Full Title:

Nurse mentor perceptions in the delivery of a home-based cardiac rehabilitation program to support patients living in rural areas by telephone: An interpretive study.

Running Head:

Nurse mentor perceptions of a home-based cardiac rehabilitation program delivered by telephone

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Highlights.

- Nurse mentoring of cardiac patients transitioning from hospital to their homes represents a new model of care
- Coronary care nurses were able to transition successfully from a hospital based role to a nurse mentor role after two days of training via workshop.
- Although nurse mentors sometimes found their new mentoring role challenging, most found the experience satisfying and professionally rewarding.
- Mentors perceived their role integral in providing after hospital care and timely support for patients.
- Nurses potentially can mentor patients in a range of disease-specific community or residential programs to improve their health.

Abstract

Home-based cardiac rehabilitation (CR) programs improve health outcomes for people diagnosed with heart disease. Mentoring of patients by nurses trained in CR has been proposed as an innovative model of cardiac care. Little is known however, about the experience of mentors facilitating such programs and adapting to this new role. The aim of this qualitative study was to explore nurse mentor perceptions of their role in the delivery of a home-based CR program for rural patients unable to attend a hospital or outpatient CR program. Seven nurses mentored patients by telephone providing patients with education, psychosocial support and lifestyle advice during their recovery. An open-ended survey was administered to mentors by email and findings revealed mentors perceived their role to be integral to the success of the program. Nurses were satisfied with the development of their new role as patient mentors. They believed their collaborative skills, knowledge and experience in coronary care, timely support and guidance of patients during their recovery and use of innovative audiovisual resources improved the health outcomes of patients not able to attend traditional programs. Cardiac nurses in this study perceived that they were able to successfully transition from their normal work practices in hospital to mentoring patients in their homes.

Keywords.

Home-based cardiac rehabilitation, home based cardiac rehabilitation, cardiac rehabilitation, nurse, nurse mentor. mentoring, patients.

1. Introduction

In global terms, more people die from cardiovascular disease than any other condition and approximately half of these deaths are attributed to coronary heart disease (World Health Organization, 2010). In 2015, nearly 20,000 men and women died from ischaemic heart disease in Australia (Australian Bureau of Statistics, 2016). CR programs are available in many countries and reduce mortality (Heran et al., 2011 and Lewin & Doherty, 2013), improve the health literacy (Edwards et al, 2012) and quality of life of patients (Shepherd and While, 2012). Despite this evidence, not all patients have access to such programs.

While CR is available in many cities and metropolitan areas of Australia, distance and cost of travel make it difficult for some patients to attend CR programs (Angelis, Bunker and Shoo, 2008 and Van Engen-Verheul et al., 2013). Because CR services are not available in many rural or isolated areas, innovations such as home-based CR programs (Clark et al., 2013) have been developed, which have been shown to be as effective as hospital-based CR programs in the United Kingdom (Taylor et al., 2015 and Buckingham et al, 2016). Such programs aim to empower patients to take an active role in their recovery and adopt healthier lifestyles (Heron et al., 2016). Despite international and national guidelines (National Institute for Health and Care Excellence, 2013 and Woodruffe et al, 2014) advocating CR for all, these services are not available in some rural areas in Australia. Thus, innovative ways to address this policy practice gap are required.

2. Background

Some home based CR programs are advocating the use of health professionals as mentors, but mentoring remains a complex phenomenon because of its many varied

definitions (Haggard et al., 2011). Mentoring can be used in a wide variety of situations and how it is enacted can vary widely. Commonly, the word mentor is used interchangeably with facilitator, coach or preceptor and often found in a variety of settings including professional development, business and sport. Historically, the name “Mentor” can be traced to Greek mythology and meant “a wise counsellor.” Mentoring has been used widely in academic, sporting, business fields and to a limited degree in nursing.

Mentoring has been used in nursing to attract assess and retain new nurses (Clark and Casey, 2016) and in professional development (Jokelainen et al, 2011) but not widely as a strategy to support patients. Several concept analyses have been undertaken to clarify meaning, provide operational definitions and report the various attributes relating to mentoring in nursing (Hodgson and Scanlan, 2013 and Meier, 2013). To date no concept analysis has been undertaken to clarify a mentoring relationship between nurse and patient in the context of after hospital care. Outcomes from these previous concept analyses and from research on mentoring in general may not be readily transferable to the present study about nurse mentors and patients. Hence, there is a need to explore the nurse mentor experience to understand the outcomes for both mentors and patients.

