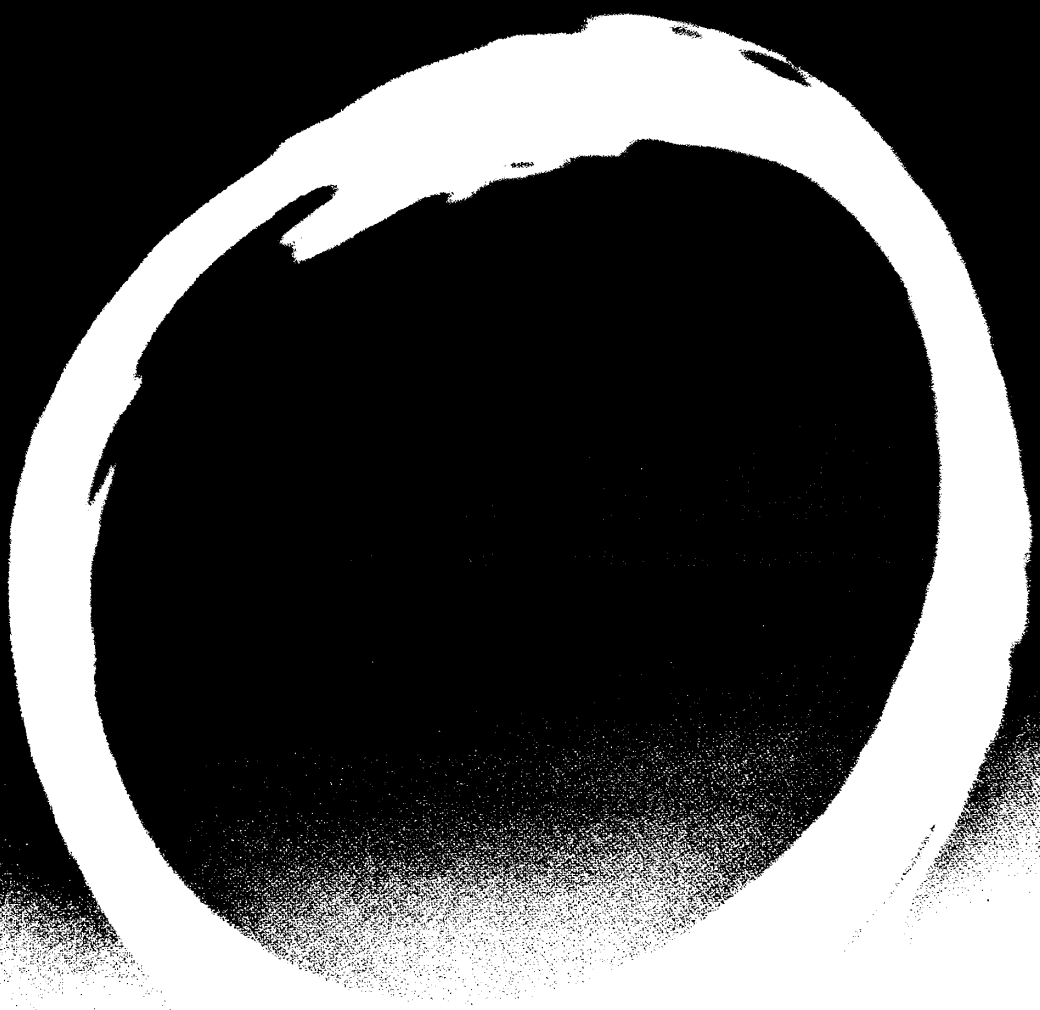
Self-care

Application in practice



Glenfield Hospital NHS Trust

KING'S FUND CENTRE

Nursing Development Units

Self-care

Application in practice

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Foreword

It is always refreshing to be a part of a group of nurses who are seriously reconsidering their practice, who are exploring their philosophies and identifying that which is central to the tenets of good nursing care. Such close examination of our work is essential if practice is to meet current needs, and one of the joys of a Nursing Development Unit (NDU) is that time and some resources are made available to do just that.

Glenfield NDU has used this opportunity well. The following text describes the best of self-care and illustrates superbly, through individual case studies, the very real and positive difference in outcomes in care which can be achieved by adopting the principles of self-care. The booklet also offers excellent examples of well researched, well written nursing processes and should be used as an educational tool.

Achieving consensus is not easy in any group. However, Dr Furlong has skilfully interwoven the expertise of those practitioners who participated in the collaborative conference with agreed overall professional principles. The resulting publication has given the nursing profession examples of focused care planning which are applicable across all specialities and sectors.

