research from harm or risk, and that follow the professional and legal rules laid down in the code of professional conduct (Nursing and Midwifery Council, 2015).

Ethical approval was sought and agreed from the university ethics committee and the research and development department in the NHS acute trust (Appendix 4 and 5) An application was submitted for ethical approval to the National Research Ethics Service (South East London REC 3) in June 2010, and subsequent changes were made at the request of the ethics board (Appendix 5) In November 2010 the research was approved. The research proposal was submitted to the local ethics committee at the NHS acute trust and at the university where the researcher was studying. A copy of the participation information letter to describe the study was given to patients identified (Appendix 6). Written forms were used to obtain consent. All the materials used for data collection and analysis are stored in a locked filing cabinet in the researcher's office. Data stored electronically is password protected. Pseudonyms were used to protect the participants' anonymity.

Recruitment of patients took place through the identification of diagnoses and treatments on ward rounds; further, a letter explaining the study was offered to the patients after the ward rounds. The researcher visited each patient the next day to find out if they wished to take part in the study. Consent forms were signed by both participant and researcher, and were kept locked in a cabinet in the researcher's office (DOH, 2006).

2.10 Data Collection

Data collection took place at the NHS acute trust in West London where the researcher is employed. It has a coronary care and cardiology ward.

There were two principal sources of data:

1) Focus groups: involving clinicians, managers and service users (patients).

2) Semi-structured interviews: involving service users.

The semi-structured interviews began in March 2012 and were completed in June 2012. Interviews were taped and transcribed by the integrated governance lead working at the NHS acute trust. A diary was used to identify the dates of focus groups and semi-structured interviews, and those who attended. Codes were used to replace personal details. The audiotapes were completed by May 2013. All transcriptions were themed and coded by July 2013. Quotations were used to preserve integrity, truth, meaning and validity (Kitzinger and Barbour, 1999; Webb and Kevern, 2001).

2.10 Data Analysis

Qualitative approaches are recognised to be incredibly diverse, complex and nuanced. Holloway and Todres (2003) suggest that thematic analysis should be seen as a foundational method for qualitative analysis. Thematic analysis is flexible and can be a useful research tool; it can potentially provide rich and detailed data. However, it can be subject to criticism for fostering an 'anything goes' attitude as there is an absence of clear guidelines on how to use it — indeed, there is no clear agreement about what it is and how it should be approached (Tuckett, 2005). However, the researcher selected this form of analysis because of its flexibility and inductive 'bottom-up' approach (Frith and Gleeson, 2004), whereby the themes identified are strongly linked to the data.

Thematic analysis is one of the most common forms of analysis in qualitative research and is used to emphasise, pinpoint, examine, and record patterns (or themes) within data (Holloway and Todres, 2003). Themes are patterns across data sets that are important to the description of a phenomenon, and are associated with a specific research question. The themes become the categories for analysis. Thematic analysis is performed through the process of coding in six phases to create established, meaningful patterns. These phases are: familiarisation with data, generating initial codes, searching for themes among codes, reviewing themes, defining and naming themes, data saturation, and producing the final report.

There is a need to bring order to the material by organising it into patterns, categories and descriptions. The first step is to look for concepts, make an index, re-read every piece of the data, and note down all categories that are relevant to the purpose of the study. In this study, the analysis of the focus group and structured interviews included the reading of each transcribed script from the taped sessions.

Firstly, paragraphs were reviewed to identify the overall topic areas arising. Then these were further categorised into groups of similar relevance (those that went together) by abstracting from them and drawing attention to what the researcher felt was of particular significance, or managing the data by reducing its size and scope so it could be reported on adequately and usefully.

Data analysis was carried out on separate sections of the research; focus groups were used to obtain 'rich' narratives from patients. The integrated governance lead attended the focus group sessions and transcribed the tapes from them. Thereafter, the researcher read the transcripts in a chronological order, looking at the patients' group first, then the clinicians', and lastly the managers'. The transcripts of individual interviews were read in chronological order and, as with the focus groups, emerging themes were identified and coded. Coloured marker pens were used to identify categories and themes, with notes made in the margin to assist in identifying commonalities. This approach allowed the researcher to focus on selected themes that were relevant to the research questions.

In the initial reading, colours were used to identify themes; after re-reading over several periods of time, more dominant themes and quotes emerged. As the researcher undertook this task, one can be certain that the analysis of the themes is accurate. This is because the researcher could recall the emphasis in the way the participants spoke, including their body language and emotional expressions. This assisted the researcher with clarifying the meaning and significance of what was said, rather than solely focusing on the words used.

The narratives can identify key themes. Thoughts and observations were recorded and each interview transcription was compared with the others. Commonalities and similar codes were grouped together. As common themes appeared in the data they

were highlighted and coded. Comparison with the data and selective sampling of the literature continued until saturation occurred and no data emerged e.g. the commonality with medicine issues, such as a lack of discussion about medicines to take home and a long wait.to receive.

2.11 Rigour: Reliability and Validity of Qualitative Content Analysis

Researchers must be open to scrutiny. Researchers working in health are required to consider the 'truth value' of their studies and to demonstrate that it is credible and valid.

Guba and Lincoln (1989) use the term 'trustworthiness' instead of validity. Trustworthiness exists when the findings of a qualitative study represent reality. Munhall and Oiler (1986) argued that, in the view of the qualitative researcher, subjective experience is not merely a private inner world, but it is inextricably bound with objective reality and the basis from which scientific knowledge is derived. The researcher's interpretation and description is presented as an account that is grounded in the participant's thoughts and feelings. Qualitative research studies require different approaches to validity and reliability, including different concepts. Silverman (2011) argues for the need to retain criteria for reliability and validity, whilst arguing at the same time that these cannot be directly translated from quantitative to qualitative research because qualitative inquiry has its own criteria by which it can be evaluated. Rigour indicates thoroughness and competence. Indeed, the researcher consistently checked and re-checked the data. Reliability refers to consistency and stability of the research instrument (i.e. the researcher). The concept of validity in qualitative research can be difficult, truth telling by the participants — in addition to descriptions and interpretations — is very important.

The researcher's diary log and notes were invaluable, as paying attention to detail would avoid misinterpretations and the imposition of meaning onto the participant's narrative accounts. Qualitative researchers must be mindful that they are required to be systematic and well organised, in addition to being open minded and flexible. This needs to be clear and demonstrable throughout the study as a decision trail that demonstrates the whole research process which can be followed by other researchers (Sandelowski, 1993). Such a trail would include the researcher presenting, illuminating and qualifying the chosen methodology and data analysis. The elements of rigour and trustworthiness, including the decision trail, are central for both students and supervisors as they attempt to ensure meticulousness in qualitative research.

2.12 Summary

Primeau (2003, p.32) states that:

Reflexivity enhances the quality of the research through its ability to extend our understanding of how our positions and interests as researchers affect all stages of the research processes.

Robinson and Thorne (1998) suggest that the researcher becomes immersed in the data. This immersion generates familiarity with the setting, the process and the world of the participants. Bott (2010, p.160) stresses the importance for researchers to be 'constantly locating and relocating themselves in their work.' This is considered important in healthcare as researchers can be socialised into professional ways of thinking. The research method used in this study enabled the researcher to follow a structured approach. This is because qualitative interviews are considered to be

conversations with a purpose, so that information can be obtained from one side only; therefore, an irregular relationship exists (Spradley, 1979). Semi-structured interviews put a focus on the issues that need to be covered; still, the sequencing of questions is not identical as this is dependent on the process of the interview and the answers of each individual. The interview guide ensured that the researcher collected comparable types of data from all participants. The choice to use patient narratives felt fitting for this study. Narrative research has been increasingly used in social sciences and is much advocated in terms of nursing enquiries. As narratives are accounts of experiences, narrative data can be collected through listening to patients stories about their experiences and their own interpretations of illness, treatment or care (Holloway and Freshwater, 2007,p.vii) For some narrative researchers, the most interesting features of personal narratives lie in what they tell us about individual thinking or feeling, whether the narratives themselves are about events or experiences (Labov, 1997, p.6; Holloway and Jefferson, 2000; Chamberlayne et al., 2002). The researcher then analyses and explores whether a meaning emerges so that the story can be written up in a scientific manner. The patients reconstructed their stories and experiences in a 'topic-centred narrative'.

3 Findings

3.1 Introduction and Overview of Findings

This study aimed to identify themes from patients' narratives. Thematic analysis has enabled the researcher to identify the emerging themes. Patient narratives have been used to further elaborate. The researcher has found that themes emerging from the data demonstrated patients still need more detailed and specific information on discharge, which is at times similar to others in the group or personal to the self. It appears communication features prominently, whether in treatment (including angioplasty), medication, pre-procedure care (including monitoring), nursing intervention and information on cardiac rehabilitation. Participants were happy to be involved in a forum to discuss their care and make suggestions for improvement.

The clinicians' and patients' themes were interestingly similar; all gave examples as to where processes could be changed and discussed practical elements. The managers discussed processes and pathways, including the broader aspects of other disciplines involved in discharge, giving opinions on why things were not working.

3.2 Patient Themes (Focus Group)

Below, Table 1 identifies the emerging themes and sub-themes as identified by the researcher following analysis of the patient focus group discussions.

Table 1: Patient Themes from Focus Group

Themes	Sub-themes
Communication	Lack of explanations
	Conflicting advice given
	Not listened to

	Not informed if they are getting better
	Lack of confidence in clinical staff knowledge
	Heard nothing once at home
	Most participants' experiences were good but there is scope for improvement
	Clinical decision-making
	Information to support their decision-making about their treatment and discharge
	Inconsistent involvement of medical professionals
Medication	Lack of explanations and/or conflicting advice
	Waiting for drugs before discharge
	Lack of advice on how to take
	What to do if they experience side effects
	Why are they important?
Lifestyle Modification	Conflicting advice on diet, medicines, exercise, driving or flying — lack of one solution that fits all
	Four patients enjoyed the video
	Five patients enjoyed the books
	Three patients did not get to see the dietician and physiotherapist
Technology	Patients focused on the efficiency of the technology and speediness of assessment treatment for the procedure
Treatment	All eight patients were happy with their care, all were able to identify where changes to care/treatment would make a difference
Care at Tertiary Centre	Mixed response, mainly positive
Environment	All patients mentioned the monitoring facilities in particular, and how scared they felt whilst being monitored
Discharge	All participants agreed they wanted to be told when they would be going home

3.2.1 Communication

Eight patient sub-themes were identified in relation to communication (see Table 3), including concerns to do with the length of stay, understanding the diagnosis, lack of clarity, not feeling they are listened to, and not being told they are getting better. Decision-making was viewed as a medical responsibility; all three focus groups identified this as being a considerable concern.

From the transcripts, selected quotes have been used below as evidence that patients had experiences that were both good and poor; some patients wanted to know what was going to happen to them, and why and when. Not all participants were given information to support their decision-making about their treatment and discharge, with communication seen as intermittent.

Participant (1) 'I never heard anything for a month when I left hospital.'

Participant (8) 'When I was discharged I heard nothing; it was about three weeks. You are like 'lost'; we put our trust in the cardiology department to know how you are.'

Health professionals were not consistent in their involvement with the patient; as a result this caused concern and anxiety for the patients.

Participant (4) 'I got a telephone call at home — that's a morale booster. I did find I was never sure what doctor was talking to me; they change. I had three different doctors come to deal with me. I would have loved someone to tell me what they were going to do to me. I had an idea, still in my mind I really don't know.'

Participant (3) 'The telephone call should stay. It was helpful.'

Participant (7) 'My wish would be to know more about the procedure and who was going to do it.'

Participant (7) 'I mean it's wonderful, because if you have a concern even when it's unfounded you can put a person's mind at rest, and thank you for giving us this opportunity to share views with you. It is so great to be able to share this with the hospital professionals because so often you know, you don't have the opportunity.'

Participant (8) 'Another thing, when you get discharged you get discharged from the chief cardiologist. I called the cardiologist down to me and said, "Can I speak to you,

how I feel about things?" You need reassurance that you are 70% fit to go out. I did not receive a telephone call at home.'

Participant (8) 'Now in the current day, including this hospital, unless the top cardiologist says you do this and you do that there's no initiative from the nurses because they are scared. We can't have all the time senior older nurses and all the doctors. The younger people are a quicker team; they should come up and build their confidence, that's where we are lacking. They need at least a heart specialist to tell you exactly what your situation is, but your situation is never discussed, communication is not there. Encouragement is very important.'

Participant (3) 'Yes I needed more information, especially on the day that you're discharged and I found I wanted to ask questions. I found I had been given the wrong information.'

Participant (3) 'The doctor explained the procedures but I didn't realise he was under supervision. Everything went well but I think they should have told me at the beginning. I was tense when I realised he was under supervision. I would have prepared myself.'

Participant (1) 'They don't really explain that much to you.'

Participant (1) 'I was told to keep my leg still and quiet for four to five days, then start to walk. It should have been four hours. Confusing.'

Participant (7) 'I think I should have had more information. You know if you ask if I can bathe the wound they said "no, no." I asked about swimming. They said "no, no," but didn't tell me when I could. On discharge the staff should spend more time with the patient and carefully explain exactly what is going to happen and the opportunities you have to improve your life. You have rehabilitation with exercises,

you have the dietician and the physiotherapist but actually go into detail and explain so you have clarity in your mind that you know exactly what is available to you. A lot of people don't realise.'

Participant (3) 'I was specifically told I could drive, but on the ward it says you shouldn't drive for four weeks and also inform insurance companies and the DVLA.'

Participants (2) and (3) had heard nothing about the clinic to see the dietician and physiotherapist.

Participant (8) 'I never heard anything about a clinic date and my biggest situation is when you are discharged, right, you cannot go to work unless you are fit. There is an understanding, sort of like unwritten, that the cardiology area should define a law to say you are capable, and that link is missing.'

Participant (8) 'No control over discharge; the cardiologist didn't work Saturday or Sunday and I had to wait until Monday until he came just to discharge me!'

Participant (7) 'I was certainly told I was going to be discharged, but they certainly did not ask. And if the date is going to change then they need to come and explain why.'

Participant (2) 'I think they talked more to the visitors, they will happily not tell you what's going on but will tell the visitors. I thought, my age as I am they probably thought she's an old lady who sits alone with her dogs and she won't know what we are talking about anyway (laughs).'

Participant (2) 'Only thing the blood pressure, I mean my son kept asking, they would say to him it was good rather than to me. I thought, "Oh I'm dying, it's gone too high," (laughs), but they don't tell you.'

Participant (4) 'Words are very important. I did find I was never sure what doctor was talking to me. They change. I had three different doctors. I did not know who was who and what he was after. They pulled the curtain, "How are you?" and that sort of thing and that's it. I never really knew. I mean some doctors just don't naturally communicate; it's just the way they are. I would have loved someone to show me what they were doing to me (procedure). I had an idea and still in my mind I really don't know.'

Participant (1) 'If that head man comes and speaks to you and says, "You have done very well, it went brilliantly," you've got a lift straight away.' The participant was referring to the consultant ward round and the comments made to them.

Participant (7) 'It's amazing how you do remember the positive things. I remember nine years ago when I had my bypass the surgeon came and said, "We've got five good grafts," and I sort of remember they were all good (laughs).'

3.2.2 Medication

Medication issues featured strongly. Patients remarked on the lack of discussion about medication and advice that was sometimes conflicting.

Participant (7) 'My only criticism with my discharge was the pharmacy. I saw the pharmacist who went through the medication with me but they were not ready for hours. They should tell you if they can't stick to the time, it was just left. When you're being discharged your family is waiting for you. That does cause concern.'

Participant (1) 'I was given no information about my tablets.'

There were long waits for medicines to take home and some patients were asked to return to pick up medicines. The concern was echoed through all groups. Within the

clinicians' and managers' group suggestions were made with reference to marrying up the patient and a discharge letter using web-based technology.

Participant (2) 'I shouldn't say, but we find pharmacy the worst to get tablets. You can be there all day! Till the evening, or usually the family has to come back, which is very bad I think.'

Participant (1) 'They wanted my bed, so I sat outside the ward, sat there all afternoon, gone 5pm. I said, "I've gotta have them, I must take them every day." The nurse looked on the shelf and found them. There was one tablet they said I have to take for the next year, that was the sister and the chap that did the procedure. He was very good, the sister said some people don't take the tablets and have to have the procedure.'

Participant (3) 'I accepted it that special one for the blood thinning the pharmacy here put on the boxes when to take.'

3.2.3 Lifestyle Modification
Patients observed conflicting advice on several aspects of lifestyle changes.

3.2.3.1 Written and Visual Information
This would be both in the form of BHF leaflets and local information developed by the cardiology team.

Participant (3) 'A young man came along and said, "You can go home and play football." (laughs) I've never played football in my life!'

Participant (1) 'The film about what we do when we go home was subtitled, with Indian people who had a bypass [sic]. I didn't have one. They had eight weeks off, and I was back working in two weeks.'

Participant (7) 'I had the same video. I enjoyed it. I have had a bypass.'

Participant (3) ''I was pleased with the books — they were very interesting.'

Participant (4) 'I got the impression it was the video in the DVD, so they just plugged it in.'

