



## ORIGINAL PRACTICE DEVELOPMENT AND RESEARCH

### Implementation of a nurse-led education programme for chronic heart failure patients during hospitalisation, and strategies supporting their self-management at home: a practice development project in the context of the Swiss healthcare system

Cornelia Bläuer\*, Irena Anna Frei, Wilfried Schnepf and Rebecca Spirig

\*Corresponding author: University Hospital Basel, Switzerland  
Email: [cornelia.blauer@usb.ch](mailto:cornelia.blauer@usb.ch)

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#### Abstract

*Aim:* This study focuses on nursing practice for patients with chronic heart failure (CHF). The aim is to reflect on a practice development project to improve patient care in a person-centred way and to implement evidence into practice. The project consists of two phases with individual aims and evaluation processes. Part one describes the development, implementation and evaluation of an education programme for CHF patients. The goal is to change nursing culture by involving the healthcare team and to build up skills and expertise. Part two describes the further development of the programme through integration of the patients' perspective.

*Methods:* A person-centred approach formed the basis for changing nursing practice. The development and implementation of the CHF programme was carried out via action research, to expand the healthcare team's knowledge and improve patient outcomes. A mixed methods design was chosen for the evaluation of the pilot programme. Grounded theory was used to examine the perspective of the patients.

*Findings:* In the first project phase, an educational programme for CHF patients was developed using action research. Key elements were multiple training sessions for nurses and skills training for hospitalised CHF patients. The educational topics were based on the patients' needs. The programme evaluation showed that the patients were well prepared for hospital discharge but that their needs concerning their living situation were not sufficiently considered. Patients were not adequately prepared for the problems that occurred once they were at home. The second phase of the project focused on patients' perspectives. Using the grounded theory method, a model explaining factors that benefit or hinder self-management was developed. The key phenomenon in this method was intrinsic motivation for self-management, meaning the ability to achieve the feeling of being 'at ease with oneself'.

*Conclusion:* Initiating change in practice that considered the healthcare team and the patient's perspective was challenging and complex. A combination of different methodological approaches was required. The healthcare team needed to broaden its expertise to sustain the developments in practice. The change process required intensive support and supervision of the team over time. A thorough examination of the patient's perspective indicated ways to optimise the education programme. Using the person-centred approach and integrating the healthcare team and patients into the programme, as well as working over several years, were all fundamental elements for successful practice development.

*Implications for practice:*

- The knowledge and skills of the healthcare team need to be broadened in order to achieve sustainable change in practice
- The process of change in practice requires the use of different methodological approaches

**Keywords:** Person-centred practice, self-management support, action research, chronic heart failure, team facilitation, patient education

## **Introduction**

This study focuses on the care of patients with chronic heart failure (CHF) in clinical nursing practice and then reports on a systematic practice development project with the goal of improving patient care by implementing evidence into practice and by supporting patients to manage their chronic condition. The project was carried out in two phases with individual aims and methods.

## **Identifying the evidence**

A CHF diagnosis usually means complex lifelong therapy and lifestyle adjustments for patients and their families (Dickstein et al., 2008). The goal of treatment is to achieve the ability to cope independently with everyday routines and to experience the best possible quality of life. To reach this goal, CHF patients need to acquire specific self-management skills, alongside receiving medical treatment (Koelling et al., 2005). These skills include knowledge about their illness, the ability to identify health problems and developing and implementing problem-solving strategies. For this, patients need to identify and apply their own resources, make everyday decisions concerning their illness and show willingness to build partnership-based relationships with their healthcare team (Lorig and Holman, 2003). Interprofessional patient education programmes, with different content and intensity, such as disease management programmes, have been proven to improve self-management skills, especially in outpatient settings (Roccaforte et al., 2005). After participating in disease management programmes, CHF patients have shown a significantly better quality of life (Rich et al., 1995), lower mortality (Rich et al., 1995; McAlister et al., 2004; Roccaforte et al., 2005) and better self-management abilities (Jaarsma et al., 2000). Interventions in the home environment (Roccaforte et al., 2005), a combination of several different support services (Jovicic et al., 2006) and follow-up care by a multidisciplinary and specialised CHF team have proved effective. In addition, educational interventions by trained CHF nurses, including family members, contact with CHF clinics (McAlister et al., 2004) and the patients' personal contact with clinical nurse specialists (Sochalski et al., 2009) have had a positive effect. However, educational interventions using software programmes without follow-up care (Jovicic et al., 2006), telephone follow-ups without face-to-face care, and programmes that focus only on increasing self-management activity (McAlister et al., 2004) seem to have less positive results. Research showing no sign of positive effects on patient outcomes from disease management programmes also exists (Boren et al., 2009); one reason for this could be that only elements of the programmes were implemented: administering medication, medication side-effects and weight control (Boren et al., 2009). The COACH study (Coordinating study evaluating Outcomes of Advising and Counselling in Heart failure), a large research project in this field, did not show a significant reduction in hospitalisation rates or mortality (Jaarsma et al., 2008). The researchers from the COACH study suggested this was because the control group received high-quality standard care due to systematic interventions by the cardiologists. Other studies provided a more limited standard care than the COACH study (Gonseth et al., 2004; McAlister et al., 2004). Furthermore, one must critically question rates of mortality and rehospitalisation in such a fragile patient population with fast disease progression and high comorbidity.