It was a delight and a privilege to chair this group, and I hope that our discussions stimulate further debate in the continual striving to improve patient care.

Professor Veronica Bishop

Department of Health, Leeds

one Introduction

Aim of the booklet

The aim of this booklet is to describe how the concepts of self-care are applied to nursing practice. It is hoped that the booklet will provoke discussion, through which a broader understanding of self-care will be reached.

Why is self-care of interest?

Patients' expectations of health care are changing. Increasingly, patients are demanding and are taking more control of their health care. This phenomenon has been termed 'self-care' (*Chang, 1980*). Self-care appears to have arisen out of a dissatisfaction with, and rejection of, the paternalistic approach to health care (*Hill and Smith, 1985*), in which the patient was treated as an ignorant and passive recipient.

Self-care represents a new approach to health care. Its focus is upon wellness, not disease (*Kinlein, 1977*), and it is one of the concepts to have emerged from the holistic approach to healing (*Chang, 1980*). Nursing was the first health care profession to embrace self-care (*Hill and Smith, 1985*). The approach, which acknowledges individuals and their needs, is reflected in modern nursing ideology (*Burns, 1994*) and the four simple concepts of self-care (**Table 1**) have been incorporated into several nursing models (for example, *King, 1981*; *Orem, 1991* and *Roy, 1984*).

Interpretation of the concepts of self-care

In theory, patients play an active and central role in a self-care approach. Their care is individualised and they are empowered to take an active and informed part in their care. In practice, the concepts of self-care are open to misinterpretation. For example:

- Nurses may unwittingly coerce patients to self-care because they consider that patients should do so.
- Without proper explanation and consultation, patients may feel obliged to self-care and may consider that nurses have become lazy and uncaring.
- Relatives may feel that the burden of caring has been forced upon them and that they are being asked to make up for a shortfall in the number of professional carers.
- Through encouraging patients to become more self-reliant, managers may see a self-care approach as a way of reducing costs.

A self-care approach, in which patients are encouraged to do more for themselves, could, therefore, easily be viewed as a 'cheap option'. Part of the difficulty in interpreting the concepts of self-care appears to arise because few operational definitions exist explaining how the concepts can be applied in practice.

What does this booklet offer?

The booklet is based on a consensus reached by a group of nurses, all expert practitioners of self-care, who attended a collaborative conference in March 1994 to consider two questions: 'What is self-care?' and 'How can self-care be recognised in practice?' The booklet comprises three types of information:

- An operational definition of self-care, including a detailed description of the constituent steps of a self-care approach.
- A description of visible factors indicative of a self-care approach.
- Examples of applications of self-care.

It is anticipated that this booklet will be of interest to community and hospital based nurses.

For reasons of clarity, the word 'patient' is used in this booklet to mean 'patient' or 'client'. The group reached its decision by following the example set by *The Patient's Charter* (1991). Where the pronouns 'he' and 'she' are used, the group decided to remain with tradition. The patient will be referred to as 'he' and the nurse will be referred to as 'she.' However, the assignation of gender will be avoided as far as possible by the use of the plural pronouns 'they' and 'them'.

Table 1

The concepts of self-care

- ✓ **The individual is responsible for his own health**
- ✓ **The individual takes ownership of his own health**
- ✓ **If help is needed, it must be actively sought**
- ✓ **Any intervention should aim to achieve self-care**

Mullin, 1980

two The collaborative conference

Objectives of the study

This study sought to explore the meaning of self-care among practitioners who had adopted this approach. The method used was based on two commonly used techniques:

- Consensus conference (reviewed by *Hingel, 1993*)
- Delphi Technique (reviewed by *Goodman, 1987*)

and was referred to as a collaborative conference.

Study design

The collaborative conference comprised three distinct stages:

Stage 1 Selection of participants

A group of 15 nurses, from various disciplines, was selected opportunistically. Each member of the group was identified and nominated by their Director of Nursing (or equivalent) and was considered by their peers to be an expert in self-care. Following nomination, each nurse was approached directly and invited to participate in the study. Unfortunately, due to other commitments, three nurses felt unable to participate and the final group comprised 12 members (Appendix 1).

Stage 2 The collaborative conference

The purpose of this study was to encourage discussion among nurses, from various disciplines and geographical locations, on the nature and format of self-care. It was, therefore, considered that the best way to achieve this was to invite participants to meet face-to-face. The conference provided a forum that facilitated discussion about self-care, and enabled the group to reach a consensus and to produce a conference statement outlining their conclusions.

The conference lasted for one day and was divided into two sessions. The discussion was aided by two facilitators, who took notes, and was led by a chairperson (Appendix 1).

