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## Patients' perspectives on the educational preparation of cardiac nurses

**Keywords** - Cardiac nurses; patient involvement; patient experience; nursing curriculum

## **Abstract**

### **Background**

Over the last two decades the United Kingdom (UK) health service has endeavoured to place patient and public involvement at the heart of its modernisation agenda. Despite these aspirations the role of patients in the development of nursing curricula remains limited.

### **Aim**

A descriptive qualitative design was used to explore the views of cardiac patients about the educational preparation of cardiac nurses.

### **Method**

Eight participants attending an annual conference of a patient and carer support group were recruited to the study. A focus group was conducted to explore their views on how the educational preparation of cardiac nurses in the UK should develop. Taped-recorded data were transcribed and a thematic analysis was undertaken.

### **Findings**

Four themes were identified: contradictions around practice and education; demonstrating compassion; delivering rehabilitation expertise; leadership in practice. Participants perceived that they had a valuable role in the educational development of nurses, enhancing nurses' understanding of how individuals live and adjust to living with cardiovascular disease.

### **Conclusion**

Cardiac patients believe that the education of cardiac nurses should be driven by experiences in practice, nevertheless they want them to be equipped to deliver care that is underpinned by a strong knowledge base and skills combined with an ability to engage, educate and deliver high quality care that is both compassionate and individualised.

## Introduction

In the United Kingdom (UK) there have been major changes in the way that patients and carers are viewed within the National Health Service (NHS). Traditionally patients' knowledge has been regarded as having less value than health care professional knowledge and care has been organised and delivered within a well-intentioned, but nevertheless paternalistic framework [1]. The Department of Health report [2] *Patient and public involvement in the new NHS* attempted to redress this deep rooted mind-set by emphasising the importance of public engagement. This new way of thinking which placed value upon patient knowledge was reinforced and subsequently embedded as health service ambitions [3, 4]. This ideological shift, where patients and carers become involved as partners in care and the growing recognition that health professionals can learn from those under their care led to the development of expert patient panels in many health care organisations [4]. Since then, patients have been involved alongside other lay individuals and organisations as stakeholders in developing strategies for improving the outcomes of cardiovascular disease [5].

Despite these aspirations the role of patients in activities such as the development of nursing curricula has failed to progress. Examples of user involvement in the design of mental health and children's nursing curricula exist [6-9] but there is an absence of user involvement in the development of adult nursing courses. Arguably, this has resulted in education programmes that remain dominated by a professional lens and so fail to embrace the contribution of important and valuable stake - holder perspectives. A recent British Heart Foundation funded project [10] sought to evaluate their nurse education pathway from multiple perspectives, including that of patients. Patients' views were sought, firstly to ascertain whether they were aware of the use of an education pathway to direct the development of cardiac nurses and, secondly to explore their perceptions of what was important in the education and development of cardiac nurses. The British Heart Foundation (BHF) education pathway was not developed in order to list competencies for UK cardiac nurses, as these have been clearly articulated elsewhere [11-14]. Rather, the purpose was to guide the continuing professional development of nurses working under the auspices of the BHF could meet agreed education standards within a defined timeframe. This paper reports on part of the overall evaluation [10]. The data reported here were elicited from a focus group held with members of a patient forum based in central England.

**Aim**

To explore cardiac patients' perspectives and views on the education preparation needs of cardiac nurses

**Method**

A descriptive qualitative design was used.

**Sample**

Members of a coronary aftercare support group in mid-England, attending their annual general meeting (n=87), were invited to participate following a detailed presentation on the study aims. The group has a wide membership consisting of patients, carers and other family members. Those willing to participate gave their details and were invited to attend a focus group meeting at a pre-arranged date and time. To be eligible, individuals had to be over 18 years of age, and have either experienced a cardiac event or were the carer of a patient who had suffered a cardiac problem. A cardiac event was defined as a myocardial infarction, arrhythmia, coronary intervention or cardiac surgery. This broad definition allowed the inclusion of participants from different cardiac sub-specialties and therefore provided a broader view of the knowledge and skills needs of the nurses that had cared for them.

Eight individuals volunteered to participate in the tape-recorded focus group interview of which six were male and all but one being over 60 years of age. One carer attended the group but did not contribute to the discussion. The demographics of this group are outlined in Table 1.

**Data collection**

A qualitative focus group interview was used to facilitate in-depth discussions around the topic of inquiry [15, 16]. A brief semi structured interview guide was developed to guide the discussion which centred on the education needs of cardiac nurses (Table 2). Probing techniques were used to encourage participants to elaborate, explore and clarify points raised during the focus group interaction.