## **The research context**

To date, disease management programmes for CHF, as described in other countries (Jaarsma et al., 2006; Roccaforte et al., 2005), have not been implemented in the Swiss healthcare system. To our knowledge, patients in Switzerland receive information from various sources that may contradict each other, and support from the healthcare team in implementing self-management is often missing.

This derives from the fact that the Swiss healthcare system does not support patient education programmes, and preventive measures and patient education provided by nurses is not covered by health insurance. The Swiss system also lacks a systematic communication between the inpatient and outpatient settings and there is no specific training for CHF nurses at Masters level, as is provided in other countries (Roccaforte et al., 2005; Jaarsma et al., 2006).

A patient satisfaction survey conducted in 2006 on the cardiology inpatient department of the University Hospital in Basel showed that CHF patients received insufficient support for self-management and were not prepared enough for hospital discharge (Qualitätsmanagement, 2004-2005: Milbich, 2006). The patients reported poor education about warning signs, medication effects and side-effects, and insufficient information about resuming normal activities. Families received too little information about support services or professionals to contact about concerns and fears. As a result of these neglected aspects, patients and their families felt insecure and practised poor self-management at home. This resulted in late detection of the symptoms of decompensation, or incorrect interpretation of the symptoms, leading to anxiety and re-admission to hospital.

Due to this patient feedback, the nursing leadership team conducted a SWOT analysis (strengths, weaknesses, opportunities and threats) (Pearce, 2007). Weaknesses were noted on the following topics:

- Nurses had an insufficient understanding of the needs of hospitalised chronically ill patients
- Patients' expertise was only partially acknowledged
- Patients did not receive enough support for self-management
- From a nursing and medical point of view, control of the treatment for CHF patients was inadequate

Despite these findings and the commitment of the nursing team to improve care for these patients, the standard practice was not significantly modified or adapted following the SWOT analysis. The nursing team identified the following reasons:

- Limited education and training about CHF and dealing with chronic illness
- Responsibilities and skills within the team were insufficiently defined
- Lack of a multiprofessional treatment plan
- Poor knowledge among the nursing team of up-to-date research findings and how to integrate them into nursing practice

In order to achieve a sustainable change in practice, the nursing leadership team decided to initiate a practice development project led by the clinical nurse specialist.

### **Aims and objectives**

In the light of the discrepancy between the findings from the literature and the nursing care of CHF patients, the nursing and medical leadership of the cardiology department decided to develop and implement a nurse-led multiprofessional educational programme for hospitalised CHF patients (Bläuer et al., 2011). A person-centred approach was chosen as the method for practice development because CHF patients form a heterogeneous group with respect to the cause of the illness, comorbidities, symptom burden and social support. The educational content described in the CHF guidelines (Remme and Swedberg, 2002) does not take these characteristics into account. A person-centred approach that takes cultural aspects into consideration should overcome these failings.

The aim of this article is to describe and reflect on the development and implementation of this patient education programme. The person-centred approach is a key element for good clinical practice and therefore this study chose this approach. McCormack, Manley and Titchen (2013a) describe person-centredness as follows:

*'Person-centredness is an approach to practice established through the formation and fostering of healthful relationships between all care providers... patients and others significant to them in their lives. It is underpinned by values of respect for persons, individual right to self-determination, mutual respect and understanding. It is enabled by cultures of empowerment that foster continuous approaches to practice development'* (p 9).