To focus the discussion, a question was posed at the beginning of each session:

Session 1 What is self-care?

Session 2 How can self-care be recognised in practice?

At the end of the day a summary of the group's conclusions (a working conference statement) was formulated.

Stage 3 Revision of the conference statement

To overcome the difficulties of bringing the group together on several occasions, and to overcome some of the problems of using a committee decision-making process (discussed by *Goodman, 1987*), it was decided to seek comment on the conference statement by post. Revisions were made in accordance with the group's recommendations. The facilitators formulated a report from the working conference statement, which was sent to all participants for comment and amendments. All the original group members participated in the revision stage.

The following chapters summarise the group's conclusions.

three What is self-care?

The conference participants answered the question posed in the first session (What is self-care?) by addressing three factors:

1 Self-care and society

2 A definition of self-care

3 Application to practice

Self-care and society

Self-care has been discussed widely in relation to both health and society (see, for example, *Schiller and Levin, 1983*). The concept of self-care extends beyond health care and is a reflection of the current philosophies of our society. Indeed, *Linn and Lewis (1979)* considered that self-care was a reflection of general economic, social and political concerns.

Our society values the individual and encourages self-reliance. This is manifest in the emphasis placed on the individual in recent government policy documents such as *The Citizen's Charter* (1991), *The Patient's Charter* (1991) and *The Health of the Nation* (1992). The concepts of self-care are also fundamental to current nursing theory, policy and practice. For instance, modern nursing theory emphasises individuality and individuals' rights in controlling their own bodies (*Hill and Smith, 1985*).

The individual is highlighted in the most recent nursing policy document, *A Vision for the Future* (1993). Indeed, two of the 12 nursing targets identified relate specifically to patient involvement and individualised care.

Many practitioners of nursing have rejected the notion that the patient is a passive recipient of care. The focus of nursing care has shifted away from a task-oriented approach towards a consideration of the needs of individual patients.

Conference participants identified two factors that they considered encompassed self-care:

- Empowerment
- An acknowledgement that everyone has the right to self-care

and concluded that these factors are essential to the successful application of self-care in practice.

A definition of self-care

Each member of the conference group was asked to write a definition of self-care (Appendix 2). The definitions, which reflect personal beliefs and clinical background, were pooled and used to formulate the following definition:

> 'Self-care is a process, based on assessment and informed choice, whereby patients are helped to achieve optimal care for themselves. Patients are supported by others, who follow an agreed, individualised plan to provide holistic care.'

The constituents of a self-care approach

In health, implicit within the phrase 'self-care' are two assumptions. First, that a shortfall (known as a 'care deficit'), or a potential shortfall, in someone's ability to care exists and, second, that the shortfall needs to be realised or prevented.

A person's ability to self-care is dependent upon his social, psychological and physical environment (*Ling, 1989*). For example, the stress of hospitalisation and treatment can hinder an individual's ability to self-care so that recovery is impeded (*Biley, 1989*). Many people feel they have to give up their right to self-care when they require health care. Indeed, patients are frequently encouraged, or even required, to do so. People appear to behave in a submissive manner when they come into contact with health professionals, because they have come to expect a paternalistic approach – that is, they expect an unequal relationship in which the health care professional is dominant and they are subservient (*Rankin and Stallings, 1990*). Such a system of health care actively encourages patient dependence. This activity appears to be based on the assumption that patients are incapable of making decisions concerning their care (*Biley, 1992*).

The notion of the patient as a passive recipient of care is rejected in the self-care approach. Emphasis is placed upon patients and their needs as individuals. The purpose of a self-care approach in health care is to encourage patients to remain or to become independent (either as independent as possible or as before) if they are able and so wish. Therefore, a self-care approach offers the patient the opportunity to stay in control.

However, not all patients wish to self-care and in order to avoid coercing them against their will, they must be allowed to make a conscious choice to self-care (*Waterworth and Luker, 1990*).

A self-care approach has six constituent steps:

(i) Joint assessment
(ii) Information-giving
(iii) Negotiation
(iv) Planning
(v) Caring
(vi) Joint evaluation

The patient, the nurse and possibly other care agents are involved at each stage. Specific activities are associated with each constituent of the self-care approach and these are listed in **Table 2**. In the following sections each constituent of the self-care approach will be discussed in turn.

(i) Joint assessment

The purpose of joint assessment is to enable the patient and the nurse to reach a common understanding of the patient's problems, needs and priorities. It has two main functions: to find out what is normal for the patient and to decide how their current situation differs from their norm.

