LONG-TERM CONDITIONS

Role of nurses in supporting patients to self-manage chronic conditions


Abstract

The burden of chronic illness is increasing globally as a result of increased life expectancy, unhealthy lifestyles, and advances in medical interventions and treatments. Therefore, people living with chronic conditions, and their families, will have to assume greater responsibility in managing such conditions. However, to do so they require appropriate support from healthcare services. This article explores some of the tensions that hinder the self-management of chronic conditions. It emphasises the importance of individuals and their families having the desire, and being enabled, to assume an active and decisive role in the management of chronic conditions. Nurses have a role in enabling patients to optimise their self-management skills, but organisational constraints in healthcare services, as well as constraints in nurse training and nursing roles, may mean that nurses are unable to fulfil this role. This article considers some of the factors that may limit the development of patient and nursing roles in relation to self-management of chronic conditions.

Keywords
chronic conditions, chronic illness, Florence Nightingale Foundation, health promotion, nurse training, self-management

CHRONIC CONDITIONS ARE the leading cause of mortality and morbidity in Europe. It is predicted that by 2020 they will be the main cause of death and disability globally, accounting for 73% of all deaths and 60% of the global burden of disease (World Health Organization (WHO) 2017). However, although the demand for care is increasing, the budget for care is not. Therefore, alternative ways of providing care are urgently required.

Managing chronic conditions is a complex process that is guided by the culture in which care is delivered, health policies, local service provision and available resources that are usually finance-dependent (McEvoy 2014). The focus of healthcare service policy is to encourage enhanced community provision and minimise the length of time individuals spend in acute care facilities (Department of Health Northern Ireland 2011, Donaldson et al 2014). Such policies make it necessary for people who have a chronic condition to take on increased responsibility for its management.

Self-management involves adopting lifelong treatment regimens and lifestyle changes, which can only be achieved if underpinned by appropriate skills and support. Barlow et al’s (2002) definition of self-management shows the range of skills that it requires: ‘Self-management refers to the individual’s ability to manage symptoms, treatment, physical and psychosocial consequences and lifestyle changes inherent in living with a chronic condition and to affect the cognitive, behavioural and emotional responses necessary to maintain a satisfactory quality of life. Thus, a dynamic and continuous process of self-regulation is established.’

It is acknowledged that there are many challenges for people with a chronic condition, which might be compounded by the increasing number of individuals who have more than one condition (Department of Health 2014). This article explores some...
of the tensions that may limit individuals’ self-management of chronic conditions. It also discusses how nurses can support people with chronic conditions to optimise their self-management skills.

**Enduring use of the acute medical model**

The concept of chronic illness management remains hindered by the enduring use of the acute medical model in healthcare. This approach to care focuses on providing biomedical treatments; treating the illness rather than the person who has the illness (Sacristán 2013).

The acute medical model of care does not take into account fully the social, psychological and behavioural dimensions of chronic illness (Tinetti and Fried 2004) and often does not include continuing care. It is not broad enough to account for, or promote, understanding of the stressors experienced by many people with a chronic condition that might affect self-management (WHO 2005).

Szasz and Hollender (1956) were among the first to provoke debate about the differing roles for patients and clinicians according to whether the presenting health issue was acute or chronic. The WHO (2005) has consistently emphasised that healthcare for people with chronic conditions ‘requires a fundamental change in perspective from the familiar approach, which evolved out of treating acute illnesses’. This issue is well recognised, but change in this area has been slow. New approaches are required and several models have been proposed in England, such as:

- **Multi-specialty community providers** in which ‘groups of GP practices would come together to offer a broad range of services, including community and outpatient services’ (Collins 2016).
- **Primary and acute care systems**, in which ‘a single entity would take responsibility for delivering the full range of primary, community, mental health and hospital services, to improve co-ordination and move care out of hospital’ (Collins 2016).

To implement these models, acute and primary care budgets and healthcare services need to be integrated. Although considered a vanguard model in England, the primary and acute care systems approach has been used in practice in Northern Ireland since 2007. However, there are enduring tensions in relation to conventional practices and the allocation of budgets in Northern Ireland, which illustrates that the approach is neither a simple solution, nor a panacea, for the management of chronic conditions.