Data collection lasted 65 minutes and took place in the local cardiac centre which was familiar to participants and offered adequate privacy. Prior to starting, verbal consent was obtained and participants were reminded of their rights and that information disclosed would be made anonymous, kept confidential and that the research team intended to produce a publication.

## Data analysis

The audio recordings of the focus group were transcribed verbatim, however given the small number attending the focus group personal data such as participant's gender has not been included in the transcript to ensure the anonymity of two individuals. Two members of the team unconnected with the data collection (SM and JWA) conducted an initial thematic analysis. Initially the transcript was read to gain an overall impression of the context and narrative. On further reading, codes were assigned to key words, passages, emotions and sentences capturing specific issues and ideas which were then organised into clustered and subsequently themes reflecting the areas of inquiry emerged [16]. Any discrepancies in the interpretation of data on the emergence of themes were discussed until consensus was reached by the whole team.

## Ethics

Ethical approval was granted by the University of the West of England research ethics committee and the study conformed with the principles outlined in the Declaration of Helsinki [17].

## Findings

In terms of familiarity with the BHF education pathway, only one person was aware of this development from a British Heart Foundation nurse employed at the local hospital.

*“we actually had nurses here that had been funded by the BHF”*

When invited to consider what they believed cardiac nurses needed to learn in order to care for cardiac patients, four broad themes emerged which represented the participant perspectives:

- Contradictions around practice and education
  - Demonstrating compassion
  - Delivering rehabilitation expertise
  - Leadership in practice
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- Contradictions around practice and education

Whilst the focus group participants recognised that basic nurse education and training was insufficient to develop the knowledge to within a specialist area, it was recognised that to gain further knowledge and skills in the field of cardiac care, experience in the specialty was vitally important to produce competent and confident nurses:

*...they know the care of like pre-implantation op um and it depends on their experiences... their level of knowledge...I think a lot of it comes, the knowledge comes with experience...*

This desire for nurses to be grounded in practice was acknowledged because trends in healthcare were continuously changing to either further develop or maintain skills, knowledge and clinical competency within the sphere of cardiac practice. The role of formal education, at one level, was less dominant in their thinking. From another perspective, participants described that in their view nurses' ability and willingness to explain the benefits and side effects of cardiac medications was limited. The following quotes exemplify the participants experiences, suggesting that at times they felt they were cared for by nurses without in-depth understanding and knowledge of the cardiac medications that they are giving to patients.

*I was asking them afterwards what they [were] giving me... but the ordinary nurses couldn't tell you. I think at least a basic knowledge of the drugs which they are likely to come across with people with heart problems would be a, certainly be an advantage to um to them."*

*"Well I don't know whether it's a lack of knowledge or whether it was a reluctance to tell me!"*

The inference here, although not implicitly stated was that participants expected nurses to be well informed about the medications being prescribed to patients, skilled in communicating and able to disseminate information to patients simply, clearly and in an accessible manner. It would seem that there was some contradictory expectations on how nurses gain their knowledge. However there was a deeper concern, currently attracting wider public debate, about nursing work and the importance values and compassion in care delivery [18], a point examined in greater depth in the next section

- Demonstrating compassion

The argument between compassion and technical knowledge was played out by focus group participants. Participants discussed that wished to be cared for by individuals who were technically competent and knowledgeable, but of equal importance they wanted nurses who could also demonstrate compassion, and address their emotional concerns through effective interpersonal skills;

*“Some maybe very technically qualified, but what’s the cause of many complaints? It’s because their manner of application ...It’s obvious that some people never make a good nurse because a nurse, I think above all they’re expected to show compassion.”*

*“... it’s making sure that we also have um nurses able to deliver psychological care because they go hand in hand, they should never be separated.”*

Positively, nurses in many settings were deemed to be supportive and endeavoured to create a therapeutic and comforting environment. However, issues around interpersonal communication were another overriding concern in which participants described mixed experiences. Participants wanted their worries to be dealt with promptly and honestly by a professional with appropriate expertise

*“...the worst time to have problems is after you’ve left the hospital because you’ve got the fear factor that there is no-one there to help you...your carers probably are getting as agitated as you are um so whoever makes the call, there should really be someone, if they don’t know any answers at the end, not to fob you off and say come in at 9.00 o’clock tomorrow morning or go and see your GP.”*

In contrast another participant talked about a particular nurse, who was extremely good for three main reasons, which involved offering support, a sense of optimism and acting as a patient advocate:

*“Reassurance, first of all reassurance! you know, well they say you know this isn’t the end ... and you’re thinking well I had two arrests...she was very good in that respect...restricting visiting times... it’s your own limit, you know how much you can take, so that’s another thing I think which a nurse and she was good like that.”*

A shared notion among the group was that advanced communication skills and the provision of individualised emotional support was something that should be addressed within nursing curricula for specialist cardiac nurses.