Example

A resident in a mental health unit was prone to frequent bouts of challenging behaviour. As a result of a self-care initiative, following a joint assessment, the patient was moved from the hospital ward to a warden-controlled bungalow where he was given more freedom. The patient subsequently took on more responsibility for himself and the frequency of the bouts of challenging behaviour decreased.

Some patients, for example those who have been admitted for an elective surgical procedure, may not have a current care limitation. Instead, potential future limitations need to be predicted and, possibly, prevented.

Most units use a standard assessment tool to facilitate joint assessment and, in recognition of the different needs of each, some use different tools according to whether a patient is admitted for an elective procedure or as an emergency.

Table 2

The six constituents of a self-care approach and their associated activities

Constituent	Associated activities
Assessment	Introduction
	Building rapport
	Collection of baseline data
	Identification of the patient's needs and expectations
Information-giving	Offer written and verbal information
	Avoid jargon
	Make sure that the patient understands that a self-care approach is advocated because the nurse cares about his well-being
Negotiation	Facilitate informed choice
	Encourage patient ownership of care
	Forge a dynamic contract, that is, adopt a flexible approach
Planning	Patient-centred and patient-owned
	Lay down, in written form, what the patient and the nurse will do
	Team-centred, multi-disciplinary approach involving external agencies as appropriate
Caring	Application of relevant knowledge to provide appropriate care
	Multi-disciplinary. May involve the patient's relatives
Evaluation	Patient empowerment
	Reflection
	Determination of the value of care inputs

Standard assessment tools can have disadvantages, however. For example, they may contain questions that are irrelevant to some patients. Attempts to overcome this include the patient narrative approach. Here, no standard assessment tool is used. Instead, the patient tells a story and the nurse prompts him to obtain additional information. This approach minimises the amount of information that is collected but not needed. The patient narrative approach is based on what the patient considers to be important, which is a fundamental part of a self-care approach. Without determining the patient's perceptions and priorities, the self-care approach will not succeed, particularly if change is needed. Unfortunately, this approach may also mean that some problems that patients could be helped to address are missed because they are unaware that anything can be done about them. Therefore, it may be more appropriate to combine aspects of the standard and patient narrative approaches.

Joint assessment is often considered a time-consuming process. Indeed, this can be the case: it takes time to determine the patient's care limitations. However, the time investment can have a payback. Time spent on determining what patients can, and would like to, do for themselves during assessment can be saved later. For example, situations where the nurse does something for a patient only to find that he can do it for himself can be avoided.

Example

A patient with Parkinson's Syndrome was admitted to hospital. The patient's condition was adequately controlled by the regular administration of drugs, which she took herself while at home. When in hospital, the patient's nurse took her drugs away. As a result, the patient received her drugs through the traditional drug round and often received them late. The patient's condition became less well-controlled. Through a process of negotiation between the patient and her nurse, a self-medication programme was developed. The patient was able to continue taking her own tablets while in hospital and her condition remained well-controlled on future visits.

(ii) Information-giving

Patients need information in order to make informed choices about their care. One of the major roles of a nurse caring within a self-care environment is to educate and support the patients for whom she is caring. Teaching and educating are relatively time-consuming activities. Teaching someone to do something for themselves, for example, takes longer than doing the task for them.

Example

A patient with infective endocarditis was admitted to hospital. Over the patient's six-week hospital stay, the nurse and patient worked together, following the patient's individualised care plan. Through education and knowledge assessment, the nurse was able to help the patient understand how infective endocarditis is contracted, so that by the time he was discharged he was fully aware of what he needed to do to avoid contracting infective endocarditis again.

The information given to patients must be specific and appropriate to their needs, not what nurses consider to be important. The appropriateness of the information, therefore, depends on the efficacy of the assessment process. During assessment, the patient's needs and wishes should have been determined.

The educative process does not often begin until the patient is admitted to hospital. To enable patients to make informed choices, therefore, nurses will generally need to spend a lot of time teaching and educating them when they first meet. This may mean that patients are bombarded with a lot of information in a short space of time. As a result, they may be unable to assimilate all the information they receive, so that they are unable to make an informed choice.

In addition, patients are often anxious. There appears to be a relationship between anxiety and an ability to absorb information (*Litt, 1988*). For instance, mild to moderate anxiety may be conducive to learning, whereas high levels of anxiety may inhibit learning (*Janis, 1958*, cited by *Rankin and Stallings, 1993*). If joint assessment is done well, nurses will be better placed to determine the patient's anxiety level and will, therefore, be able to act accordingly.