Participant (7) 'My experience was actually good; books were interesting, diet and exercise. Was very impressed with offer for exercise rehabilitation, I was pleased with my discharge. I was told "no, no, no, don't swim," but what they didn't say was when I could.'

Participant (3) 'I was told I could drive. On the ward they said, "You can't drive for four weeks."'

Participants (1), (2), (3), (4) and (8) had not heard from the dietician and physiotherapist.

Participant (8) 'There should be an understanding of when you can go back to work, that link is missing.'

3.2.4 Technology

All patients discussed the technology and revascularisation procedure, remarking on the efficiency and reduced length of time in hospital; this is not unique to the patients group as the same themes were highlighted in the clinicians and managers groups.

Participant (4) 'I couldn't believe it had been done, it's a strange thing, I'm lying there with a screen and they're getting on with it. I was thinking what on earth is going on? Next to no time it seemed to be finished.'

Participant (8) 'It's all about fibre optics, fibre optics technology.'

Participant (1) 'Doctor took a photograph out and said, look at that, where he put the stent in, perfect, really nice bloke.'

Participant (7) 'Brilliant, brilliant.'

3.2.5 Treatment

All eight patients reported being satisfied with their care, with six offering solutions to problems they experienced.

Participant (1) 'I came in on Tuesday, put to bed, went to Hammersmith Wednesday and left on Thursday, brilliant!'

Participant (7) 'Brilliant!'

Participant (8) 'In this current day, including this hospital is the same, unless there is a top cardiologist who says to you, do this and do that there is no initiative, whoever provides the classes should supervise student nurses and new sisters. My confidence will go up. We can't have the senior older nurses and doctors all the time. The younger people are a quicker team; build their own confidence, that's where we are lacking.'

Participant (2) 'There were only two nurses on at Hammersmith from 7am till 7pm. Those nurses were whacked out. There was nobody answering the phone, I thought that was shocking, you know.'

Participant (3) 'Unfortunately a needle had gone into my muscle and not the vein when they were taking blood. I was in a lot of pain; they gave me morphine. It shocked me, I was frightened.'

Participant (7) 'I know they have a major problem finding my veins; two nurses tried. I said, "Look there is always a problem, I will give you one chance to try again". She couldn't do it, I said, "That's it, no more." My being a little demanding got me a better service. Too many people lie there and just accept, and I don't think that's right.'

Participant (8) 'I didn't get an appointment to see someone. I had to make telephone calls; you get passed from person to person. You're spending your own money trying.'

Participants (5) (8) (4) All reported the word 'improving' was positive to them.

Participant (1) 'If the head man comes and speaks to you and tells you, "You have done well, it went brilliantly," you've got a lift straight away.'

Participant (5) 'It makes you elated again, straight on the phone to the wife, come and pick me up, everything's terrific.'

Participant (1) 'He said at the time, "This is a good one." I thought, "Oh great!"'

Participant (4) 'Things went great.'

Participant (7) 'I'm so glad we are discussing this.'

3.2.6 Care in Tertiary Centre

In the tertiary centre there were mixed responses from patients — however, they were mostly positive. Patients reported how amazing the technology was, acknowledging that drivers for modernisation and service redesign have made an impact on the patient journey. Those patients who went direct to the centre commented on the speed of the service. They said staff were mostly knowledgeable about the procedures and in explaining what they were doing.

Participant (7) 'Previous experience had made me worried. I demanded I wanted a certain cardiologist, but it was over Christmas. After much persuasion I had a very good cardiologist, all compliments to him. He did explain what would be happening to me.'

Participant (8) 'The operation side of it was really marvellous.'

Participant (3) 'Everything went well. The cardiologist explained all the procedures, but I didn't realise he was under supervision and that made me tense. I should have been told at the beginning.'

Participants (4) and (2) were not offered any advice.

Participant (2) 'I was taken up and down the stairs twice.'

3.2.7 Environment

Participant (2) reported a blood pressure reading causing alarm; reporting the nurse's response, unsettled them. Participants (2) and (7) were genuinely concerned —the sounds, alarms and beeps of the machinery were not being fully explained, causing unnecessary anxiety and distress:

Participant (2) 'Only thing the blood pressure, I mean my son kept asking them, they would say to him it was good, rather than to me, I thought, "Oh I'm dying, it's gone too high," (laughs) but they don't tell you. They said I could go to the toilet but they didn't tell me I had got all these things connected to me. They just popped off.'

The food was also noted to be a concern for participants (1), (2), and (7):

Participant (1) 'The food wasn't very good. It was to be expected. You're in a heart ward and they give you fish and chips!'

Participant (2) 'Fish and chips. I couldn't find the fish!'

Participant (7) 'I was happy with the food.'

3.2.8 Discharge

All patients agreed it was appropriate they were informed and included in the decision-making for discharge. This was a theme that the clinicians and managers group identified as a critical benchmark.

Participant (7) 'I was told I was going to be discharged. On discharge you should spend more time with the patient and carefully explain. Maybe a person should be specifically trained to deal with discharge on the day or the night shift, because I don't know that every nurse could actually be able to put the information across.'

Participant (2) 'I think they — the staff — are more inclined to speak to the visitors about discharge.'

Participant (3) 'I was told I was going home after a test.'

Participant (1) 'The discharge process was rushed. I didn't know anything when I was discharged. Until I called they had totally forgotten about me.'

Participant (4) 'I was told I was going to be discharged early in the day and I didn't come out till early evening. The ward sister and I had a chat about things; yes I was aware what it was all about (information on discharge).'

There is clearly a disparity among the participants; the care was not always joined up. The information is available but not always imparted. Processes are disjointed, which leads to dissatisfied patients.

3.3 Clinician Themes (Focus Group)

Table 2 identifies the emerging themes and sub-themes as identified by the researcher following analysis of the clinicians' focus group discussions.

Table 2: Clinician Themes from Focus Group

Themes	Sub-themes
Length of stay	Patients waiting longer than anticipated pathways. Problematic for both the patients/families and the hospital service.
Communication	Acknowledged there is a lack of meaningful communication with patients and families.
Assisted technology	This theme prompted much discussion and debate around discharge, generic email, webmail, and marrying up patient information to support discharge.
Advice to patients	Staff not possessing the right skills or experience/confidence to deliver information. Lack of staff decision-making. Skills mix and job roles.

3.3.1 Length of Stay

The multi-professional team consisted of one consultant cardiologist, one cardiac pharmacist and two cardiac sisters. Clinicians' themes focused on process and length of stay. All commented on the need for greater communication between healthcare professionals and patients. In terms of planning our care and overall patient pathway, this needs much better refinement.

Participant (4) 'Well the discharge process means ensuring that the patient has the discharge letter, having it all done by clinicians. Ensuring they have medication, ensuring they are counselled on their treatment. It's like a process step by step in that it leads you to a safe discharge of patients in terms of both medical and socially, so that's how it works, giving consideration to the treatment but also the social side. You have to consider there may be other medical issues.'

3.3.2 Communication

Both nursing and medical staff acknowledged that there was not always a planned approach to discharge; in particular it was not thought about at the beginning of the patients' journey. The consequence of this is that the discharge is then rushed. It was recognised by the whole group that it was essential to realise that conversation is important and that you will glean much about the person and their social circumstances.

Participant (2) 'We work as a team, so whatever the process is we have to discharge safely.'

Participant (4) 'There are competing interests. I think one of the ways around this is to look at better discharge planning. If we had more senior-level input onto the wards on a daily basis… I think the cardiology ward in particular is vulnerable mid-week, we have a full ward round on a Monday and a Friday, but on Tuesday, Wednesday and Thursday we essentially trouble-shoot. If we had a better system where we had a more senior-level input we would have less of an issue with the take-home drugs writing.'

3.3.2.1 Operational Concerns

There were concerns that affected the operational business; teams appeared to work in a fragmented way together. Discussions about patients' care and decisions made do not always happen in the right place or time with the right people. Indeed, processes vary for each team. The idea of a multidisciplinary meeting at a regular time daily with the whole team could help to clarify patients' treatment and care. Here, the members of the team can agree or challenge the discharge date, discuss

medication and the discharge letter, and offer information obtained by the patient and their family/friends.

Issues relating to leaving hospital without medication were discussed; for example, sometimes on a Friday there are pharmacy delays, which are more noticeable. The involvement of the ward pharmacist is crucial. The discharge process is delayed when the discharge letter is delayed, which then affects the availability of take-home drugs.

Participant (4) 'I try to prompt the team to do the discharge letter as soon as possible. I also look at medicine reconciliation.'

Participant (2) 'We get involved from the day they are admitted, because you have to, you have to assess what they need upon admission and after having the heart attack. You have to do an interview, e.g. "are you working?" Like, we mention if a patient is an HGV driver it will affect their job dramatically.'

3.3.3 Advice

The clinicians showed concern about advice to patients, as did both the other focus groups. In particular, they spoke about 'what advice, and who should give it.' It appears there are opportunities to impart information, but is it consistent? Or is there a lack of confidence or knowledge? This may be a reference to a lack of confidence, skill and knowledge in staff, or an acceptance that it is not their responsibility. The quotes give the impression there is a certain risk associated with imparting information. This may be exacerbated by the lack of joined-up working and teams not understanding what other teams are doing in terms of competing demands. The clinicians see themselves as offering information and solutions to help empower the

patients. They make reference to innovations that will assist both patients and staff — for example, generic email.

Cardiac rehabilitation teaching can prove difficult — issues relating to ensuring the family were incorporated in discussions were mooted. There are options to choose from — for example, gym-based versus home-based exercise.

Participant (4) 'In cardiac rehabilitation there is no "one fit" to suit all patients.'

Participant (2) 'For a few patients they want their partner, family, friends involved, just to help them remember (laughs). We will arrange a convenient time for them to come to get feedback, anything we can do. The families play a big part.'

Participant (4) 'Setting up a generic email address would be useful where people can drop us an email and then a member of the team can pick up and provide advice.'

This substantiates the themes identified by the patients; some are common and others more personal in terms of individual need. The principles may remain the same, but individual need cannot be excluded.

Participant (4) 'We show the DVD to the patients. It's in different languages, but it's not just about that, it's about patients who are living with a learning disability. We need to find the right way to communicate, make sure they are aware of their heart attack and how to look after themselves when they get home.'

Participant (4) 'Some people are left on the monitoring system because we have no default option. There is no active decision. It makes the patient more institutionalised and reliant on these extra gadgets to keep them safe.'

Recognition of patient and staff values and beliefs is paramount; the whole group agreed it is healthy to challenge these. The general consensus of opinion in the group was that challenging one's own opinions and values, and those of others, was

important. The group felt it was important to recognise the MDT's efforts and constraints.

Participant (3) 'Another aspect of concern is when patients have special needs — for example, compliance aids — clinicians do not always make allowances for the time it takes to organise. This can delay the discharge process.'

3.3.4 Assisted Technology/Discharge

All clinicians mentioned themes around technology, including adjuncts that assist in discharge — for example, generic emails and patient databases. There appeared to be an emphasis on acute pathways of care rather than the discharge pathway. There is evidence of pathways of care, as seen in the body of this thesis. Indeed, they exist, but they are not used in a pragmatic manner. Even though they have been written and ratified by healthcare professionals, their use is still sporadic. The culture at present does not support the use of pathways, or see them as helpful. Instead they are often viewed as a hindrance. However, they are necessary from a patient's and clinical governance perspective. All teams know what is expected; treatment and care are evidence-based and stand up to scrutiny. All members in the group acknowledged that the use of a database for logging and monitoring/auditing diagnostics was extremely useful and necessary.

Issues relating to policies and guidelines were debated with the acknowledgement that this was difficult given patients' access to primary and secondary care.

Participant (1) 'It's a process doing individualised discharge letters for patients. The problem is the language; we would have to do a second for the GPs with medical speak on it.'

Participant (4) 'That's the tricky thing, marrying it up.'

Participant (2) 'I think it's better now because of real-time [patient database], so the patient assessments take all the patient's details and there is a connection to social services.'

The use of patient databases created much discussion and it was widely accepted that staff value these interventions.

Participant (4) 'All members in the group acknowledged the use of a database used for logging and monitoring/auditing diagnostics was extremely useful and necessary.'

Participant (2) 'Tomcat [cardiology database] is very good. All medical and professional staff can get patients' details, their treatment, care, interventions.'

Participant (4) 'In my experience it is true that if a patient is told they are going home, they believe they are feeling better and are getting better.'

Participant (1) 'You need to understand what the patient has gone through and what they need to have to do, like education. I think a lot of patients feel very vulnerable.'

Participant (4) 'We need to listen to the patient, get feedback as to why they are not happy, get back to them, whatever we can do to improve I think. Moral support and the thought that you are going to see the specialist and the dietician is important.'

Participant (2) 'We do have complaints, we have to consider that and then at the same time to do an action plan to prevent it from happening again. You need to understand what the patient has gone through and what they have to do.'

Participant (1) 'There may be an increased length of stay, as important conversations may not have taken place.'

3.4 Manager Themes (Focus Groups)

Table 3 below shows the emerging themes and sub-themes as identified by the researcher following analysis of the managers' focus group discussions.

Table 3: Manager Themes from Focus Group

Themes	Sub-themes
Process and change	All managers agreed it was necessary to look in detail at the service, mapping the processes. It was felt essential that all the focus groups should challenge 'what we do and why we do it.'
Pathways linking all disciplines to patients	The development of patient pathways was considered critical. Patients will follow a pathway of care linked to their disease, which is supported by evidenced-based research.
Length of stay	How can we manage length of stay? What measures should we use to ensure safe discharge?
Leadership	Generally a feeling that 'something was missing' in terms of leadership from all of the MDT.
Advice	Accepting the balance between healthcare professionals and patients and looking at what this means.

3.4.1 Process and Change

Every manager in the group supported themes focused on process and change. The managers' group ranged from assistant general managers, medicine and care of the elderly managers, discharge liaison team managers, and chief executive. All recognised the need to look in detail at the service — challenging what we do and why we do it. All managers suggested a pathway that was linked to all disciplines treating the patient; this theme was common in the clinicians' group too. The managers' group focused on similar themes to the clinicians — for example, the lengths of stay, processes and care pathways.

Participant (4) 'We leave the prescribing of take-home drugs to the most junior members of the team. We have pharmacists who have the skills, and we have non-

doctors prescribing. Let's bring it up to the 21st century! I think we need to see the role of the pharmacist as a key to unlocking this, by being more proactive.'

Participant (1) 'The discharge summary isn't really for the patient is it? It's very medically driven. Nurses can influence the discharge process by reconciliation of the patient's medicines.'

Participant (3) Suggested an innovative approach — an evidenced-based pathway, having the information and understanding of the process, setting the expectation with team back-up.

Participant (4) 'We don't do joined-up working, so we have letters for doctors, district nurse letters, the follow-up appointment, transfer letter back to the care. It should be in a standard global document. The patient should know what is happening to them.'

Participant (1) 'There are also some things about principles that don't become a strait jacket, like visiting hours. The interaction between families and patients can be therapeutic, like meal times. We should be actively encouraging relatives/friends to help. I think it is shocking the number of people who die in hospital, who, if given the choice, would not do that. I feel it is a terrible indictment of society that we keep people in hospital when they want to die at home in the comfort of their home with family and friends around them. If you reduce your reliance on acute beds, then we can invest. It's absolutely do-able.'

3.4.2 Pathways

All agreed this would be a useful process to follow. Clinicians have developed pathways; work is required to put procedures and policies in place to ensure they are followed. This was recognised as best practice. As seen in the body of this thesis,

there is evidence of pathways of care. They exist but are not used in a pragmatic manner.

The group noted that electronic systems for discharge were helpful; however, there was room for further thought on the data collected and how this can be used to model future needs.

Participants (1) and (3) and (4) suggested electronic discharge systems are helpful and that care pathways should be included on these systems to prompt and assist with discharge. They agreed a living document is dynamic and should be multidisciplinary.

Participant (1) 'I don't think we are using the database tool as a real tool. We have to unlock it, because it gives staff ownership. I think we have started on a journey; we are not there yet, but we are making progress. The patient database will allow us to track people and we can begin to see how good we are at predicting, what's the margin of error and how do we shorten that? I think it is important that we look at what diagnostics are important to wait for, how crucial are they in making a definitive decision on whether the patient goes home or not? We need to look at the core clinical pathway.'

3.4.3 Length of Stay

All agreed the challenging issues relating to length of stay were not given the scrutiny and authority required. Again, working with the patient pathways could assist the service to remodel and plan for a realistic length of stay. All acknowledged the challenge this would bring, including different ways of working, service remodelling and out-of-hours working (24/7 service).

The issue relating to length of stay prompted much debate. The group recognised that risk is acceptable. However, keeping patients in hospital unnecessarily for longer than they need to be there is not acceptable. Communication about what the length of stay looks like for the patient was featured. The input of families and friends was recognised as vital.

Participant (1) 'Identifying that, at times, risk is acceptable, acknowledging that we do not live the patient's life and that what we may think is an unacceptable situation may not be seen as the same for the patient, therefore accepting how people live and not judging.'

