A multidisciplinary approach to cardiac rehabilitation care

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In reviewing our rehabilitation service in line with the national service framework a number of issues were identified to be addressed by the nursing and psychology team. It was decided that a group should be set up to help address and contain anxieties in line with patient needs and provide practical information during this interim period of treatment. Patient feedback has shown the sessions meet their needs and staff have found that less time is taken up during individual appointments answering commonly asked questions and repeating information that is frequently asked for.

Until the recent government guidelines were produced, cardiac rehabilitation was a little-known specialism that was implemented largely by nursing staff and willing volunteers. The National Service Framework for Coronary Heart Disease (Department of Health, 2000) has brought cardiac rehabilitation to the attention of the wider medical and patient communities. The aim was to prompt consideration of how health services could best help patients who have had heart attacks, revascularisation or other cardiac events to maximise their chances of leading a full life and resuming their place in their community (DoH, 2000) (Box 1).

Cardiac rehabilitation is defined by the World Health Organisation (1993) as ‘activities that favourably influence the underlying cause of the disease and provision

**REFERENCES**


Heart and Mind Conference Summary (2003) Available at: www.bios.unc.edu/cscc/ENRI

**BOX 1. REHABILITATION ASSESSMENT**

Assessment for rehabilitation should address the following needs (DoH, 2000):

- Physical needs – including increased physical activity, smoking cessation, diet, alcohol consumption, medication, and further clinical management;
- Educational needs;
- Psychological needs;
- Social, cultural, and vocational needs;
- Family and carer needs.

of the best possible, physical, mental, and social conditions, so that patients may, by their own efforts, resume as normal a place as possible in the community’. WHO suggests rehabilitation must be integrated within secondary services, of which it is only one facet.

The rehabilitation of cardiac patients involves four stages of medical treatment and care:

- Phase one – immediate acute physical, psychological, and social care following the cardiac event or diagnosis and before discharge from hospital;
- Phase two – expands on the initial needs identified in phase one during the early period postdischarge, extending advice to family members and carers;
- Phase three – builds on phase two by introducing further assessment and allocation where appropriate to cardiac rehabilitation groups. These involve structured exercise and relaxation, and psychoeducational, health promotion, and vocational advice. At this point patients may be referred for specialist input, if required;
- Phase four – focuses on the long-term maintenance of a healthy lifestyle within the community. This involves encouraging the patient to undertake the required activity to maintain good cardiac health, such as increased physical exercise, losing weight, improving diet, and managing stress. This phase may be carried out in conjunction with local community sports centres, where appropriate. However, it should be noted that the onus to change during this stage lies with the patient and her or his individual choice. Again patients may be referred to specialist services if they require specific help to meet their individual targets.

Johnston (1997) states that disease is rooted in behaviour and it is clear that improved lifestyles involving diet, exercise, and not smoking, would reduce risks to illness as well as aid recovery (Heart and Mind Conference Summary, 2003; Bardber et al, 2001; Kop et al, 2001; Scottish Intercollegiate Guidelines Network (SIGN), 2002).

The range of needs outlined above necessitates a multidisciplinary approach to the care of cardiac patients. This approach has been initiated in Oldchurch where the cardiac rehabilitation team includes specialist rehabilitation nursing staff, as well as occupational therapy, physiotherapy, and psychology staff.

**Background**

In reviewing our rehabilitation service in line with the National Service Framework for Coronary Heart Disease (DoH, 2000) a number of issues were raised specifically for the nursing and psychology team. These related mainly to the apparent lack of input between phases two and three for patients with cardiac rehabilitation needs.
Patients indicated that during all four phases of medical treatment and care, medical and recovery information about their individual situations was not easily accessible and there was a lack of general contact with services. This problem was exacerbated by patients who were keen for clarification about their condition and therefore sought information themselves. This included sourcing leaflets, gaining advice from friends or neighbours, and searching for information on the internet.

The information they obtained was inconsistent and this added to the patients’ anxieties, which in turn complicated the recovery process and hindered necessary behavioural changes. Consequently, when patients reached the cardiac rehabilitation group in phase three, lots of time was spent clarifying these misunderstandings, and challenging myths and unhelpful beliefs about their situation.

From the psychologists perspective, it was noted that during psychology sessions a number of referrals required only single session input where the patient generally needed reassurance and normalisation regarding their psychological experience and reaction to their cardiac event. However, although this was a very focused and easily met need, patients were required to wait a number of months for this appointment.

The wait for this information was not considered acceptable by the team and it was thought this need could somehow be addressed in a different way. In addition, during the psychoeducational rehabilitation sessions, patients often commented that the psychology sessions would have been more beneficial to them in the early stages postdischarge when their distress was apparently increased.

**Setting up the cardiac care group**

The literature on psychological support or psychoeducational groups is well established (Roth and Fonagy, 1996; Scheidlinger, 1994; Yalom, 1975). Therefore, it was decided that a group should be set up to help address and contain anxieties in line with patients’ needs and provide practical information during this interim period of treatment (Box 1).

There were a number of considerations to be made in setting up this group. Some were specific to setting up any group, such as:

- Group capacity;
- The agenda;
- The choice of whether to have an open or closed group;
- Group layout.

Others considerations were specific to a cardiac rehabilitation group, such as:

- How to assess risk;
- The need for medical aid should emergencies arise;
- Whether members should be inpatients or outpatients;
- How the aims for this group were different from those in cardiac rehabilitation, individual psychotherapy sessions, or general cardiac support groups in the region;
- Which professions should be involved.