One way of enhancing the patient's ability to make an informed choice, while overcoming the time constraints of a hospital stay, is to begin the information-giving process in the community. Some units have introduced a system of pre-admission ward visits and discussions to help to prepare patients. Written information is provided to enhance and complement such discussions, since statistics show that we only remember 10% of what we hear (*Wong, 1992*). Nurses need to consider literacy skills when designing written and visual information, since 16% (one in six or 6.5 million) of the adult population of England and Wales has a literacy problem (*Adult Literature and Basic Skills Unit, 1994*). Patients with visual or hearing impairments, or those unable to read or speak English, need additional considerations. Several units now provide information in a variety of languages.

Some are also experimenting with tape recorded information and large print books. However, such ventures require additional time, resources and finance that may not always be available.

Information given to patients at pre-admission clinics can encourage them to ask questions concerning procedures and care on admission. The amount of information and education given to a patient must be realistic. It should be tailored to meet both the patient's needs and their length of stay.

Consequently, the nurses' approach to information-giving varies according to the patient and to the situation. For example, there may be little time prior to their procedure to provide information to patients attending as a day case. This can be overcome in two main ways:

- Information can be provided at a pre-admission clinic. However, this approach may require additional resources and staff. In addition, patients may be required to make an extra journey to hospital. This may not be a convenient or financially viable option for them.
- Information-giving can be prioritised so that prior to his procedure the patient is given a small amount of information tailored to his needs, followed up by more information post-procedure, if necessary.

Example

In response to the short amount of time that nurses have to prepare day-surgery patients for their procedures, a day-surgery unit now runs pre-admission clinics to educate and prepare patients before they come into hospital for their procedure. Patients learn about several aspects of their care, including the sensory experiences they may have post-procedure, for example pain and nausea. Patients are also given advice for discharge, for example wound care advice. By providing information before admission the patient is able to return rapidly to normal after discharge.

(iii) Negotiation

Negotiation ensures that the patient and the nurse agree on the care that is to be given. Without negotiation it would be easy for the nurse to coerce patients, since they often ask questions such as, 'What do you think I should do?' When coupled with information-giving, negotiation ensures that patients are making informed choices about their care.

In an ideal world, the purpose of a self-care approach would be to facilitate the patients to overcome all their care limitations. However, this may not be realistic. For example, time or resources may not be available. The purpose of negotiation is, therefore, to strike a balance between what the patient would like to achieve and what is realistically possible. If patients are unable to negotiate for themselves, another person (often a relative) usually acts on their behalf.

In some circumstances there is little room for negotiation. For example, patients are often expected to comply with specific post-operative regimes. If the patient remains in hospital during this time, then nurses have more opportunity to stress the need for compliance with the recommended regime. If, as is becoming increasingly common, patients leave hospital during the post-operative period, then nurses have very little opportunity to stress the need for compliance. Patients may therefore choose not to comply with the recommended regime. Patients may induce complications by not complying, so that their self-care ability is subsequently decreased. If patients understand the importance of a particular regime, they may be more likely to comply with it. It is, therefore, the responsibility of the nurse to provide sufficient information before patients are discharged, so that they are able to make informed choices.

(iv) Planning

For legal reasons the care plan takes the form of a written document. It lays down, in language that the patient can understand, the roles that will be played by them, the nurse and other carers. The plan is a dynamic, working document that can be altered as necessary. The care plan provides a permanent record of the patient's progress and facilitates effective shift-to-shift communication. The patient is encouraged to maintain ownership of the care plan. In many units, this means that documents are kept at the patient's bedside and they are invited to write comments in them.

(v) Caring

The care given as part of a self-care approach will vary according to patient need and may be given by a nurse, another member of the multi-disciplinary team, another carer, such as a relative, or by the patients themselves.

(a) Caring for patients with special needs

Patients with special needs, for example those who are deaf or blind or patients who are unable to read English, or who belong to a different culture, are often

disadvantaged by a lack of resources to provide them with optimal care. Such patients may need additional nursing attention to help them achieve their maximum potential for self-care.

(b) The nurse

The nurse's role in a self-care environment is very different from the traditional nurse role. Nurses who work in a self-care environment spend more time working with, rather than doing for, the patients for whom they are caring. Consequently, they need to be educated and helped to understand how to apply their skills and knowledge wisely and appropriately.

The term 'self-care' may imply to some that little input is required by the nurse. Indeed, if the purpose of self-care is not fully explained to and understood and accepted by the patient, the nurse could be seen as being lazy or not doing her job properly. However, the opposite tends to be the case: nurses who care within a self-care framework adapt to the patient rather than the patient adapting to them. This is a time-consuming and often difficult approach and the demands should not be under-estimated.

