Coronary Artery Disease as a "Long-Term Condition"

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A diagnosis of heart disease or coronary artery disease (CAD) can have a profound effect on an individual’s personal identity. This can be especially difficult when it occurs to an individual who previously viewed themselves as healthy, active and independent or those who are vulnerable when faced with change. One of the most challenging aspects of rehabilitation is supporting people to deal with the psychological impact of the condition. Many have been exposed to heart disease either through the media or through personal life experiences. Often these are negative experiences, with expectations of physical disability and premature mortality (Lewin et al. 1992). Challenging these misconceptions and helping people to accept their condition and the meaning that this may have for them as individuals can be a complex process.

The main thrust of cardiac rehabilitation is to support recovery, while offering information about the cause of the disease and the associated lifestyle factors. It is hoped that this exchange of information will aid informed decision making in the future. Often this requires clarification of misunderstandings and identification of specific areas of causation. Frequently people associate CAD with stress or overwork rather than focusing on the ways in which they deal with these problems. Many people deal with such problems by adopting unhealthy habits. Unfortunately it is these activities which inevitably increase susceptibility to the condition. Making changes to these aspects of daily life can be difficult as these behaviours are often identified as rewards or may be strategies used to deal with the pressures of life.

Long-term conditions (LTC) are defined by the Long Term Conditions Alliance as being disease processes which require on-going care, limit the individual's quality of life, and last longer than one year (Scottish Government 2008). The most common long-term conditions within the world today are: coronary artery disease, stroke, diabetes, asthma, cancer and chronic obstructive pulmonary disease (Rosen et al. 2007). Although mortality rates continue to fall, the incidence of these conditions continues to grow as the population's life expectancy increases and the exposure to risk factors becomes prolonged. All of these conditions have multiple associated risk factors. However, many cases can be attributed to modifiable risk factors such as smoking, limited physical activity and an unhealthy diet (Department of Health 2008).

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Figure 1

The Heart Manual teaches the individual, as early as possible post-event or intervention, how to manage their own health needs (Figure 1). This not only reduces the possibility of secondary events but also reduces the demand placed on health services.

The Role of Practitioners in Long Term Condition Care

An ageing population and rise in multi-morbidity is placing the NHS under unprecedented pressure. Over the next 10 years, the proportion of over 75s in Scotland will increase by an estimated 25% (Scottish Government 2013) We also know that long term conditions are more prevalent in older people, affecting 58% of people over 60 years old compared to 14% in those under the age of 40. Social deprivation is also a factor, with a 60% higher prevalence of long term conditions in the lower socio-economic classes (Department of Health 2012). In terms of expenditure, LTCs are a financial burden on the NHS, with approximately £7 in every £10 being spent on health and social care treatment (Department of Health 2012).
The number of LTCs experienced by patients is also on the rise, (see figure 2) which can complicate treatment pathways, and lack of continuity and communication between departments can cause confusion.

