Exploring the Patient Educational Challenges Experienced by Healthcare Professionals Working with Heart Failure Patients: A Narrative Inquiry

Ramon Mangion
Corresponding Author: Ramon.Mangion@mcast.edu.mt
Centre for Learning and Employability, MCAST

Abstract: This study explores the experience of two healthcare professionals regarding the patient educational challenges when working with heart failure patients. This is also enriched by the author’s experience as a caregiver to such a patient. The study was based on a qualitative research design using narrative inquiry. This methodology was used in order to elicit the participants’ rich experiences. In-depth interviews were used together with follow-up discussions and communication with participants. Data was analysed using thematic narrative analysis. Following this process, five central themes emerged: (1.) Patients’ uncertainty about the condition until they start the educational process; (2.) The importance of education and self-care for all heart failure patients to reduce admissions and save lives; (3.) Educational challenges faced by healthcare professionals and adaptation through professional experience; (4.) Caregivers’ crucial participation in good self-care and in mitigating educational challenges; and (5.) Strengthening timeliness and resources available for education. The study also contributed towards two models that emerged from the narratives: (1.) The Patient Educational Process Model; and (2.) Involvement of caregivers in the Patient Educational Process Model. Various recommendations were also provided with practical applications for the health sector and for the educational sector.

Keywords: patient education; heart failure; narrative inquiry; patient educational challenges; caregivers; healthcare professionals

Research Theme

Background

The study of the educational challenges that are experienced by healthcare professionals dealing with heart failure (HF) patients is the main research theme. HFI is the most common reason for admission to hospital in people aged over 65 years (Strömberg 2005). This is also prevalent in Malta, with the various symptoms of HF being the main reason for the increased number of patients each year at the Emergency Department of Mater Dei Hospital (Vassallo 2019). In an interview published in the Times of Malta as part of the Heart Failure Awareness days for 2018, Dr Robert Xuereb2 Stated that “Heart failure is on the rise in Malta, and awareness of the condition was still quite low” (Grech 2018). There are over 8,000 people who suffer from this condition in Malta. The Department of Cardiology at Mater Dei believes that in a decade, a quarter of the population may suffer from HF (Vassallo 2019). Patients with HF have high hospitalisation and readmission rates, resulting

1 Heart failure means that the heart is not pumping as well as it should be. It describes a heart that cannot keep up with its workload (American Heart Association 2017)

2 Dr Robert Xuereb is a Maltese Cardiologist and the Chairman of the Department of Cardiology at Mater Dei Hospital
in a substantial economic and public health burden (Su et al. 2019). HF management programmes, in which patient education is an essential component, have improved self-care and reduced readmissions (Strömberg 2005).

Indeed, education principles are also fundamental in such settings. While many people associate learning with locations involving the conventional teacher, others are fulfilling this role on a daily basis. These persons may also be found in challenging situations since the location where such education takes place is not typically conducive to or associated with learning. One such place is a clinic or hospital environment with healthcare professionals taking the role of educators regarding their patients’ health in both inpatient and outpatient situations. Healthcare professionals work in “emotionally charged settings” (Heyhoe et al. 2016: 2). Patients may also have varying degrees of education, family or other social support, abilities and physical or intellectual disabilities. In Malta, patients that are diagnosed with HF combined with reduced ejection fraction\(^3\) are referred to a specialist doctor and a specialised nurse-led outpatient clinic. Apart from the provision of specialised treatment, nurses in this clinic provide a lot of education\(^4\) as patients need to monitor specific parameters related to their condition daily, start or change medications and contact the clinic through a dedicated telephone number for queries and to report drastic parameter changes. Even so, a specialist HF cardiologist monitors such patients and others with a less severe form of HF (preserved ejection fraction). This work is based on the narrative inquiry methodology. Clandinin (2016) states that this approach has three key components that are fundamental contributors to the research theme at hand: personal justifications, practical justifications, and social justifications. The following justifications were essential for the emergence of the central research theme for this work.

**Personal Justifications**

I have been dealing with cardiac morbidities for the past 15 years with two family members suffering from myocardial infarctions\(^5\) that eventually resulted in HF. I always supported them and was a crucial part of their education as patients. However, I was always curious about the educational challenges that healthcare professionals experienced with patients that might not have someone like myself or who have supportive family members or friends who may lack education, literacy, health literacy or even themselves suffer from other conditions that inhibit understanding and learning (both physical and intellectual limitations). I am also a volunteer first responder with a local ambulance NGO. Hence, I also found myself trying to educate people about their health or an acute injury in different situations. I am also a practitioner in adult education. I felt that I could link my personal experiences and my academic and professional background in education to approach this situation from an educational position.

**Practical Justifications**

At the time of writing, I hold the position of Director, Education & Training Programmes and Learning Support at MCAST. My remit is not specific to one area, however, as part of my work, I am constantly in touch with different people to better understand what is needed for our courses or how MCAST can contribute to the community through its course.

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3 In simple terms, ejection fraction is expressed in percentage format and shows the heart’s pumping ability. Patients with a reduced ejection fraction are referred to this clinic as they need more attention due to specific medication needs.

4 Information based on an online e-learning video on Heart Failure delivered by a heart failure specialist, a nurse from the heart failure clinic and a general practitioner (Moore, Grixtri, and Caruana, n.d.). Available at: https://thesynapse.net/heart-failure-module-episode-6/ (accessed 20 December 2020).

5 This is the medical term for heart attack. This occurs when blood flow to the heart is blocked (Mayo Clinic, n.d.).
offering. The latter is particularly relevant in view of the college’s strategic plan 2022-2027, reflecting MCAST’s tenet to be a “community college for all”. I also support MCAST institutes in their programme design process. In this case, this would entail the college’s courses in health and social care, health science, physiological measurement and nursing.

Social Justifications

The practical justifications mentioned above are important as they lead to actions of a social nature. The theme of this work will also contribute to new disciplinary knowledge and insights. I come from an educational position. Therefore, the practical insights gathered from the experience of healthcare professionals dealing with HF patients can further strengthen the college’s organisational understanding of these situations. There is one key aspect that contributes to the social justification component. It is vital that we also understand better how we educate in practice as a college. In considering if the topic should be studied, Creswell and Creswell (2018: 64) observe the following:

... also relates to whether anyone outside of the researcher’s own immediate institution or area would be interested in the topic. Given a choice between a topic that might be of limited regional interest or one of national interest, we would opt for the latter because it would have wide appeal to a much broader audience.

The lack of local research in this area creates a justification for providing new insights or actions.

Research Aim and Objectives

The research aim refers to the overarching purpose of a research project (Thomas and Hodges 2010). The aim of this research is to explore the patient educational challenges that healthcare professionals encounter and deal with when working with HF patients as expressed in their re-storied narratives. This study will seek to address the following objectives:

- **Objective 1:** Crystallise the real-life experiences of healthcare professionals in their endeavour to provide HF patients with the education needed to manage the symptoms and effects of the condition.
- **Objective 2:** Identify the challenges encountered by such professionals and the efforts to mitigate them to enhance the efficacy and adherence to patient self-care requirements.
- **Objective 3:** Obtain insights which, if applicable, can further enrich MCAST programmes in the healthcare sector.