Since self-care aims to empower patients, nurses must, by definition, relinquish some of their power. This could be difficult, as many nurses may, either consciously or subconsciously, enjoy the power associated with their role and some may unwittingly coerce their patients to self-care, particularly if the nurse feels they are able.

Ultimately, however, patients' caring activities are limited by nurses and their ability to prioritise them. For instance, the nurse will not be able to fulfil the wishes of more than one patient at a time, especially if direct help, for example with bathing, is needed.

Example

A patient with chronic renal failure needed to visit hospital regularly for dialysis. The patient's nurse taught him about the functioning of the dialysis equipment, so that he was more familiar with the dialysis process. The patient went on to learn how to prime the dialysis equipment for his own use. As a result, the patient became able to control his own dialysis.

(c) Multi-disciplinary caring

Caring is a multi-disciplinary phenomenon and care is given by agents other than nurses. For example, physiotherapists and occupational therapists also have a role to play. Each discipline tends to have its own approach to care, however, and this may mean that the care received by the patient is disjointed. Ideally, there would be a single, common approach to caring and many units are working towards this.

Example

An elderly, wheelchair-bound man, resident in a private nursing home, was referred to a day unit by his GP. The man had lived in the nursing home for several years and had no possessions of his own. Through a process of rehabilitation, which involved several different agencies including nursing, occupational therapy and social services, the patient was helped to gain sufficient independence and possessions to enable him to move to a warden-controlled bungalow, where he lived for two years. After this time, the patient's care needs increased and he moved into an aged persons' home. However, the man had gained sufficient self-esteem from his contact with the day unit that he exercised his independence by becoming a member of the residents' committee.

(d) Relatives as carers

Sometimes, when they enter into a caring relationship with their nurse, patients are already dependent on another person (for example, a relative) to fulfil their self-care requirements on their behalf. It may be beneficial to both the patient and the nurse for this relationship to continue. This is because it enables patients to maintain contact with their usual environment and, second, because it enables nurses to work within, rather than replace, the patients' external support network. The nurse acts as a guide or mentor in such situations.

Example

A terminally ill patient was admitted to hospital. Confusion arose due to poor communication between the patient's GP, consultant and surgeon. This led to the patient's daughters making a complaint about their mother's treatment. The patient was subsequently moved to a gynaecology ward. Following transfer, the patient's primary nurse talked with her relatives and planned her care in consultation with them. Through a process of negotiation and planning, it was decided that the patient's daughters would become involved in providing their mother's care. Throughout the last week of their mother's life, the daughters were able to provide most of their mother's care themselves, which was their wish. Input from the nursing staff was minimal, though they provided physical and psychological support at the daughters' request.

It is essential that the patient, the nurse, the usual carer and the public at large understand the purpose of such an approach to care. If this is forgotten, there is a danger that relatives may be used simply to make up for shortfalls of staff. Relatives need an occasional break from caring, however, and at such times this approach to self-care could instil feelings of guilt. This can easily be overcome by ensuring that the wishes of the patient and their relatives are listened to.

(vi) Joint evaluation

The conference debated whether 'joint evaluation' should be part of a self-care approach. Some members of the group felt that evaluation reflected the process rather than the philosophy of self-care. Others considered that self-care was meaningless without evaluation. The group ultimately reached consensus and agreed to include joint evaluation.

The primary purpose of joint evaluation is to empower patients and to encourage them to take ownership of their care. Joint evaluation has three main functions:

- It provides an opportunity for patients to reflect on their progress. This process can help to motivate patients, particularly if they feel they are progressing too slowly – through evaluation patients are able to look back and realise how far they have come.
- It enables the nurse to determine the patient's perception of the value of care inputs. For example, is the information given to the patient of any use?
- It enables both the patient and the nurse to determine the efficacy of care inputs.

Example

A patient who had been resident in an adult cardiology ward for some time felt he was not making a good recovery. However, he had no way of measuring this. Joint evaluation enabled him to take a more active role in his care. Each day the patient's primary or associate nurse asked him to say how he felt he had responded to that day's care. The nurses recorded such discussions in the patient's care plan in his own words. The care plan became meaningful to the patient, and he and his family and friends used it to measure his recovery. The patient and his wife regularly referred to his care plan and found that it was a source of comfort and support when their moods were low.