Participant (3) 'We need to acknowledge the interaction between carers and families and realise it can be therapeutic.'

Participant (4) 'Sometimes I think we pay lip service, we have pencilled in a discharge date and everyone is happy. We should be looking at them from a point of view of how do we get the patients home? Looking at it from a multidisciplinary perspective and keeping the patient involved and their families engaged.'

Participant (1) 'We don't always communicate well with all members of the team and therefore it can be a bit of a rush and scrabble at the end, rather than being something we build into.'

Participant (1) 'I think what we have done is created specialists, like the discharge coordinators, and people then think, "It's not my job anymore." Some areas are more complex; perhaps there is not enough team working with linked-up thoughts. Partly we are leaving that responsibility with the discharge coordinator. We should involve patients more, inform patients about the expected length of stay, which sets out an expectation.'

Participant (1) 'Something in a letter provokes the patients and relatives to phone or contact, asking about the discharge date.'

Participant (4) 'I work in the community. When I see patients and relatives they tell me, "Nobody told me that would happen when I got home." Information is lacking; if it states the discharge nurse is coming, what does that mean? When, what time, what will they be doing?'

Participant (4) 'I think there are patients who need to know who they should go back to if there is a problem or a complication. We have to be completely clear about the role of the acute trust; we need to equip staff to help them deal with this.'

Participant (1) 'Sometimes we are judgemental, we judge people. The house isn't very clean. This is the way people chose to live; that's their right.'

Participant (4) 'I think, for me, people don't want to talk about discharge until people are going home. People don't want to talk about it from the beginning. The conversations are important, like: you came by ambulance — how will you get home? Where are your keys? Who's going to put milk in the fridge? Who will put the heating on? For me it's about the conversation, the welcome to the ward, expectation of length of stay, etc. On the other side of that the fine balance is important; some patients may suggest the neighbours can help, when they have been doing this for years and under duress.'

3.4.3.1 Education and Empowerment of Patients and Staff (sub-theme)

The discussions focused on the empowerment of patients and staff. There was a recognition that staff members are required to value each other and their roles. The assessment of the patients is dependent on a step-planned effect. The group identified a need for discipline in their approach. Value sharing and creative,

multidisciplinary meetings with debate can take place in order to achieve this. There was a consensus from the group that there was a reliance on acute beds. There was agreement that this is a significant issue, which needs to be formally addressed with a wider audience.

3.4.3.2 Values and Beliefs (sub-theme)

The whole group agreed it is healthy to challenge, feeling it was important to challenge their own and others' opinions and values.

Participant (4) 'There needs to be a consistent message. I think there is not much consensus about what we say and how we say it.'

Participant (3) 'Another aspect of concern is when patients have special needs — for example, compliance aids — clinicians do not always make allowances for the time it takes to organise. This can delay the discharge process.'

3.4.4 Leadership

The participants recognised the need for credible role models and that good leadership is essential.

Participant (1) 'It comes back to partnership working, the role of the consultant and sister. I do think that the ward sisters have retreated behind the office doors on occasions.'

Participant (5) 'I think the doctors have lost their way when talking to relatives. What's wrong with sitting with the relative, patients and notes? I think it comes back to the sister, and I do think for whatever reason the ward sisters have lost their way,

not all, the days of the ward sister owning the ward, she managed it; I do think we need it back to that.'

Participant (2) 'I know it's an old-fashioned view, but I think it is pivotal that the nurse is on the ward round, in some areas the nurses do not see it as part of their roles.'

Participant (3) 'A nursing presence on the ward round is really important; this has changed when we moved away from having single-consultant ward rounds.'

Participant (1) 'A nursing presence I see as being one of the key things the ward sister can do, and can be used for dissemination of information to the team.'

Participant (1) 'I have no doubt that the patients that have access to the specialist nurse get better care. Patients should have access to a specialist nurse and the nurse should interact with a broad range of staff. I think we should see the specialist nurse as a huge resource that the wards should tap into, they should call and use them.'

3.4.3.3 Decision-making and Skills (sub-theme)

The management teams make it clear that responsibilities change and there is a lack of decision-making. Reference was made to the expectations of certain staff; the managers in this group had a belief about what other staff should be doing and why. This appears to be due to a mixture of participants' length of service, previous roles, experience and values, which can be observed in the quotes. All participants were in positions of authority, and therefore their opinions carried impact. They spoke with experience.

Participant (2) 'I don't always think we communicate well with all members of the team.

Participant (4) 'Decision-making on the wards requires addressing.'

Participant (3) 'It's about giving staff the confidence.'

Participant (4) 'I don't think nurses are proactive enough in the discharge process.'

Participant (2) 'Planning for discharge on admission, we are looking at how do we get the patient home. Looking at it from a multidisciplinary perspective, there is a real need for joined-up working, as it is pivotal in delivering services that make a difference to the patient. So there is something about having a planned and expected date of discharge. Some may change over time, but planning and keeping people engaged and involved.'

Participant (2) 'The nursing and medical skills mix and levels of correspondence driven by the system can affect patient care.'

Participant (1) 'There is also the nature of risk to the organisation and clinical decision-making, it worries me when we have 15-20 discharges that are dependent on diagnostics; the question is will the diagnostic make a difference? Is it a sort of safety blanket for the staff in case something may happen?'

Participant (4) 'I'm quite vocal about the nurses, but it's also about the medical staff. When the ward round was 8.30 and you have proper leadership, and when I say leadership I mean a consultant, you see movement and a reduced length of stay. It comes back to clear clinical leadership.'

Participant (4) 'Skill and competence are not always achieved together.'

Participant (2) 'I know it's an old-fashioned view but it's pivotal the nurse is in on the ward round. Now nurses don't see this as their role, for me if you're on the ward round you are thinking about the discharge process.'

Participant (4) 'I think a nursing presence on the ward round is really important, and I can remember when it all changed when we went away from having single-consultant wards. We had one social worker, one occupational therapist, one physiotherapist. It was much more of a multidisciplinary team. It is absolutely crucial we have a multidisciplinary team.'

Participant (1) 'One of the reasons for making the ward sister supernumerary was for them to be able to hold the ring around some of these things. This is a key thing there should be a nursing presence, and there is something about the art or science of nursing, rules and regulations, particularly around continuing care, deprivation of liberty are very complex for people [sic] and that's what's driven us to have people who have a lot of very specialist knowledge. Influence is important, I'm a great believer in what you can measure you can change, because you have objective evidence.'

3.5 Patient Themes (Semi-Structured Interviews)

Table 4 below shows the emerging themes and sub-themes as identified by the researcher following analysis of the patient semi-structured interview discussions.

Table 4: Patient Themes from Semi-Structured Interviews

Themes	Sub-theme
Communication	Lack of information
	Lack of clarity
	Conflicting advice
	Not enough time to discuss issues
	Lack of explanation
Medication	Lack of information; discussion about drugs lacking overall
	Advice not consistent
	Drugs to take home arrived late, not explained in four

	cases
	Relatives had to return for medication
	Written literature not always given
	Conflicting
Dignity and Privacy	Three participants mentioned open discussions around the bed, and other patients hearing
	Curtains not drawn
	Activities of daily living not addressed
Anxiety	Seven participants reported feeling fearful, scared, worried, tearful and petrified/guilty, surprise and denial
Lifestyle Modification	Participants who had advice were generally pleased with this
	Two participants received very little advice
Discharge	Six patients were not kept involved about their discharge date or told if they were getting better

3.5.1 Communication

The group made reference to a lack of confidence in nursing and medical staff communication about what was to happen, what had happened and what the next step would be. Six participants — (2), (3), (4), (5) (6) and (8) — reported being relatively happy with the care and commented the staff had been kind and caring. Two reported how amazing the staff had been. Seven participants reported there was no clear, discussed date for discharge. Of the participants, (1), (2), (7) and (8) reported concerns around communication between clinicians on issues such as length of stay, understanding the diagnosis, attitudes, and differing opinions. Seven participants discussed a lack of clarity and explanation, saying they felt misinformed and/or were given conflicting advice. Two participants' — (1) and (2) — did not feel they were listened to, and that the diagnosis was not explained.

Participant (1): 'Consultant in a rush could spend more one-to-one time.'

Participant (3) 'The only thing is to give us more time for one-to-one (mentioned the ward round) to explain you've got these stents: this is what we have done.'

Participant (7) reported a lack of confidence in the nursing team at the acute trust.

Participant (7) 'I don't think they knew what they were doing, they connected me up to the monitors; no one came to make me comfortable. A couple of nurses just gave you your pills and then walked off. I think if I had said, "What are they for?" she would not even have known. I saw a doctor on a Friday afternoon and then I saw a doctor, I'm sure on the Monday.'

Participant (8) 'I have to say great credit. We went straight to A&E. We were seen within five minutes. On the ward I found the doctors and the nurses were incredibly sympathetic.'

Participant (6) proposed that a 'more robust human interaction' follow-up of the patient around week two or three would be beneficial.

Whilst Participant (6) indicated that they liked the telephone call at home and access to the specialist nurse, they felt a visit to their home and chat with the family would have been beneficial and would have met all the family's needs.

Two participants were happy with the discharge date.

All the participants who were called at home during week one had found the call beneficial.

Participants (1), (2) and (7) commented on staff attitude.

Participant (1) suggested 'the nurses could talk more; they were always busy with chores.'

Participant (8) 'The staff were fantastic… the staff told me, "Don't worry, you are in good hands."'

All eight participants reported being satisfied with their care, and all reported exceptional care from London ambulance crews. Some are quoted below.

Participant (5) 'Ambulance there within two minutes, the service was 100%. I was given morphine and reassured; they directed us to the tertiary hospital. The ambulance driver and young lady were exceptional; I haven't seen anyone like that.'

Participant (4) 'London ambulance crew, A1, fantastic. Their conduct was unbelievable. They looked after me; they tried to calm my concerns and fears.'

Participant (7) 'Of the team the four paramedics were fantastic.'

Participant (6) 'Absolutely brilliant, I cannot thank them enough, really. They diagnosed I had a heart attack before they left my house.'

Participant (8) 'All appointments I have had have been bang on time. The staff have been particularly pleasant, chatty, helpful, informative and keeping me fully updated. The dietician and cardio physio were very pleasant, so I applaud them.'

Comments about communication from participants who were treated at the tertiary centre:

Participant (5) 'Within an hour I could breathe, the pain was disappearing and I started to feel like I was going to survive this, which is a nice feeling. You just hand over complete trust. I was just about to ask them, "When are you going to start because I'm feeling sleepy," and they said, "We've finished," to my amazement. Believe me, I couldn't tell they had done anything. The consultant told me, "Look, this is before," they showed you what was blocked, "And this is what we have done, we have unblocked." It looked good to me.'

Participant (1) 'I only knew I had the stent put in because I was listening to him putting it in. No one told me what I had done.'

Participant (4) 'At certain times they are too technical.'

Participants (4) and (7) reported 'good treatment'.

Participant (7) 'I must tell you the staff at Hammersmith were fantastic. The sister was unbelievable, yes very good.'

Participant (8) 'I think everyone on that ward should be proud of themselves and the hospital because they are a tremendous, tremendous ambassador for the hospital and the NHS as a whole, very professional, exemplary organisation.'

3.5.2 Medication

Medication featured strongly, and clearly was important to the patient. Some information was lacking — in particular a lack of explanation and detail was an issue. This was particularly pertinent in the discharging hospital. Indeed, whilst some participants had excellent explanations of their medicines, that was not the case for all. Information about medicines clearly had an impact on their lives. Generally patients wanted answers to questions such as:

- What are the medicines for?

- How are they going to help?

- When do I take them?

A participant remembers a doctor at the tertiary centre spending 30 minutes discussing the drug therapy.

Participant (4) 'He actually spent a good half an hour with me discussing the drugs.'

Participant (2) offered information about a medication payment card, which they thought may be helpful to others; they suggested the staff should share this information and include it in our documentation, so it will not be forgotten.

Participant (3) 'The nurses talked to me about the drugs, but I wanted to know more, like, what did they do? I suppose because she was not a doctor she couldn't explain further, but she said I must take them.'

Participant (6) 'I was worried about my tablets; I thought if I didn't take them I would die. Then I understood I need them to keep me well.'

Participant (1) 'Nobody told me about the drugs. I can honestly say I was given a bag of tablets to take home.'

Participant (3) 'I can honestly say nobody told me anything. I was given a bag of tablets to take home. No one explained them.'

Participant (5) 'She only said the medicine I would be taking and make sure I take them regularly. That is what I am trying to say, you should be told, this is basically what it causes, and this is what will happen, yeah.' This participant also advised 'I was comfortable with the tablets.'

Participant (6) 'I would have liked someone to say to me, "This is a statin, this is what it does, possible side effects," that sort of thing.'

3.5.3 Dignity and Privacy

Privacy and dignity are basic components. There appeared to be mixed feelings around this issue. Three participants identified being concerned about privacy and dignity.

Participant (7) noted feeling 'physically uncomfortable' sitting on the bed eating their meals with other patients watching in the bay.

Participant (1) 'When I got admitted, I just got wired up. No one told me what was happening at any stage. I was told I was going for tests, but he didn't tell me what tests (laughs).'

Participant (8) 'I felt very uncomfortable to start with because I am quite a private person and I found being on a ward with a lot of people difficult. I was so impressed with the ward, every person I came into contact with, be it from the cleaner, to a nurse, one of the people wandering around with the medicines, even to the young boys who were coming with the tea trolleys were all pleasant, they were helpful, polite and you know professional.'

3.5.4 Anxiety

Three participants reported wishing they were able to have more time to discuss feelings and concerns. All participants implied they felt emotional about the cardiac event. The entire group reported being anxious, and four said their cardiac episode had been a life-changing event in their lives. It was apparent that the anxiety around it would have an effect on themselves and others. Clearly the emotional support for some participants was lacking.

Participant (1) 'They didn't explain what they were going to do, I went completely blind, I didn't know what they were going to do. After nobody actually said what I had done, this is the consequences, just nothing.'

Participant (6) 'I tell you why, because it is a life-changing event in your life; it really is absolute because it could have gone one way or a very different way. It had an

effect on my wife and some of my children. I did notice my wife was quite anxious and worried, not if I was going to survive but I think it made her fragile. I probably could have done with a bit of emotional support for my family and me for reassurance.'

Participant (8) 'It was extremely traumatic for me because I have never been ill in my life; suddenly I'm told I have a heart attack. There was a really nice nurse, I just remember breaking down in tears and she was incredibly supportive.'

Participant (1) 'Suggested the staff could talk more, no one explained anything, the nurses seem too busy, and the nurse who saw me said, "If you weren't up talking to me as you are now I would have pressed the button because your blood pressures is so low!" Three times she found the doctor; the doctor said I was fine.'

Participant (6) 'Some kind of emotional support around the first six weeks for the patient and the family, because just the word "a heart attack" is such a headline. In your world you hear it every day, in our world you hear it when it actually happens, it's like blimey! If you weren't here for that week, there wouldn't have been a life for me to carry on.'

Two participants (3), (7) were not told they might experience feelings of anxiety or possibly become depressed. Both of these participants wished that someone had told them these feelings were normal following their experience.

Participant (3) 'Only when the nurse told me about my medication and I'll be discharged later in the day, that's when I got emotional. She said, "Don't worry, it's better it happens now, rather than like that footballer, Muamba." I think she was embarrassed, she didn't want to say nothing, she just kept quiet and said, "I understand, I understand, yeah, yeah."'

Participant (5) 'No, no, I was not told about these feelings.'

Consideration was given for visiting hours and this was very much appreciated by participants. Attachment to monitoring equipment made personal hygiene difficult for several days. Three participants were attached to telemetry (portable heart monitors) until the day of their discharge.

Participant (3) 'Because of this I couldn't wash myself or have a shower for two-three days'.

It was recognised that information was conflicting and inaccurate, leading to frustration. Other participants received pivotal information, which helped with their decision-making. Participants (4), (3) and (7) were anxious because they lacked confidence in the nursing and medical team.

Participant (4) '*Some patients may be disadvantaged. If you were more articulate you would be more likely to get better care.*'

Participant (3) 'I was feeling very anxious about disturbing my stent because of coughing. The nursing staff responded they could not say anything, the doctors would be coming.'

Participant (7) 'What I'm saying is, you don't really see the doctors, I don't think, enough. My personal opinion is — who am I going to trust, a doctor or a nurse? They should take five minutes per patient.'

Participants (6) and (7) made reference to the staff not being as helpful as they could be and some nurses were not able to discuss issues with patients, referring them to a doctor. References were also made about the knowledge and skill of the nursing staff.

Participant (7) 'There was no time for the nurses to sit and talk to patients as they were too busy cleaning up, confirming the care was very different between hospitals, worlds apart. I felt uncomfortable with some of the nurses. It's not being what it used to be, not like years ago.'

Participant (2) 'She said to my face you've had a heart attack; I didn't expect to hear that at all. Just fear, I could not believe a word she was saying. I was in denial; I was in complete denial about the whole thing. When finally I got away from her, I didn't even get the medicines. I just got in the car and drove home and ignored the whole thing. When I was told I was really shocked, I thought my head knows what she is talking about, but my heart, if you like, knew she was right.'