Home-based programs (Wang et al, 2012 and Taylor et al, 2015 and Heron et al, 2016) were originally developed as alternative CR models to widen patient access, improve uptake and adherence to CR (Dalal et al, 2010). They have been found to be comprehensive, safe and effective when compared with hospital based programs (Clark et al, 2015 and Buckingham et al, 2016) and most follow established CR guidelines (NICE, 2013 and Woodruffe et al, 2015). Patient preference for home-based CR stem from perceived barriers associated with distance from hospital

especially for rural patients (Shanmugasegaram et al, 2013), lack of time and cost (De Vos et al, 2013).

Nurses and other trained health professionals have been used to facilitate home-based CR programs such as the Heart Manual (Lewin et al., 1992 and Wingham et al, 2006). Health outcomes from these programs include improving the health literacy of patients (Brown et al, 2013), reducing anxiety and depression, improving quality of life and fewer readmissions to hospital (Clark, Kelly and Deighan, 2011 and Clark et al, 2015). Despite the benefits of home-based CR there remains little published material exploring the experience of nurses or others who mentor or facilitate such programs. The dynamics of the mentor-patient relationship and the importance of this relationship in determining successful health outcomes for patients recovering from a cardiac event should be of interest to clinicians. Junehag, Asplundb and Svedlund, 2013 found standardized information given to patients upon leaving hospital was inadequate. Patients need ongoing timely support in their recovery to overcome personal crises. Thus, this study sets out to explore how nurses perceived their new roles as patient mentors and how integral they consider their part in the delivery of this home-based CR program. Although patients' perceptions of the mentoring experience in home-based CR has been reported previously (Frohman, Lin and Chaboyer, 2016), evidence from this study may assist others planning similar CR programs or other chronic disease programs in similar settings (Wood-Baker et al, 2012 and Brady et al., 2013). Nurse mentors delivering this program set out to improve patient access to CR and the transitional care of patients returning home from hospital and support patients in their efforts to reduce known cardiac risk factors via patient centred goal planning, feedback and monitoring. The aim of this research was

to explore mentor perceptions of their role in the delivery of a home-based CR program to patients by telephone.

3. Research methods

This interpretive study is part of a larger project using a case study research (Yin, 2009) methodology to examine the structures, processes and outcomes (Donabedian, 1992) of a home-based CR program conducted in three Tasmanian hospitals in Australia. As a whole, the case study sought to evaluate the quality of the program in terms of structures, processes and outcomes and both qualitative and quantitative data was collected. As part of this larger study, the perceptions of patients and mentors undertaking the home-based CR program were explored. This paper reports on nurses' perceptions of their role in the delivery of a home-based CR program for rural patients.

3.1 Sample and setting

The setting for this study was a home-based CR program, named the Aussie Heart Guide Program (AHGP) and was delivered mainly by telephone over a six-week period. AHGP nurse mentors were recruited from three Tasmanian hospitals. All nurse mentors were surveyed about their mentoring experience if they mentored a minimum of one patient who had completed the home-based CR program. All mentors were experienced CR nurses with a minimum of five years clinical experience working with cardiac patients.

3.2 The Aussie Heart Guide Program

The AHGP was adapted from the "Heart Manual" available in the United Kingdom (Lewin et al., 1992). It is an educational audiovisual resource modified for

the Australian setting in 2008 by the Australian Cardiovascular Health and Rehabilitation Association and publishers of the program audio-visual resources, Medical-Ed, Australia. The six week AHGP featured nurse ‘mentors’ providing CR to adult people living in rural locations and who were unable to attend a traditional hospital-based CR program. Nurses continued to undertake their normal work duties and responsibilities as well as mentor patients. Meetings with patients via telephone occurred during mutually convenient times and were completed mostly during normal working hours. Each mentor mentored no more than two patients at a time and was responsible for introducing the program to suitable patients once identified by other nurses or doctors.

3.3 Mentor Training

To upskill CR nurses in the AHGP and in particular, information about mentoring cardiac patients post hospitalisation, two eight-hour training workshops were conducted. The workshops included discussions about the mentoring role, patient centred care (PCC), and some basic training in cognitive behaviour strategies. A comprehensive paper based training manual was provided to mentors before the workshops outlining theoretical and practical components of the AHGP. Concepts relevant to skill development included learning about, motivational interview techniques, correcting patient misconceptions about coronary heart disease and lifestyle risk, goal setting and action planning to guide mentors in their efforts to provide a plan of care unique to each individual. Individualising care to the patients’ needs and preferences, a key aspect of PCC, was also an important part of the training. All training was standardised across all three hospital sites. Mentors conducted a face to face interview with each of their patients in hospital to discuss the home-based CR program prior to

hospital discharge and then provided information, support and guidance weekly via telephone calls.