Research Puzzle (Question)

Researchers implementing the narrative inquiry methodology frame a research puzzle rather than a research question with a precise definition or expectation, as each narrative inquiry is framed around a particular wonder (Clandinin 2016). The identified research aim and objectives inform the research puzzle (question). This was determined to be the following:

- What are the experiences and narratives of healthcare professionals and patient educators working with HF patients regarding the challenges they encounter in their dual role as clinicians and educators within a healthcare environment?
Literature Review

Introduction

This section presents a literature review on existing research on the theme and associated topics. Sekaran and Bougie (2016: 64) explain that a critical literature review is “a step-by-step process that involves the identification of published and unpublished work from secondary data sources on the topic of interest, the evaluation of this work in relation to the problem, and the documentation of this work.” As part of the process to identify the theme and better understand my research ideas, an exercise was conducted involving searches through the Malta Medical Journal, The University of Malta Online Access Repository, MCAST online resources, and general online searches. Unfortunately, articles or other literature on the subject within the local context are scarce or only touch base on a part of the theme, such as HF alone as a condition or patient education in general terms. In this section, I first tackle the notion of health literacy, given its critical impact on health outcomes for various conditions. I then move on to the subject of patient education (contextualised to HF), and barriers healthcare professionals face in their efforts to educate their patients. Figure 1 below shows a literature map depicting the literature review structure and the different literature consulted.

![Literature Map](image_url)

**Figure 1: Literature Map**

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6 Focus was limited to the Faculty of Medicine and Surgery and Faculty of Health Sciences.
Health Literacy

The importance of adequate health literacy stems from the fact that such competency is the first step to preventing illness and taking care of one’s health. It can be defined as “the capacity of people to access, understand and apply information related to health so that they can make informed choices related to their health” (EACEA 2015). The European Association for the Education of Adults identifies the ability of patients to understand doctor explanations, instruction leaflets on medication, information on illnesses and know how these are applied. This is also a pertinent topic in European Public Health discourse (Visscher et al. 2018). Different authors agree that there is also a clear link between low functional literacy and low health literacy (Berkman et al. 2011; Easton, Entwistle and Williams, 2013; Visscher et al. 2018). According to the study by Easton, Entwistle, and Williams (2013), participants gave various examples of how their literacy difficulties manifest themselves in healthcare contexts. This includes difficulties with written communication due to the use of medical terminology, on-the-spot leaflets, and other forms that led participants to miss appointments or were not prepared for appointments as they did not understand instructions. Furthermore, Easton, Entwistle, and Williams (2013) also stress that people with low literacy can have various difficulties in spoken interactions and consultations with health professionals, leading to poor understanding of what was said during consultations and the eventual poor management of health conditions at home. Their results also showed that such patients also were afraid to disclose their literacy problems due to experiences of stigma and thus gave various excuses or pretended that they were understanding. Unfortunately, low health literacy acts as a barrier to preventive healthcare (Yun et al. 2017). Regrettably, those with low health literacy are 1.5-3 times more likely to experience adverse health consequences when compared to those with higher health literacy (Berkman et al. 2004). Studies have shown a direct link between inadequate health literacy, worsening health outcomes, poor preventive care behaviours, higher health care service use and costs (Berkman et al. 2011; Visscher et al. 2018). Below, I summarise points about the relationship between health literacy and outcomes based on a systematic review by Berkman et al. (2011):

1. Increased use of emergency care and hospitalisation;
2. Low probability of health screening;
3. Poorer skills in taking medications, particularly in the elderly population;
4. Poor interpretation of prescription medication labels;
5. Greater probability of misunderstanding instructions and lack of ability to describe how a number of medications required should be taken;
6. More likely to have poor mental health outcomes;

In agreement with the above points and considering the theme of this paper, Dennison et al. (2011) corroborate that individuals with inadequate health literacy and chronic\(^7\) conditions such as HF are at bigger risk for poor care outcomes, including lack of knowledge about the disease, poor self-care, increased hospital admissions, and increased mortality.

This is also emphasised by Su et al. (2019) who mention health literacy as one of the socioeconomic risk factors associated with HF hospital readmissions. In the next section, I delve into the specific case of HF patient education. Health literacy can play a crucial role in this process.

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\(^7\) Chronic diseases are defined broadly as conditions that last 1 year or more and require ongoing medical attention or limit activities of daily living or both (National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) 2021)
Patient Education and Heart Failure

Health education is a mechanism that develops the awareness and skills that influence the behaviours needed by the patient to sustain appropriate health behaviour (Aliti et al. 2007). Patient Education is critical in the management of HF and its symptoms. The aim of patient education for those suffering from HF is to provide information that enables patients to garner essential knowledge and skills to understand and cope with their ailment (Casimir et al. 2013). Education is critical to reduce the likeliness of death and the effects of the disease (Aliti et al. 2007). HF patients need to know the signs and symptoms that indicate the need to seek medical care, how to follow complex medical requirements, restrictions on salt and fluid intakes and lifestyle changes. Lack of compliance to such necessities leads to a reduced quality of life and possible hospital readmission (Casimir et al. 2013). The matter of non-compliance is a recurring issue in healthcare, particularly in HF (Van Der Wal, Jaarsma and Van Veldhuisen, 2005). In addition, patient education for HF patients involves instrumental action that affects the patient’s attitude and behaviour and preventive action to mitigate the patient’s fear of the treatment. Koser et al. (2018) look at the importance of a dedicated HF clinic. Their study showed a statistically significant reduction in discharged patients’ 30-day readmission and mortality rates. Nevertheless, the availability of information (instruction) in this process is important, but does not guarantee that behavioural improvements are achieved on their own (Aliti et al. 2007). Reference can be made to a local Doctorate of Pharmacy thesis where Debono (2019) denotes various modifiable non-clinical predictors of readmissions, particularly once the patient is in the community, namely: lack of ability to read labels, no observance of dietary limitations, low readiness for discharge, inconvenient or lack of early follow-up scheduled, and fear of symptoms. Repeated readmissions also have an economic impact. Furthermore, many of these readmissions are considered preventable (Huynh et al. 2019). This confirms the importance of education in this context. In her report, Jaarsma (2006) lists several important topics that should be discussed with patients suffering from chronic HF and their close relatives (Table 1). This is guided by the European Society of Cardiology.