Participant (3) 'When I got there they said sign this form in case anything goes wrong and they can resuscitate me. I said, "Should I sign this?" They said, "We recommend it, in case anything goes wrong." They explained the risk, one in 1,000. That's when I said, "No, I don't want to go ahead with this." The paramedics were so good; they spoke softly to me. They got the top surgeons in here; I do appreciate what they said to me. I said to the doctor, "I'm ready." The staff at the tertiary centre were fantastic; I can't find any fault with the nurse wearing blue, she was unbelievable.'

3.5.5 Lifestyle Modification

There were discrepancies in some of the information offered. Some participants received information on lifestyle, including diet, psychological concerns, medication, returning to work, flying, driving, work restrictions, sexual activity, exercise and advice to stop smoking. Three participants received very little information relating to

the above. Two were unhappy with the advice given. Unmistakably, the information was inconsistent, and changed depending on who offered it.

Participant (6) 'I was not told about the clinic visit. The driving restrictions were not clear at all. Exercise was mentioned, she said I must keep walking, but this was not clear. And also I would have preferred a face-to-face talk. The phone call did reassure me, but I felt like everyone had got back to normal and you're left with this condition.'

Participant (1) 'I did not know I could not fly or lift.'

Participant (2) 'I actually left with quite a lot of information to be honest; everyone seemed very professional.'

Participant (1) said that no one actually said 'this is what we have had done, this is the consequences, just nothing. I didn't know I had to sit down to take that pump (medicine) until the other day… they cared about everyone. Information fantastic, the experience was fantastic... the staff I think they really cared, I mean all of them.'

Participant (7) 'I didn't know there was a patient library. The devices used for relaying information on the ward were appreciated, but felt non-personal.'

Participant (3) 'The television for showing the video was too big. I was looking around thinking I'm disturbing you, this should have been a personal thing, a little DVD and headphones.'

Participant (1) recalled discussions about diet and made reference to the *'lack of knowledge'* of staff in relation to ethnic meals, and the needs of ethnic patients and their lifestyles being important*.*

Participants (2) and (7) 'I think if you've just had a heart attack your dietary menu should be different.'

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Participant (8) 'I didn't think the video was helpful, but the pamphlets were. I found the ward cardiology library, with the video. It would be nicer if it was in a room so that you could go and watch in privacy.'

3.5.6 Discharge

One of the main identified themes with discharge was the wait for medication and not enough emphasis given to preparation for a discharge date.

Participant (1) 'What happened was, they said we could go home; they didn't say anything about my medicine, then the nurse came and said, "You've got to wait for some medicine." So we waited, we went and sat in the thing and then she came out and said, "Well you can go and you can ring up at 5pm and pick up your medicine then." And that's what we did; my son-in-law came up and got the medicine.'

Participant (7) 'I was told I was going home on the day I went home. I had to wait when my wife arrived another 40 minutes, then we waited outside the reception for another half an hour for medicines.'

Participant (5) reported they were told they were going home the next day.

Participant (3) 'I would have liked to know when I was going home, you can inform the family.'

3.6 Summary of Findings

The researcher was able to identify key themes as detailed and discussed above. From analysis of these semi-structured interviews, the researcher recognises that, due to the various narratives, both negative and positive responses were received

from participants under each key theme. These, for example, ranged from some participants feeling happy with the information provided to them, to others feeling disappointed at the lack of education and information. Overall, these findings suggest there is a lack of continuity around information and education, which may be dependent on the patient's perception or expectation, and also may be dependent on who is providing this information. The narratives explored demonstrate that patients who have had a heart attack with PPCI need specific, accurate and timely information; their usual length of stay in the acute hospital setting is three days. It is reasonable to agree that the behaviour and confidence of healthcare staff will need to be considered.

4 Discussion

4.1 Communication

In summary, a number of reports suggest that staff demonstrated a lack of understanding towards the patients, which included providing information that lacked detail, and a deficiency of knowledge in medicines and treatment. However, where staff communicated, patients reported feeling satisfied. The researcher believes that each time we communicate with the patient we should consider being congruent in our approach. Staff members do not need to seek to counsel patients, but to embrace the clear approach and principles of person-centred care.

The theme of 'communication' appears paramount and consistent within the data and previous research. Dullaghan et al. (2014) suggests that, when planning secondary prevention interventions, nurses should consider the patients' experiences of illness; as a result, the researcher developed an empowerment tool from the findings laid out in this thesis The significance of this theme demonstrates the power that communication has on individuals; communication brings with it insight, thought, emotion and suggestion, and is inclusive of non-verbal cues. Communication can unlock the door; everything staff members do begins with a form of communication.

The literature on psychosocial adaptation to a myocardial infarction strongly suggests that post-MI survivors commonly experience temporary reactions of anxiety, depression, denial, and, to a lesser degree, irritability and anger (Astin et al., 2005, 2008). Thompson (1991) suggests it is critical that health professionals look at their attitudes and behaviours. It is important to impart and empower effectively and compassionately by being respectful and consistent in their approach to providing

information for the patient. Three of the participants report their care was managed well.

The way in which staff members speak — including their manner, approach, and efforts — have an effect on the patient. Participant (2) reported feeling 'spoken down to' — whilst others reported the ward round team could be dismissive and not forthcoming with information that the patients believed would have been helpful to their recovery (transcribed themes). Conflicting advice was a theme identified by two participants. This left them feeling unsure and nervous; they reported that they felt unable to ask for clarification for fear of looking stupid. Zinzinger (1992) suggested that anxiety is often compounded by lack of information. Kristofferson et al. (2007) found that women minimised the impact of the MI; they tended to delay seeking treatment and did not want to bother others with their health problems, whilst men were more likely to seek social support. Kristofferson et al. (2007) suggests that healthcare professionals should serve to empower patients so that they may experience more control over their disease. Healthcare professionals can achieve this by placing themselves in a similar position, asking themselves questions such as: 'What would I do if this happened to me? What would I want in this situation?'

However, healthcare professionals need to recognise that there are various ways in which communication can be undertaken effectively. The researcher would include the need for the healthcare professional to look at the situation whilst asking what impact they can make to assist the patient in managing their disease and care. Kelly (2004) emphasised using a holistic assessment strategy to assess MI patients' physical, psychological and social wellbeing, and the views of the family members.

4.2 Anxiety and Stress

The participants in this study expressed anxiety and stress, often referring to levels of anxiety that affected their recovery. All participants referred to the fact that they welcomed support in the first six weeks, but at differing levels. The researcher believes that it is possible this may be dependent on the participant's coping abilities/strategies. There is recognition from the researcher that there are similar themes mentioned by the participants, although it does not feel appropriate to give 'menu-based' information that may be prescriptive. This may not suit an individual's needs; therefore, an opportunity to help and empower could be missed.

An important point to highlight — and one that must be addressed — is how healthcare professionals can assist patients to meaningfully manage their lives following an MI. The researcher believes we must make reference to the 'why, when and what' questions.' Examples of these are: 'Why did I have a heart attack?'; 'When will I receive information to assist me to move on?'; and 'What will I need to do?' These are valid, credible questions. They ask for specifics and details, but more importantly they express the patient's need to be involved. Arnetz et al. (2008) found participants were generally satisfied with the way in which health information was provided. They highlighted the need for more specific information about the risk of recurrence, the level of heart muscle damage, discharge medications, appropriate levels of physical activity, and diet. There was no clear preference for the informants, and preferences for the timing of information delivery varied considerably. On reflection, it appears that health information provision was satisfactory for most, but could be improved by closer matching patient preferences with provisions. The shortened hospital stay, rapid throughput and emotional shock experienced by patients influenced their ability to absorb information. This makes the optimum timing

for health information delivery vary. Practice Implications: Current guidelines about the provision of health information for patients recovering from heart attack may need to be reviewed to reflect the recent technological advances in treatment. One approach may be to better 'stage' information to reflect patient priorities. Home visits by specialist nurses may need to be scheduled earlier to improve continuity of care and to address information 'gaps.' Further, health professionals need to demonstrate commitment and be prepared to listen. They must embrace patient involvement; the matter of realising and managing expectations needs to be owned by both health professional and patient. Belief in each other is essential. Lazarus (1991) suggests stress should be viewed as a relationship (transaction) between the individuals and their environment. Psychological stress refers to a relationship with the environment that the person appraises as significant for his or her wellbeing, and in which the demands tax or exceed available coping resources (Folkman et al., 1986). The concept of appraisal, introduced into emotional research by Arnold (1960) and elaborated with respect to stress processes by Lazarus (1966), and Lazarus and Launier (1978), is a key factor for understanding stress-relevant transactions. These appraisals in turn are determined by a number of personal and situational factors. The most important factors on the personal side (are motivational dispositions, goals, values and generalised expectancies.

Defining person-specific goals, such as — in terms of coping — reducing uncertainty, inhibiting emotional arousal, or trying to change the course of a stressful encounter, relate to the core of the personality (Karoly, 1999). Participants in this study talked about their goals and coping strategies, all of which have different meaning to them, as their personalities, beliefs and cultures are different.

Individual reactions to MI have been postulated (Krantz and Deckel, 1983, cited in Livneh and Antonak, p.116; Hackett and Cassem, 1984, cited in Livneh and Antonak, p.116; Bell, Bell and Lewis, 1987, cited in Livneh and Antonak, p.116):

(1) Psychic shock or the fear of impending death.

(2) Anxiety about one's present and future situation.

(3) Denial, including the repression of one's feelings and minimisation of the seriousness of the condition.

(4) Depression, including feelings of helplessness, reduced self-esteem and dependency on others.

(5) Anger and resentment, especially against society and the ensuing medical treatment.

(6) Recognition and acceptance of the condition.

The incidence of anxiety immediately following an MI was reported as high as 50% to 75% (Stern, Plionis and Ackerman, 1984; Waltz, Badura, Pfaff and Schott, 1988). Further, depression in MI survivors has been reported to range from 20%-70% (Dovenmuehle and Verwoerdt, 1962, cited in Livneh and Antonak, 1997, p.117; Cay et al., 1972a; Cay et al., 1972b, cited in Livneh and Antonak, 1997, p.117; Block, Boyer and Imes, 1984, cited in Livneh and Antonak, 1997, p.117; Silverstone, 1987, cited in Livneh and Antonak, 1997, p.117; Nickel et al., 1990, cited in Livneh and Antonak, 1997, p.117; Forrester et al., 1992, cited in Livneh and Antonak, 1997, p.117; Legault, Joffe and Armstrong, 1992, cited in Livneh and Antonak, 1997, p.117; Garcia et al., 1994, cited in Livneh and Antonak, 1997, p.117).

Lane, Caroll and Ring (2002) assess changes in depression and anxiety immediately post MI; the results showed that during hospitalisation 30.9% of patients reported elevated depression scores and 26.1% reported elevated anxiety scores. The results also indicate that this increase in psychological morbidity persisted over the year of the study. The literature on psychosocial adaptation to MI strongly suggests that post-MI survivors commonly experience temporary reactions of anxiety, depression, and denial and, to a lesser degree, irritability and anger. Personality variables and family variables appear to play the most prominent role in predicting psychosocial adaptation to MI and the resumption of work and physical activities. Astin et al. (2005) conclude that their findings lend support for the closer surveillance of the emotional status of this population. Moreover, anxiety may have medical or psychological consequences when it is persistent or severe, including difficulty adhering to prescribed treatments and making recommended lifestyle changes, adoption of or failure to change risky behaviours, increased risk for acute cardiac events, and increased risk for in-hospital complications after admission for acute coronary syndrome (Moser, 2007). Individual appraisal of a given situation helps to shape health behaviours and is influenced by our 'common sense' definitions of health threats. These threats are referred to as 'illness representations' by Leventhal and Nerenz (1983), and include beliefs regarding the causes and consequences of an illness, along with a perception that the individual can influence the outcome of their illness. Self-regulation theory refers to a personal health management system, involving the self-monitoring and personal appraisal and evaluation of one's health status, with resultant changes in an individual's behaviour where they feel this is appropriate and necessary.

Therefore, self-regulation theory represents an attempt by an individual to make personal sense of their current health issue. There is compelling evidence implicating depression, anxiety, social isolation, low perceived emotional support, hostility and work-related stress in the development of heart disease, with clustering of these factors possibly increasing risk further. Marmot and Hemmingway (1999) and Rozanski et al. (2005) recognise that these factors are also likely to impact negatively and increase risk further in a range of chronic disorders, not only aetiologically, but also in terms of ongoing coping. In 2001, *The Expert Patient: A New Approach to Chronic Disease Management for the 21st Century* (DoH, 2001) outlined how a more patient-centred NHS could help people with long-term conditions maintain their health and improve their quality of life. This was achieved with the expert patient programme (Lorig et al., 1999, which developed a generic chronic disease self-management course that has been promoted worldwide.

Evidence suggests a strong link between physiological and psychological symptoms. Strandmark (2004) suggested that suppressed feelings could transform into physiological symptoms. Further, and Bolwerk (1990) suggests that health professionals should assume all MI patients are anxious, as they may be masking their anxieties. As mentioned by Clark et al. (1998), Kristofferson (2003), and Albaugh (2003) there are also factors (such as gender and culture) that have a potential effect on psychological intervention. It has been suggested that the relationship between nurses, patients and relatives has significance and that the first encounter between the two groups is important in building trusting relationships. The researcher has no empirical evidence that it is the case — however, all patients who participated in this study made reference to the fact that the ambulance crew were 'amazing.' This supports the view that in the first encounter with any healthcare

professional, it is how they 'manage' the patient's treatment and care that makes the biggest difference.

However, what is meaningful for one person may not be meaningful for another. This is a challenge. The researcher attempted to manage this by seeking to build a rapport with the patients she came into contact with. In the case of those she did not come into contact with, she made attempts to ensure clear objectives were set out in the documentation, to signpost staff in assisting them with imparting information about the patient's condition and recovery. However, as the narratives in this study have demonstrated, there are clearly times when information and communication is either not offered, or does not answer the 'why, what and when' questions. The findings have highlighted that half the participants interviewed were concerned that healthcare professionals were not always consistent, fair and respectful in their approach when communicating verbally, which can contribute to patients experiencing anxiety, anger and disbelief.

4.3 Care

Those patients who commented on their care being excellent or good were in the majority. There is an impressive body of evidence confirming that a significant proportion of coronary patients experience some degree of emotional stress (Cay et al., 1972a; Cay et al., 1972b; Stern et al., 1977; Hackett and Cassem, 1984; Lane, Caroll, and Ring, 2002; Astin, Jones and Thompson, 2005).

Furthermore, the manner in which participants in this study were told about procedures, medicines and lifestyle changes either assisted or hindered them in their recovery. Anxiety is common after acute myocardial infarction; it may induce

complications and poorer outcomes because of activation of the sympathetic nervous system, and the hypothalamic pituitary adrenal axis. Stress can change the body's physiology; the consequences of this have been studied extensively. According to Selye's stress model (1976), there are two main groups: sympathetic activation and hypothalamic-pituitary-adrenocortical (HPA) activation.

Sympathetic activation occurs when an event is appraised as stressful and triggers responses in the sympathetic nervous system. This in turn produces catecholamines (adrenaline and noradrenalin), which cause changes in factors such as blood pressure, heart rate, sweating and pupil dilation. This is experienced as arousal. Catecholamines can also have an effect on a range of the body's tissues and can lead to changes in immune function. HPA activation also triggers the production of increased levels of corticosteroids, the most important being cortisol. This results in diffuse changes, such as the management of carbohydrate stores and inflammation. In the long-term this may have an effect on recovery.

The researcher is familiar with the above research and has developed a relaxation tape to assist patients to learn to relax. Research around relaxation indicates that it can reduce the blood pressure and heart rate (Neves et al., 2009). Stress management involves teaching individuals the theories of stress, encouraging them to be aware of the factors that can trigger stress, and teaching a range of strategies to reduce stress, such as 'self-talk' and relaxation techniques. Stress management has been used successfully to reduce some of the risk factors for coronary vascular disease, including raised blood pressure (Johnston et al., 1993), blood cholesterol (Gill et al., 1985) and type A behaviour (Roskies et al., 1986). Some studies have indicated it can reduce angina, which is highly predictive of heart attack and/or death.

Appels and Mulder (1989) and Appels et al. (2002) indicate that 'vital exhaustion' is common in the year preceding a heart attack. It is predicted that heart attacks are more likely to occur following exercise or anger, upon waking, during changes in heart rate and during changes in blood pressure (Muller et al., 1994; Moller et al., 1999). They are acute events that involve a sudden rupture and thrombogenesis. Johnston (2002) argues that this reflects an acute model of the link between stress and illness, with acute stress triggering a sudden cardiac event. Preventative medicine has taken a back seat in the health economy compared to acute medicine. Healthcare professionals do not give enough credence to preparing patients with information that can assist in helping them make realistic changes to their lifestyle, which may reduce or prevent stress, anxiety and disease.