3.4 Data collection

After all other case study data was collected, nurse mentors were surveyed via email about their experience of mentoring patients participating in the home-based CR. The mentor survey comprised nine open-ended questions, six of which focused specifically on the mentor role (Table 1). Mentors wrote their responses to the questions and returned them to the research team by email. Mentors preferred to be surveyed by email rather than being interviewed as a group because of the distance between hospitals and time constraints.

3.5 Data analysis

Thematic analysis (Baxter and Jack, 2008) was used to analyse the mentor survey data. Transcripts from the mentor survey were read and reread several times to understand meanings and gain an overall sense of the data. Data analysis occurred first within each transcript and then across transcripts. Line by line coding of the data was conducted with similarities and differences observed. Common ideas and patterns emerged from nurse mentor perceptions but unique ideas were also identified. Emerging codes were interrogated and interpreted to form subthemes, discussed and revisited by the research team until overall agreement was achieved and then further abstracted to reveal themes. These were further scrutinised by the research team.

3.6 Rigour

Trustworthiness of qualitative research data is commonly considered in terms of credibility, transferability, dependability and confirmability (Lincoln and Guba, 1985). In the current study, nurse mentors were recruited from multiple hospital

settings ensuring a broad representation of survey responses. Analyst triangulation (Patton, 2001) occurred via regular meetings with the members of the research team who ensured codes, sub-themes and final themes accurately reflected the data for transferability, credibility and confirmability. A code book and memos were written to document the analytic process including decisions about emerging sub-themes and final themes. An audit trail of the analysis also enhanced confirmability (Lincoln and Guba, 1985). Confirmability was facilitated by the research team adopting a reflexive approach (Barry et al., 1999) to find meaning from the research data. Direct quotations from the mentors enhanced the findings (Lincoln and Guba, 1985).

3.7 Ethical considerations

A written ethical approval to conduct this study was provided by the Human Research Ethics Committee of Griffith University and the Human Research Ethics Committee of Tasmania. Nurse mentors provided their consent in writing prior to being surveyed.

4. Findings

All seven nurse mentors agreed to participate and all provided responses to the survey. They were all female and their ages ranged from 27 to 55 years. Three interrelated themes emerged from the data analysis; identifying oneself as a mentor, mentor proficiency, and assisting patients to improve their health. A description of each theme supported by way of participant quotes is provided next.

4.1 Identifying oneself as a mentor

The theme 'identifying oneself as a mentor' reflected their transition from a traditional hospital nursing role to a mentorship role; working collaboratively with

patients to support their rehabilitation. It highlighted the importance of developing a partnership with patients based on mutual trust and collaboration, and being passionate about the merits of the home-based CR and CR in general. Persistence in encouraging patients to undergo lifestyle change was considered by mentors to be a critical aspect of their role as mentors. Mentors believed their role was integral to the success of the AHGP and viewed mentoring as a unique service to patients especially in terms of after hospital care. Experiences gained specifically from the collaborative relationships they formed with patients coupled with new skills they had acquired through program training, enhanced their previous level of knowledge and skills about CR. One mentor believed:

“It helped me learn about and understand the patient “journey”
beyond the hospital door.” (Mentor 4)

Mentors reported some challenges related to mentoring patients. They found some aspects of their work were mentally tiring and frustrating at times. Time constraints, lack of patient motivation or effort to engage with the program, and maintaining a meaningful relationship with patients solely via telephone contact were common sources of frustration:

“A feeling of frustration and failure occurred when the person
was unable to successfully make changes to their lifestyle.
I found the experience very emotionally draining at times.”
(Mentor 5)

However, the majority of mentors found their mentoring experience professionally rewarding:

“Satisfaction occurred when clients where able to make healthy choices and make changes to their lifestyles that they were able to commit to and maintain over time.”