<table>
<thead>
<tr>
<th>General Advice</th>
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<tbody>
<tr>
<td>Explain what heart failure (HF) is and why symptoms occur</td>
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<tr>
<td>Causes of HF</td>
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<tr>
<td>How to recognise symptoms</td>
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<td>What to do if symptoms occur</td>
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<tr>
<td>Self-weighing</td>
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<tr>
<td>Rationale of treatments</td>
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<tr>
<td>Importance of adhering to pharmacological and non-pharmacological prescriptions</td>
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<tr>
<td>Refrain from smoking</td>
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<tr>
<td>Prognosis</td>
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</tbody>
</table>

**Drug Counselling**

<table>
<thead>
<tr>
<th>Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dose and time of administration</td>
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<tr>
<td>Side effects and adverse effects</td>
</tr>
</tbody>
</table>

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*Heart Failure is abbreviated to HF.*

*Medical personnel typically refer to mortality and morbidity.*
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<table>
<thead>
<tr>
<th>Signs of intoxication</th>
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<tbody>
<tr>
<td>What to do in case of skipped doses</td>
</tr>
<tr>
<td>Self-management</td>
</tr>
<tr>
<td><strong>Rest and Exercise</strong></td>
</tr>
<tr>
<td>Rest</td>
</tr>
<tr>
<td>Work</td>
</tr>
<tr>
<td>Daily physical activity</td>
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<tr>
<td>Sexual activity</td>
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<tr>
<td>Rehabilitations</td>
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<tr>
<td><strong>Vaccinations</strong></td>
</tr>
<tr>
<td>Travel</td>
</tr>
<tr>
<td><strong>Dietary and Social Habits</strong></td>
</tr>
<tr>
<td>Control sodium intake when necessary, e.g. some patients with severe HF</td>
</tr>
<tr>
<td>Avoid excessive fluids in severe HF</td>
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<tr>
<td>Avoid excessive alcohol intake</td>
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</tbody>
</table>

**Table 1:** Subjects to discuss with HF patients and their families – adapted from Jaarsma (2006)

It is notable to see the mention of both patients and their families who also act as their caregivers in many cases. Self-care,\(^{10}\) specialised outpatient education, and proper follow-up among such patients are fundamental (Raines and Dickey 2019). Nevertheless, according to Durante et al. (2019), while self-care is essential in HF care, patients struggle to perform these tasks and frequently depend on caregivers. These are described as “those people inside or outside the family who provide most of the informal care to patients with HF and are important in the self-care process” (Durante et al. 2019: 29). Buck et al. (2015) agree that medication adherence, lower hospital readmission rates, and dietary and daily weighing compliance are all outcomes associated with such support. Fry et al. (2016) consider how strong support from friends and family help in the acceptance of the diagnosis of HF. Nonetheless, although we have established the significance of educational interventions for HF patients, the process does fail with various adverse outcomes.

In fact, healthcare professionals are dealing with various educational challenges as part of this process. This is the matter that will be discussed in the next section.

**Patient Education and Challenges for Healthcare Providers**

*The Skills of Healthcare Providers*

Healthcare providers are faced with the need to deliver complex information (Beagley 2011). This brings to light the fact that the knowledge and skills of different healthcare professionals in caring for and educating patients are a decisive reason in healthcare outcomes for patients suffering from chronic conditions. It is essential to understand that chronic conditions influence all aspects of life and not just a person’s physical function, and needs differ from one patient to another (Mikkonen and Hynynen 2012). HF patients live

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\(^{10}\) Durante et al. (2019) refer to Riegel and Dickson (2008: 192 and their definition of self-care: “those activities that patients perform to maintain the physiological stability of the disease (self-care maintenance) and to respond to the symptoms of HF exacerbation when they occur (Self-care management)”
with the direct impact of the disease, dealing with different pharmacological treatments and probably receiving care for other illnesses by different healthcare professionals. At the same time, healthcare professionals need to provide support and act in the best interest of their patients (Lambrinou, Protopapas, and Kalogirou 2014). Authors such as (Mikkonen and Hynynen 2012) and (Beagley 2011) refer to the shift towards a more patient-centred approach to education. Nevertheless, healthcare professionals may be quite knowledgeable in their particular medical field but have insufficient knowledge of appropriate tools and interventions to inform patients and support in the behavioural changes that may be required (Mikkonen and Hynynen 2012). These authors say that the patient-centred approach and the support of self-management and care require several skills, namely educational skills, self-management education, and teaching problem-solving skills to patients. Beagley (2011) states that to educate patients effectively, healthcare providers must be knowledgeable about the principles of adult education. The same approach is also taken by Fleming (2014), who discusses her experience as a nurse and how it felt that she was practising adult education within a healthcare context.

**Barriers and Challenges**

Barriers or challenges in educating patients suffering from HF can stem from both the organisation or the healthcare provider’s side and the patient’s side. Ponikowski et al. (2014) emphasise that although many live with and die from HF, there is a low awareness among different groups. Strömberg (2005) highlights the importance of providing patients with coherent information since patients receive educational content at different times and from different caregivers in many situations. It is stated that patients are less likely to adhere to instructions when unclear and contradictory information is received from different healthcare professionals. Stull et al. (1999) highlight that when patients are initially diagnosed, they may experience difficulties in making sense of the situation and experience a crisis, so they might not be receptive to any educational interventions. Additionally, Lambrinou, Protopapas, and Kalogirou (2014) highlight other factors such as healthcare providers complaining of a lack of time, lack of support from peers, limited patient education materials, lack of proper training, a constraining environment, unsupportive administration and failure to balance overlapping responsibilities within the multidisciplinary team involved in the education of HF patients. On the other hand, healthcare professionals responsible for providing education to HF patients must consider different factors that impede the process. Table 2 summarises and compares the barriers highlighted by Lambrinou, Protopapas, and Kalogirou (2014) and Strömberg (2005). These also further support the various arguments discussed throughout this chapter.

<table>
<thead>
<tr>
<th>Strömberg 2005</th>
<th>Lambrinou, Protopapas, and Kalogirou 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functional limitations-visual, hearing, mobility</td>
<td>Providing an individualised approach for each patient</td>
</tr>
<tr>
<td>Cognitive limitations-memory problems</td>
<td>Non-adherence to self-care recommendations</td>
</tr>
<tr>
<td>Misconceptions and lack of ‘basic knowledge’</td>
<td>Low-Health Literacy</td>
</tr>
<tr>
<td>Low motivation and interest</td>
<td>Cognitive Impairment</td>
</tr>
<tr>
<td>Low self-esteem</td>
<td>Patient Beliefs/Motivation</td>
</tr>
</tbody>
</table>

**Table 2: Summary of barriers in patient education**

11 HF is prevalent in the elderly population who may also suffer from other chronic conditions that can cause functional and cognitive limitations.
Methodology

Introduction

Methodology denotes “the way in which we approach problems and seek answers” (Taylor, Bogdan and DeVault, 2016: 4). An application of the research onion framework (Figure 2) by Saunders, Lewis, and Thornhill (2016) in relation to the adopted methodology for this study is shown below.

Figure 2: The Research Onion Framework, adapted from Saunders, Lewis, and Thornhill (2016)

Philosophy

The first layer of the research onion identifies the research philosophy. According to Creswell (2007), the philosophical assumptions made when starting a research project are an important part of the process. Taking into consideration the research aim and subsequent objectives, interpretivism was noted as the most appropriate underpinning philosophy. Considering the focus on complexity, richness, multiple interpretations, and meaning-making of interpretivism, a subjectivist stance is taken (Saunders, Lewis, and Thornhill 2016). I also consider a transformative aspect since when considering the justifications in relation to this study, there is an agenda for reform that may lead to change in my life as a researcher, in the respective institutions and participants’ lives (Creswell and Poth 2017).