Through the process of joint evaluation, the patient's care plan was transformed from a cluster of paper and charts at the end of his bed to a living document that he was able to use. The time spent together during joint evaluation also helped the patient, his family and friends, and his primary and associate nurses, to build a strong, meaningful relationship with one another.

four Factors indicative of a self-care approach

Conference participants answered the question posed in the second session (How can self-care be recognised in practice?) by agreeing that visible factors, indicative of a self-care approach, can be observed in an area where self-care is practiced. The group then went on to list factors that they had observed. The factors identified by the collaborative group fell into three distinct categories, relating to access to information (**Table 3**), comfort (**Table 4**) and choice (**Table 5**). The tables are not necessarily complete, and factors are not ranked in order of importance. The factors are intended to serve as examples of the type of activities that might be observed in an area where self-care is practiced.

Information and communication

The key characteristic of this category is that information is freely available and is easy to access. **Table 3** illustrates some of the elements that may be observed.

Table 3
Examples of observable factors indicating good communication and information-giving

- ✓ The ward philosophy is prominently displayed
- ✓ Documentation reflects self-care and terminology is patient-centred
- ✓ Bedside handover/report
- ✓ Offering of and explanation of information (written, visual and verbal)
- ✓ Patients appear to be well-informed
- ✓ Evidence of collaborative, multi-disciplinary approach to care
- ✓ Visual evidence of health education

Home-from-home environment

The key characteristic of this category is that patients are encouraged to relax and treat the hospital environment as their home. **Table 4** illustrates some elements that may be observed.

Table 4

Examples of observable factors indicating a home-from-home environment for patients

- ✓ Involvement of patient's usual carer is apparent, if appropriate
- ✓ Open visiting (although this may need monitoring to protect patients)
- ✓ Patients helping themselves to drinks
- ✓ Option of self-service meals
- ✓ Patients wearing their own clothes/day clothes during the day
- ✓ Evidence that patients have their own possessions around them. For example, long stay patients have their own pillows/quilt (although health and safety regulations may preclude this)

Patient choice or control

The key characteristic of this category is evidence of patient choice of or control of the self-care activities in which they are involved. **Table 5** illustrates some elements that may be observed.

Table 5

Examples of observable factors indicating that patients are given choice and control of care activities

- ✓ Feedback from patients reflects self-care (how did they feel?)
- ✓ Patient ownership of their care plans is apparent
- ✓ Patient involvement in their care is apparent
- ✓ Evidence that the patient/client and nurse have negotiated the patient/client's routine
- ✓ Patients completing their own charts. For example: Glucose monitoring for diabetics, fluid balance charts, observations (BP, pulse, weight)
- ✓ Patient self-assessment and evaluation
- ✓ Patients preparing themselves for procedures (with guidance/ help if needed)

five Conclusions

The aim of a self-care approach is to empower patients so that they and their carers can choose to become more involved in their health care. Patient choice differentiates a self-care approach from more traditional approaches to health care. However, the concepts of self-care are open to misinterpretation. In order to fulfil the aim of self-care, it is crucial that everyone involved in patient care has an opportunity to gain insight and understanding into its concepts. A self-care approach has implications for patients, nurses, carers and health care managers.

It is important that patients are given the opportunity to decide to self-care, since they do not always wish to do so (*Biley, 1992*). Nevertheless, patients do gain from a self-care approach. This may depend on several factors, however, including how ill patients are, how much information they have received and the number of organisational and situational constraints that they perceive (*Biley, 1992*).

Nurses frequently encourage patients to self-care. Recent evidence suggests that nurses often go further than encouragement, and coerce patients to self-care, possibly against their will (*Kappeli, 1986; Waterworth and Luker, 1990; Doyle and Noerager Stern, 1992*). Some authors believe that coercion is a legitimate approach (*Jensen et al., 1993*), since nurses need to act to help patients to fulfil their self-care potential and patients may need to be persuaded to do so.

The self-care approach places a major emphasis on the nurse. Firstly, nurses must be willing and able to relinquish some of the power traditionally associated with their role. Secondly, nurses must be skilled communicators, since, if they are to avoid coercing patients to self-care against their will, they need to determine what patients want. There will often be little time in which to achieve this. Therefore, nurses need well-developed interpersonal skills so that they can rapidly develop a good rapport with the patients for whom they are caring. Part of the purpose of a self-care approach is to help patients to maintain contact with their usual environment and support network. Consequently, patients' usual carers are often encouraged to become involved in patient care. Carers must be given choice and an opportunity to decide whether or not to participate. This activity must be carried out with considerable sensitivity, as carers may feel obliged to participate and may experience feelings of guilt if they consider themselves unable to do so. This is particularly apparent amongst the parents of hospitalised children (*Callery and Smith, 1991*).