This article is divided into two parts. The first part describes the development, implementation and evaluation of the educational programme, focusing on the change in nursing culture through expanding the team's skills and building patient-centred practice (Shaw, 2013). The second part explores the development of person-centred practice from the perspective of the patient during the transition from hospital to home.

## **Part one: nurse-led education programme for CHF inpatients**

### **Objectives**

This part of the article describes the development, implementation and evaluation of the nurse led CHF patient education programme. The goal was to implement a nurse-provided systematic self-management education programme for CHF patients who were hospitalised due to cardiac decompensation. As part of the evaluation, patients were asked if they were satisfied with the education programme and if their needs were taken into consideration. In addition, their self-care behaviour after discharge from hospital was measured.

### **Methods**

#### *Programme development*

Action research with the steps 'look', 'think' and 'act' was chosen as the method for practice development, with the goal of expanding the professionals' knowledge in order to improve patient outcomes (Stringer, 2004).

The educational programme sought to eliminate the gap between theory and practice in CHF patient care, and it was important that both patients and professionals participated and this formed the basis on which the project was organised. The project was led by a nursing science Masters student, who was supported by a project group consisting of five registered nurses with experience in cardiology from the department and the chief resident physician. Depending on the topic, other professional groups, such as dieticians and physiotherapists, were consulted. A multiprofessional team of experts assessed the contents of the programme and decided on the information that would be included.

#### *'Look': analysis of the current literature and practice*

A thorough examination of the evidence and a structured participatory process of change were required to develop the CHF patient education programme. The healthcare team members reflected on their present practice as part of their commitment to the programme (Clarke and Wilson, 2008). Nurses read basic literature on CHF and self-management skills to prepare them for their involvement in the programme. The team discussed current patients as case studies and identified gaps in the care process. They also discovered that because they lacked an understanding of the home environment of the CHF patients, including their healthcare needs, targeted education for self-management was not possible. Discussing the case studies brought about great motivation for change and triggered an initiative for a 'bottom up' approach. Literature searches of various scientific databases were conducted by the first author to gain an up-to-date perspective. The project leader reviewed the literature and discussed relevant content with the project group.

#### *'Think': synthesis from the literature and preparation for the change in practice*

Recommendations on CHF care, based on the current European guidelines (Remme and Swedberg, 2002) adapted and published by a multiprofessional working group from the Swiss Society of Cardiology (Buser et al., 2006), served as the basis for the patient education and counselling programme. The educational methods used were based on the self-regulatory model for chronic disease management

by Vincenzi and Spirig (2006). Keeping in mind that CHF patients represent a heterogeneous group with different abilities and limitations due to comorbidities, person-centred practice was emphasised alongside the standard content (McCormack et al., 2013b). While developing the programme, patients' views on the changes were sought and discussed with them to help understand where standardisation would be possible and where individualisation was necessary. Ten patients were randomly selected to reflect on their education sessions and on the methods chosen. The personal values, beliefs, knowledge, coping strategies and resources of the patients were integrated into the design of the actual educational sessions (McCormack et al., 2013b). Cards with self-management topics such as medication, symptom control and nutrition were created (Luniewski et al., 1999) and helped give nurses and patients an overview and prioritise educational topics. In preparation for the change in practice, the members of the project group were trained specifically on methods of patient education. In addition, all nurses from the cardiology department were provided with an overview of the programme and received tailored training on methods of patient education.

#### *'Act': Implementation of the change in practice and method of evaluation*

The change in practice started in June 2007 after an intensive preparatory phase. This period required the project leader to provide strong support, such as facilitation of skills, structured reflection, observation, feedback and practice (McCormack and Dewing, 2013). Selected CHF patients were enrolled in the programme for an optimal implementation of the programme contents. The project group thereby had the opportunity to acquire specific experiences and so reduce uncertainty.

The programme was evaluated after a year as a cross-sectional study using methodological triangulation with respect to patient satisfaction, usefulness of the counselling content and self-care behaviour (Bläuer et al., 2011). For patient involvement, ethics approval was obtained from the local research ethics committee. A total of 15 patients were questioned about their experiences seven to ten days after hospital discharge, via a questionnaire and semi-structured telephone interviews. The self-care behaviour of the participants was measured using the European Heart Failure Self-Care Behaviour Scale (Jaarsma et al., 2003). Qualitative content analysis (Mayring, 2003) was used to analyse the qualitative data, which were reported with descriptive statistics.