(Mentor 6)

4.2 Mentor proficiency

The theme ‘mentor proficiency’ encompassed the knowledge, skills and strategies required to effectively deliver the program with the aim of improving patients’ health outcomes. Mentors reported the experiences gained from being part of the program improved their knowledge. In particular, insights from mentoring, coupled with the brief but specialised training in cognitive behaviour therapy enabled them to support patients during their recovery. Learning about motivational interviewing, individualising care, developing collaborative relationships with patients, exploring patients’ health beliefs and correcting their misconceptions relative to the patient’s illness helped shape their development as mentors. One mentor suggested:

“Being able to adapt the program to suit the individual person, and tailor it to suit the habits and interests of the individual was important.” (Mentor 7)

Mentors found a training and skills workshop improved their knowledge and understanding in relation to implementing a home-based CR program. Mentors provided examples of skills they thought they needed to master over time including:

“... active listening, open questioning, positive feedback, establishing, monitoring and evaluating patient health goals and motivational interview techniques.” (Mentor 3)

In understanding the home-based CR program, mentors acknowledged that as part of their skill set to be proficient as mentors, they needed to fully understand all theoretical and operational aspects of the program. In addition, mentors required up skilling in specialist strategies associated with cognitive behavioural therapy such as motivational interviewing, collaborative goal setting and motivating patients with demonstrated ambivalence towards making changes to unhealthy lifestyle behaviours:

“[Mentors need to] know the AHGP resource in-depth and importantly, be able to apply the principles of cognitive behavioural therapy to practical situations.” (Mentor 2)

4.3 Assisting patients to improve their health

Mentors perceived their role included ‘assisting patients to improve their health’ and well-being following a potentially life threatening illness. As a result of their discussions with patients, mentors better understood patients’ experiences throughout their recovery trajectory. An individualised or patient centred approach was used while in hospital and after discharge from hospital. Mentors assisted patients to identify at risk lifestyle behaviours and suggested strategies to overcome them in

collaboration with each patient. Helping patients learn about coronary heart disease to improve their understanding was considered a priority of the program according to mentors. Patients were encouraged to engage with the program's audiovisual resources to learn about coronary heart disease and follow mutually agreed treatment plans in order to understand how to reduce risks associated with unhealthy lifestyle choices. The ability of nurse mentors to facilitate learning by identifying and rectifying patient knowledge gaps was considered integral by mentors:

“Sound knowledge of cardiac rehab principles and cardiac risk factors, plenty of life skills and a large kit bag of heart health knowledge are needed to cater for individual patient differences.” (Mentor 7)

According to the mentors, positive improvements in patients' sense of wellbeing occurred more often when patients understood their illness, improved their levels of physical activity, received supportive counselling and mastered self help skills such as deep breathing and relaxation. One mentor suggested:

“Patient misconceptions about heart disease need to be corrected before they can learn to move forward and adopt the central role in their own health.”
(Mentor 2)

In contrast, despite encouragement and guidance from mentors, mentors reported some patients found it difficult to change unhealthy behaviours. It was challenging for some mentors to step back providing only support in order to let patients work through their decisions and self help strategies. Mentors recognised that there were

many barriers to patient's following treatment plans and maintaining the positive effects of smoking cessation, improving diet and levels of exercise in the long term.

One mentor explained:

"I was shocked at the disinterest some people showed in wanting to change their unhealthy lifestyles, but very satisfied when clients were able to make healthy choices and commit to maintaining them." (Mentor 5)

Mentors were also mindful that ongoing support networks for patients (ie. peer social groups, walking and exercise clubs etc) were needed in the community setting to encourage successful long term lifestyle change. Mentors also found that motivating patients to make better choices was at times a challenging aspect of their role as mentor. Patients with low levels of motivation often found it difficult to actively engage in self-care tasks, for example:

"While many patients made gains, some just could not be bothered or just did not believe change was possible."
(Mentor 5)

Some mentors reflected that they lacked the experience to assist ambivalent and or poorly motivated patients achieve their health outcomes and suggested additional training was needed to help mentors develop different strategies to assist such patients:

"More practical training is needed to overcome negative responses from patients." (Mentor 3)

Other mentors felt that building a good relationship with patients and contacting them regularly helped encourage most patients to strive for personal health goal attainment:

“Mentors can give patients hope and motivation to change poor lifestyle choices that may have impacted on their illness.” (Mentor 1)

5. Discussion

The study provided nurses with the opportunity to build on their existing CR knowledge and explored their role as patient mentor and facilitator of a home-based CR program to support patients recovering from myocardial infarction. The program challenged nurse mentors to move from a profession-centric (information and advice) to a patient-centric model of care (patient participation) (Berglund and Kallerwald, 2012 and Olsson et al, 2013). It was evident from the findings that nurses were able to develop their role as mentors by recognising and understanding their patient’s journey, particularly from discharge to home, bringing to light the highs and lows patient’s transcend during their rehabilitation post myocardial infarction. Interestingly, as identified by others (McCormack et al., 2010) mentors in this program reflected that professional competency concerning all aspects of CR and knowing oneself were important aspects and necessary to “buy into” individualising care, an integral aspect of PCC.