Initially it was agreed that given the resources available the group would only be open to outpatients awaiting angiograms and cardiac rehabilitation. The group was offered only to patients rather than carers because of their differing needs. Throughout their attendance it was emphasised that patients would continue to remain under the care of their medical team.

**The pilot**

Initially, a pilot group was run over a period of 10 weeks with a limited number of patients. The aim here was to develop ground rules, identify patient needs, clarify the outline of the group as well as consider formalities, such as if or when to have a break and the room size. During and after this period each member was asked to complete a self-report questionnaire to evaluate the effectiveness of the group.

Changes implemented after the pilot included increasing the number of patients to 10 and limiting attendance to 10 weeks in total, to allow other patients to benefit. In addition, the pilot group enabled clarification and confirmation of ground rules and session outlines. Experience of the group and types of question asked also enabled the facilitators to develop a range of psychological and nursing information resources, which were added to by patients as the group progressed.

**Group facilitators**

Two members of the existing cardiac rehabilitation team facilitated the group: a clinical psychologist working in an acute medicine and community mental health team, and a cardiac rehabilitation sister who had some additional acuteness and normalisation to their and during psychology sessions a number of referrals required only single session input where the patient generally needed reassurance and normalisation regarding their psychological experience and reaction to their cardiac event. However, although this was a very focused and easily met need, patients were required to wait a number of months for this appointment.

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Both facilitators had experience of setting up and running a range of groups across physical and mental health. It was felt that a combination of team members was needed to address core issues, due to the fact that medical and psychological issues were often presented in tandem. It was emphasised to referrers that the group would centre around psychological rather than psychiatric problems. Any patients who required a psychiatric service were assessed by the psychologist and referred to mental health services. The same principle was applied to patients requiring specific medical attention.

The role of the two facilitators was to work closely with patients on their experiences of the medical and psychological aspects of their cardiac event. The rehabilitation sister advised on medication, possible side-effects, outcomes, and possible types of treatment, addressing

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problems relating to recovery. She gave advice on referring back to consultants, diet and exercise, challenging myths around cardiac illness, and recovery.

Information about medical procedures and waiting times or appointments was also given. In addition, as some patients were still medically unstable and, therefore, possibly at high risk, the role of the nurse was also to offer advanced life support if required.

The role of the psychologist involved supporting patients in exploring and identifying the psychological aspects of their cardiac problem, and contextualising and helping them to understand their experiences as well as the practical and psychological impact on their lives and that of others. The psychologist emphasised the doctrine espoused by Hippocrates – it is not the problem that happens to the person but the person the problem happens to that determines its impact. This allowed for individual psychological differences to coexist within the group, which in turn allowed an explanation and understanding of individual patterns of behaviour and the development of a range of helpful or unhelpful thoughts. Consequently, patients felt more able to accept differing rates and states of recovery.

Active problem-solving was encouraged mainly using solution-focused and cognitive-behavioural strategies, as well as normalisation and reassurance around reactions (current and past) to the cardiac event (White, 2001; Johnston, 1997; Coates et al., 1995). The psychologist’s role also included identifying and supporting patients who required individual psychological therapy (within the acute medicine service) as well as referral to adult psychiatric services where necessary.

Achievements, challenges and consequences of the programme

Patient feedback has been both encouraging and constructive (Box 2). Our definition of ‘encouraging and positive’ is feedback that indicates that a greater understanding and possible resolution of a problem has been achieved for the patient.

The main benefit of the cardiac care group has been that it more readily allows patients’ needs to be addressed within their requested time frame rather than over a period of time ascertained by the service providers. In addition, the group has also enabled patients who need some practical information and limited psychological input to receive help without a long and unnecessary wait. The group has provided clarification for some psychology referrals; filtering out short-term input from those with a more serious level of need where more work is required.

The consequence for staff has been less time taken during individual appointments clarifying information over and over again. Paradoxically, the success of the group has meant some patients have found it difficult to accept that the programme only lasts for 10 weeks. This remains a frequent source of debate.

Replacement of group members has been a problem during initial stages a waiting list rapidly developed for the group. Additionally, attendance at the group can and has occasionally been irregular due to other necessary medical treatment, which in turn has obvious implications for patients on the waiting list.

The role of the group within the overall cardiac rehabilitation process raises an interesting issue. Clearly there will necessarily be overlap in the information requested and discussed in such a group. This raises a concern about how resources are used, especially if this leads to a repetition of services provided later.

However, at the same time clinical experience tells us that patients often need to have information repeated numerous times before they are ready to hear – or actually do hear – what is said. It would be interesting to research what impact attending the cardiac care group has on subsequent interventions offered within rehabilitation and whether this experience improves later uptake of information, reducing overall anxiety and unnecessary dependency on the service.

Regarding group outcome and evaluation, as the group draws upon a range of therapeutic approaches and emphasises both psychological and medical issues, there is some difficulty in assessing specific therapeutic benefits of particular orientations. However, although there is currently no formal evaluation of this input, self-report evaluation sheets are completed by each group member at the end of input. The group is modified according to patient suggestions where possible.

Conclusion

Although the group is seemingly a success with patients, the long-term benefits and difficulties are not yet apparent. While there are no direct links between specific psychological factors leading to heart attacks, research indicates the mental health of the patient or specific psychological factors influence the quality of recovery as well as affect the behavioural changes required after diagnosis. Indeed this is when most referrals to psychologists are made.

Certainly the evidence from the rehabilitation team, as well as patient feedback, strongly suggests the success in achieving the previously mentioned targets comes from the combination of disciplines linking and addressing their problems holistically.