Stress has been mostly studied in the context of CHD. Research exploring links between stress and CHD highlights the impact of the classic risk factors for CHD, namely raised blood pressure, raised cholesterol and smoking. These risk factors are strongly influenced by behaviour and reflect the behavioural pathway between stress and illness (Krantz et al., 1981). Research suggests that greater stress reactivity may make people more susceptible to stress-related illness, and individuals with both hypertension and heart disease have higher levels of stress reactivity (Fredrickson et al., 1991, 2000).

Over half of the participants experienced stress, had an emotional time, and spoke of how they were comforted. In particular, the care of the ambulance crews was exceptional, as reported by each patient. They made reference to feeling reassured and safe. The research questions referred to experience and concern. The experience of the participants' cardiac event will be reflected in their level and amount of concern, and whether it was acknowledged and afforded credence.

Feeling safe is an innate feeling, which signals comfort. MI and stroke often result in a reduction in physical functioning through impaired speech or movement. They can also trigger a sense of goal disturbance. According to goal theory (Carver and Scheier, 1999), a hierarchy of goals drive our behaviour and give life meaning. Lower-order goals could be eating, getting to work and getting enough sleep. Higher-order goals include supporting others or ensuring safety. It has been argued that a major health event such as a heart attack can disturb an individual's means of attaining their goals, which could challenge how they see themselves in future (Kuijer and DeRidder, 2003). With reference to CHD, goal disturbance at baseline predicts both depression and lowered health-related quality of life at follow-up (Boersma et al., 2005; Joekes et al., 2007). Research also shows there is a role for beliefs in predicting recovery from a heart attack and quality of life, as measured by returning to work and general social and occupational functioning. Exacting studies indicate that those who experience poorer outcomes have more negative beliefs about their work capacity (Maeland and Havik, 1987) and future MIs, show 'cardiac invalidism' (Riegel, 1993), and believe that their MI has more serious consequences and will last a longer time at baseline (Petrie et al., 1996). The belief that the illness can be controlled or cured at baseline predicts attendance at rehabilitation classes, which in itself predicts better outcomes (Petrie et al., 1996).

4.4 Medicines

Medicines are a substantive theme, discussed by all patients. Obtaining medicines to take home was a particular concern; four participants reported waiting hours after they had been told they could go home. Some even had to return to collect their medication. Four patients reported they would have liked more information about the

medications; one was fearful about taking medicines in the past but understood the reasons why they were so necessary, so was happy to take them. Not everyone was given the same advice; some of the advice was conflicting or omitted. One participant felt that the nurse could not explain the medicines, and another reported that they had chest pain at home and returned to hospital.

Participant (1) '*The staff were concerned I had not taken the spray as I had chest pain. When they asked why I had not used the GTN (Glycerel Trinitrate) spray, I informed them it had been given with the medicines and not explained, I did not know I should take it or how to use it.*'

When information was offered pertaining to medicines the detail was lacking. This particular theme provoked concern for all the participants. Clearly understanding their medicines, what they are for, how and when to take them and when to report contraindications is paramount to promoting adherence and compliance. Horne (1997) identified two key beliefs: 'necessity' beliefs (such as, *how much do I need the medication?)* and 'concern' beliefs (such as, *I worry about side effects*). This has been called the necessity/concerns framework (Horne, 1997; Horne and Weinman, 2002) and research indicates that beliefs about necessity and concerns are good predictors of adherence in the context of illnesses such as asthma (Horne and Weinman, 2002), diabetes, cancer, and CHD (Horne and Weinman, 1999). There is an inverse relationship between beliefs about necessity and beliefs about concern, which lowers the levels of adherence.

The evidence for beta-blockers and ACE inhibitors informs the healthcare professional that these preparations are hugely beneficial during the first year following a heart attack. They have a high impact on patient outcomes, in particular mortality and morbidity (DoH, 2000). These targets are discussed with patients in the

clinic setting, as the medication requires titration and the patient is required to see their general practitioner and have bloods taken. It is important that the right information is given. The drugs are most beneficial at a higher dose, but not all patients reach the maximum dose as the blood pressure and pulse may be affected. The Leventhal self-regulatory model argues that illness beliefs and beliefs about medicine are linked to behaviour, including adherence (Leventhal and Nerenz, 1983). Lee et al. (2011) used a web-based intervention to show participants images of heart disease (with or without text). They concluded that imagery caused more changes than text alone, but that a combination of the two forms of communication was most effective, suggesting that images appear to change cognitions and behaviour. Ley and Morris (1984) examined the effect of written information about medication and found that it increased knowledge in 90% of the studies, increased compliance in 60% and improved outcome in 57%. However, Hayes et al. (2002) concluded that, although information-based interventions can improve adherence for short-term regimes (less or equal to two weeks), more complex interventions are needed for longer-term medication taking. Kripalani et al. (2007) undertook a systematic review of interventions to improve medication adherence in chronic conditions and concluded that, although good information is important, it is not sufficient to improve adherence.

Ley (1989) suggests oral information can improve adherence by facilitating understanding and recall. Primacy effect patients have a tendency to remember the first thing they are told, stressing the importance of adherence, simplifying the information, using repetition and being specific, and following up the consultation with additional interviews. The researcher attempts to do this in the clinic consultation four weeks after a discharge has been made. The medications are

discussed once more, and the patient is encouraged to ask questions and report concerns.

4.5 New Approaches to Care

New technologies such as web-based interventions and advances are shaping the way in which healthcare professionals communicate with patients. These include treatments for cognitive behavioural therapy (CBT), relapse prevention, education and goal setting; others address psychological issues such as anxiety and depression. Rosser et al. (2009) carried out a systematic review of novel technologies for the management of chronic disease (both psychological and physical) and identified that approximately half the articles discussed interventions that were web-based (53%), with other technologies being interactive CD-ROM programmes, online message boards, video presentations, email contact or virtual reality delivery. From this review they highlighted a number of packaged interventions: MoodGYM, Diabetes Priority Programme, Beating the Blues and CHESS.

Rosser et al. (2009) made key observances about the studies they included in their review. First, they noted the sample sizes were extremely high (mean size at start of study n = 780), reflecting, they suggested, the ease with which patients can be targeted with this approach. Secondly, they highlighted the high level of dropouts over the course of the studies as patients stopped engaging with the interventions, ranging from 0-84% (mean sample size dropouts n=258). Finally, they noted that although the interventions were delivered remotely (that is by computer or email), 73% still included some involvement with a therapist and that greater involvement with a therapist was associated with lower dropout rates. The researcher has found

during her consultation visits with patients the value of web-based information, particularly visual images, which can act as an aid. On observation, this appears advantageous for the patient. For example, when a patient has had an echocardiogram the researcher explains the diagram of the heart muscle, which is shown in dimensions with a numeric key used to demonstrate the severity of the damage. Patients often like to look at the report.

The belief about the disease for the participant is of substantive importance. They ask questions such as: '*Am I now ill?*'; '*Do I have a chronic disease?*' and '*Does this restrict me?*' or use sentences that start with '*I can no longer….*' The healthcare professional's role is to help dispel the myths and assist them with focusing on coping cognitions to improve their behaviour.

4.6 Summary

The participants in this study highlighted that they experienced anxiety. All were offered cardiac rehabilitation six weeks following their discharge. This would include exercise and healthy eating advice. First phase cardiac rehabilitation should commence on the acute ward before discharge; however, this study has demonstrated many variables. Not all patients discharged were given advice that would have been supportive and helpful during the recovery phase. It is suggested that clinical interventions to promote good health can be used to empower and support individuals. These may be local or community-based e.g. self-help movements or public health interventions. However, Matcham et al. (2014) suggest that research in this field is thwarted by methodological and theoretical limitations, and therefore higher quality evidence is required to form robust conclusions. They conclude that self-help materials, if based on a theoretical model, may make modest improvements to anxiety and depression scores in patients with physical health

problems. Self-help based solely on providing information is probably ineffective, but unlikely to be harmful. The researcher agrees with this conclusion. Without support and facilitation and a change in understanding it is likely the patient will not succeed in managing the required changes to make a real difference in their health. The clinical interventions the researcher refers to are the individual treatment programmes, six to 12 weeks of regular attendance, and drawing upon behaviour change strategies — for example, cardiac rehabilitation services. Effortful change includes decisions to eat healthily, stop smoking, and take more exercise. In contrast, effortless change is mostly a reaction to external changes in the environment, as people alter their behaviour in response to a world that has changed — stopping smoking due to the ban in public places and avoiding carbonated drinks as they have been removed from schools are two such examples.

Theoretical perspectives inform therapeutic approaches that have been used to facilitate behaviour change. These include reinforcement, modelling, associative learning, incentives, exposure, CBT and relapse prevention.

5 Implications for Practice and Service Review

5.1 Implications for Services

Service redesign is closely aligned with current NHS initiatives. Clinical service redesign is an approach to improving quality and productivity in health. A redesign is clinically led and involves all stakeholders (e.g. primary and secondary care clinicians, senior management, patients and commissioners) to ensure national and local clinical standards are set and communicated across care settings. By following the patient's journey or pathway the team can focus on improving the patient experience and outcomes of care. The teams are required to be open, empathetic and empowering, whilst ensuring they feel they are fully valued and supported. Making a change to services requires a clear and united vision and commitment.

5.2 Leadership

The patient-centred leadership report (Coulter, 2013) entitled 'Rediscovering our purpose' focused on the role of leaders in engaging staff and other stakeholders to bring about improvements in care. Further, 'Leadership and engagement for improvement' in the NHS (NHS, 2012) suggests that organisations with staff who are engaged deliver a better patient experience, better outcomes and low absenteeism. At the same time, engaging patients in their own care can ensure that care is more appropriate and can also improve outcomes. Within the report there are frequent references to the inclusion of patients in discussions about their care (Coulter, 2013). The researcher welcomes the report, which examines the issues highlighted in the Francis Report, whilst making recommendations on how we as employees and patients can make a difference. Indeed, it is important that we are inclusive with our

patients (DoH, 2012). The coalition of health and social care charities in England suggests that by addressing questions of recruitment, roles and skills, patient leadership programmes can ensure that patient leaders have legitimacy and impact. One new concept — patients as leaders — is beginning to gain popularity in the voluntary and community sector. The aim is to give 'teeth and meaning' to the oft-vague concept of 'public involvement' (DoH, 2012), enabling patients to help frontline teams redesign services according to patient needs.

An effective decision is seen as one that is informed, consistent with the decision-maker's values, and behaviourally implemented. Marteau et al. (2001) developed a new measure of informed choice, which was based upon O'Connor and O'Brien-Pallas's definition; it included measures of knowledge, attitudes and behaviour. They commented that when these components are consistent the person can be seen to have made an informed choice. Whilst health professionals have an opinion based on experience and/or evidence-based practice, the way in which they deliver their request and responses to patients will shape patients' adherence. The researcher has championed an approach that embraces the involvement of patients for over 20 years; the value of a positive patient experience can make a difference to how the individual responds to the management of their treatment and care.

5.3 Shared Patient Autonomy

Shared patient autonomy is undoubtedly important when looking at developing patient services. Gilbert (2012) argues that patient experiences of ill health often act as 'the crucible within which many have to rethink their lives, reframe and build new identities' — that is, it is both a crisis and an opportunity. Having to cope with everyday difficulties can release a new capacity for innovation and

entrepreneurialism, as well as an empathy and a passion to help others. When appraising the NHS, patients see all too well what needs to improve and can provide innumerable ideas for how things could be better. Patient leaders can contribute to an organisation's work in two ways: as a community channel — externally facing, keeping in touch with local communities and introducing wider perspectives; and as a critical friend — internally facing, flying the patient flag and offering strategic advice from a non-institutional perspective.

According to Dixon et al. (2012), trust boards need other ways of obtaining regular and frequent real-time patient feedback. This is encouraging to hear and resonates well with the researcher, who understands and welcomes the challenge. This study will require hospital teams to think 'outside of the box,' and with the involvement of senior executives at board level the buy-in and support will not only be appreciated but expected. Boards should be able to show an emotional response and not hide behind performance based management-speak. If they are not capable of a strong response to bad news, where will the energy come from to change the situation? Like all teams, boards can be guilty of avoidance on a grand scale. Boards should encourage a culture where services are improved by people learning from mistakes, and staff and patients are encouraged to identify areas for improvement, rather than being afraid to speak out (NHS Commissioning Board (2012).

In addition, the report suggests that board members should visit teams within the organisation that are striving to improve quality, and support successful staff initiatives. Alimo-Metcalfe (2012) suggests that board members could champion a specific project to raise its profile, signal board support, and improve their own understanding of clinical and organisational issues. The board should regularly invite

staff leading quality improvement programmes to report on the progress being made as part of a wider review of such initiatives.

5.4 Communication

Clearly the standard of good communication and educated practice does not transpire in all instances; however, communicating clear objectives and variables would enable the process of positive change, with recognised resources and organisational buy-in, including the belief that redesign is possible. Developing meaningful communication skills leads to patients feeling empowered to make life-changing decisions for themselves and their families. The researcher believes it is not all about what we tell patients — equally important is how we tell them. Given the narratives explored within this study and the data collated, healthcare professionals are not always consistent and clear when communicating with patients and their families. There may be many reasons why this happens. One example is medical and nursing staff working in diverse ways in today's acute hospital climate. There are increasing demands in waiting list initiatives, wait times in A&E, and a constant flux of audit, which can magnify a sense of urgency that hinders and precludes. The primary focus on the patient can get lost among all this activity. Toedter et al. (1995) recognise that with briefer hospital stays the psychological issues and affective reactions that may be crucial factors affecting the eventual outcomes of cardiac rehabilitation might be poorly identified.

5.5 Partnership

Partnership working is regularly talked about. The question is: how do we this? Do we consider patients as our partners? How do we return to the fundamentals, the core essentials, and manage to work in a high-paced environment with all its restrictions, whilst maintaining the momentum?

Sometimes staff are nervous about including the patient in their care. They fear criticism and questions about decision-making. It is recognised that health professionals have their own beliefs about the nature of clinical issues, health and illness, and, just as they do for the patients, these may vary. Bohmer (2009, p.77) suggests:

> *Speaking clearly, inquiring respectfully, acting decisively, demonstrating humility and fallibility are the simple and essential elements of leadership in a clinical setting.*

The researcher would argue that these are essential components that will assist clinical leaders to drive care and develop philosophies that will embed a concept of care around the patient.

The emphasis of healthcare in the NHS is on patient centredness, shared decision-making, informed decisions and respecting the patient's perspective and understanding. In reality, health professionals have training and gain expertise that encourages them to feel they know what the correct mode of management and treatment is. There are times when both perspectives can cause conflict. O'Connor and O'Brien-Pallas (1989) take a process approach to informed choice, but also add in the individual's behaviour.

There are different ways in which this can be achieved, both in education and policy change. It is not constructive to develop standards that are often viewed as 'tick box' exercises, and are cumbersome to healthcare professionals. It is also recognised that not all patients are the same, though similar fundamentals should apply — such as dignity and respect.

5.6 Humanisation

The researcher will be required to share the findings of the study with all the team and those involved in the focus groups, looking at ways in which we could explore a way of working collegially and collectively. As part of their conduct, healthcare professionals are expected to treat patients with respect and dignity; in other words, to value the patient. The value of the narrative becomes apparent when the teller of the story has an opportunity to impart their experience to the listener, who in turn gets to understand. Todres et al. (2009) suggest that research into healthcare has achieved substantial advancement in knowledge and improvements in care through its focus on interventions, treatment and cure. They note how increasing specialisation alongside technological advances and research has improved health and wellbeing. They suggest that, alternatively, there is increasing evidence in the media and from qualitative research in particular that the human dimensions of care can be obscured by a technological and specialised focus that is only necessary on occasion.

The author of this study would agree with the above statement. In her 36 years of experience this issue has been talked about and debated, but with very little acknowledgement of the value of the human dimension. Todres et al. (2009) explore the mutual relationship between a humanising value framework for health care and the practice of qualitative research. They aim to show that a conceptual framework

for humanising healthcare may provide a dedicated focus for guiding both research and practice, and that the nature of qualitative research is able to offer distinctive support to a humanising emphasis for care. They suggest that what makes us human is that we carry a view of living life from the inside. To be human is to live in a personal world that carries a sense of how things are for the person. The author chose to interview patients for this study to understand their lived subjective experience. This method encourages the person to tell their story, which is personal and unique to them. I have made reference to the patient's journey in this study, as Todres et al. (2009) make reference to it in their writing.

The patient's journey and story includes the past and present. They suggest a loss of personal journey can happen when healthcare professionals do not pay sufficient attention to the history and future possibility of a person's life, manifesting an emphasis on *how* the person is and not *who* the person is. An example they suggest is a snapshot medical consultation in which individuals are separated from their normal social context and are treated as cases — rather than as persons with a history and biography. In our healthcare system there is sometimes little room for considerations of continuity, as the focus is often on the present. The author senses the present is of equal value — however, without both present history and biography it may not be possible to offer appropriate care or treatment that could make a difference to the person's life. Healthcare professionals can empower patients by understanding the factors that motivate them to want to change. The researcher embraces the necessity for healthcare personnel to think about the human in front of them, who has a story and is on a journey, just as they are.

