EVIDENCE ON SELF-CARE SUPPORT WITHIN COMMUNITY NURSING

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ABSTRACT Macduff, C., Sinclair, J. (2008) Evidence on self-care support within community nursing. Nursing Times; 104: 14, 32–33. Supporting self-care is a core element of community nursing in Scotland. This study examined the nature and extent of support for patient self-care in community nurse casenotes of patients with one or more of six long-term conditions. It revealed considerable variation in written evidence. There is scope for more systematic consideration of support for self-care in community nursing casenotes.

INTRODUCTION

UK health policy advocates the promotion of self-care to improve health, particularly for patients with long-term conditions (Department of Health, 2005).

Self-care comprises everything people do to maintain health, prevent illness, seek and adhere to treatment, manage symptoms and side-effects, accomplish recovery and rehabilitation, and manage the impact of long-term illness and disability (Alliance for Self Care Research, 2008). Professional support for self-care ranges from facilitation (such as setting up the conditions for self-care) to actively enabling self-management (such as joint goal-setting and follow-up).

Although supporting self-care is a core element of a redesigned community nursing model in Scotland (Scottish Executive Health Department, 2006), little is known about support for self-care provided by community nurses for patients with long-term conditions.

This article aims to address this gap, focusing on district nurses and family health nurses (FHNs). Family health nursing was introduced in Scotland in 2001 (Macduff, 2007). The role is multifaceted and aspires to help individuals, families and communities to cope with illness and improve their health. A literature review was undertaken (for details see www.nursingtimes.net).

STUDY RATIONALE AND AIM

There is little evidence on Scottish community nursing practice in supporting self-care for patients with long-term conditions or about which elements of practice are useful. Our team is researching nursing practice in three sites, each of which uses different nursing models:

- Orem’s (1971) self-care deficit model, which aims to guide nurses to identify gaps in self-care and optimise patient behaviour;
- Roper et al’s (1983) activities of daily living model, which guides nurses to assess, plan, deliver and evaluate care in relation to 12 activities;
- A family health nursing adaptation (Macduff, 2007), which guides nurses to assess family resources and coping strategies in response to threats to health.

The main aim was to clarify the nature and extent of support for patient self-care recorded in nursing casenotes. The study also sought to compare the potential of the three nursing models to support self-care.

METHOD

A total of 124 patients on district nurse or FHN caseloads who had one or more of six long-term conditions – diabetes, depression, dementia, heart failure, multiple sclerosis (MS) and leg ulcer – and were not acutely or terminally ill were invited to take part. The invitation asked patients or, where they lacked capacity to consent, a welfare guardian or relative, to consent to the research team reviewing their nursing notes. A data collection form for extracting information from the notes was developed using criteria relating to each element of the nursing process. Similar criteria were also developed to assess elements of Glasgow et al’s (2002) self-management model, which comprises five areas to help patients with action planning: assessing; advising; agreeing goals; assisting; and arranging plans for follow-up.

RESULTS

A total of 54 patients (44%) consented to their casenotes being reviewed and 47 sets of notes were accessed.

FHNs typically used casenotes based on an Orem adaptation, rather than those developed by Macduff (2007), which were only used in two cases. Evidence of support for self-care varied considerably, although some common practices were seen.

Consideration of self-care was most often evident within assessment structures and processes. Where an assessment structure directly addressed self-care, it was more likely to be explicitly considered in both assessment and planning.

This typically involved considering...
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patients’ and/or carers’ self-care abilities, needs and/or dependencies. Some of the best notes also addressed patients’ and carers’ understandings and motivations, and the consequences for self-care capacities.

While self-care was most often explicitly considered in assessment, this was often as a one-off episode, with formal reassessment or updates relatively rare. A few notes contained no evidence of formal assessment.

Evidence of planning that considered self-care was more mixed. In a few notes, there was explicit consideration of patient and/or carers’ roles, aims/goals, and nursing care planned to support activities related to them. However, there was rarely evidence of explicit discussion or agreement between nurse and patient or carer. More often there was little or no consideration of patient or carer roles and associated nursing support activities. The focus was predominantly on nursing tasks or procedures.

The intervention and evaluation aspects of the nursing process were considered together, and evidence relating to self-care tended to be absent from casenotes. In some notable exceptions, there was substantial consideration of the extent to which interventions affected patient and/or carer roles, and how those fit with aims or goals. These also considered the need for reassessment of goals and/or the nature and extent of nursing support. Much more often, there was little or no consideration of the impact of nursing support on self-care.

The written evaluation of care was typically a list of tasks. It was relatively rare to find any analysis of why a situation or a pattern of events had developed and how this might influence a future care plan.

The advise, assist and arrange stages of Glasgow et al’s (2002) model are broadly analogous to the intervention and evaluation phases of the nursing process. Evidence of these three stages tended to be patchy. Evidence of providing advice on health risks and benefits of change tended, at best, to focus on information-giving (for example, on warfarin procedures).

Evidence of nursing assistance tended to reflect social or environmental support rather than personal barriers and/or strategies.

Follow-up was one of the most difficult stages to judge. While there was usually at least a minimal plan for patient follow-up (such as a blood sample or clinic visit), it was often hard to know to what extent this might also involve self-care needs.

**DISCUSSION**

A specific focus on self-care in community nursing casenotes can be useful, especially in the assessment and planning stages.

The Orem model adaptation addressed self-care most overtly and frequently, while the Roper et al adaptation did so more implicitly. The presence of an explicit self-care framework did not guarantee its use.

This is perhaps not surprising. There are many influences on nurses’ behaviour in documentation, including motivation, knowledge, staffing levels, case mix, skill mix, morale, leadership and the constraints of writing in notes kept in patients’ homes.

This small study found little evidence relating to community nursing practice in supporting self-care. The priority is to build knowledge of what is actually happening.

In effect we created operational definitions of support for self-care for the four stages of the nursing process and the five stages of an influential self-management model.

The resulting approach necessarily involved subjective judgements. Although we identified and resolved some differences in interpretation and categorisation, the tools developed for this study remain ‘works in progress’ that would benefit from further development and testing. There are limits to what can be inferred about nursing practice from nursing notes alone. The ongoing wider study will provide a more rounded picture.

Although there was variation across long-term conditions, the casenotes of patients with MS tended to contain more explicit consideration of self-care across more phases of the nursing process. This was somewhat lower in younger patients, which may have influenced nursing considerations, while some had considerable self-advocacy skills that influenced their expectations of service.

The example of patients with MS also raises questions about whether their notes tended to ‘score higher’ simply because they, typically, had complex health issues and an uncertain disease process. However, some of these patients were relatively independent of nursing input, despite substantially debilitated health. This raises the question of what sort of self-care consideration (nature, frequency and depth of engagement) nurses should be expected to give patients and carers. One view is that assessment then purposive engagement will prevent future problems, while another sees self-care as signifying the point at which nursing input should be stopping.

**CONCLUSION**

There is significant potential for community nurses to support more patients to self-care but it is not clear whether there is or will be the service capacity to engage substantively at these levels. More consideration of the criteria for engaging with patients to support self-care and enable anticipatory care approaches is needed.