## **Results**

### ***Contents of the change in practice***

The programme included three educational sessions on self-management, focusing on implementation at home. Central to our person-centred practice was the prioritisation of educational topics, and this was accomplished with help from the patients using the topic cards. The sessions were led by the nurses from the project group, all of whom had had special training for CHF self-management and patient education.

The sessions were complemented with training components provided by the nursing team. Patients were given the opportunity to adjust their medications themselves, to weigh themselves and to keep a symptom diary. To ensure that the staff nurses could support the patients in self-management, they received a tailored education programme. All nurses working in the cardiology department were required to complete this training. In addition, the team reflected on patient situations using actual cases (McCormack and Dewing, 2013).

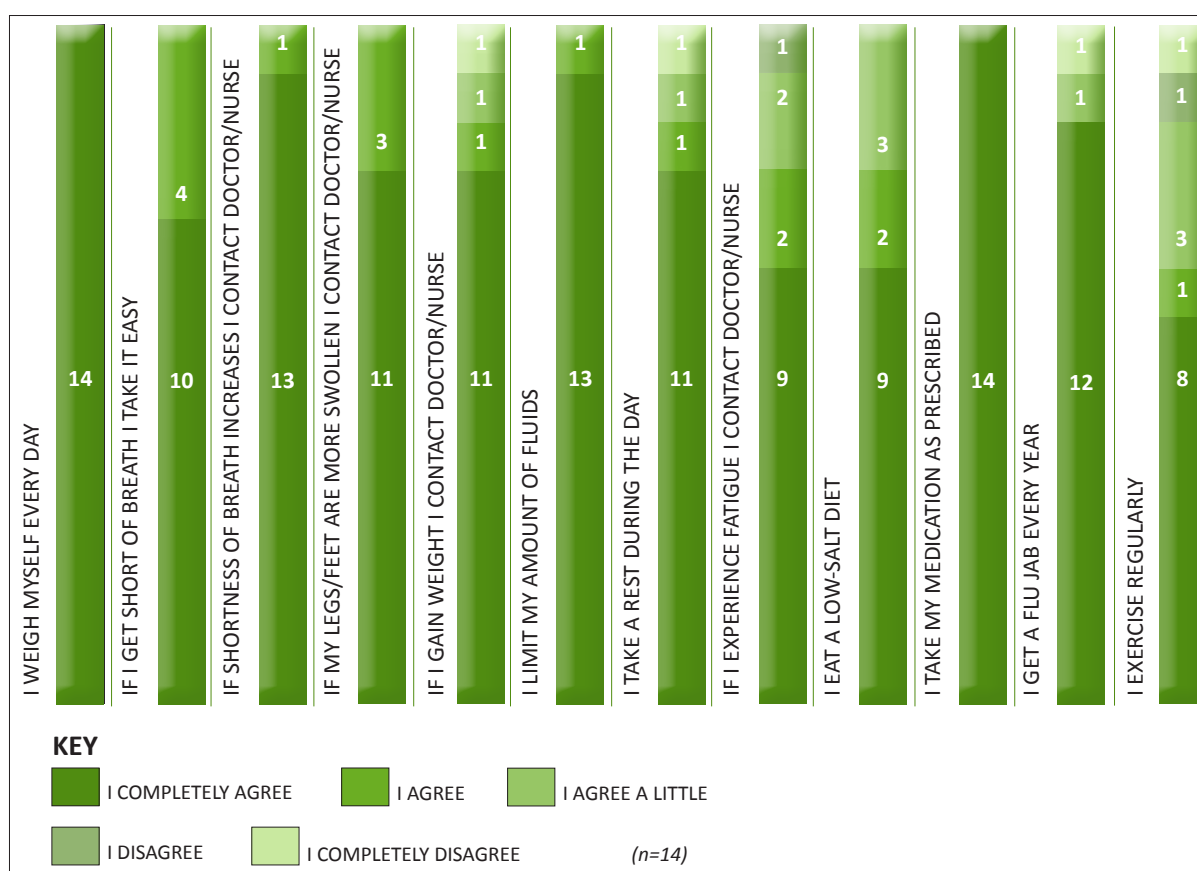
### ***Patients' feedback***

The evaluation showed a high level of satisfaction with the education programme among the participants. Of the 15 participants, 12 rated the entire CHF programme as 'good' and three as 'excellent'. All participants said they felt well prepared for hospital discharge, with 11 reporting they felt 'very well prepared'. All 15 said they would recommend the programme.