- Delivering rehabilitation expertise

One area singled out for inclusion in cardiac nursing curricula centred on rehabilitation skills. The participants felt that cardiac nurses should be equipped and prepared to support, guide and engage patients through the various phases of rehabilitation. This would include interpersonal skills, models of behaviour change, counselling skills and adopting strategies for promoting an appropriate level of optimism among patients about the future.

*“...what nurses should be learning, ...forgetting the physical side of what the nurses have to do, I think from the other side and rehabilitation starts straight away in on the ward...because the first thing you feel at this is the end is; ‘I ain't going to be able to do anything that I did before’ which is a load of rubbish because you quickly learn on the rehabilitation course...you’ve got to change your life and there are going to be things you never ever going to do again, like pushing cars.”*

*“But one of the things that needs to be taught to young nurses um you know is that the most um important thing in my view ...is for a nurse to sit on the side of the bed and to reassure the patient, this isn't the end”*

There was an overall consensus that nurses must be able to answer patients' questions appropriately and informatively as well as reassuring and comforting those under their care.

- Leadership in practice

The participants noted that junior nurses needed strong inspirational role models to emulate and the leadership style of senior staff was fundamental to the provision of high quality care. This was summed up by one participant, who stated that,

*“a lot depends how the sisters and the charge nurses behave”.*



How the nursing profession prepares nurses for leadership roles was considered important by the participants but they were unsure what mechanisms, if any, were in place to achieve this. However, they felt that continuous professional development was fundamental to maintain high quality care. Whilst recognising the need for continuous professional education, the group expressed some concerns that some nurses may become over educated and lose some of the caring qualities. The traditional view of nursing as a vocation in which nurses possess specific traits and learn their skills in practice was highlighted by one participant who stated that the profession should recruit:

*“...something like the ordinary girl straight from school”.*

Participants felt that they could have a positive role in informing cardiac nursing curricula. Group discussion highlighted that they would be most able to contribute through real life experiences of care and treatment.

*“...input is on the effect of the treatment on the patients, that’s the only input that we can give.”*

*“[Patients have] got a valuable input, I mean I find that myself from being on some of the committees in London you know the professionals, the clinicians if you like, they know their jobs and I wouldn’t tell them their jobs but they sometimes forget the obvious!”*

The quotes above illustrate the increasing involvement of patients, not only in contributing to health policy but have a key role in the development of nursing curricula.

## **Discussion**

The findings of this study offer a unique perspective from a patient group on their views about the educational preparation of cardiac care nurses in the United Kingdom. The participants were cared for by registered nurses with a range of knowledge, skills and experience and this inevitable coloured their perceptions. It is inevitable that patients’ perceptions of the education and practice of nurses is governed entirely by personal subjective experience. However drawing on current policy that aims to promote increased patient engagement and participation in the planning and delivery of health services, the findings of this inquiry can contribute to the debate about future cardiac care provision. Moreover, this

study serves to illustrate the relevance of seeking patients' perspective in developing cardiac nursing curricula, as the professional and lay lens may have diverging views on the relevance and importance of core aspects. For the purposes of the discussion, this will be structured around the four themes emerging from the data.