Approach to Theory Development

The study’s design necessitates an inductive approach. Rather than being handed down entirely from theory or the viewpoints of the inquirer, inductive research takes a bottom-up approach (Creswell 2007).

12 Considering MCAST and Hospital Environment.
Research Approach

This study will tackle the problem through a mono-method qualitative approach. The qualitative approach is described as a “form of social inquiry that focuses on how individuals understand and make sense of their experience and the world in which they live” (Holloway 1997: 2). We use qualitative research because of the deeper understanding needed for the identified issue (Creswell 2007).

Research Strategy-Narrative Inquiry

Narrative inquiry is a design of inquiry from the humanities in which the researcher studies the lives of individuals and asks one or more individuals to provide stories about their lives (Riessman 2008). As a method it focuses on the exploration of the life of an individual and tells stories of individual experiences (Creswell and Poth 2017). The attractiveness of narrative inquiry lies in its flexibility and fluid nature. It is a “fluid inquiry, not a set of procedures or linear steps to be followed but a relational inquiry methodology that is open to where the stories of participants’ experience take each researcher” (Clandinin 2016: 33). The narrative inquiry approach permits a rich description of the real-life experiences and an exploration of the meanings derived by participants from their experiences (Wang and Geale 2015). In implementing a narrative inquiry study, the researcher must establish an active collaboration with the participant (Creswell and Poth 2017). It is to note that in narrative inquiry, “the inquirer emphasises the importance of learning from participants in a setting. This learning occurs through individual stories told by individuals” (Ollerenshaw and Creswell 2002: 331).

Time Horizon

Whilst this study adopts an educational position, the context is mainly a healthcare environment. In their work, Grossoehme and Lipstein (2016: 4) conclude that “longitudinal qualitative research has the potential to be a powerful approach to understanding the complexities of health care: from relationships between providers and patients to the experience of chronic disease, to the impact of health policy.” The study adopted a longitudinal perspective since respondents talked about their narrative from a temporal space.

Data Collection and Analysis

Sampling

The nature of the study and narrative inquiry as a methodology necessitates using a purposive sampling approach. The latter does not suggest the need for a large number of participants. Based on a review of various qualitative research studies, Creswell and Creswell (2018) state that narrative inquiry can typically even include one or two individuals. The study’s target participants were healthcare professionals who specialise in HF and work with patients suffering from this condition.

Method

The study implemented unstructured open-ended interviews that can go in-depth and elicit the participants’ experience. Participants were first contacted via email and slots were set for the interviews/discussions. In view that this study was conducted during the COVID-19 period, and as per the participants’ preference, these were conducted online. Narrative inquiries often start with the notion of telling stories based on ‘conversations’ or interviews as conversations that create space for both the researcher and the participants. These are not guided by predetermined questions (Clandinin 2016). Creswell (2007) asserts that open questions enable the researcher to listen to participants. On obtaining participants’ permission, interviews were digitally recorded to facilitate the analysis process.
Another tool for recording and collecting data is the researcher’s reflexive journal. Keeping self-reflective journals is a strategy that can “facilitate reflexivity for the researcher to examine “personal assumptions and goals” and clarify “individual belief, systems and subjectivities’’” (Ortlipp 2008: 696).

**Analysis**
The data available needs to be analysed to elicit the required results. Data from this study was analysed through a thematic narrative analysis approach that focuses on narrative themes from a chronological standpoint within the narrative itself. MAXQDA was utilised as an effective tool during the analysis process. The recorded data was listened to multiple times to immerse in the process and experience. The field notes and reflexive journal also contributed to enriching the narrative generated. Riessman (2008:80 ) states that thematic analysis within the context of narrative inquiry keeps a story “intact” by theorising from the case rather than from component themes (categories) across cases. In this case I worked with a single interview at a time and considering each narrative separately. I also went further to “zoom in, identifying the underlying assumptions (themes). Particular cases are then selected to illustrate general patterns-range and variation and the underlying assumptions of different cases are compared” (Riesman 2008: 57).

**Validity and Reliability**
Criteria for the ethical conduct of qualitative research are linked to increased research quality. These criteria are also important to establish the “trustworthiness” of a study (Creswell 2007: 202) and thus to ensure that the findings can be trusted.

**Credibility**
Credibility is an important component whereby the researcher ensures that a true representation of the participant’s realities is provided. For this study, the researcher built trust and rapport and collected sufficient data. Furthermore, as part of the natural process of the narrative inquiry methodology, the researcher went back to participants for further insights. The researcher also made sure that “own preconceived expectations about what the research will reveal are not privileged over the social constructions of the participants” (Saunders et al. 2016: 206)

**Transferability**
This criterion refers to the study’s transferability to a different situation where the reader could be interested in conducting research (Sunders et al. 2016.). For this study, an appropriate description of the research design, context, findings, and interpretations was provided for possible application in other settings.

**Dependability**
As highlighted by Saunders et al. (2016), it is important to record changes in the research focus to produce a reliable/dependable account to ensure that this can be understood and evaluated by others. This paper records the process undertaken in this study through appropriate explanations of the research design and its implementation. The researcher must explain all the research steps taken from start to end. The records of the research path are also kept throughout the study (Korstjens and Moser 2018).

**Reflexivity**
Reflexivity is also another vital process. This is described by Korstjens and Moser (2018) as the process of critical self-reflection about oneself as researcher and the research relationship. The first considers own biases, preferences, and pre-conceptions whilst the latter considers the relationship to the participant and how this affects participant’s answers to questions. This is also highly pertinent to narrative inquiry as a methodology. The researcher implemented a reflexive journal whereby thoughts were recorded. Furthermore,
Ethical Considerations

Approvals
Ethics are essential in any research study. These are defined as “the standards of behaviour that guide your conduct in relation to the rights of those who become the subject of your work, or are affected by it” (Saunders, Lewis, and Thornhill 2016: 239). In narrative research, “ethics define a set of responsibilities in human relationships: responsibilities for the dignity, privacy and well-being of participants” (Wang and Geale 2015: 197). Contact was made with the appropriate department to obtain the necessary approvals and discuss the nature of this research. Assistance was also given to contact the relevant participants. A proposal was also submitted and approved by the MCAST Research Ethics Committee. Throughout the research process procedural ethics, situational ethics, and relational ethics (Tracy 2010) were thoroughly considered.

Confidentiality
Necessary steps were taken to ensure informed consent, confidentiality, and anonymity if and as requested by the participants. However, in view of the specific nature of the study and the high degree of specialisation by the healthcare professionals that were interviewed, participants were informed accordingly and gave their approval to use their real name. Participation in this research was through informed consent. Participants were also free to withdraw from the study with the assurance that necessary steps will be taken to delete all data.

Handling of Data
Creswell (2007: 141), recognises that “a qualitative researcher faces many ethical issues that surface during data collection in the field and in the analysis and dissemination of qualitative reports”. The data gathered was respected, handled only by the researcher, and used only for this research. The safety and access to data was guaranteed through appropriate storage procedures. Both originals and backups were stored on password-protected and encrypted local and cloud based systems.