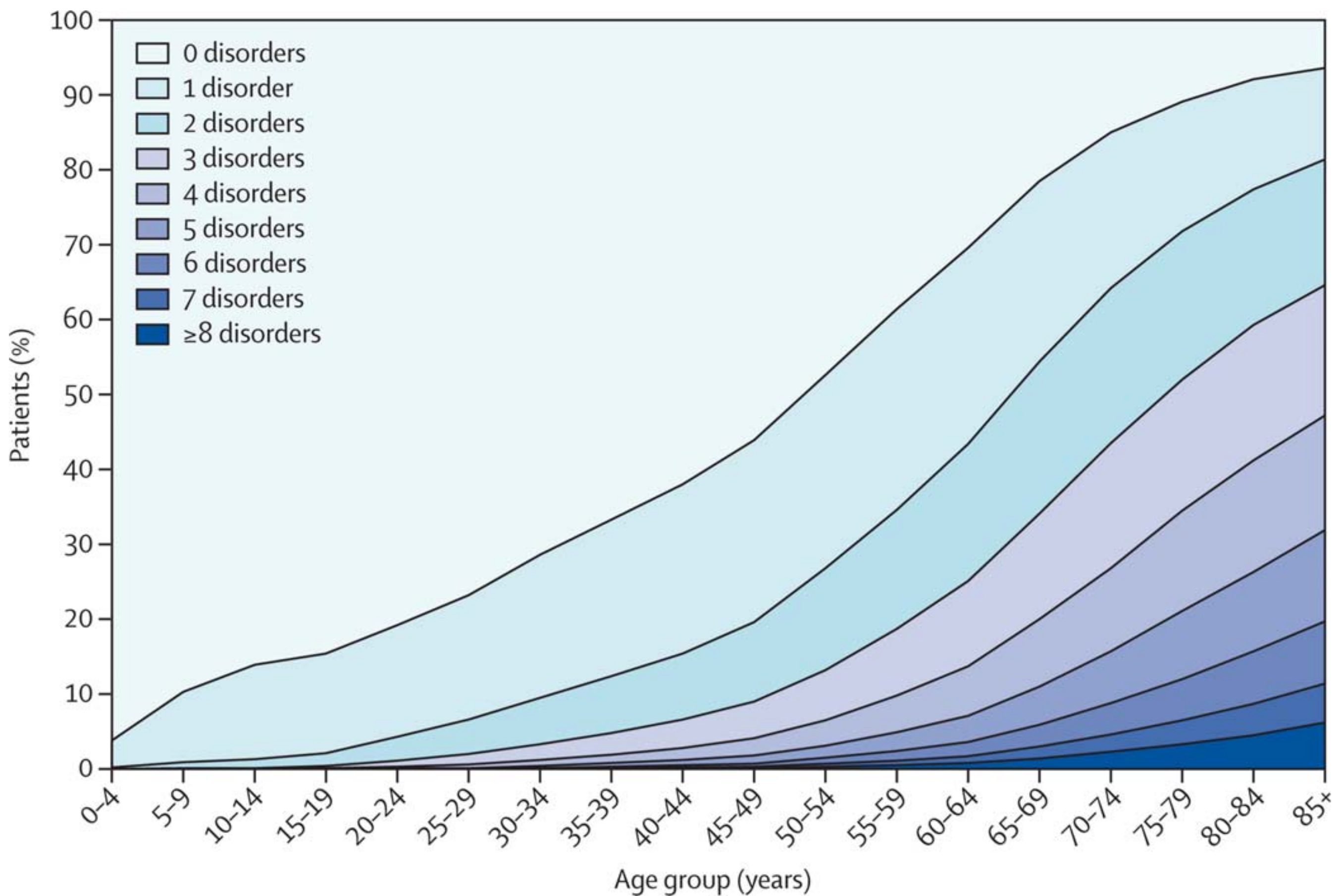

Figure 2. Barnett et al (2012)

The NHS and Scottish Government seek to address inequality and provide person centred, quality care to allow patients to be cared for at home, or in a homely environment, for as long as possible (Scottish Government 2013). Part of this drive is to avoid hospital admissions, which are costly, and distressing. 80% of individual admissions to hospital are in the over 75 age group (Scottish Government 2014), who are the highest service users. 30% of those admissions could have been avoided if an anticipatory care plan had been in place (Scottish Government 2014). The importance of advance planning and sharing of clinical information through electronic mediums such as the Key Information Summary (KIS) is essential to the process of ensuring patients' wishes for place of care and escalation of care are heard and self management plans and anticipatory medication are known. A national action plan, template and support materials for patients and health professionals are due to be launched in 2017 (Scottish Government 2014).