- Contradictions around practice and education

This theme draws attention to a lay public perception of graduate nurses which has received much attention. Learning in the clinical area is viewed as critical to the development of nurses, who are also able to demonstrate the qualities of compassion and being good listeners. The sub-text within this discourse is that a nurse could be 'the girl next door' who is sensible, responsible but not university educated suggesting that patients did not see the need for formal classroom learning. However, when participants' concerns around medications were analysed, there is a clear message that they expect nurses to be fully informed about medications, thus creating a contradictory position. However, despite this their experiences reflects previous research which has shown that at the time of discharge from hospital significant numbers of cardiac patients lack knowledge about the medications they have been prescribed, with many expressing particular dissatisfaction with information about side effects [19]. In this study, the participants believed that pre-registration nursing education was inadequate to provide nurses working in cardiac care with the knowledge and expertise needed to care holistically for patients. The area where participants expressed especial concern related to nurses understanding of pharmacology and how information about their drugs was conveyed. The participants suggested that when they had questions about their medications, nurses were often unable to explain the drug's effects and associated side-effects. These findings are supported by the work of others [19, 20] who reported that despite drug administration forming a major part of nurse training, nurses were often insecure in aspects of pharmacology including patient education. In addition, other work identified that education [21] and communication skills [22] were below the satisfactory standard needed to undertake medicines administration competently. These findings are concerning and may explain why participants in this study believed that nurses' cardiac curriculum should devote more time to communication skills and increasing their understanding of pharmacological issues and how to present information to patients. Additionally, the implication arising from this study, is that participants felt that communication skills gained through nurse training were insufficient and needed enhancing to work in a cardiac specialty.

Ensuring patients understand their medications, dosages and promoting concordance are fundamental to improving well being and outcomes. It is arguably even more important in minimising the risk of further adverse events and hospital readmissions [20]. Indeed, it has been argued [23, 24] that if patients are to become concordant with treatment they need to be considered as partners in care rather than passive recipients. It is therefore recommended that post qualifying programmes must include an in-depth focus on pharmacology interpersonal skills to facilitate patient education. Albert [25] recently discussed that nurses are well placed and have a pivotal role to educate patients about the complexities of drug regimens, the potential of side effects and the importance of adhering to treatments. In this way, nurses can influence patient outcomes.

#### Demonstrating compassion

Data analysis uncovered that while participants appreciated the knowledge and expertise of those caring for them, they valued the compassion and empathy that some nurses exhibited. Individuals who demonstrated such behaviour were deemed to be 'good nurses'. While others who were technically adept and competent, were perceived to lack and or demonstrate compassion. This reflects the findings of a study which set out to explore the experiences of 26 patients admitted to acute chest pain units in the UK [26]. In this study, patients also valued how nurses provided reassurance and calmness. As in our study, others [26] have reported that some patients did not always receive the information they required to meet their needs.

The discussions delivering highly technical care in a compassionate manner has been explored over a number of decades. It remains debateable whether increased technology is incompatible with good nursing care [27] or that highly technical and compassionate care are not mutually exclusive [28, 29]. A phenomenological study with a sample of critical care nurses described how participants were able to care for patients in harmony with the technology [29]. The possible reason for the difference in the outcomes of these studies may be related to the level of experience of those investigated. Little [30], who explored the meaning of learning in a sample of critical care nurses, concluded that clinical competence was essential to apply holism to the care of patients.

Ensuring patients receive adequate, relevant and tailored information to individuals' need is a fundamental aspect of the nursing role. However, it seems that patients' some educational/health promotion need is not

met either during the acute stage or upon discharge, whether this was in part due to poor knowledge or poor communication skills on the part of the nurses is an area that needs to be addressed and resolved within educational curricula. Cardiac nurses are in a prime position to influence the health of their patients. If individuals are to be encouraged to manage their own health then it is imperative that they are given appropriate information and support to achieve this aim.

#### Delivering high quality rehabilitation expertise

Having a comprehensive understanding of the causes of cardiovascular conditions and the knowledge on how to implement lifestyle changes were considered essential skills for nurses in this study. Successive health reforms in the UK [2-4] have extolled the merits of patients managing their own condition but Scott and Thompson [31] argue in their systematic review of the literature that nurses are not always alert to the information and responsive to needs of their patients.

Greater understanding of the rehabilitation process was seen as important in the preparation of cardiac nurses. Cardiac rehabilitation is an extremely cost effective and clinically effective intervention. In a meta-analysis of 48 randomised controlled trials, Taylor and colleagues [32] reported that cardiac rehabilitation reduced all cause mortality by 20% and cardiac death by 27% at 2-5 years. Yet data from our study suggests that nurses were unable to promote a vision of future health based on key lifestyle changes. Additionally, these participants highlighted that many nurses' working in cardiology lacked knowledge of the patient journey beyond the confines of the cardiac unit, illustrating the need for greater knowledge of the life beyond critical care and the understanding of heart disease as a long term condition. It would seem that preparing nurses in key and advanced concepts of cardiac rehabilitation needs to be a priority in post-registration programmes to enable nurses to gain confidence and increased competence in this vital aspect of nursing care.