The participants oriented themselves on 12 predefined topics during the educational sessions and most of them (n=12) were able to partially or entirely determine the topics for the education. Three participants were accompanied by family members during the education sessions which was highly appreciated by them. Another three participants expressed their desire to engage their family members more during the process.

Ten of the participants weighed themselves independently during hospitalisation and nine found this to be helpful. Twelve participants kept the symptom diary and each of these saw it as beneficial. All participants reported that they felt sufficiently supported during the training. The assessment of self-care behaviour is shown in Figure 1. The total score was calculated from the results. The lower the total score (15-60 points), the better the self-care behaviour. The mean value for the participants was 16.3 points (range 12-29). The participant with the lowest self-care behaviour score was a 50-year-old man who was in full-time employment, which prevented him from carrying out sufficient self-care.

**Figure 1: Assessment of self-care behaviour**



### Discussion of part one

The CHF programme brought improved person-centredness in the inpatient care of this population in the University Hospital Basel and the use of evidence in practice. The educational sessions were well received by the participants and rated as good to excellent. The results of the pilot evaluation suggested options for programme optimisation.

The evaluation showed a high level of patient satisfaction. Satisfaction is a multifactorial phenomenon, so is likely to have been influenced by factors such as devotion of staff and the qualities of the organisation, aside from the actual educational sessions (Panchaud et al., 1999). It can be assumed that aspects such as devotion, listening and experiencing the counselling sessions as positive had an influence on satisfaction levels in this study.

Prioritising topics within the person-centred approach seems to have been difficult for the participants (McCormack et al., 2013b). The patients oriented themselves to the specifications of the nurses and rarely suggested their own topics. Given that nurses and patients weigh the value of educational content differently (Hagenhoff et al., 1994; Frattini et al., 1998), the implementation of patient-centredness showed improvement.

When looking at the usefulness of the content of the education sessions, one can say that, primarily the medical advice, based on Buser et al. (2006) proved to be helpful and important to the participants. In addition, the participants' views reflected the content of the CDM model (Vincenzi and Spirig, 2006) such as third-party support, health-related quality of life and their health beliefs.

Participants gave themselves high scores for self-care behaviour (Figure 1). The average score for self-care behaviour was 16.3 points – significantly better than the 29.6 points reported in previous studies (Jaarsma et al., 2003). It was satisfying that all participants showed very good compliance for weighing themselves and taking medication. These are topics that were emphasised during the educational sessions and were discussed and practised daily. The participants' scores in this study are much better than in the studies that Van der Wal and Jaarsma (2008) described. However, the participants brought up new problems in the interviews conducted at home, such as uncertainties, fears and a lack of energy. In addition, implementing the contents of the educational sessions in everyday life was not without problems. The results suggest that, in the future, educational sessions need to be further tailored to individual patients.

It is important to take into consideration that this evaluation only included a small convenience sample of patients who had attended an education session and showed good cognitive functioning and language skills. Nevertheless the results show potential for further development.

The discussions to further develop the educational programme revealed that in order to improve the support given to patients with transitioning to home, nurses needed more knowledge about patients' perspectives and their living environment. These insights formed the focus of the next study, which is described below.

## **Part two: patients' perspectives on transition from hospital to home**

### ***Objectives***

Research shows that education programmes that take place in the participant's living environment have a positive influence on self-management (Roccaforte et al., 2005). However, even though the patients participating in the CHF educational programme were well prepared for self-management at home, implementing the contents of the educational sessions in everyday life was not without problems. The results suggest that, in the future, educational sessions need to be further tailored to individual patients. The Swiss healthcare system, however, does not require that CHF patients receive follow-up care from specialist CHF nurses after hospital discharge. For this reason, the following questions were examined to develop further the educational programme:

- What kind of support do CHF patients participating in an educational programme in Switzerland need in order to develop self-management strategies and implement them at home?
- What kind of social network do patients need in order to have enough support to implement the strategies at home?

The collated responses to these questions should help nurses better understand patients living with CHF and their self-management at home, and thus improve the support given to the patients within the educational programme, so that they can develop appropriate self-management strategies for home.

