Understanding Watson's caring model in the self-management program for chronic heart failure patient: a literature review

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Outlines

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- Disease prevalence of chronic heart failure
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Definition of Heart Failure

- Heart failure (HF) is a complex clinical syndrome that can result from any structural or functional cardiac disorder that impairs the ability of the ventricle to fill with or eject blood.
- The cardinal manifestations of HF are dyspnea and fatigue, which may limit exercise tolerance, and fluid retention, which may lead to pulmonary congestion and peripheral edema. (ACC/AHA ,2005)

Disease prevalence of chronic heart failure

- United states prevalence of disease
  - A 2010 update from the American Heart Association (AHA) estimated that there were 5.8 million people with HF in the United States in 2006(Lloyd-Jones D,2006).
  - There are an estimated 23 million people with HF worldwide. There has been an increase in the prevalence of HF in the population over time. (Lloyd-Jones D,2006)

- Asian - Chinese prevalence
  - prevalence of HF in India is 1.3–4.6 million with an annual incidence of 0.5–1.8 million.
  - Jiang and Ge reported that in China, the HF prevalence rate among the general population was 0.9%. (Sheldon Lee,2012)

- Hong Kong prevalence
  - The incidence rate is 3–3.8/1000/year rising to 20/1000/year in women over the age of 85 years.
  - And in Hong Kong there has been a 10% annual increase in hospital admissions over the past five years . (J E Sanderson, T-f Tse,2003)

- Macau prevalence
  - Unknown
  - ?

Why we need Heart failure Self-management program ???

- Studies have shown that patient knowledge of heart failure is often poor, including awareness of the importance of compliance and of self-management strategies to optimise control of the condition. (S.P. Wright,2002)

Heart failure disease-management

- Self-management is defined as an active cognitive process undertaken by the patient to manage their heart failure (S.P. Wright,2002)
- Heart failure disease-management interventions appear effective in reducing rehospitalizations and improving quality of life.(Darren A DeWalt,2006)

Heart failure disease-management

- Typically the adoption of practices such as self weighing and monitoring of symptoms, and the interpretation of changes in weight and symptoms (S.P. Wright,2002)

Introduction of Watson's caring model

- Watson's caring model provides a framework central to human phenomena which integrating art, science, humanities, spirituality, and mind-body-spirit medicine into nursing practice.

(Kathleen, 2011; Watson, 1994; Watson, 2007)

Introduction of Watson's caring model (Continuous)

10 Carative Factors	Caritas Processes
1. Humanisitc- altruistic values	1. Practicing loving-kindness & equanimity for self and other
2. Instilling/enabling faith & hope	2. Being authentically present to/enabling/ sustaining deep belief system and subjective world of self/other
3. Cultivation of sensitivity to one's self and other	3. Cultivating of one's own spiritual practices; deepening self-awareness, going beyond "ego self"
4. Development of helping-trusting, human caring relationship	4. Developing and sustaining a helping-trusting, authentic caring relationship

Introduction of Watson's caring model (Continuous)

10 Carative Factors	Caritas Processes
5. Promoting and acceptance of expression of positive and negative feelings	5.Being present to, and supportive of, the expression of positive and negative feelings as a connection with deeper spirit of self and the one-being-cared-for.
6. Systematic use of scientific/creative problem-solving caring process	6. Creatively using presence of self and all ways of knowing/mulitple ways of Being/doing as part of the caring process; engaging in artistry of caring-healing practices.
7.Promotion of transpersonal teaching-learning	7. Engaging in genuine teaching-learning experiences that attend to whole person, their meaning; attempting to stay within other's frame of reference.

Introduction of Watson's caring model (Continuous)

10 Carative Factors	Caritas Processes
8. Provision for a supportive, protective, and /or corrective mental ,spiritual environment	8. Creating healing environment at all levels (physical ,non-physical, subtle environment of energy and consciousness where by wholeness, beauty, comfort, dignity and peace are potentiated.
9. Assistance with gratification of human needs.	9.Assisting with basic needs, with an intentional, caring consciousness of touching and working with embodied spirit if individual, honoring unity of Being ; allowing for spiritual emergence.
10.Allowance for existential-phenomenological spiritual dimensions.	10. Opening and attending to spiritual-mysterious, unknown existential dimensions of life-death; attending to soul care for self and one-being –cared-for

Literature review

- Searching strategy

Searching terms
- Chronic heart failure(CHF), congestive heart failure, disease management program, self-management, nursing and nurse-led program

Databases
- CINAHL, Ovid and Medline
- English studies between 2003 and 2013

Selection Criteria
- Types of study: quantitative, experimental studies with RCT design
- Population: adult CHF patients
- Interventions: disease management program with detail caring components
- Study outcomes: self-care components or quality of life

=> 12 studies were selected.