Thematic Narrative Analysis Depicting the Main Findings that Emerged from the Narratives

Main Findings from Collaborative Discussion with Cardiologist and Heart Failure Specialist

Alice is a medical doctor and specialist in cardiology and HF. As a specialist in the area and due to the chronic nature of the condition, Alice is quite involved in the care of such patients. She sees herself performing various roles in the care of HF patients, including the educational role, since patient education is fundamental for HF patients. Her narrative shows that due to the chronic nature of the condition, patients might face various difficulties. Patients and their relatives or other caregivers need to understand the condition and what it is all about. Such understanding would help them in their treatment, self-care, and management of the condition. A needs analysis is also conducted to identify limitations and needs and she works on them to educate patients. This helps in providing a more individualised educational approach. In terms of education, the critical role of caregivers is acknowledged, in particular for older patients. Alice recalls experiences whereby the caregiver was essential in the patient’s self-care.
Another core finding relates to different challenges encountered by such doctors in educating HF patients and strategies to use to mitigate them. A key core finding is in fact the importance of building a rapport and a sense of trust with patients. This is vital for any educational process.

Nevertheless, another core finding from the cardiologist’s narrative is how saving a life through education can act as a motivating professional facet. She mentions examples whereby the education provided was a lifesaver. These types of experiences show the importance of education and act as motivators to spend as much time as possible educating patients.

The cardiologist’s narrative highlights the importance of growth, in that more patients are living longer also with HF. Hence more specialised doctors are needed together with more nurses that can start the education process once a patient is admitted and not just on an outpatient basis.

Main Findings from Collaborative Discussion with the Nurse

Janet is a nurse who specialises in HF. Janet sees herself performing various roles since, together with her team, she continuously provides support and guidance. The latter can also include referral to other services provided by the hospital or other appropriate entities. A key finding reflects the importance of the first visit to the HF clinic. This visit normally entails a longer time slot, as key education is provided to patients and their caregivers. Such key educational messages are further reinforced through subsequent outpatient visits and follow-ups. Her narrative strongly emphasises that in HF, education is critical. The education provided covers different aspects including what patients and caregivers need to look out for in terms of signs and symptoms and what actions to take, what medications and food items to avoid, and how prescribed medication is to be taken. The critical role of caregivers in facilitating the educational and self-care processes is also recognised, with patients encouraged to bring someone with them, particularly for the first visit. The narrative by Janet likewise recognises the difficulties that certain caregivers face, particularly when patients have multiple conditions and are dependent on one caregiver.

A key finding relates to the challenges encountered during the patient educational process in relation to HF. Experience is recognised as a key contributor in the provision of education and to deal with related challenges. Those suffering from HF sometimes also need to experience something to learn the importance of certain aspects.

In order to deal with the different challenges mentioned, different approaches are used. This includes involving relatives and caregivers as facilitators in the patient’s educational plan. Repetition and reinforcement are also used to continuously drive key messages. Janet recounts how when patients are given an explanation about the rationale behind the treatment being given, they are also more likely to cooperate and understand its importance.

Discussion and Analysis Based on Emerging Themes from the 2 Narratives

The narratives were further analysed and compared, and the themes shown in Table 5 were identified. The process of thematic narrative analysis within narrative inquiry entails that each narrative is compared. Consequently, this discussion also identifies narrative resonances and divergences across the two narratives. Reference was also made to literature as a means to consolidate the discussion. Verbatim quotes were also inserted for
the reader to better understand and immerse in the theme through the actual participants’ voices. I also include my own reflections based on my own personal experience.

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**Table 3: Emerging Themes**

**Theme 1- Patients’ Uncertainty About the Condition Until they Start the Educational Process**

A common element in all narratives reflects the uncertainty that such patients face when diagnosed with HF. For them this is shocking, and many tend to associate HF with imminent demise.

*In the beginning, yes it is a big shock so during the first consultation when we give them this diagnosis the patient might not understand what this is all about.* (Alice)

This situation of uncertainty is shown by Stull et al. (1999) in that the process of becoming a patient with HF triggers a search for meaning and identity. The novelty of the situation also leads to responses of uncertainty. In this study, Stull et al. (1999) suggest that patients follow five distinct phases of identity formation namely: crisis event, the diagnosis, their acceptance, and adjustment to life with their condition and the decision to get on with life. In the patient’s response to diagnosis many patients feel that “…heart failure conjures up images of near death, of only a short time to live” (Stull et al. 1999: 288).

*No not everyone understands. Generally, they would know that the heart is weak because when they do tests, the result shows that they have heart failure so they would know that their heart is weak.* (Janet)

Such reactions also correlate with results from other studies. Solomou, Stavrou, and Marley (2016) refer to a case study whereby the participant stated that “it was those last two words that got my attention. When I was told I was suffering from ‘heart failure’ I was shocked. The heart is one muscle that can’t regenerate itself”. Likewise, Lambrinou, Protopapas, and Kalogirou (2014) state that one of the sources of uncertainty and fear for patients is the lack of knowledge and understanding. We need to recognise that HF is a chronic illness, and therefore the diagnosis means that there is a continuous manifestation.

*Obviously, when someone hears the word heart failure it’s very daunting for them, it’s life-changing, they think that they are going to die tomorrow. This is not the case however. In reality, it is a condition where patients are living for many years.* (Alice)
I can also relate to my own experience involving relatives. This was frightening for me as ultimately it is basic knowledge that no one can survive without the heart as the main pump of the human body. Hence, adding the word *failure* inherently implies that something is very wrong with this organ.

Individuals with HF experience a significant impact on their quality of life compared to other chronic diseases and those that are healthy (Heo et al. 2009). Equally, in a qualitative study by Fry et al. (2016: 4), it is specified that following the initial diagnosis, participants and their families described HF symptoms as a “disruption” to their lives. Patients may also be confused about how to share the diagnosis or what to share with family members (Solomou, Stavrou, and Marley 2016).

Moreover, consideration is to be given to the psychological aspect of the condition. According to Katon et al. (2007), cited in Mansouriyeh et al. (2018), HF and other chronic conditions are associated with increased psychological problems caused by physical, emotional and lifestyle changes. In fact, the HF specialist (Alice) mentions that she would be “…involved a lot in the care of the patient. Not only from the clinical point of view but multiple aspects; social aspects and psychological aspects”. Something mentioned only by the cardiologist is the fact that there might be younger patients as well. Certain patients might also require a defibrillator due to issues with heart rhythm. This leads to limitations in certain jobs.

*So we need to be careful to also care for that aspect as well.* (Alice)

**Theme 2- The Importance of Education and Self-care For All Heart Failure Patients to Reduce Hospital Admissions and Save Lives**

The importance of education and self-care by patients was noted in all narratives. This is documented by Strömberg (2005) who recognises that education is fundamental for the management of patients with HF. This has various critical implications since, according to Fry et al. (2016), poor understanding of HF and how to manage it leads to a cycle of hospital admissions and re-admissions. In their remarks, Jaarsma et al. (2021) also stated that those with HF who practice more effective self-care have a higher quality of life and lower mortality and re-admission rates than those who practice less effective self-care. Results from the study by Raines and Dickey (2019) also showed that the less the patient knows about their disease, the higher the frequency of HF hospital admissions.