Mentors found the transition of adapting from coronary care nurse to that of nurse mentor challenging, which may relate to what others have described as

transition shock an integral and often dramatic process of role adaptation for nurses entering the profession (Duchescher, 2009 and Harwood, 2011). It has been described as a feeling of groundlessness due to the disconnect between what nurses understand about nursing and the impact of being faced with ‘real world’ nursing experiences (Duchescher, 2009). Moving from a standardised approach of patient teacher to a new role of shared decision-maker was difficult for some mentors initially but with experience, most mentors were able to adapt to their new role. Many welcomed the autonomy associated with working along side patients, providing support, advice and guidance while they undertook their rehabilitative journeys. This indicates the need to provide adequate training to the nurse mentors.

According to the findings, engaging the patient in their own care appeared to signify a major component of the nurse mentor’s initial work with the patient in hospital. Others have also found that the PCC promotes patient engagement and participation and this may translate to improvements in health outcomes (Lusk and Fater, 2013 and Institute of Medicine [IOM], 2013). A recent concept analysis of PCC found it was consistent with many nursing beliefs, attitudes and values with the ability of patient’s to engage and participate in their own care inextricably linked to the likelihood of positive patient health care outcomes (Lusk and Fater, 2013). Others have also highlighted the importance of patient participation in reducing stress, improving motivation and patient satisfaction with health care received and the important role nurses perform in encouraging and facilitating patient participation in their own care (Sofaer and Schumann, 2013 and Vahdat et al., 2013). Mentor findings in this study are consistent with previous research which confirms the importance of a PCC approach in the planning of transitional or post hospital care (IOM, 2013).

Mentors in this study found focusing on the patient as an “person” assisted them to develop competencies that compare favourably with other research (Ekman et al., 2011) where the concept of patient or person centred care represents a core competency for all health care providers in the context of providing excellence in quality health care (Boykins, 2014). In PCC, health providers respect individual patient differences, their values, needs and preferences. Specific attributes include behaviours of developing a relationship or partnership (McCormack et al., 2010 and Australian Commission on Safety and Quality in Health Care [ACSQHC], 2014) based on the patient narrative or experience (Ekman et al., 2011 and Wolf et al, 2014), effective listening and communication (King and Hoppe, 2013), patient access to teaching and learning (Clay and Parsh, 2016), respect and caring for the patient and maximising family involvement (Meterko et al., 2010 and Epstein and Street, 2011). Strategies such as attending to the individual physical and psychosocial preferences of patients, providing accessibility to care (IOM, 2013) and individualisation in terms of the continuation of after hospital care (Leone et al, 2012) are commonly reported in the literature.

Central to PCC and presumably mentoring, shared decision-making improves patient autonomy and makes patient empowerment more likely (Muller-Engelmann et al., 2011 and Ekman et al., 2012). Others have found PCC improves the perceived health care and satisfaction of patients (Ekman et al., 2012 and Lusk and Fater, 2013) and improved the hospital discharge process (Ulin et al., 2015). The findings from this study reflect that mentors found the concept of PCC a valuable tool in encouraging patient participation and engagement in agreed goals of CR care. Mentors also suggested a number of skills required mastery in order to become proficient in the role of mentor in a home-based CR program. These include establishing a trusting and

collaborative relationship with patients, planning, implementing and evaluating an individualised plan of care and providing the program's audiovisual educational resources to inform patient choice and improve understanding in terms of their future health goals.

While the written resources of the home-based CR program were standardised, mentors strove to tailor information and support to the individual by focusing care on each patient's specific health needs and their abilities to self manage. A recent systematic review of 515 unique studies (Taylor et al., 2014) discovered interventions aimed at improving the self management capabilities of people living with long term chronic disease were profoundly complex. In addition, support should be “multifaceted, tailored to the individual, their culture and beliefs and underpinned by a collaborative /communicative relationship between the patient and health-care professional” (Taylor et al., 2014, p.1). In terms of improving the patient's ability to self manage their condition, the mentoring approach used in this study appears to satisfy the core components of support. These include education about the condition, recognising what people already know about the condition, strategies provided to promote adherence to treatments, practical support tailored to specific activities of daily living, actions plans to monitor and treat recurrent symptoms and appropriate social support (Taylor et al., 2014).