### **Method**

The second part of the article focuses on the qualitative study conducted to explore the subjective perspective of the CHF patients. An appropriate research method to explore patients' perspectives in self-management at home is the grounded theory. A comprehensive analysis of the literature was conducted to identify current knowledge and identify any gaps. During this phase of the study a substantive theory was generated to describe the phenomena from chronic disease management (Strauss and Corbin, 1996). For this part, ethics approval was obtained from the local research ethics committee.

### **Sample**

The sample consisted of patients who had completed the CHF educational programme at the University Hospital Basel. When using grounded theory, it is common to build a theoretical sample. A heterogeneous sample was initially selected in order to capture as many different points of view as possible. Sensitising concepts such as age, sex, education, subjective assessment of health status, restrictions in daily life and social support helped determine the heterogeneity. In a second step, the participants were carefully selected to answer new questions that had arisen from the analysis (Böhm, 2000). The aim of the theoretical sample was to validate the categories identified in the analytic process of interviews (Glaser and Strauss, 2010).

The choice of the theoretical sample was based on the sensitising concepts. It consisted of nine women and 13 men (mean age 76.5; SD  $\pm$  10.5). Seven participants rated their health status as good, 11 as moderate and two as bad. Two did not respond. Sixteen participants complained in the interviews about discomfort due to comorbidities such as pain from various causes and depressive moods.

### **Data collection and analysis**

The first author conducted interviews in the participants' living environments seven to 14 days after discharge from hospital (duration: 23-60 minutes; mean: 38.7 minutes). The data collected in these interviews were context- and time-bound, being strongly affected by the experiences of the patients and their everyday life. The interviewer recorded their observations, non-verbal behaviour such as facial expressions, and their own perceptions in a research diary, which was then incorporated in the analysis. All collected data were anonymised. The interviews were recorded and transcribed according to the transcription rules of Hoffmann-Riem (1984). Various methods of coding (open, axial and selective) were used in the data analysis. During analysis, new questions were developed and statements compared, with the goal of forming categories and concepts (Strauss and Corbin, 1996).

A main phenomenon – intrinsic motivation – was identified using selective encoding. The process was complete when the new theory could be justified based on the collected data (Haller, 2000).

### **Results**

The following section describes the main beneficial and hindering factors in self-management. These are factors that have implications for the further development of the educational programme.

- Living with chronic disease and its impact
- Support from healthcare provider: access
- Support from family and friends: need- accept- experience

### **Intrinsic motivation**

The results of the interviews show a main phenomenon: intrinsic motivation. This means to encourage self-management, to aspire, build and sustain a feeling of being 'at ease with oneself'. This motivation gives patients strength and energy to develop strategies for dealing with CHF and for achieving a good quality of life.



The intrinsic motivation of being 'at ease with oneself' involves feeling comfortable, safe in one's own mind and body, and feeling taken care of and secure. Energy must be invested in order to achieve the feeling of being 'at ease with oneself'. The driving force in finding this energy could be the hope for recovery, but also the experienced threat.

*'Right, just because I do not want the water (lung oedemas) anymore. So this is already clear to me...'* (81-year-old man).

Experiences of success can be helpful in maintaining the feeling of being at ease with oneself.

*'If you are successful at what you want, then it is a lot easier to do... Then I just feel good'* (77-year-old man).

Experiencing success can motivate behaviour in terms of adapting to good health. Likewise, wellbeing can motivate people to be active:

*'... that it feels good (physiotherapy)... when I go three times for only half an hour...'* (77-year-old man).

But both experiences of success and wellbeing require the basic intention to reach a goal or the desire to change something.

The ability to obtain and maintain intrinsic motivation is closely related to three main categories:

- Living with the illness and its consequences
- Access to support from the healthcare providers
- Need, accept and experience support from family and friends

#### *Living with the illness and its consequences*

The consequences of the illness lead to limitations in everyday activities. Some patients connect their limitations to their CHF and some just to age. To experience things, such as maintaining friendships and pursuing tasks at work or hobbies, means living well despite illness.

However, the onset of symptoms and the progression of the illness can also mean that certain treasured activities cannot be carried out anymore. In these cases benefits and risks need to be weighed against each other:

*'Twenty years, a good time, when you took trips and stuff, and um, you know and with this heart, um, it's just a little risky, right?'* (82-year-old man).