Result

- Program linking with "The instillation of faith-hope"

Goals/ Carative Process	Care Components	Patient outcomes
- To nurture & respect the deep belief of the pt. - To facilitate health behavior development	- Apply empowerment to attain goal & self management(Shearer,Cisar and Greenberg,2007) - Apply behavioral management to set goal & motivate health life-style change(Shively et al,2005) - Apply motivational-behavior-change strategies (decision-making skills)(Brodie,Inoue and Shaw,2006 ;Shively et al,2005)	Improvements in: - Health- related QoL - HF specific QoL - The attitudes to change - Physical function - Social function - Self-efficacy - Motivation score

Result

- Program linking with "development of help-trust relationship"

Goals/ Carative Process	Care Components
- Develop a supportive help-trusting caring relationship(Grancelli et al,2003;Shearer, Cisar and Greenberg,2007;Strombe rg et al ,2003)	- Advantages for the nurse to assess patients' status, needs & wants - Provide psychological support - Foster patients' awareness to practice

Result

- Program involving "Problem-solving to fulfill human needs"

Goals/ Carative Process	Care Components	Patient outcomes
-To achieve better determinant of behavioral change	- Apply self-efficacy to motivate behavior change(Smeulders et al,2010) - Emphasize on skills of symptom control and relief - Skill mastery - Social persuasion with peer support group	Improvements in: -Cognitive symptom management - Self-care behavior - Cardiac specific QoL

Result

- Program linking with " transpersonal teaching & learning to fulfill human needs"

Goals/ Carative Process	Care Components	Patient outcomes
- Work with patients - Promote interaction during teaching and learning	Tele-education & case management in a nurse-led clinic for pt. & family: (Grancelli et al.,2003; Laramee et al.,2003; Stromberg et al.,2003) - Knowledge of disease, - S&S of HF, - Importance of dietary change - Hydrosaline retention control - Smoking & alcohol cessation - Importance of Treatment Group learning & peer support (Ryan and Mason-Johnson,2009)	Improvements in: - Health- related QoL - Physical function - Social function - Self-efficacy - Readmission for HF - Hospitalization - Length of stay in hospital - Medication compliance & cost - Self care behavior

Result

- Program integrating "a supportive environment and acknowledging the expression of feelings"

Goals/ Carative Process	Care Components	Patient outcomes
-Providing physical, mental and psychosocial supportive environment for CHF management - Psychological support for feeling expression	A relaxation program: - Relaxation techniques: (meditation, breathing awareness, muscle relaxation) (Chan, Hendricks, Zhao, Rothendler, LoCastro & Slawsky, 2005 ; Yu, Lee & Woo, 2009) - A peaceful and comfort environment Individual consultation: - To foster pt's awareness of their needs and solution to their concerns (Stromberg et al.,2003) - Provide support, information & encouragement (Shearer,Cisar & Greenberg,2007)	Improvements in: - QoL - Psychological & social aspect in health-related QoL - Readmission rate - Hospitalization - LoS in hospital - Medication compliance & cost - Self care behavior

Limitation on current care

- Spiritual aspect was not highlighted in the reviewed program.
- Patient with HF concerned spiritual care was important and expressed needs for love, meaning, purpose and sometimes transcendence whoever held religious or not.

(Murracy, Kendall, Boyd, Worth, & Benton, 2004)

Suggestion

Further chronic heart failure program should include spiritual care as a care component.

Conclusion (continuous)

- Program outcomes for CHF readmission rates, hospitalization, length of stay, survival rate, self-care behavior, medication compliance, symptom management, quality of life, cardiac specific quality of life and medication cost-effectiveness were found improvements.

Conclusion (continuous)

- Nurses whose practice is guided by the theory based intervention are able to enhance the awareness of the comprehensive caring elements in their clinical practice. Ideally, carative factors application would help to facilitate the greatest degree of blessing, achievements and longevity for the CHF patient.

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Thank You