*We educate a lot about and emphasise a lot on self-care.* (Alice)

*In heart failure, education is everything. Ok there are medications and interventions. But if the patient is careful and attentive to education and advice that we give, the patient has a really good chance to do well.* (Janet)

Sanchez and Cooknell (2017: 17) mention that “the goals of patient education are to help patients and their families improve their ability to provide self-care, assume responsibility for their own care, and leave the hospital with information that supports better lifestyle choices”. Education in the context of HF comprises many areas. Boyde and Peters (2014) explain that clinicians within HF management programmes provide information about HF as a condition, beneficial lifestyle changes, adherence to pharmacological and non-pharmacological therapies, symptoms monitoring, and self-care behaviours.

*Education is very important yes when it comes to HF. Obviously, a lot of the time entails myself explaining to the patient how to take care of himself/herself.* (Alice)
...we see that we invest enough time so that they understand the condition. (Alice)

Patients need to understand the signs and symptoms or changes in parameters such as weight and how to respond accordingly (Casimir et al. 2013). Participants also mention these aspects. For example, the nurse says that “...part of the education is that they need to adapt at limiting the amount of fluids they intake” (Janet). Similarly, the specialist mentions that “…if they see an increase in their weight this might mean that the patient is experiencing an accumulation of fluid in their body. So it is important that we teach them how to maintain their weight and to phone us if they have any issues” (Alice).

I can also relate to this experience and the educational advice provided by Janet and Alice as this is put into practice in a real situation. My relative noticed a marked increase in weight and, as instructed, we reached out to the clinic, and we got further instructions to monitor and that if this continues to increase (weight) we were to immediately contact back as this would mean that there is a fluid overload.

Both healthcare professionals see themselves performing various roles, with that of educator being a noteworthy one.

The Importance of Trust

Trust is critical in such a process and serves as a sound basis for an effective educational process. This was explicitly emphasised by the specialist (Alice) when she said that “...once you build a rapport with patients, they start to trust you more and they start slowly understanding the importance of this treatment”. This aspect is mentioned by Fry et al. (2016) who comment that the effective management of chronic illness requires a good foundation in terms of the relationship between a patient and their doctor. In addition, Fry et al. (2016) also show that a negative impact on future relationships with certain clinicians was reported by respondents who felt that their concerns were not taken seriously. Similarly, Lambrinou, Protopapas, and Kalogirou (2014) emphasise that a lack of education about the condition and failure to recognise such needs by health care professionals can act as barriers to developing positive relationships between patients and healthcare professionals.

Education and Saving Lives

In addition, all narratives refer to how education within a HF context can also be critical in saving lives. This upholds statements by authors such as Strömberg, (2005) who explains that education combined with psychosocial support improves self-care and reduces mortality. The nurse for example describes an episode about a patient “who was released from hospital, we provided the education, however that patient did not maybe take it seriously”. Similarly, the specialist mentions a case where a patient reached out due to particular symptoms and further testing showed that immediate intervention was required. She says that “because of the education and because she knew what the symptoms were, it saved her life.” This motivates her to “spend more time educating patients as it clearly works”. She also adds that “it’s better to spend a few more minutes explaining because that could mean the life of a person”.

This is evidenced through a study by Koser et al. (2018) who sought to analyse the process and patient outcomes of an independent outpatient HF clinic. They demonstrate that patients in the HF clinic were less likely to experience a re-admission to hospital within 30 days. Furthermore, such patients also had a lower inpatient mortality rate.

On the other hand, I can relate to a personal experience from a different temporal context where the educational approach and management were different. This resonates with the
results from the study by Koser et al. (2018). I believe that if the same education that is provided today existed during those years, another relative might have fared better and probably lived a few more months or years.

**Theme 3 Educational Challenges Faced by Healthcare Professionals and Adaptation Through Professional Experience**

Both Alice and Janet highlighted a number of educational challenges, with some being identical and others only mentioned by one participant. As stated by Alice, “in our profession we meet with people from different walks of life, and with different levels of education”. Lambrinou, Protopapas, and Kalogirou (2014) underline that healthcare professionals responsible for providing education must consider various patient-related factors that can hinder or limit the success of the process. In such cases you “have to alter your education technique depending on the type of patient you are dealing with at the time” (Alice). Healthcare professionals need to consider different parameters and adapt delivery, method and content to ensure a more lasting effect of the educational programme (ibid.). This is an interesting notion that can also link with adult learning concepts as applied to patient education. Fleming (2014), Mikkonen and Hynynen (2012), and Beagley (2011) emphasise the notion of patient centred education, thus shifting the focus from what the healthcare provider is to provide to who the patients are and what they need to learn. Although not explicitly mentioned, healthcare professionals practice these concepts: “We identify limitations and work on them in order to educate the patients” (Alice).

**Dealing With Challenges Through Experience**

Whilst reference was made by both participants regarding how such challenges are dealt with, this is not due to any training or theoretical knowledge of adult learning principles, but mostly related to experience.

*We see an average of 15 patients per day so experience gives you many learning opportunities.* (Janet)

*You learn as you go along through experience. You also reinforce more what you know and adapt or change.* (Janet)

*We give tutorials or lectures. So you still end up learning how to educate through experience.* (Alice)

This, therefore, leads to the need for healthcare professionals to have knowledge and skills in adult learning (Beagley 2011). Healthcare professionals are increasingly being asked to be educators themselves (Beagley 2011). This is obviously the case of the professionals involved in this study who work directly with HF patients. Janet realised, for example, that “through time as we go along, you see that in one time I did education in one way and the other time I did education in another way”. This is a reassuring comment since “it is important that the healthcare professionals providing education reflect upon their own attitudes and opinions about knowledge, learning and education as well as their treatment of the patient” (Strömberg 2005: 366).

**Key Challenges**

Common challenges mentioned by both healthcare professionals include non-compliance, literacy issues, patients who live alone, medication issues, and patients dealing with multiple comorbidities.

*Non-compliance mostly, they do not understand and follow our advice. There are others who just do not turn up for appointments.* (Janet)
Non-compliance is a major challenge, as evidenced by Van Der Wal, Jaarsma and Van Veldhuisen (2005) who observe that non-compliance with medication and lifestyle changes in HF patients can lead to many complications. It is a triggering factor for a possible acute increase in the severity of the condition and further hospitalisation.

*They try to find any excuse so as not to take medications.* (Alice)

*You can have patients that you constantly tell them not to drink for example, but still do not care.* (Alice)

Literacy presents a challenge for such healthcare providers as well. “As I explained, it is impossible if someone lives alone and does not know how to read or write. It is a big problem. Firstly, due to medicines. The patient would not know which is which and there would be a whole mess. So this is a big challenge for us” (Alice). Poor self-management capacity can be associated with poor literacy and low education levels (Parajuli et al. 2017). The participants did not specifically mention health literacy as a term. However, the ability to read and understand text, locate information, and adhere to medication requirements fall within the definition of the term (Berkman et al. 2011). Unfortunately, a lack health literacy is linked to poor health outcomes and ineffective or inefficient use of health care services (Berkman et al. 2011).