**Changing roles for patients**

An issue that is fundamental to the future of self-management is a change in philosophy, in which patients are actively involved in their care, decision-making and problem-solving. This is as opposed to patients assuming a passive, traditional role, in which they follow the directions of clinicians (McEvoy 2014). This change in philosophy presupposes that patients are willing to become increasingly involved in decision-making and are enabled to take on greater responsibility for managing their health. This requires some negotiation, because many patients tend to adopt a passive approach to self-management (Coates et al 2015). The challenges that need to be overcome to enable patients to fulfil different roles have been explored in a previous article in this series (Baillie 2016).

**Knowledge and other factors associated with self-management**

It is generally acknowledged that the patient’s knowledge about their condition and how to manage it, is a prerequisite for optimal self-management. This is the focus of much healthcare in relation to preparing people to manage chronic conditions (Williams 2010). While providing appropriate information should be the starting point, knowledge alone is not enough to enable optimal self-management. It is important for patients to learn how to articulate their needs and locate and analyse health information from a variety of sources, and to have increased knowledge of the role of healthcare professionals and available treatments. Suboptimal health literacy will prevent many patients from taking an active role in the management of their condition, even if they want to do so (Berry 2016).
Research regarding patients’ adherence to management plans has shown that many cannot, or do not, make behavioural changes to support effective management of their condition. For example, there is a substantial literature base to indicate that taking prescribed medications (Dunbar-Jacob et al 2000, Brown and Bussell 2011), attending appointments for monitoring conditions (Department of Health 2016), and adopting healthy lifestyle behaviours to change diet or exercise patterns (The King’s Fund 2016) can be challenging for patients. While these areas present challenges for patients, they are essential to ensure optimal self-management of chronic conditions.

Ahola and Groop (2013) identified a range of individual and environmental factors associated with self-management of diabetes, as an example of a common chronic condition. Some of these factors included: knowledge, empowerment, health literacy, motivation, depression, anxiety, co-morbidities and lifestyle. Ahola and Groop (2013) concluded that effective self-management is a continuous process that aims to promote health and quality of life. The list of factors that might support or hinder effective self-management indicates that preparing the patient to self-manage, beyond the provision of information, is vital.

Lorig and Holman (2003) suggested that people with a chronic condition require a core skill set, comprising: problem-solving; decision-making; effective use of resources; ability to participate in patient-provider partnerships; capacity for action planning; and self-tailoring. Self-tailoring describes knowledgeable, skilled individuals applying decision-making and problem-solving skills to optimise the management of their condition. Although these skills are important to support self-management, they are not always evident among patients with a chronic condition (Coates et al 2015).

The WHO (2005) also recommends that patients have a range of cognitive and behavioural self-management skills, including:

> Self-monitoring.
> Environmental modification, for example developing a context to maximise success.
> Self-reward.
> Arranging social support.

Lorig and Holman (2003) and the WHO (2005) asserted that providing clinical information about specific conditions is not adequate to support effective self-management; however, other research indicates that access to education and support remain an issue (Speight 2016).

**Changing roles for nurses**

**Power dynamics**

If patients with chronic conditions are to achieve the self-management skills and abilities described by WHO (2005), the ways in which nurses prepare patients for long-term self-management should also change. It has been suggested that: ‘The role of the healthcare professional should change from experts who care for patients to enablers who support patients to make decisions’ (Marshall and Bibby 2011). However, Snow et al (2013) demonstrated that healthcare professionals can find knowledgeable patients challenging. They suggested that the power imbalance between clinicians and patients needs to be addressed if the goal of patients making self-management decisions is to be achieved in practice.

**Perceptions of the nurse’s role in self-management support**

van Hooft et al (2015) investigated the ways in which nurses perceived their role in self-management support and identified four distinct perspectives: the coach; the clinician; the gatekeeper; and the educator. These findings illustrated that there is no single interpretation of self-management support. Furthermore, nurses may need to employ different support strategies for different patients, since one approach will not be effective for all patients.