A certain satisfaction can be felt when patients can consciously decide what they want to give up. They are satisfied with the past good times and want to take risks. In such moments it is beneficial to discover new activities that are worth living for. But some patients are burdened because they have not been successful in discovering new things. In these situations, however, the question arises as to whether these feelings are an expression of the illness or a result from a depressive mood:

*'I'm fed up, I just don't want to anymore... best would be to lie in bed all day... that's what would feel right. Physically and emotionally I'm worn out'* (89 year old woman).

In addition to engaging in enjoyable activities, CHF patients need to develop everyday coping strategies to overcome restrictions. When a 62-year-old man had shortness of breath, he found a way to cope by stopping on the street and looking at the store window displays. CHF patients must always adapt to new situations, rethink their behaviour and revise their decisions. An 82-year-old man sold his house and planned his new living situation in detail. He soon realised, though, that he had miscalculated the situation and that he had to rely on a third party to walk up the slope to his new apartment.

### *Access to support from the healthcare providers*

Self-management is greatly influenced by the way the patients experience their working relationship with healthcare providers. Their own experiences shape their behaviour. Confidence is created by experiences such as excellent round-the-clock care in the intensive care unit, the feeling of being taken care of and knowing that one can always ask questions. If patients' experiences are not considered or respected during treatment, it may have a negative effect on their cooperation with the healthcare providers.

An obstacle to self-management may arise when patients interpret symptoms (of decompensation) as side-effects of their therapy:

*'... the therapy is to blame and it is not my body that is reacting like this'* (62-year-old man).

Confidence is the key factor for cooperation between patients and healthcare providers. Factors that build confidence include:

- Knowing staff can be relied on
- The ability to ask questions again and again
- Being listened to and being able to talk with healthcare providers
- Being taken seriously
- Getting to know staff and feeling understood

Patients expect concrete advice or a clear statement when they see a doctor. If these expectations are not met, they will only seek medical care in an emergency.

Transitions from inpatient to outpatient care and vice versa are critical events in the treatment process. Healthcare professionals often ignore the fact that patients are confronted with an entirely different situation when they go home from hospital.

*'Yes, yes, you feel better in the hospital and then coming home is a real shock'* (73-year-old woman).

Patients are often still in poor physical condition when they are discharged. In addition, the transition can be psychologically stressful. An 88-year-old man fell into a 'mental hole' after being discharged from the hospital. He said he felt something like 'mothered' in the hospital and at home he suddenly had to depend on himself. It was difficult for him to find his 'daily routine' again.

Another problem arises when treatment strategies determined by the inpatient team are not continued in primary care. Patients rarely experienced that treatments were discussed with them and initiated with their consent. The consequences are that patients decide on their own what they will do.

### *Need, accept and experience support from family and friends*

With the onset of new symptoms and the progression of CHF, patients need increasing support. They especially need help with heavy housework. Help with the shopping and driving, such as trips to a doctor's appointment, came primarily from family members. It is difficult to organise help if family members are not available as a helping hand in everyday activities. Experiencing support does not always mean receiving concrete help. For many patients, it is important just knowing that they can call on someone for an occasional conversation or in an emergency situation:

*'Friendship is comforting, to know there is someone I can always call, someone to chat with or have a conversation, and someone who knows me and is sympathetic'* (75-year-old woman).

The most important relationships are with life partners and children. They take on different roles, for example becoming mediators with healthcare providers. However, partners are typically elderly and frail and are also in need of support.

Patients without a network of family members and friends find it difficult to organize enough support.

*'I know, I was always on my own... it is hard to come home and have nobody around' (73-year-old woman).*

### **Discussion of part two**

A better understanding of beneficial and hindering factors from the patients' perspective should help to develop the CHF education programme further. The goal is to provide additional support for the development of self-management behaviour during hospitalisation and thus to improve the transition to home.

The feeling of being 'at ease with oneself' is comparable with relative equilibrium – that is, giving meaning to life despite disturbances of the body (Corbin and Strauss, 2004). The degree to which this feeling is achieved will be influenced by the progress of the illness; every change can lead to disruption of daily life. Patients are constantly seeking, building and maintaining the feeling of being 'at ease with oneself' throughout the course of the illness.

As described in other studies, these results also show that personality, beliefs and values have an influence on coping with illness (Scotto, 2005). Handling illness depends on psychological adjustment and mental health. There are patients who 'feel free' despite their illness and others who feel 'trapped in their illness' (Ekman et al., 2000, pp 132-33).