A challenge that was mentioned by only the specialist refers to financial challenges, since, at the time of writing, certain medication needs to be purchased by patients. “This is one of my main barriers, to try to explain how important it is that these medications are bought as they are the best for them” (Alice).

The financial aspect is mentioned by Lambrinou, Protopapas, and Kalogirou, (2014) in their paper related to educational challenges to the healthcare professional in HF care. These authors state that healthcare professionals should consider their patients’ financial aspects since medical costs may be barrier in terms of seeking treatment and adhering to drug therapy or other recommendations. Nevertheless, “there are others who for example prefer to spend money on a packet of cigarettes daily rather than buying these important medications” (Alice). Alice mentions that this is dealt with by “bringing them in more frequently so that I can explain better and repeat”.

Janet and Alice mention this repetition aspect in relation to other challenges as well.

*However, in our clinic we repeat, reinforce and keep reinforcing.* (Janet)

The concept of reinforcement is an effective approach. Repetition of clear and brief instructions should reinforce new information (Lambrinou, Protopapas, and Kalogirou 2014: 302). Both healthcare professionals feel that patients also need to do their part. It is clear that “this has to be a two-way process”. The provision of education is fundamental, but does not necessarily ensure a change in behaviour (Aliti et al. 2007).

*We tell them, we do not want to bother you, but this is important.* (Janet)

A link can be observed with principles of adult learning as per the theory of andragogy, in that adults need to know why they need to learn something (Houde 2006). Hence, in this situation, why medication is essential as compared to smoking:

*So this is a big struggle to educate patients that they stop smoking and buy these medicines instead.* (Alice)
Within this context of need, Houde (2006) also links this need with motivation and associates knowing why learning something is important with further motivation to learn. Another principle of adult learning is also applicable since adults need to be self-directing; “They resent and resist situations in which they feel others are imposing their wills on them” (Knowles, Jolton III, and Swanson 2005: 65). Fleming (2014) asserts that we must acknowledge that we are partners in assisting people in meeting their needs, sharing rather than mandating decisions. Even so, this is also mentioned by Janet, who says that “If we explain the rationale behind our treatments, typically they would understand better”.

Another common challenge relates to patients suffering from both HF and other illnesses such as diabetes and chronic kidney disease since patients might “be confused” with instructions/education from different specialists.

*Renal specialists would tell them to drink as much as possible so the kidneys do not dry out, on the other hand we are telling them not to drink more than 2 litres because the heart cannot take it.* (Alice)

*They come to us confused and tell us that one tells them to drink a lot and the other tells them not to drink water.* (Janet)

This is incidentally mentioned by Lambrinou, Protopapas, and Kalogirou (2014) who recognise that multiple conditions require different therapeutic approaches, which increase the possibility of compliance difficulties. Furthermore, conflicting information from healthcare professionals may also act as a barrier in the educational process (Lambrinou, Protopapas, and Kalogirou 2014). This may lead to other consequences since “the patient will not trust you or will end up deciding himself/herself.”

Raines and Dickey (2019) also showed a connection between poor self-care and the existence of comorbidities. A high number of comorbidities leads to further difficulties for patients to adhere to their self-care requirements. Similarly, results from the study by Fry et al. (2016) show that patients might experience difficulty distinguishing between symptoms of different illnesses and therefore if these are from HF, other illnesses, or side effects of medications.

Both healthcare providers in this study also mention the use of leaflets and the provision of suitable links, particularly for those patients and caregivers that are computer literate. These can support the educational process. Huynh et al. (2019) mention the provision of leaflets and other approaches after discharge to ensure understanding of various aspects of the condition such as causes and consequences of HF, symptoms, medication and their purpose, the need for fluid restriction and HF risk factors.

*We also give them leaflets for self-study. We also give them websites if they are computer literate so that they can go home and read and then come back to use with their questions etc…* (Alice)

*We also give them leaflets so that if they forget they can also refer to leaflets.* (Janet)

Lastly, although these healthcare professionals deal with these challenges using different strategies, it does not mean that they are always successful or that there aren’t any moments of doubt. Janet states that “we ask ourselves, did that patient understand? was he attentive?” On the other hand, Alice states that “in many instances you feel like you are ploughing in water. You try your best but, yes there are moments of frustration”. 
Theme 4- Caregivers’ Crucial Participation in Good Self-care and in Mitigating Educational Challenges

Caregivers can include relatives and friends that within the context of HF assist patients in the self-care requirements as guided by the education given through healthcare professionals. This was a common theme in both reflecting the significance of such persons in the patients’ lives.

We notice that caregivers are critical and important because they would be taking care of this self-care for the patients in many cases. (Alice)

It is interesting to note that those with “strong support networks of family and friends, appeared to accept their diagnosis of HF more quickly” (Fry et al. 2016: 5). Furthermore, such persons also took a very proactive role in helping patients.

Yes caregivers are very important, particularly for elderly patients. We have many that for example do not even give us their telephone numbers but instead give us the number of their children. (Janet)

Durante et al. (2019) refer to a systematic review in which it was observed that caregivers help patients with HF perform their self-care needs. This includes assistance to improve patient lifestyle, improving medication and diet adherence, recognising patients’ symptoms and calling for assistance if the condition worsens. Caregivers might also be counterproductive in that they may be performing incorrect practices or providing patients with incorrect information (Durante et al.). This aspect was not mentioned by any participant in this study and, therefore, might require further exploration.

Caregivers can be seen to be a complementing component in the educational process, particularly to encourage patients to comply with instructions given.

...he called and said that he spoke at length with his son about the matter and that the will try the new medication. So the caregivers are important and they can help. (Janet)

Even if they (patients) are reluctant to call, the caregiver sometimes just calls and tells us what happened so we guide them accordingly. (Janet)

Caregiver contribution is also mentioned by Buck et al. (2015), who state that clinicians need to educate and support caregivers as co-providers of HF care. They suggest that the presence of caregivers in the examination room (with the patient’s permission) is encouraged and seeing the patient and caregiver together instead of separating them.

In our case, we actually insist that they bring someone with them, because some patients will not understand or they forget. (Janet)

This is also corroborated by Ponikowski et al. (2014). They remark that a fundamental part in promoting self-care is educating people how to support their friends and relatives. Furthermore, they emphasise that if patients have someone to assist them, they are probably more enticed to employ valuable self-care behaviour.

Alice relates a case where an illiterate patient was supported by his wife, who would his check weight, prepare medications and take care of other self-care aspects for him. For sure, “if this person was living alone, I am 100% sure that his management would have been on a completely different level” (Alice).
This statement reflects results from the study by Raines and Dickey (2019). Findings show that living without any form of support or caregiver can lead to lower self-care and knowledge, resulting in inferior disease management.

One also needs to consider the cultural influences on such a process. This was not dealt with in this study and neither participant mentioned this aspect as part of their narrative. For example, Durante et al. (2019) mention that, in southern Europe, cultural factors related to family come to play, with caregivers having a strong sense of family duty which influences their contributions to patients’ self-care. Nevertheless, this might not be the case in other countries.