Todres et al. (2009) ask whether humanisation of healthcare is a luxury. They do not think so, and the author would wholeheartedly agree. They suggest the quality of the

journey is just as important as the destination. Repeatedly the media and policy-makers refer to the need for compassion, dignity in care and greater patient choice (DoH, 2012).

5.7 Narrative

Andrews, Squire and Tamboukou (2013) suggest that 'narrative is a term frequently heard in popular dialogue.' This suggests a particularly acute understanding of the term. The value of attaining the patient narrative is a powerful medium and is well suited to the exploration of this study.

The researcher looks to empower the patient and is interested in their subjective accounts, including their individual and social changes. She is interested in what the story brings, not particularly in how it is structured. In essence, she is interested in the person and, with this, their humanity. Patients' personal stories or narratives can be shared with clinical teams, which can enable them to feel the patient's journey. When the researcher has collaborated previously with patients to tell their stories, she has read out the transcripts in an arranged meeting. The clinical team reported finding this a powerful and enlightening experience, and demonstrated a healthy acceptance and focused approach to action planning.

The patients' focus group would be invited to share their experience, including making suggestions/recommendations, and their feedback would be reported in a constructive manner to the team. The researcher has developed a patient empowerment prompt tool, which can assist patients to ask the questions they have reported are important to them (Appendix 3). This would not prove too time-consuming for the staff and the researcher, along with an interested member of staff.

5.8 Sustained Behaviour

There has been much research and intervention into behavioural change; nonetheless, many people continue to behave in unhealthy ways. The prevalence of diet and exercise-related problems, in particular obesity and being overweight, is rising. Though many people show initial changes in their health-related behaviours, rates of sustained behaviour change are poor, with people reverting to old habits. The researcher asks: 'how do we assist our patients to continue to make the necessary changes for their best health?' and 'what happens to them and the health economy if we do not'?

Work may have been carried out to support patients in changing unhealthy behaviour; however, the evidence does point to the fact that one strategy alone does not sort out the problem and that care for these patients requires a whole-person approach. The researcher believes the service she runs lacks the psychological support that could be so beneficial in assisting patients. Recommendations for such a multifaceted team should be considered as essential.

There is much research that clearly identifies the heavy burden on the health economy when strategies are not available or do not meet the needs of individuals to assist them as they return to their lives whilst making changes to their diets, to smoking habits, to drinking habits, to over-eating habits, to exercise habits, and as they commit to adhering to taking medication and to using relaxation techniques. Indeed, adherence is considered essential to the patient's wellbeing. There are studies that have explored how adherence can be improved with a particular emphasis on information given to improve recall, and to change cognitions and emotions. Mullen et al. (1985) found that 64% of patients were more likely to adhere when using instructional and educational information. Haynes (1982) reported that

information could improve adherence from 52% to 66%. An example the researcher would like to use is the Heart Manual (2002), a home-based cardiac rehabilitation programme now in use in more than 80 NHS trusts treating around 7,000 patients a year. The World Health Organisation (WHO), Scottish Intercollegiate Guidelines Network and the NSF for Coronary Heart Disease all recommend it. The Heart Manual is a cardiac rehabilitation bibliotherapy course rolling over six weeks, which includes a question-and-answer and relaxation CD, and is facilitated by a trained facilitator. Lewin et al. (1992) identify that the evaluation of such a manual has been very well received. The researcher is a trained facilitator and continues to facilitate patients through this process. The researcher, being familiar with this form of therapy, envisages that there are opportunities to treat people with other cardiac conditions, such as patients with angina, or those who have had coronary bypass surgery or ICD implantation. The manual encourages patients to take responsibility for their care with a facilitator to assist, and again these have been well evaluated.

6 Conclusions

6.1 Personal Reflections

The eminent American psychologist and therapist Dr Carl Rogers believed the central truth for him was that the client knows best. It is the client who knows what is hurting and in the final analysis it is the client who knows how to move forward. So convinced was Rogers of this fundamental insight that he first called his way of working non-directive counselling, thereby emphasising that the counsellor's task is to enable the client to make contact with his/her own inner resources rather than to guide, advise or in some other way influence the direction the client should take. Later he referred to his work as client-centred counselling, thus emphasising the central importance of the client's phenomenological world. Whilst undertaking her MSc in Rehabilitation Counselling in 1999, the researcher used Rogers' methods with the patients who were being counselled; she has attempted to stay true to this person-centred approach when engaging in dialogue with patients today (Rogers, 1951; The researcher's desire to assist patients to achieve and reach their maximum potential remains as strong now as when she first began working with patients with CVD. She remains aware of the rigour that needs to be observed and regarded. Authenticity refers to the truthfulness of origins, attributions, commitments, sincerity, devotion and intentions. In existentialism, authenticity is the degree to which one is true to one's own personality, spirit or character, despite external pressures; the conscious self is seen as coming to terms with being in a material world and with encountering external forces, pressures and influences that are very different from, and other than, itself. The researcher remains committed to being open about the purpose and accepts that she is responsible to the person for developing a dialogue.

Although she is aware of desired health goals, ideally the patients are required to make choices for themselves, as inevitably she is only in their journey for a short period of time and they must accept the responsibility for their choices.

6.2 Professional Application

Rogers (1951) often comments that his way of being and working runs counter to the mechanistic ethos of a technological society that thrives on efficiency, quick answers and the role of the expert. In his view, such an ethos has the effect of reducing human beings to the level of objects and of placing disproportionate power in the hands of a few. This is interesting and fits well with the researcher's thinking and beliefs that such an ethos gives ample scope to those individuals who are willing to hand over responsibility for their lives to others, perhaps out of fear or apathy. A person-centred approach places a high value on the experience of the person and of the importance of his or her subjective reality. It also poses a challenge to the individual to accept responsibility for his or her own life. The very nature of secondary prevention hinges on making choices and changes to a person's lifestyle. Health professionals can assist with the pillars that support full recovery, which include dietary advice, smoking habits and cardiac rehabilitation — however, the participant needs to believe they can make the change, that the steps undertaken by them and only them, with support and guidance, can achieve the best health outcomes and satisfaction.

Dewing (2007) argues that values and beliefs underpin professional practice and it is essential to clarify these, agreeing common shared values. Collaborative practice is vital. The development of a shared vision underpins practice development. Dewing (2007) maintains that before we can explore our patients' needs we must first

explore our own values and beliefs. In nursing we have long been fascinated with practice, skill, task and routine, focusing on disease processes and conditions, and social and political issues. We have not always been concerned with interaction, language and approach. However, our values and beliefs underpin what and how we do things.

Person-centeredness has a long association with nursing. Here, the principal focus is on treating people as individuals, respecting their rights as a person, building mutual trust and understanding, and developing a therapeutic relationship and standard of care that reflects these principles. One of the benefits of person-centred planning is that it can address the perennial service problems of ethnicity, gender, culture and age by starting with planning by (or with) the 'whole person'. Person-centred planning offers an alternative to traditional models, striving to place the individual at the centre of decision-making, and treating family members as partners. The process focuses on discovering the person's gifts, skills and capacities, and on listening for what is really important to the person. It is based on the values of human rights, interdependence, choice and social inclusion, and can be designed to enable people to direct their own services and supports in a personalised way.

In general nursing, the researcher believes we do not always think in a person-centred way. We use more of a technical approach, with a focus on 'ticking the boxes' and speaking about the 'chest infection in bed 34.' To ask the health professional to take into account the principles above means to examine our own feelings. This can be overwhelming and may even change how we work. The inherent good of providing care within a philosophy of person-centredness is irrefutable, but it has been recognised that translating the core concepts into everyday practice is challenging (McCormack and McCance, 2006). In today's

rapidly changing health economy the quality indicators are becoming even harder to quantify. This means it is difficult to find indicators that are person-centred to demonstrate and evidence the impact of patient experience. Within the UK, person-centredness is embedded in many policy initiatives, such as The National Service Framework for Older People (DoH, 2001a) and the Dignity in Care Campaign (DoH, 2006).

A recent publication of a report by the Royal College of Nursing (RCN, 2008) highlights the challenges for nurses and midwives in providing sensitive and dignified care.

In the researcher's experience, the importance of patient involvement and patient narratives has drawn her to develop initiatives to develop tools that attempt to seek out meaningful interventions. When given the chance to discuss the initiatives with colleagues, most can see the real benefits; however, the implementation remains a challenge. The drive to redress has never been so strong, though in practice this can appear daunting. Healthcare is changing; this change brings with it innovation and technology, advances in treatment that drive us towards technological care, targets to be met, and effectiveness and efficiency. Change within an organisation can cause unrest, destabilisation, and fear among teams and staff. This in turn can have a causal effect on healthcare and patient relationships. Indeed, a healthcare worker that is unhappy in their role feels undervalued and stressed at work, and carries a burden that can be projected onto the patient. Of course, it is not what we would want to happen, but in reality it can. So where does caring fit into this — how do we define 'caring'? This has been the subject of much debate, which has been ongoing since the 1970s when caring was considered to be synonymous with nursing

(McFarlane, 1976; Leininger, 1988). Models of nursing have drawn on the importance of relationships (Boykin and Schoenhofer, 1993; Watson, 2001).

In person-centred nursing, the relationship between the nurse and the patient is paramount. It has been argued that sustaining a relationship that is nurturing to both requires a valuing of the self, moral integrity, reflective ability, knowing one self and others, and flexibility derived from reflection on values and their place in the relationship (Nolan et al., 2001; Titchen and Higgs, 2001; McCormack, 2003; Dewing, 2004).

Slater (2006) suggests concept analysis shows evidence of a therapeutic relationship between the person and the healthcare provider, describing this relationship as a partnership between the person and the carer that ensures the person's own decisions are valued. The relationship is based on mutual trust, is non-judgemental, and does not focus on the balance of power.

6.3 Recommendations: Building on Good Practice

Excellence in Care (E4E) is a quality framework for nursing and midwifery that aims to support the delivery of safe and effective care, creating positive patient and staff experiences that build in momentum and sustainability; this is underpinned by thinking about social movements. The programme, which aims to provide easy access to tools, techniques and stories, will enable nurses and midwives to make the improvements to care that they feel are necessary. Nurses, midwives and health visitors can sign up and share their stories of best practice and cost savings. Through this programme, nurses can demonstrate their personal commitment to

improving nursing care for their patients and reinforce their position as role models within the MDT.

At the time of writing, compassionate care is discussed openly and frequently. The 'six Cs' build a vision and strategy for nursing to make a difference (DoH, 2012). They are: compassion, courage, competency, commitment, care and communication. Indeed, throughout any change we must ensure that the best possible care we give is person-centred, safe, evidence-based (the right thing delivered at the right time), documented clearly, accurate and timely, and supportive of people as they take responsibility for their own health — in other words, the carer acts as an enabler. This echoes the researcher's feelings and supports the principles expounded within this thesis.

All the six components are profoundly imperative; however, 'courage' has particular poignancy for the researcher. In healthcare we need people of courage who are passionate about delivering care to patients, helping to empower them to manage and make changes that have a significant impact on their lives. Too often healthcare professionals of all disciplines do not support strategies that ensure the patient has access to the most appropriate professionals, such as clinical psychologists that are attached to acute medical services. In the literature, it is clear that when patients have access to psychological services and treatment they do much better. Within the researcher's thesis it is possible to observe the recurring theme of patients making reference to needing to talk, expressing their concerns and anxieties, clearly voicing their concerns and not always being heard. Having the courage as a health professional and a human being to take a stand and insist on services that will enable 'best care,' whilst respecting boundaries and not being afraid, has to be the best advocacy. The NHS is stretched; funding and resources must be monitored and

allocated appropriately. However, thinking laterally and intelligently will benefit to make savings. Empowering patients who are living with heart disease to live a healthy and happy life in a positive way has many advantages, not just for the patient and those around them, but for the health service and healthcare professionals.

One such example could be offering programmes that develop coping strategies for patients who need help, therefore reducing visits to GP surgeries, urgent care centres, and A&E departments. Specialist nurses have the potential to play a greater role in identifying those at risk of developing anxiety and depression. However, this unmet need will remain unmet until specialist nurses who spend the most face-to-face time with patients are equipped with the skills and resources to systematically identify those at risk. Gulanick et al. (1998) suggested nurses have an excellent opportunity to expand their focus, and to provide guidance and support to patients as they adopt a healthy lifestyle.

Whilst undertaking this thesis, the researcher developed an empowerment tool (Appendix 2) that encouraged and assisted patients in asking staff questions that were particularly pertinent to themselves as they prepared for discharge and home. This idea came about following the focus groups; it felt appropriate to develop a tool as the researcher had the knowledge reflected in the patients' concerns. It seemed professional and fair to attempt to address them sooner rather than later. All of these questions may be relevant to the patient, yet they are not always asked by the patient or suggested by the staff. The tool is described as a prompt. Locally the heart health team (researcher, cardiac physiotherapist and dietician) offers the patient and family an opportunity to attend a one-day workshop to review information given on discharge and additionally within the clinics. The evaluation of this tool has generally been positive.

6.4 Doctoral Element of the Research

Research undertaken for this study has demonstrated that, at times, discharge care can be inadequate, and that it does not always fully meet the needs and expectations of patients. Resonance with national policy and guidelines limits policy practice and research. At the level of engagement there are several models of discharge planning. The findings from this study will add to a 'patient's perspective,' thereby allowing for the translating of evidence into practice for a growing group of patients with extensive consideration of clinical intervention (PCI). It is anticipated that new avenues for care and treatment concerning patient experiences of discharge and professional clinical practice should be explored.

6.5 Conclusion

There is a driving need to make changes to the way in which healthcare workers manage this process with dignity and respect. The study looks at those patients who have required cardiovascular treatment/care — this is a group of vulnerable people. However, the ramifications are that it is likely that we are talking about all patients who are discharged from acute care. This suggests a change in discharge policy and future health care reform. Lifestyle behaviours are a major cause of illness and premature death (Mokdad et al., 2004). The NICE guidance for behaviour change (NICE, 2007) suggests there are some effective principles for instigating individual behavioural change. These are to strengthen motivation to engage in the desired behaviour, to reduce motivation to continue with the undesired behaviour, and to maximise self-regulatory capacity and support activities.

Michie et al. (2013) have created the behaviour change wheel, a comprehensive framework for behaviour change interventions, based on a systematic review of 19 frameworks. Abraham and Michie (2008) suggest that interventions are made up of specific behaviour change techniques. The nine functions identified in the behaviour wheel reflect a synthesised version of the many strategies that are used to change behaviour and were derived from a detailed coding process. Behaviour change is necessary at different levels in healthcare.

- *Individual level: cessation of smoking, increasing physical activity, adherence to medication.*

- *Practitioner/professional level: service delivery (procedures and techniques, communication).*

- *Organisational level: adherence to guidelines, complying with policy.*

The result is that policy enables interventions to occur, which changes the essential conditions of behaviour and brings about changes in behaviour. It is suggested the model can be used to describe and understand why interventions do or do not work, and can also be used to design more effective interventions; these could be linked to a policy or promote a new policy.

Over more recent years there has been a move towards using psychological theories to inform and develop intentions with regard to behaviour that relates to health. There are two reasons for this. Firstly, it was observed that many interventions designed to change behaviour were only minimally effective — for example, dietary interventions for weight loss may result in weight loss in the short-term, but the majority of patients show a return to baseline by follow-up (NHS Centre for Reviews and Dissemination, 1997). Secondly, many interventions were based on a theoretical

framework that did not draw upon research that had identified factors correlating with a particular behaviour (Fisher and Fisher, 1992).

The Wanless Report (2004) suggests that a more fully engaged population-wide prevention strategy might save £36bn a year. In their study, Barton et al. (2011) suggest that reducing the cardiovascular risk of the population by just 1% and sustaining this for over ten years would prevent approximately 25,000 new cases of CVD and 3,500 deaths related to CVD.

Being fully engaged also means promoting patient empowerment. While empowerment is a contemporary concept, the word 'empower' is not new, having arisen in the mid-17th century with the legalistic meaning 'to invest with authority. Shortly thereafter it began to be used with an infinitive in a more general way meaning 'to enable or permit.' Its modern use originated in the civil rights movement, which sought political *empowerment* for its followers. The word was then taken up by the women's movement, and its appeal has not flagged. Since people of all political persuasions have a need for a word that makes their constituents feel that they are or are about to become more in control of their destinies, *empower* has been adopted by conservatives as well as social reformers. In healthcare there is talk of empowering patients and staff, but the researcher believes it very often remains as 'talk' rather than the actual 'doing.' To empower others can mean to 'give away' or 'give up' information, knowledge or skills, which does not always resonate well with all individuals. Indeed, building an understanding of the benefits of 'empowering' others makes unqualified sense from a personal, organisational and economic stance.

Overall, public satisfaction with the NHS fell by five percentage points in 2015 to 60%. At the same time, dissatisfaction with the service rose by eight percentage

points to 23%, taking dissatisfaction back to the levels reported between 2011 and 2013. The three main reasons people gave for being satisfied with the health service were due to the quality of care in the NHS, the fact that the NHS is free at the point of use, and the range of services and treatments available. The three main reasons that people gave for being dissatisfied with the health service were: long waiting times, staff shortages, and a lack of funding. Public satisfaction with the NHS is a multifaceted measure influenced by respondents' views on politics, policy and public institutions — as well as their experience of the NHS. It is not a straightforward indicator of NHS performance (Kings Fund, 2016). To date, we still have a long way to go.