For example, if the nurse adopted a coach perspective to support the self-management of a patient with rheumatoid arthritis, the patient would be recognised as the expert on their condition because they live with the condition daily. The
patient would take the lead on healthcare decisions, and the nurse would support them to integrate management of the condition into their daily lives. However, if the nurse adopted a clinician perspective, the starting point would be supporting the patient to adhere to the treatment regimen, alongside regular monitoring of the condition. The primary goals would be to achieve optimal medical outcomes rather than personal goals, and self-management support would be organised to achieve these primary goals through adherence to prescribed treatment.

In contrast, a nurse adopting a gatekeeper perspective would encourage a patient with rheumatoid arthritis to become independent of healthcare services. For example, one nurse in van Hooft et al’s (2015) study stated: ‘As a nurse you have a societal function. You have to defend general interests in health care, and health care should remain affordable for a lot of people’. Each encounter with the patient would aim to promote self-management, seeking solutions to issues, such as relieving pain, joint stiffness or fatigue.

A nurse adopting an educator perspective would collaborate with the patient to ensure they are able to manage potential situations and challenges related to their chronic condition. According to one nurse in van Hooft et al’s (2015) study: ‘You have to make sure someone is capable of managing himself, which is my goal. Then you don’t have to be available at all times.’ For a patient with rheumatoid arthritis, use of the educator perspective would prepare the patient to manage exacerbations of their symptoms without needing to consult the healthcare team in the first instance.

van Hooft et al (2015) acknowledged that it could be challenging for nurses to know the most appropriate perspective to use in a given situation, and nurses may not be prepared to do so. The clinician perspective is usually the dominant approach, and it may be challenging for educators and some service providers to achieve a refined approach to the promotion of self-management of chronic conditions.

**Expanding competence**

The competencies of the nursing workforce at general and specialised levels continue to be relevant and important. However, these competencies need to be expanded to develop a broader or more strategic approach to self-management of chronic conditions. To extend self-management support beyond knowledge provision, associated with the clinician perspective, nurses and the wider healthcare workforce should be prepared to expand their competence.

Facilitating patient empowerment is one example of how nurses can expand their competence. Empowerment is a process that enables patients to change their health behaviours and is an important aspect of self-management (Ahola and Groop 2013). However, nurses are not routinely equipped to facilitate the empowerment process. Anderson and Funnell (2010) asserted that: ‘Embracing empowerment means making a paradigm shift that is often difficult because the traditional approach to care is embedded in the training and socialisation of most healthcare professionals.’ However, it is generally recognised that nurses are already working to full capacity. Therefore, there would be implications for the healthcare workforce if nurses’ roles were to be expanded.

**Service organisation**

The ways in which healthcare services are organised and provided should be challenged. The current system is not ideal, because it usually entails patients seeking specialist expertise in an outpatient setting, governed by appointment schedules that may constrain rather than enable a comprehensive patient-centred approach. For example, expertise and time will be required by those involved in delivering healthcare services, to adapt the management of a condition to take account of contextual and cultural issues, offer patients options and allow for patient preferences, discuss potential barriers to self-management and seek solutions to challenges. Time and resources should be invested to enable changes to be made. This will require shifting resources.
from acute to community settings and modifications to the competencies and roles of nurses. Achieving such changes when the healthcare workforce is already under significant pressure is another area of tension, with the potential to limit the development of change (Douglas 2011).

**Conclusion**

Many changes are required to enable the shift from a model of care based on the treatment of acute illnesses, led by healthcare providers, to a patient-centred model of care. In particular, changes in service provision, nurse preparation and continuing professional development are required. These ideas are not new, but evidence of change across the healthcare workforce has been slow to emerge. Some of the tensions that might hinder change include the enduring use of the acute medical model of care, and complexities in adjusting the allocation of funds between acute care and primary care. These tensions, among others, should be addressed before significant progress in the self-management of chronic conditions can be achieved. Changes could include: promoting health literacy among patients with a chronic condition beyond the provision of information about its clinical management; enabling people with a chronic condition to develop core skills to sustain behavioural change; and expanding nurses’ roles in supporting self-management.

**References**


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