**Theme 5- Strengthening Timeliness and Resources Available for Education**

There are some common points that both participants mention. These can further add value to the educational process since more resources would enable these professionals to undertake more activities. One of the common aspects mentioned is the time limitation and how more resources can help the process. This is one of the reasons revealed by Raines and Dickey (2019) who mention that HF patients, particularly the elderly, face various difficulties, including the limited amount of time for health care professionals to deliver health education.

> You have like 10-15 minutes with them and you have to move to the next patient. If you have more human resources, you can spend more time in education. (Alice)

> There is a lot that we can do, however we need more time. (Janet)

These healthcare professionals see 4,000 patients per year and therefore other approaches to complement the work done can be considered. It is not easy for healthcare professionals to find a balance between patients’ needs, their expectations time, resources, and systematic restrictions that they have available (Lambrinou, Protopapas, and Kalogirou 2014a).

Training is also essential, particularly when we consider current or anyone studying to become a doctor or nurse. The specialist mentions the importance of communication skills and how to educate patients, since “in heart failure that is what we want, that patients are comfortable enough that when there is even the smallest of problems they come and speak to us so that we can help them immediately.” This should also be reflected in educational programmes for future healthcare professionals.

At the moment, such education is provided on an outpatient basis following diagnosis or discharge from hospital. However, there is a gap between discharge and the actual visit which might lead to a relapse for the patient. This was specifically mentioned Janet believes that “ideally education is given immediately”. This correlates with Koser et al. (2018) who refer to a study by Jackson et al. (2015). For those with multiple comorbidities who were evaluated within 7 days of discharge from the hospital, a significant reduction of 20% was observed.

**Emerging Models**

The findings of this study led to the following two models. The first model depicted in Figure 3 shows the patient educational process within the context of challenges. The patient is given the initial education during the first visit. At this point, caregivers and relatives are encouraged to be present. The patient is expected to carry out self-care at home whilst
attending scheduled or unscheduled appointments. During these appointments, new instructions might be given or changes are done to medication or other aspects to manage the condition. Challenges can manifest themselves at all stages of the process, such as during the actual self-care, clinic visits, and telephone support. Mitigation actions are taken to deal with these challenges. These challenges can lead to patients experiencing poor outcomes in terms of their condition.

The second model depicted in Figure 4 looks at the involvement of caregivers and how they can support patients for a positive outcome and good management of the condition. These caregivers start the journey with the patient, and assist or oversee the self-care process whilst also liaising with healthcare professionals. All these efforts can contribute towards different positive outcomes.

Model 1- Patient Educational Process

Figure 3: Patient Educational Process Model

13 Unscheduled appointments refer to visits or consultations arising from changes in the condition such as an increase in weight, blood results, or other parameters.
From the interviews conducted it is evident that healthcare professionals do a lot of good work as part of the educational process for HF patients. However, this is based on the experience of such professionals with no formal training and no inherent link to andragogy and practices arising from the theory of adult learning. Various references were made to literature supporting the need for such training. MCAST, as a community college, can have a significant role in working with the relevant authorities and departments to develop programmes that equip healthcare professionals with knowledge, skills, and competences to use adult learning principles as part of the process to educate HF patients. This initiative can help to further strengthen the process by combining experience with a good foundation in adult learning theory.
Enhance Resources and Introduce New Tools to Complement the Educational Process and Mitigate Challenges

It is recommended that new tools are made available so that the excellent educational process provided by these professionals is complemented by material or tools that can make it easier for patients to focus on their self-care. Through EU funding, MCAST can also support in practice the development of educational resources that go beyond the use of leaflets. This can take the form of dedicated video recordings that can be online or given as recordings for patients. Videos provide an opportunity to present information, together with realistic case studies or scenarios that demonstrate the consequences of non-compliance or what to do in the event of an exacerbation of symptoms. They can also be provided by other doctors or nurses, even for inpatients or once patients are discharged. This can help ease the uncertainty and fear aspect that patients experience until they start the educational process. An app can also be developed for computer-literate patients and caregivers. Apps are an excellent tool that are also implemented by organisations such as St John Ambulance with the theme ‘life-saving apps at your fingertips’. Such resources are there to cater for different literacy levels, learning styles (VARK) and should be aimed at providing information in an accessible and easily understandable manner. Social media is also a very effective tool that can easily reach thousands of people for free through organic growth by actively engaging with users and sharing of videos, case studies and other material to create awareness about the condition. All these elements can help address the issue of timeliness by providing other resources that can also be used for inpatient and outpatient cases.

Implications for Vocational Education and Training Programmes in the Health Care Sector

The educator role performed by these healthcare professionals came out very clearly through this study. Healthcare professionals need to build trust through proper interpersonal and communication skills. Furthermore, they need to pass on their educational message whilst dealing with different barriers that can impinge negatively on the process. Those responsible for the design, development, and review of programmes in this sector are to ensure that students are exposed to learning outcomes that cater for communication skills and basics in adult education within the context of patient education. Whilst this study focused on education provided for one condition, such knowledge, skills, and competences are fundamental for all healthcare professionals. Communication and teamwork are also important when one considers the reality of patients dealing with different professionals from different specialities.

Such curricular implications are also applicable from a community perspective. Through collaboration with the respective departments, MCAST can also develop programmes for the community that target caregivers of HF patients. As demonstrated through literature, the actual participant narratives and the involvement of caregivers in the patient educational process model, these persons have a fundamental role. They also face their own difficulties at an emotional, psychological, and even physical level. Hence such educational

14 There are various programmes available, with Erasmus+ being a good candidate for such initiatives.
17 VARK stands for Visual (V), Aural (A), Read/write * and Kinesthetic (K) and refers to the mode or sense through which people take in and process information in learning situations (Boyde et al. 2009: 318)
programmes can also help caregivers in dealing with these new situations. They also need to be prepared to support patients given the possible impact of the condition.

**Research Limitations and Suggestions for Future Research**

This study considered these experiences from the healthcare professionals’ perspective. This was limited to two healthcare professionals. Future research can look into the same aspect from the patients’ perspective. There is also an opportunity to look into the theme considering other medical professionals. Furthermore, the role of caregivers, bearing in mind the socio-cultural context of the Maltese islands, can also be considered.

**Final Conclusions**

This study used narrative inquiry to elicit the experiences of healthcare professionals working with HF patients focusing on the patient educational process and challenges that they encounter. There are studies from other countries, but no studies were available to look at the local context. These narratives illustrate the importance of such educational intervention. Nevertheless, this is a two-way process whereby patients and caregivers need to do their part to ensure proper management of the condition, positive outcomes, reduce mortality, and avoid admission and re-admission for hospital treatment. Various recommendations were also provided with practical applications for the health sector and for the educational sector, particularly MCAST. These recommendations can lead to transformative action to further enhance the outreach and day-to-day work done by healthcare professionals working with HF patients. It is hoped that this study will create awareness and make a difference, even if this is to save one life. Research creates new knowledge with the aim of having a valid contribution to society. Knowledge is the key to new practices and actions that lead to change.

**References**


Exploring the Patient Educational Challenges Experienced by Healthcare Professionals Working with Heart Failure Patients: A Narrative Inquiry