Galvin and Todres (2013) believe that something is missing in health and social care. They suggest patients and service users are telling us in different ways that they do not feel fully met as human persons in the way that care is organised and practised. They suggest a struggle that people and practitioners are intuitively identifying concerns the challenge of how to hold onto something less measurable but keenly felt. This intelligent feeling appears to be telling them that something important is in danger of being lost when we overly rely on technological solutions to cover crucial dimensions of care. The researcher in this thesis has commented on the need to recognise the 'human,' and believes we should be concerned with 'their' needs. For that reason, it is exceptionally positive to see in Galvin and Todres two like-minded individuals who recognise the benefits and achievements of medical technology, but equally wish to maintain an inclusive notion of 'wellbeing'.

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8 Appendices

(1) Acute Coronary Syndrome integrated pathway

(2) Interview guide

(3) Patient empowerment tool

(4) University (TVU) Ethics approval

(5) National Research Ethics Service (South East London REC 3)

(6) Patient information and consent form

Appendix 1: Interview guide

Experience questions

What happened when you were admitted to hospital?

What was the journey to Hammersmith with London Ambulance like?

What was it like at the tertiary centre?

What was it like in the ward?

Were you told a discharge date?

Feelings questions

How did you feel about you hospital stay?

How did you feel about your discharge plan?

Did you feel you were kept informed?

Did staff introduce themselves to you?

How did you feel when you were told you had a heart attack?

Knowledge questions

Did you understand the procedure?

Were you informed about your medication?

Were you informed what would happen after discharge?

Were you telephoned at home?

Did you know you would come back to clinic?

Were you asked to visit the cardiology library on the ward?

Were you encouraged to pick up leaflets and information?

Were you given a contact telephone number?

Were you given the specialist nurse call card?

Were you informed you could speak to a librarian about your diagnosis and obtain other information that may help you with your recovery?

Cas Shotter Weetman – researcher

Appendix 2: Patient Empowerment Tool

West Middlesex University Hospital **NHS**
NHS Trust

The questions included in this leaflet are real concerns raised by patients as part of a research project on discharge.

Useful contacts:

If you would like to receive this leaflet in a language or format of your choice please contact pals.service@wmuh.nhs.uk
or call 020 8321 6261

West Middlesex University Hospital
Twickenham Road
Isleworth
Middlesex
TW7 6AF

Main switchboard: 020 8560 2121
www.west-middlesex-hospital.nhs.uk

A first class hospital for our community

Version 2

West Middlesex University Hospital **NHS**
NHS Trust

Patient information

What you need to ask before you go home

Author: Cas Shotter Weetman, Lead Specialist Nurse Cardiology

A first class hospital for our community

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It is important you have the right information to have a safe discharge from hospital.

This leaflet gives you some of the questions patients have found useful to ask hospital staff before going home. **Please feel free to ask any other questions which are important to you.**

- I need to understand what is wrong with me. What is my diagnosis?

- What is the day / date / time I will be discharged from hospital?

- Can the nurse or doctor explain my care to my family / partner?

- I don't understand my medication:
    - Please can you explain what it is for and when I need to take it?
    - How will it benefit me?
    - What happens if I forget to take it?
    - What happens if I take too much by mistake?
    - Are there any side effects?

- What investigations might I need after I go home? What do they involve and what will they show? How will I get the results?

- When I go home, who should I call if I have any concerns about my treatment?

- What do I do if I am not feeling well?

- What do I do if I have the same symptoms like the ones which brought me to hospital?

Further information

You are welcome to contact library services for specific information on your condition on 020 8321 5968 or library@wmuh.nhs.uk.

What happens next?

After you have been discharged from hospital, you may have a clinic appointment. The date and time of this will be confirmed in a letter sent to your home address. If you are unable to make this appointment, please contact the hospital to let them know and to rearrange.

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Appendix 3: Acute Coronary Syndrome integrated pathway

West Middlesex University Hospital *NHS*

Integrated Care Pathway

Acute Coronary Syndromes For use with:

All Chest Pains presenting with a diagnosis of:

♥ **Non-STEMI**

♥ **Unstable Angina**

Anticipated stay 3-5 days

Patient's Name	Address
Date of Birth	Phone No.

Date of admission:-	Time:-

Any suggestions or enquires regarding the development of this
ICP should be addressed to
Raffi Kaprielian Cardiology Consultant
Cas Shotter Cardiology Nurse Specialist bleep
064 Philip Eardley ACS Nurse A&E bleep 094

Data on the patient must be entered into TOMCAT under CCU procedure

CAS/PJE/RK/   Page 1   14/01/2015

About this Pathway

This pathway is intended for use for patients with non-ST segment elevation acute coronary syndrome from diagnosis in A & E, through admission to Cardiac Care and on to eventual discharge from the Ward. The pathway covers the acute phase of the condition for an estimated 7-day stay

How to use this ICP:

An ICP is a **multi-disciplinary** plan of care based on evidence from research, incorporating national and local guidelines of care and treatment of patients

- Please complete the sample signature box on page 3 of this pathway. This will aid the identification of persons using the pathway.

- Each page documents the activities or tasks that need to be competed for a particular day for the management of patients with acute coronary syndrome. Activities are divided into 3 sections: Medical, Nursing and Professions Allied to Medicine.

- When an activity has been completed the person completing the activity must sign (initial) and record the time in the appropriate box. Responsibility for the completion of some activities may be shared between two or more professional groups; hence an activity outlined in one section does not preclude another discipline signing for that activity, if appropriate.

- If it is necessary to vary care at any stage of the pathway, put a 'V' in the box next to the activity you are variancing from, then state in what way the patient's care will vary; give explanation for the variance; describe what action is taken as a result on the opposite page in the 'variance section' on the facing page. You must sign, date and record a time for all variances identified.

- The ICP is not cast in stone. It should be used as a guideline to ensure the most appropriate care is provided by the right person, at the right time and in the right way. It should not be followed blindly. Clinical judgement should be used at all times.

- Enter any extra care provided to the patient that has not already been covered by the pathway in the multi-disciplinary notes section.

- To meet legal requirements documentation should be accurate and comprehensive.

- All sections should be addressed. None should be left blank. You must complete the patient's name and

date at the top of each page.

- The ICP should be filed in the medical notes section in the patient's notes.

- If you have any queries about using the pathway, contact your immediate line manager in the first instance

Abbreviations used in this pathway:

A & E	Accident & Emergency Full	CK CNS	Creatinine Kinase Central
FBC	Blood Count Body Mass	NOK	Nervous System Next of Kin
BMI	Index Haemoglobin Blood	CVS O$_2$	Cardiovascular System
IDDM	Insulin Dependent Diabetes Mellitus	CXR	Chest X-ray
NIDDM	Non-Insulin Dependent Diabetes Mellitus	TTAs	Tablets to Take Out
CCU	Coronary Care Unit	IV	Intra Venous
MRSA	Methicillin resistant Staphylococcus	ECG	Electrocardiogram
DVT	Deep Vein Thrombosis	U & Es	Urea & Electrolytes
Echo	Echocardiogram	Physio	Physiotherapy
LAS	London Ambulance Service	SS	Social services
OT	Occupational Therapy		

Please ensure that you have recorded your name and position and provided a sample signature including your initials for future reference within the pathway.

Name (print)	Position	Sample Signature	Bleep	Initials
CAS/PJE/RK/MS	Page 3 158		14/01/2015	

Initial suggested inpatient management for acute coronary syndrome

Clinical Diagnosis made of ACS in Emergency department

Risk Stratify to low/high group

High Risk
Cardiac chest pain settled but previous rest pain> 20 minutes
Positive Troponin
Non-dynamic ECG ST segment changes
Transient ST depression
Previous CABG/PCI/MI
High risk factors for CAD: Diabetes Mellitus/ hypertention/peripheral vascular disease
Age > 65

Oxygen if in pain or SpO2 <95%
Nitrate e.g. GTN s/l or IVI or isosorbide mononitrate 30-60 mg PO **((Do not use modified release preparations)caution in hypotension** inferior MI or right ventricular infarction)[1]
Opiate analgesia. (morphine 5-10mg slow IV or diamorphine 2.5-5mg slow IV injection)with metaclopramide 10mg I.V. (followed by further doses morphine 5-10mg slow IV injection diamorphine 2.5-5mg slow IV injection if required)
Aspirin 300 mg stat dose PO (if no contraindications to aspirin)
Clopidogrel 300 mg stat dose PO (if no contraindications to clopidogrel)[a]
Proton pump inhibitor contraindicated with Clopidogrel. If gastric protection required use H2 antagonist e.g. Ranitidine
Enoxaparin 1mg/kg BD SC[a] (once daily if Cr Cl< 30ml/min) over 75 years old dose 0.75 mg/kg SC BD[a]
Metoprolol 25 mg BD PO or if β-blocker contraindicated Calcium antagonist e.g. verapamil 80mg BD(caution if patient hypotensive)[2]
Simvastatin 20-40mg (max 20 mg if verapamil used)
If BM/lab glucose >11mmol/l or Diabetes Mellitus, treat with sliding scale[3]
If Troponin negative on presentation obtain 10-12 hour Troponin from the cessation of pain
(*Consider not treating with these agents if negative early* troponin *and no ST depression on the* ECG, *especially if patients judged to have an increased bleeding risk)*

Low Risk
Consider aspirin 300 mg during evaluation period
No current symptoms of ischemia
No cardiac chest pain >20 minutes at rest
Negative Troponin or triple marker
Minimal Risk factors for CAD
Risk factor modification consider health ED

Emergency?
Features of high risk plus any of the following:
Cardiac Chest pain ongoing
Dynamic ECG changes:
Especially ST depression
Heart failure/cardiogenic shock
Malignant Dysrrhthmia

Yes → Start Tirofiban*

No

Low risk patients may convert to a higher risk category at any time if ischemic symptoms occur re-evaluate

consider alternative diagnosis and appropriate management/referral/discharge

If symptoms still suggestive of angina or anginal equivalent discharge with urgent out patient ETT +/- Echo.
Consider prescription for GTN/aspirin
Advise return if symptoms increase

If not all ready done transfer CCC1

If not all ready done transfer to CCU

In patient coronary angiography
Treat & transfer/cat II

Contact cardiology SpR at West Mid or Hammermsith for transfer high priority inpatient angiography

* Tirofiban is a GP IIb/IIIa antagonist, should be considered on an individual basis with TIMI scores > 4 or if diabetic see next page for TIMI score chart See page 26 for information on dosing

TIMI Risk Score

	One tick per TIMI factor
	Age over 65
	3 or more risk factors for coronary disease*
	Established CAD
	2 or more angina events at rest in past 24 hours
	Use of aspirin in past 7 days
	Elevated Cardiac Troponin
	ST depression > 0.5mm in two or more contiguous leads
	Total Number of ticks

Risk Factors = hypertension, cigarette/tobacco smoking, obesity, physical inactivity, dislipidemia, DM, micro-albuminuria, GFR <60/min, family h/o premature CVD

TIMI is the Thrombolysis in Myocardial Infarction risk score. This score is a simple prognostic tool used to categorise a patient's risk of death and ischaemic events, and provides a basis for therapeutic decision- making. (Score to be used in suspected USA/NSTEMI)

Score	Risk Factor
0-1	4.7%
2	8.3%
3	13.2%
4	19.9%
5	26.2%
6-7	40.9%

TIMI Score	Date	Time	Signature	Print Name

History of presenting complaint

CAD Risk Factors
1. Family Hx IHD   Y/N   Family Hx in members <55 years old
2. Smoking   Y/N
   years   no/day   Ex smoker   O   <6 months   >6 months

   3. DM   O   type I   O   type II   O   on treatment? Y/N
   4. ↑BP   O   on Rx   O
   5. ↑Chol   O   on Rx   O

Previous Cardiac History

	When?	Where?

MI   Y/N   Prev ETT Y/N _____
Year(s) _____ Prev Angio Y/N _____
                                 PTCA   Y/N _____
Details if known: CABG   Y/N _____
Vascular disease   Y/N

Stroke   Y/N

Past Medical History

Drugs including dose & frequency   **Allergies: -**

Initial Observations   Time   _____:_____

Temp   B/P right arm   _____/_____   Mark present
                                                                    pulses

PR   _____   B/P left arm   _____/_____

RR   _____

SpO₂   _____%   Blood Glucose _____

Height _____   Weight_____   BMI_____
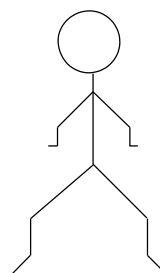
Physical Examination

Initial Investigations   Time

Signature   **Bleep No.**

ECG's Aim to repeat at	Date	Time	Changes Seen	Action Taken	**Signature of Nurse/Doctor***
Arrival ECG					
Repeat ECG					
Repeat ECG					

⌡ **CXR**

FBC	Δ	U&E	Δ
Glucose	Δ	Cardiac triple panel	Δ
Lipid Profile	Δ	LFT's	Δ
Clotting (if appropriate)	Δ	TFT's	Δ
CRP	Δ		

Additional test please state

All documentation to be dated, Timed & Signed

Blood Chemistry Investigations – Please send the following

Time taken _____

Signature _____

Print name _____

Please note all results on following page

Management and treatment please refer to algorithm on page 4

All documentation to be dated, Timed & Signed

Results Flowchart

		Date Time	Date Time	Date Time	Date Time	Date Time	Date Time	Date Time	Date Time	Date Time	Date Time
FBC	Hb 13.0-17.0 g/dL										
	WBC 4.0-11.0 x 10e9/L										
	Platelets 150-400 x 10e9/L										
U&E	Na 135-145 mmol/L										
	K 3.5-5.0 mmol/L										
	Urea 2.5-7.5 mmol/L										
	Creatinine 80-122 mmol/L										
	Magnesium 0.7-1.1 mmol/L										
	Glucose 4.5-7.0 mmol/L										
Cardiac Enzymes	Myoglobin 0-200 ng/ml										
	CKMB 0-0.5 ng/mL										
	Troponin I < 0.05 ng/mL										
Lipid's	Total Chol < 5.0 mmol/L										
	Triglycerides 0-2.0 mmol/L										
	HDL 1.0-2.0 mmol/L										
	LDL < 3.0 mmol/L										
Liver Function Tests	Bilirubin 0-22 µmol/L										
	ALT 0-45 iu/L										
	Alk Phos 31-116 IU/L										
	Total Protein 64-86 g/L										
	Albumin 35-46 g/L										
	Gamma GT 0-72 iu/L										
Clotting	INR 0.8-1.1										
	APPT 35-45 sec										
	CRP mg/L										
TFT	T4 pmol/L										
	TSH µU/ml										

All documentation to be dated, Timed & Signed

Day 1 First 24 hours – Nursing

Activity	Date	Time	Signature
24 Hour Observation Chart commenced Hourly observations for first 6 hours, then 4-hourly if condition stable			
ECG on arrival to CCU			
Next of Kin informed of admission to unit and given visiting information			
Repeat Bloods 12 hour cardiac panel			
Patient aware of diagnosis and treatment			
Continuous cardiac monitoring including ST segment analysis			
Referral to Cas Shotter (Specialist Nurse) bleep 064			
If patient is a current smoker offer referral to "stop smoking clinic". Following discussion if patient requests consider nicotine replacement therapy.			
Pain Score on admission to CCU Use Pain chart (analgesia if required) and titrate GTN infusion			
Hand patient a copy of ward leaflet "Questions I may want to ask"			

Further referrals required (if appropriate)

Inform the Specialist Nurse in Cardiology   Bleep 064 Y / N

Dietician for healthy Hearts (020 8321 5416) Ext 5416 Y / N

Physiotherapist for cardiac clients   Bleep 279 Y / N

Diabetes Specialist Nurse   Ext 6144 Y / N

Inpatient ETT   Y / N

Referral outpatient angiography (ensure form filled & Faxed by cardiology secretary) Y / N

Enter inpatient angiography data into inpatient transfer data base

All documentation to be dated, Timed & Signed

Day 2

Daily Investigations

U&E's Δ   LAB CK/CKMB Δ   12 hr TROPONIN (if needed) Δ ECG Δ Fasting Lipids & Glucose Δ

FBC only to be repeated if admission FBC abnormal unless other clinical reason

Daily Clinical Notes: Refer to algorithm on page 4 for guidance

| **Patient Data entered into TOMCAT under CCU module to facilitate MINAP return** |

Signature _____ **Bleep**

Day 2 notes continued

Secondary Prevention Treatment consider actions

		Commence	If No State	
Aspirin	75 mg OD	Y / N		_____
Clopidogr el	75mg O	Y / N	(Stop if low risk)	_____
Enoxapari	D 1mg/kg			

(Enoxaparin once daily if Cr Cl< 30ml/min) over 75 years old dose 0.75 mg/kg

(IF ACS ruled out but patient is at risk of venous thrombotic event tinzaparin 4500 units s/c OD)