Some authors believe that through encouraging patients to carry out more care for themselves, a self-care approach offers the opportunity to cut health care costs (*Harrison-Raines, 1993*). Indeed, situations could be envisaged where health service managers would view self-care in this way. At a time when spending on health is being curbed, a self-care approach could easily be used as an opportunity to save money (*Cousins, 1986*). For example, a self-care approach could have an impact on staffing levels, as it could be argued that patients who are less dependent on nurses in the traditional sense need fewer nurses to care for them. This attitude is also reflected in traditional methods of scoring patient dependency. For instance, few systems enable nurses to record time spent teaching or educating patients. These activities are, by definition, an integral part of a self-care approach, and units where self-care is applied may fare badly if such tools are used as a measure of activity and as a way of determining staffing levels.

A self-care approach may have a positive effect on health outcomes. There is considerable evidence to suggest that patients who are given choice and who experience a sense of personal control attain better outcomes than patients who are not given a choice (*Legg England and Evans, 1992*). Therefore, any economic focus on self-care needs to examine the cost-effectiveness of the approach and its impact on the quality of the service provided. The adoption of a self-care approach should not be seen as an opportunity to cut costs per se.

In order to fulfil the aim of a self-care approach – that is, to empower patients so that they can choose to become more involved in their health care – health care providers need to put the patient first. In practice, this means that nurses need to spend more time thinking about and listening to the patient and less time simply working through a list of tasks.

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appendix one List of chairperson, facilitators and participants

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Participants

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Ward 18 is a five-day surgical ward for urology, hand surgery, facial maxillary surgery and investigative procedures.

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Ward 18, Derbyshire Royal Infirmary NHS Trust, London Road, Derby.

Gill Ogden, Sister
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Ward 7 is a mixed sex, short-stay urology and surgical ward.

Sandra Brown, Ward Manager
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Ward 23 is a female surgical ward.

Colette Carroll, Sister
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Ward 33 is a mixed sex cardiology ward.

Janet McNally, Sister
Ward 33, The Glenfield Hospital, Leicester.

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Hedley Nichols, Senior Nurse
Babington Day Unit, Babington Hospital, Belper.
The Day Unit is a multi-disciplinary, inter-agency rehabilitation unit for elderly people.

Claire Milsom, Deputy Sister
1 The Grange, Leicester Frith Hospital, Leicester.

Mel Dickens, Staff Nurse
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appendix two Individual definitions of self-care

Self-care is:

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1 Negotiated plan of care respecting the client's rights and wishes to establish and maintain their own maximum level of independence.

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2 Encouraging self-care independence through assessment of the client, negotiation with the client, for establishment of the client's health care deficits, to then structure the appropriate care planning needs.

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3 To support a person and/or their carer in varying degrees to enable them to fulfil their personal needs.

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4 A person's ability to look after themselves. Where this is not possible, identification of needs through assessment, enabling the multi-disciplinary team to maximise their potential.

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5 Person's ability to maintain their current self-care status, meeting their spiritual, psychological and physical needs, which ultimately complements their personal self-care concept.

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6 An agreement of care negotiated between the nurse, her patient and carers, using multi-agency support, following individual assessment, with an end result being some degree of independence.

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7 Allowing individuals, through education, negotiation and planning, to have informed choice to achieve their daily needs using relevant agencies, with or without support from relatives, as appropriate.

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8 The ability to function to the person's maximum potential with the minimum of external intervention and is a holistic and multi-disciplinary approach.

9 Having a feeling of spiritual, physical, and psychological well-being, to ensure that any limitations are supported to enable you to function to a standard of pre-admission status.

10 Enabling the person to achieve an optimum level of independence facilitated by appropriate assessment, information-giving and agreed level of physical and psychological support.

11 Controlling own lives; normalisation; value; self-worth; promoting independence; assessing; taking into account their present skills; maintain these skills by teaching new skills; using a multi-disciplinary team; taking into account psychological, social and emotional needs; individual personal programmes.

(One of the collaborative conference participants chose not to have their definition included here. A reason for her choice was not given).

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Patients' expectations of health care are changing. Increasingly, patients are demanding and taking more control of their own health care. This phenomenon has been called 'self-care' .

Self-care has arisen out of a dissatisfaction with, and rejection of, the paternalistic approach to health care in which the patient was treated as an ignorant and passive recipient.

Self-care represents a new approach. It focuses on wellness, not disease, and is one of the concepts to have emerged from the holistic approach to healing.

This booklet describes how the concept of self-care is applied to nursing practice. It offers:

- an operational definition of self-care, including a detailed description of the constituent steps of a self-care approach
- a description of visible factors indicative of a self-care approach
- examples of applications of self-care

Self-care: application in practice will be of interest to community and hospital based nurses alike. It will provoke discussion, through which a broader understanding of self-care can be reached.

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