The interviews indicated that, within the educational sessions, patients' living environments had not been assessed systematically enough. The importance of the living environment needs to be emphasised in an initial assessment. Central topics for this assessment are the patient's attitude towards life, coping strategies, psychological state, lifestyle and the awareness of finiteness. A fundamental question is: *'What do patients believe they need to achieve intrinsic motivation?'* The goal must be that patients work on their self-management skills while in hospital with support from the healthcare team. A supportive healthcare network must be provided in the transition from inpatient to outpatient treatment.

Family and friends play an important role in the management of everyday life and the implementation of self-management (Falk et al., 2007; Thornhill et al., 2008). They need knowledge and support to develop a sustainable social network, in order to support the patient. This implies that they should be included in the work done with the patient in hospital and have the opportunity to develop their skills.

The CHF educational programme has been established over the years and has become an integral part of CHF patients' care. The recommendations of the European Society of Cardiology Guidelines (McMurray et al., 2012) are integrated within the educational framework. The evaluation of the programme and the reported grounded theory study, however, show that successful patient education is much more than the implementation of these guidelines. The person-centred approach is essential for the incorporation of the characteristics and living environment of the individual into the educational sessions.

### **Discussion and implications for practice development**

The results of this practice development initiative will help to close the gap between evidence and nursing practice. Therefore it was critical for the CHF patients and the healthcare team to participate in this change process. The reflection demonstrated that the development of sustainable practice using the patient-centred approach is work intensive and time consuming (McCormack et al., 2013b).

The approach using project organisation and the action research process (Stringer, 2004) proved to be successful in developing the programme. Initially, it was beneficial to develop a 'bottom-up' movement from a 'top-down' approach, using the healthcare team's reflections on patient situations. The team wanted a change and was committed to participating in the programme. A precondition for the nurses to provide the educational sessions and self-management training was that they needed to build their knowledge and skills. The project manager had to show great leadership abilities, such as working on shared vision, facilitation skills, structured reflection, feedback and observation practice for this to succeed (McCormack and Dewing, 2013). Even after the completion of project, structured reflection, evaluation and training of the healthcare team are essential elements for quality assurance and further development (McCormack and Dewing, 2013).

The evaluation of the educational programme demonstrated high levels of satisfaction among the participants. However, because the patients' perspectives had not been sufficiently incorporated into the programme, difficulties arose in implementing self-management. The goal of integrating the patient's perspective had not been sufficiently achieved. Likewise, personal values, beliefs, previous knowledge, coping strategies and resources were not incorporated enough into the content of the sessions (McCormack et al., 2013b). Experience shows that prioritising self-management topics with the patient is not a trivial exercise, and therefore nurses need good communication skills and an understanding of the patient's home situation. At the time the programme was developed, this knowledge and these skills were not present. Grounded theory was used in the second part of this research to complete the knowledge that was lacking regarding the patients' home situations and their perspectives (Strauss and Corbin, 1996). The in-depth examination of the patient's perspective showed that certain topics had been neglected and need to be addressed for a better transition from hospital to home in the future.

### Conclusion

This reflection shows that sustainable and successful change in practice requires a complex approach. Team competence is a prerequisite for sustainability. This should not be limited to the development of knowledge, but also to building skills within the healthcare team and for health professionals to be aware of their own values and beliefs. The process of change requires support and supervision of the team over a long period of time. The advantage of this is sustainable integration of self-management support in everyday treatment routines. It is fundamental to understand patients' living environment and thus support patients in their self-management. Therefore patient involvement is essential to improving care. Patient's values, beliefs and needs must be captured and incorporated into the modification of treatment practice. Initiating change in practice while collaborating with the healthcare team and considering the perspective of the patient is challenging and complex.

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**Cornelia Bläuer** (MScN), Clinical Nurse Specialist, University Hospital Basel, Switzerland.

**Irena Anna Frei** (PhD, MSc, RN), Head of Practice Development Unit, University Hospital Basel, Switzerland; Lecturer Institute Nursing Science, University of Basel, Switzerland.

**Professor Wilfried Schnepf** (PhD, RN), Chair Family Nursing and Community Care, Universität Witten/Herdecke, Germany.

**Professor Rebecca Spirig** (PhD, RN), Director of Nursing and Allied Healthcare Professionals, University Hospital Zürich, Switzerland.