Metoprolol *	25 mg BD	Y / N		_____
Ramipril f	1.25 mg Nocte Y / N (do not start in low risk patient)			_____
Simvastati	40 mg Nocte Y / N			_____

(Reduce simvastatin dose to 20mg if verapamil used)

(or, if LDL-C is >3.30 mmol/l, atorvastatin 40 mg OD)

f if Patient already on Ramipril continue with established dose if patient can tolerate up/down titrate as required

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Day 3

Daily Investigations	ECG Δ

Daily Clinical Notes: Refer to algorithm on page 4 for guidance

Patient Data entered into TOMCAT under CCU module to facilitate MINAP return

Signature _____ **Bleep**

Day 3 Notes continued

Secondary Prevention Treatment considerations & Titration

	Commenced	If No State why

Clopidogrel   75 mg   OD   Y/ N (stop if low risk)   _____

Enoxaparin   1mg /kg BD   Y/ N(stop if low risk)
(Enoxaparin once daily if Cr Cl< 30ml/min) over 75 years old dose 0.75 mg/kg
                                                                    _____

(IF ACS ruled out but patient is at risk of venous thrombotic event tinzaparin 4500 units s/c OD)

Metoprolol*   25mg   bd   Y / N   _____

If yes and tolerated change to next day   _____

Atenolol*   50mg   OD   Y / N

(If heart failure 1.25mg OD bisoprolol PO) S/C
                                                                    _____
insulin or
   Oral hypoglycaemic if low risk   Y / N   _____
   Ramipril ^f   2.5 mg Nocte   Y / N (stop if low risk)   _____
   Simvastatin   40 mg Nocte   Y / N

(Reduce simvastatin dose to 20mg if verapamil used)

(or, if LDL-C is >3.30 mmol/l, atorvastatin 40 mg OD)

*if Beta blocker contraindicated use verapamil 80mg BD (if no LV dysfunction) if heart failure present start bisoprolol 1.25mg OD

^f if Patient already on Ramipril continue with established dose if patient can tolerate up/down titrate as required

Angiogram Yes/No   Date referred____/____/____

Day 4

Daily Investigations	ECG Δ

All documentation to be dated, Timed & Signed

Daily Clinical Notes: Refer to algorithm on page 4 for guidance

> **Patient Data entered into TOMCAT under CCU module to facilitate MINAP return**

Signature _____ **Bleep** _____

Day 4 Notes continued

Secondary Prevention Treatment considerations & Titration

		Commenced	If No State why
Clopidogrel	75mg OD	Y / N	
Enoxaparin	1mg/kg BD	Y / N	

(Enoxaparin once daily if Cr Cl< 30ml/min) over 75 years old dose 0.75 mg/kg

(IF ACS ruled out but patient is at risk of venous thrombotic event tinzaparin 4500 units s/c OD)

Metoprolol*   50 mg BD   Y / N

If yes and tolerated change to (next day)

| Atenolol* | 50mg OD | Y / N | |
| Ramipril ^{f} | 5 mg Nocte | Y / N | (Stop low risk) |

If not tolerated change to

~~Ramipril   2.5 mg Y / N~~

Simvastatin   40mg Nocte   Y/N

(Reduce simvastatin dose to 20 mg if using verapamil)

(or, if LDL-C is >3.30 mmol/l, atorvastatin 40 mg OD)

If Dx is NSTEMI and heart failure is present, consider using eplerenone start if K^+ ≤ 5.0 mmol. Start at 25mg od & discuss with cardiology immediately and see dosing table at end of pathway*** In severe Heart failure use spironolactone 25mg OD

*if Beta blocker contraindicated use verapamil 80mg BD (if no LV dysfunction) or 1.25 – 2.5mg bisoprolol OD in heart failure

^{f} if Patient already on Ramipril continue with established dose if patient can tolerate up/down titrate as required

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14/01/2015

Day 5

Daily Investigations	ECG Δ

Daily Clinical Notes: Refer to algorithm on page 4 for guidance

> **Patient Data entered into TOMCAT under CCU module to facilitate MINAP return**

Signature _____ **Bleep** _____

Day 5 Notes continued

		Commenced	If No State why
Clopidogrel	75 mg OD	Y/ N	
Enoxaparin	1 mg/kg BD	Y / N	

Atenolol*	50mg OD	Y / N	
Ramipril [f]	5 mg Nocte	Y / N **or** (Stop low risk) _____	

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Day 6

Daily Investigations	ECG Δ

All documentation to be dated, Timed & Signed

Daily Clinical Notes: Refer to algorithm on page 4 for guidance

> **Patient Data entered into TOMCAT under CCU module to facilitate MINAP return**

Signature _____ **Bleep** _____

Day 6 Notes continued

			Commenced	If No State why

Clopidogrel   75 mg   OD   Y/ N

Enoxaparin   1 mg/kg BD   Y / N (stop if pain free)

(IF ACS ruled out but patient is at risk of venous thrombotic event tinzaparin

)Atenolol*   50mg OD   Y / N

Ramipril   5 mg Nocte   Y / N

Secondary Prevention Treatment considerations & Titration

		Commenced	If No State why

Aspirin   75 mg OD   Y / N

Clopidogrel   75 mg OD   Y / N

_____

_____

(If at risk of venous thrombolytic events continue enoxaparin 40 mg sc OD)

Atenolol*   50mg OD   Y / N

Ramipril ᶠ   5mg Nocte   Y / N

Simvastatin 40mg Nocte Y/N

(Reduce simvastatin dose to 20 mg if using verapamil)

_____

or, if LDL-C is >3.30 mmol/l, atorvastatin 40 mg OD

*if Beta blocker contraindicated use verapamil 80mg BD (if no LV dysfunction) or 2.5mg Bisoprolol OD in heart failure

If Dx is NSTEMI and heart failure is present, consider using Eplerenone start if K^+ ≤ 5.0 mmol. Start at 25mg od & discuss with <u>cardiology immediately and see dosing table at end of pathway* In severe Heart failure use spironolactone 25mg OD</u>**

ᶠ if Patient already on Ramipril continue with established dose if patient can tolerate up/down titrate as required

_____

Day 7

Daily Investigations	ECG Δ

1

Daily Clinical Notes: Refer to algorithm on page 4 for guidance

Patient Data entered into TOMCAT under CCU module to facilitate MINAP return

Signature _____ **Bleep** _____

Day 7: Notes continued

Secondary Prevention Treatment considerations & Titration

			Commenced	If No State why
Clopidogrel	75mg OD	Y / N		
Atenolol*	50mg OD	Y / N		
Ramipril ^{f}	5 mg Nocte	Y / N		
Simvastatin	40mg Nocte	Y / N		

(Reduce simvastatin dose to 20 mg if using verapamil)

(or, if LDL-C is >3.30 mmol/l, atorvastatin 40 mg)

*if Beta blocker contraindicated use verapamil 80mg BD (if no LV dysfunction) or 2.5mg bisoprolol OD in heart failure

If Dx is NSTEMI and heart failure is present, consider using eplerenone ***start if K^+ ≤ 5.0 mmol. Start at 25mg od & discuss <u>with cardiology immediately and see dosing table at end of pathway In severe Heart failure use spironolactone 25mg OD</u>

^{f} if Patient already on Ramipril continue with established dose if patient can tolerate up/down titrate as required

All documentation to be dated, Timed & Signed

Eplerenone*** (Inspra) Guidelines for use and dosage

Eplerenone is indicated, in addition to standard therapy including beta-blockers, to reduce the risk of cardiovascular mortality and morbidity in stable patients with left ventricular dysfunction (LVEF 4%) and clinical evidence of heart failure after recent myocardial infarction.

Serum potassium	Action	Dose adjustment
< 5.0	Increase	25 mg EOD* to 25 mg OD
5.0 – 5.4	Maintain	No dose adjustment
5.5 – 5.9	Decrease	50 mg OD to 25 mg OD 25 mg OD to 25 mg EOD* 25 mg EOD* to withhold
6.0	Withhold	Restart at 25 mg EOD when K+

* EOD: Every Other Day

Following withholding eplerenone due to serum potassium 6.0 mmol/L, eplerenone can be re-started at a dose of 25 mg every other day when potassium levels have fallen below 5.0 mmol/L.

*** The aldosterone antagonist **spironolactone** may be considered for patients with severe heart failure who are already receiving an ACE inhibitor and a diuretic; low doses of spironolactone (usually 25 mg daily) reduce symptoms and mortality in these patients. If spironolactone cannot be used, eplerenone may be considered for the management of heart failure after an acute myocardial infarction with evidence of left ventricular dysfunction. Close monitoring of serum creatinine and potassium is necessary with any change in treatment or in the patient's condition.

Tirofiban

In severe kidney failure (creatinine clearance <30 ml/min) the dosage of 'Aggrastat' should be reduced by 50%

The following table is provided as a guide to dosage adjustment by weight.

'Aggrastat' Concentrate for Solution for Infusion must be diluted to the same strength as 'Aggrastat' Injection Premixed, as noted under *Instructions for Use*.

Patient Weight (kg)	*Most Patients*		*Severe Kidney Failure*	
	30 min Loading Infusion Rate (ml/hr)	Maintenance Infusion Rate (ml/hr)	30 min Loading Infusion Rate (ml/hr)	Maintenance Infusion Rate (ml/hr)
30-37	16	4	8	2
38-45	20	5	10	3
46-54	24	6	12	3
55-62	28	7	14	4
63-70	32	8	16	4
71-79	36	9	18	5
80-87	40	10	20	5
88-95	44	11	22	6
96-104	48	12	24	6
105-112	52	13	26	7
113-120	56	14	28	7
121-128	60	15	30	8
129-137	64	16	32	8
138-145	68	17	34	9
146-153	72	18	36	9

Start and duration of therapy with 'Aggrastat'

'Aggrastat' optimally should be initiated within 12 hours after the last anginal episode. The recommended duration should be at least 48 hours. Infusion of 'Aggrastat' and unfractionated heparin may be continued during coronary angiography and should be maintained for at least 12 hours and not more than 24 hours after angioplasty/atherectomy. Once a patient is clinically stable and no coronary intervention procedure is planned by the treating physician, the infusion should be discontinued. The entire duration of treatment should not exceed 108 hours.

If enoxaparin has been given prior to aggrastat administration do not start unfractionated heparin. Continue with enoxaparin regime.

Concurrent therapy (unfractionated heparin, ASA)

Treatment with unfractionated heparin is initiated with an i.v. bolus of 5,000 U and then continued with a maintenance infusion of 1,000 U per hour. The heparin dosage is titrated to maintain an APTT of approximately twice the normal value.

Unless contraindicated, all patients should receive ASA orally before the start of 'Aggrastat'. This medication should be continued at least for the duration of the infusion of 'Aggrastat'.

If angioplasty (PTCA) is required, heparin should be stopped after PTCA, and the sheaths should be withdrawn once coagulation has returned to normal, e.g. when the activated clotting time is less than 180 seconds (usually 2-6 hours after discontinuation of heparin).

There is insufficient experience with the use of tirofiban hydrochloride in the following diseases and conditions, however, an increased risk of bleeding is suspected. Therefore, tirofiban hydrochloride is not recommended in:

- Traumatic or protracted cardiopulmonary resuscitation, organ biopsy or lithotripsy within the past two weeks

- Severe trauma or major surgery>6 weeks but <3 months previously

- Active peptic ulcer within the past three months

- Uncontrolled hypertension >180/110 mm Hg)

- Acute pericarditis

- Active or a known history of vasculitis

- Suspected aortic dissection

- Haemorrhagic retinopathy

- Occult blood in the stool or haematuria

  - Thrombolytic therapy (see 4.5 'Interaction with other medicinal products and other forms of interaction').

  - Concurrent use of drugs that increase the risk of bleeding to a relevant degree (see 4.5 'Interaction with other medicinal products and other forms of interaction').

Patients should be carefully monitored for bleeding during treatment with 'Aggrastat'. Treatment of haemorrhage is necessary, discontinuation of 'Aggrastat' should be considered (in cases of major or uncontrollable bleeding, tirofiban hydrochloride should be discontinued immediately).

'Aggrastat' should be used with special caution in the following conditions and patient groups:

- Recent clinically relevant bleeding (less than one year)

- Puncture of a non-compressible vessel within 24 hours before administration of 'Aggrastat'

- Recent epidural procedure (including lumbar puncture and spinal anaesthesia)

- Severe acute or chronic heart failure

- Cardiogenic shock

- Mild to moderate liver insufficiency

  - Platelet count <150,000/mm^3, known history of coagulopathy or platelet function disturbance or thrombocytopenia

- Haemoglobin concentration less than 11 g/dl or haematocrit <34%.

¹Instructions for GTN infusion

Dilute 50mg of GTN for IV injection to a volume of 50 mls with normal saline start at a rate of 0.6mls per hour and titrate to a maximum of 10 mls per hour against pain and blood pressure keeping a systolic blood pressure ≥ 95mmHg.

² Use of Metoprolol/Verapamil

Metoprolol IV (1-5mg slowly over 3 min) or PO (50 bd) or if beta blocker contraindicated, calcium channel antagonist e.g verapamil PO 80 mg BD

³ IV SLIDING SCALE INSULIN REGIME FOR GENERAL USE:

Add 50 units of human Actrapid Insulin to 50mls of 0.9% Saline in a Syringe Driver. Give Insulin as below.

Aim for target blood glucose between 4-7 mmol

If BM remains persistently above 20 mmol/l inform Doctor. Hypoglycaemia is corrected by giving carbohydrate and not continuing insulin. If hypoglycaemia develops it must be corrected quickly.

Capillary Blood Glucose (mmol/l)	IV Human Actrapid (U/Hr)
<4	0.5
4.1-7	1
7.1-11	2
11.1-15	3
15.1-20	5
>20	6

Patient Data including discharged drugs must be entered into TOMCAT under CCU module to facilitate MINAP return

Ward	**Hospital**	**Hospital Number**	
		NHS Number	
Speciality	**Consultant**		
		Forenames	
		Surname Date	
		of Birth	
GP Name GP		**Patient's Address**	
Address			

Admission Reason

Diagnoses	**Operations /Procedures**
1.	
2.	

Brief Clinical Summery

Recommended further management	**Advised to consult GP in**	
	Sickness certificate	
	Patients referred social services	
	Discharged to:	**Services organised**
		District Nurse Y/N
		Home Help Y/N
		Macmillan Nurse Y/N

Drug	Name	Dose	Yes	No	Long-Term Target
Aspirin		75mg OD			Lifelong
Clopidogrel		75mg OD			Continue for 12 months. (Lifelong if Aspirin
B Blocker [2]					Lifelong
ACE Inhibitor If cough with ACE inhibitor					 Aim for Ramipril 10mg if tolerated if develops cough on
If started on eplerenone treatment review in 12 months unless $K^+ \geq$ 6mmol in which case dose should be adjusted according to guidelines					 To be reviewed at 12 months with possible switch
Statin Therapy Simvastatin 40mg (20mg if on varapamil) **(or, if LDL-C is >3.30 mmol/l, atorvastatin 40 mg OD)**					 **Admission Fasting Levels (Aim Total chol <4 LDL <2)** Total Chol HDL LDL Triglycerides Review after 3 months with fasting sample encourage life
OMACOR Post myocardial infarction (if patient cannot obtain sufficient omega 3 fatty					
Other Antihypertensives					**No DM 140/85mmHg**

If applicable has smoking cessation therapy been offered to patient follow referral procedure and document that you have

made referral

Patient refused □   Referral made on:_____/_____/_____   Not Applicable □

[2] If Beta blocker contraindicated, use Verapamil 80mg BD (if no LV dysfunction) if heart failure bisoprolol 1.25-2.5mg

A copy of the discharge ECG has been given to the patient. Y / N

Other Discharge Medication						
Drug	Dose	Freq	Route	Supply	GP Continue	Quantity
Signed off by Doctor				Date	Time	
Signed off by Pharmacist				Date	Time	
Signed off by dispenser				Date	Time	

NAL ETTA SIGNED BY DOCTOR TO BE KEPT IN NOTES FOR LEGAL REASONS. PHOTOCOPY CAN BE GIVEN

TO PATIENT

West Middlesex University Hospital *NHS*

NHS Trust

MACOR PRESCRIBING PATHWAY

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┌─────────────────────────────────┐
│  Patient admitted with diagnosis of │
│       myocardial infarction      │
└─────────────────────────────────┘
                 │
                 ▼
┌─────────────────────────────────────────┐
│  Patient discharged with advice to increase │
│  dietary intake of oily fish (guidance on weekly │
│  portions and choice of fish to be provided) │
└─────────────────────────────────────────┘
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Patient seen by GP if unable to attend clinics

Patient seen in clinic by cardiology specialist nurse within 6 weeks*

and

Patient seen in Heart Health Clinic for secondary prevention advice by dietitian & physiotherapist within 4 weeks*

Is patient eating 2-3 portions of oily fish (7g omega 3 fatty acids) per week?

NO

YES

Encourage to continue dietary fish

GP to prescribe Omacor for four years

MULTIDISCIPLINARY NOTES   Patient's name   Date   Hospital number

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