#### Leadership in practice

Participants believed that the role of the ward sister or charge nurse was crucial to the efficiency of a ward and standards of care. These findings are consistent with the public consultation exercise that informed the NHS plan [3] where patients expressed concern that responsibility for care was too diffuse. A subsequent circular by the Department of Health [33] recognised that the ward sister is crucial to effective care.

There is a wealth of literature to support the view that the role of the ward sister is fundamental to high quality care [34-36]. However, The Royal College of Nursing [37] have expressed concern that the role of ward sister is in danger of being swamped by managerial responsibilities at the expense of clinical leadership. Arguably a vision of the ward sister role and function may be based on a historical viewpoint and may be unrealistic in the current structure. Our findings and the available literature [38-40] suggest that while the ward sister is regarded as key to maintaining standards of care, individuals in these roles do not necessarily possess the authority to influence some factors that impact on patient outcomes.

The participants also considered the behaviour of the ward sister as pivotal to the performance of junior staff as they sought to model themselves on their senior colleagues. Whether this view is correct is unclear. Whilst a literature review of 32 studies broadly supports the belief that novice nurses value knowledge that is gained from senior colleagues the studies do not specifically explore the influence of the ward sister [41]. In addition, other studies [42, 44] have found that advanced nurse practitioners are able to influence novice nurses through their expert knowledge, clinical credibility and leadership skills.

Our participants recognised the need for more technical and leadership roles, but were concerned that nurses may lose sight of the need for a caring relationship as they develop more of these skills. The nursing role has been expanding over the last two decades with an increasing amount of nursing care being provided by unqualified staff [45-48], and it is clear that many patients are not able to distinguish between qualified and unqualified staff. Pearcey [49] discovered in her qualitative study that qualified nurses reported they were undertaking an increasing number of tasks that resulted in less time available for patient contact. However the nurses in the study commented that they regretted the opportunity to interact with patients. Contrary to the belief that nurses are losing sight of their patients' needs, Pearcey [49] reported that they were aware of their patient's needs but at times struggled to meet them due to additional responsibilities.

Analysis of the data also revealed that participants believed they could make a positive contribution to the education of nurses. They felt that they could provide nurses with a deeper understanding of the effects of

illness and the psychological implications of living with a cardiovascular disease. This is congruent with the findings of a study of patients' views on their influence on the education of medical students [50]

Discovering that patients believe they have a role to play in healthcare, beyond that of recipient, is not unique. Indeed the World Health Organisation [51] and successive UK Governments have highlighted [2-4, 52-53] the need to empower patients so that they may influence service delivery and design. Indeed the Department of Health for England state that "the Involvement of patients and public in health decision making is now a central theme of national policy in the NHS [53]. In addition it is argued that patients who live with a long term condition take greater responsibility for their health if they are empowered to make their own choices [53]. However in order to empower patients and enable them to make informed decisions they require accurate information that is communicated in a language that they can comprehend. Overall, our participants believed they could positively contribute to the education of nurses through sharing their experiences which would serve to highlight the person and to recognise the priorities of individuals and their needs.

### **Limitations**

The study recruited participants from an established post coronary support group of Caucasian patients based in England. The focus group used a convenience sample of eight self selected individuals who had had at some point previously a cardiac event; therefore this group did not represent the views of any other groups of patients other than themselves. It is uncertain whether the views of younger patients and those not attending support groups would be different. In addition, although participants were invited to give their views about the education needs of cardiac nurses, the basis for their judgements was not sought. The one-off nature of the focus group interaction did not allow for an iterative cycle, so themes emerging from the data could not be examined or explored in further interactions; this meant that data saturation was not possible. As with all qualitative research generalisation is not possible, however the opinions of this focus group may have transferability for other cardiac patients or cardiac support groups.

### **Conclusions**

Cardiac patients believe that nurses need to possess a number of key attributes to ensure high quality care. These skills should be combined with compassionate and the ability to meet the information and education needs of patients and families. Whilst the participants accepted that there is a need for technical

knowledge and skills they expressed concerns that the more senior nurses will abandon aspects of core nursing such as hands on compassionate care that they, the participants value so highly, in a quest for more technical or administrative roles. The change in the nursing role and the increased use of unqualified staff may increase these concerns.

Patients believe that they could play a pivotal role in the education of cardiac nurses and felt strongly that they could provide insight into the experiences of living with a long term condition and the psychological impact of illness. It is vital that educationalists and practitioners facilitate approaches and seek the views of services users and patient groups to ensure that a modern curriculum not only incorporates the views of professionals but those receiving care at the bedside.

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