It appears from the findings of this study that the nurse mentor role developed through the implementation of this home-based CR are similar to many of the constructs proposed in the Modeling and Role-Model theory of nursing (Erickson et al., 1983). This theory encompasses philosophical beliefs about people, environments, health and nursing and was synthesised from a number of psychosocial

foundational theories (Maslow, 1968 and Piaget, 1973 and Erikson, 1963 and Engel, 1962 and Selye, 1974 and Bowlby, 1968, 1973 and 1980) and include a number of assumptions about human needs, developmental processes, stress, loss, grief and adaptation. The nursing objective of MRM is to help patients achieve quality and holistic health. 'Modeling' refers to building a model of a patient's world through their eyes in order to gain an understanding of the uniqueness of their lives. A sense of this was obtained from the theme identifying oneself as a mentor in terms of acknowledging how the AHGP influenced the mentor role. According to Erickson et al., (1983), people are similar because of their holism, basic needs, psychosocial (emotions of attachment and loss) and cognitive development over their lifespan. Differences between people occur due to inherent endowment, their model of the world, stress, adaptation and potential to adapt and self-care knowledge, self-care resources and the mobilisation of self care action (Erickson et al., 1983). Most of the above elements surfaced in the mentor findings, where mentors openly described their role in providing both comfort and support and building on each patient's ability to identify their needs and adapt to changes in their lifestyle.

In 'role-modeling' the nurse uses the model of a patient's world to plan and develop interventions to meet their needs and expectations. The findings appear to support this assertion. This is accomplished by building trust, promoting a positive orientation and sense of control, building on strengths and setting specific mutually agreeable health directed goals. From the findings, it was evident that mentors designed a holistic plan of individualised care based on each patient's health needs and expectations. While rehabilitative trajectories for some patients were mixed or convoluted, mentors provided one to one ongoing support and guidance during the program and helped to foster self care strategies to enable them to move forward and

accomplish their health goals. Reinforcing agreed health goals and motivating patients through positive encouragement during their weekly telephone contacts represented key aspects of mentor work and reflected under the theme assisting patients to improve their health.

5.1 Limitations

While the findings of this study may lack generalisability because the sample was from one home-based CR program, mentors were able to share insightful information about their unique experiences that may be applicable to other programs that are offered in similar situations. Mentors were asked to write answers to questions and return them by email and this may have limited the amount of information provided by them but there was both breadth and depth to their responses. Interviewing the nurse mentors as a focus group rather than surveying by email may have also yielded other data, though organising this was considered difficult as mentors were located in different regions in Tasmania. Only females were in the sample and had there been male mentors involved in the study, other information may have also emerged. Also, data was collected from mentors at the end of their experience as a mentor. Perhaps other insights may have emerged had data been collected during the study.

5.2 Relevance to clinical practice

In this study, nurse mentors delivered a comprehensive home-based CR program to rural patients. Although most nurse mentors were able to adopt a PCC approach to ensure patient information and personal health needs were met, fostering a collaborative relationship with some patients by telephone was at times difficult to maintain compared with face-to-face meetings. Specific skills training such as

communicating with patients by telephone and additional training in cognitive behavioural strategies would have provided additional support for nurse mentors.

The findings of this research may also be of interest and applicable to other chronic diseases where other healthcare mentors may be suitably trained to deliver disease-specific programs to patients unable to attend centre-based services. Additional research using mentors in other areas of health may also provide information that would enable the development of a theory concerning the constructs that facilitate quality patient-orientated mentor programs.

6.0 Conclusion

The findings of this study provide new insights concerning the experiences of nurse mentors delivering a home-based CR program to patients recovering from MI. Nurse mentors' guidance and support provided to patients in the program to assist patients to transit from hospital to home shows promise as a new concept of CR care in Australia. It has potential to be further developed to not only assist patients living remotely from CR services but also offer an alternative choice for patients not wanting to participate in mainstream CR. Though emotionally challenging at times, mentors found their work of supporting patients after discharge from hospital professionally rewarding. A further large scale study in Australia is warranted to determine patient preferences for home or hospital based CR or normal care.

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Length of paper.

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