Empowering patients through self-management plans

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This article in our series on the NICE Medicines Optimisation guidance discusses the use of self-management plans and how they can empower patients and help them to be involved in managing their condition.

Medicines optimisation is concerned with ensuring the best possible use of medicines and supporting patients to get the best outcomes from the medicines they take. By talking and engaging with patients with long-term conditions, we can encourage them to have a better understanding of both the condition and how to control it. Self-management plans are a key tool in empowering people to manage their own condition using medicines.

NICE, the British Thoracic Society (BTS) and the Scottish Intercollegiate Guidelines Network (SIGN) recommend that people with asthma have a personalised action plan with supported self-management in place, and a number of studies have shown benefits in terms of improved control of asthma and an associated reduction in hospital attendances.

NICE also recommends that people with chronic obstructive pulmonary disease (COPD) receive self-management advice to encourage them to respond promptly to the symptoms of an exacerbation. People with other chronic conditions such as diabetes can also benefit from supported self-management plans.

NICE recommendations for self-management plans

Different types of self-management plans exist; they can be patient-led or profession-led with the contents varying depending on the needs of the individual patient, and they can be used in different settings. They constitute structured, documented plans, which may be used by patients, their family or carers to support self-management of their condition using medicines.

Key to the successful introduction of self-management plans is a process...
that includes education of the patient and/or carer, empowerment to allow appropriate self-initiation or escalation of treatment within a defined framework, and clear instructions about who to contact in the event of defined trigger factors.

In its Medicines Optimisation guidance, NICE has defined areas of activity and discussion points for each, which should be included when writing an individualised plan with a patient (see Table 1). To be successful, it is vital that the healthcare professional is central to the process with the input of the patient and/or a relative or carer.

How can self-management plans be used in practice?

**Asthma**

Asthma and COPD are conditions that lend themselves well to the use of self-management plans. National organisations such as Asthma UK (www.asthma.org.uk) and the British Lung Foundation (www.blf.org.uk) have suggested documentation that can be used for self-management plans and information for patients with asthma. However, these need to be adapted or integrated into local procedures with relevant referral directions and professional support for patients. Both a primary care clinic and an asthma nurse in a hospital clinic are ideal settings for introducing a patient with asthma to self-management with a documented personalised action plan.

In a structured consultation, the nurse can discuss the principles behind the plan and how it works. The plan should include details of how to keep well, what to do if asthma symptoms start to develop and what to do in the event of an asthma attack. This will include individualised information regarding:

- How to monitor the condition by means of peak flow readings, how these should be recorded, personal best peak flow and when to escalate treatment.
- Prescribed inhalers and their functions. These can be described in terms of ‘relievers’ and ‘preventers’ with a description of the inhalers and their colours. Other medication taken for asthma can be identified and written down.
- The correct response if the patient feels unwell, using objective criteria such as the RCP’s three questions. These will include how to escalate inhaler doses, when to start oral corticosteroids and when to seek medical help.
- How to identify an asthma attack and clear instructions about emergency action to take, including when to call 999.

A written record for the patient to take away and use for reference is essential and documentation should be in a format that suits the patient. One example is the asthma action plan produced by Asthma UK, which forms a comprehensive template (see Figure 1). The action plan should be reviewed and updated at least once a year (six months for children) and taken to all asthma appointments.

**COPD**

Self-management plans can also be used effectively to support patients with COPD. Norfolk Community Health and Care NHS Trust (NCHC) employs a COPD nursing team to provide a support service for patients with established COPD. The team form a point of contact for patients, and nurses are available by phone to provide advice and can arrange to visit patients in their homes. The COPD nurses assess patients and advise on the management of exacerbations; they review and optimise medicines and, as independent prescribers, can ensure that patients have ‘standby’ antibiotics and steroids and understand when and how to take them. They can carry out hospital assessments and reviews during admissions, working closely with the multidisciplinary respiratory teams. On discharge, they form an important link in bridging the interface between hospital and home.

The nurses see the patients in their own home and self-management plans are written together to be used as a focus for documenting advice and support. Self-management plans provide patients with written information about medication and include an action plan for the patient to follow if their condition deteriorates (see Figure 2). The patient’s regular and ‘when required’ medication is documented with names of inhalers and details of which medication to take when symptoms are worse. The action plan includes specific signs that indicate a worsening of symptoms.
or the onset of a severe attack and the corresponding actions to be taken. It is often beneficial to include relatives and carers in discussions, as patients with more severe COPD frequently rely on others to support them to take their medication and respond appropriately to worsening symptoms. The self-management plan also includes space for the patient to document dates of exacerbations and the action they have taken; for example, starting antibiotics or steroids and whether a nurse or doctor was informed.

Specific descriptions using traffic-light colouring are used to alert patients to early signs indicating the start of an exacerbation, what action to take and importantly when to seek medical help. It is important that COPD patients know how they can expect to feel on a ‘normal’ day and when progressive symptoms signal a worsening of their condition, rather than just a ‘bad day’.

The use of a self-management plan written together with the patient can be used to optimise medication and improve adherence. In order to optimise benefit from the plan, the patient needs to feel ownership and be confident that they are happy to take actions forward when required. It helps to enable patients to feel more independent and confident that they know how to control their condition, which in turn can result in a reduction in consultations and hospital attendances.

Conclusion
Self-management plans can be used in the medicines optimisation process as a way to create agreed actions, of which decision-making is a part. They are about developing a working partnership between healthcare professionals and patients, providing information so that patients can better understand their long-term condition and giving voice to patients’ concerns about their disease and treatment, which can then be managed as part of the plan.

A written plan can improve adherence to prescribed medication and enable patients to respond appropriately and promptly to symptoms within a defined framework. They can increase confidence and result in better symptom control, increasing a patient’s ability to maintain health and reducing the need for unplanned professional intervention.

References
10. Asthma UK. Your asthma action plan. August 2015. https://www.asthma.org.uk/advice/manage-your-asthma/action-plan/

Declaration of interests
None to declare.

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