The role which practitioners play in delivering services is extensive. This has been recognised within "Delivering care, enabling health: Harnessing the nursing, midwifery and allied health professionals' contribution to implementing *Delivering for Health* in Scotland". This policy document focuses on the delivery of care within a "rights based approach". This requires practitioners to ensure that the care they provide reflects the values of those they care for, ensuring that they:

- Treat people with dignity and respect
- Consider issues related to emotional, social and spiritual welfare as well as meeting physical needs
- Actively listen to those they care for
- Seek to work in partnership when delivering and managing care
- Avoid treating those whom we care for as passive recipients
- Provide appropriate information to help people make informed and safe decisions
- Make sure that practitioners delivering care are competent, empathetic and effective, while actively seeking to help people promote their own recovery and manage their own health

This may require a change in the way in which health professionals deliver care. Historically care has been something done to people, often with a task-driven focus to correct a health related issue, such as applying a dressing to a wound or dispensing health-related advice. Those with CAD cannot be considered passive recipients of care but their knowledge and experience should be harnessed to work in partnership and learn from their experience of the condition. Just as there needs to be a less paternalistic approach to care provided by health professionals, so too patients need to feel engaged with the process and feel empowered to manage their LTC with support. This can prove challenging with the older population who have been used to "Dr knows best".

Self-care and Self-Management

Self-care refers to the concept of individuals taking responsibility for their own health, while self-management refers to one's ability to manage the condition. Both are multifaceted involving physical, social and psychological care and are often used

interchangeably. Self-care includes the activities we do on a daily basis, from eating a healthy diet to taking medication as prescribed. There are a variety of ways in which we incorporate self-management within our daily lives; these include symptom monitoring, accessing health information, searching out specialist or group support and using technical devices such as blood pressure monitoring. Self-care is done so frequently that most people are unaware that they are even doing it. It is important to consider not only the individuals' daily self-care but how they prevent ill health and react when changes to their well-being occur.

How people with CAD manage themselves can be effective, but can also be limited if the condition is complex or if dealt with incorrectly. It is therefore essential that appropriate self-care is promoted, encouraging people to take responsibility for their own well-being, while clearly stating the role of the facilitator in supporting recovery and self-management strategies. The key to this is the provision of the right support at the right time, enabling individuals to make decisions which are appropriate to their own circumstances. The evidence of the effectiveness of self-care strategies clearly states the multiple ways in which self-care/management may benefit the individual and NHS services:

Patient benefits

- Increases life expectancy
- Improves symptom control including pain reduction
- Reduces the degree of anxiety and depression experienced
- Promotes independence
- Improves quality of life
- Reduces time off work
- Increases social capacity

Service benefits

- Enhances health consultations
- Reduces GP consultations
- Improves hospital readmission rates
- Reduces inpatient stays
- Reduces outpatient visits
- Improves medication compliance and management
- Reduces A & E attendance (Department of Health 2007)

The HM and Self-Management

Self-management remains one of the least implemented and most challenging aspects of health professional work (Coleman and Newton 2005). Self-management strategies go beyond the traditional educational approach, by recognising all aspects of daily living, from goal-setting and problem solving, pacing activity and symptom management, to meeting financial demands and vocational issues as well as social and psychological needs.

The principles of self-management involve the adoption of practical approaches to sustain well-being such as adopting healthy behaviours, seeking and adhering to treatments and managing symptoms. Self-management is associated with gaining an understanding of the condition, developing skills to deal with it on a day-to-day basis and includes the use of medical devices and monitoring systems as well as minimising the effect that the condition has on quality of life. It is estimated that around 70-80% of people with long-term conditions are able to self-care with support (Department of Health 2008). The Heart Manual and facilitator provides a structure for this support, along with the fundamental self-care strategies required to ensure effective self-management.
These include:

- Gaining an understanding and acceptance of their condition
- Building a support network
- Pacing appropriately and effectively
- Learning to prioritise and plan
- Setting short, medium and long-term goals by using a SMART (Specific, Measurable, Achievable, Realistic, Timely) approach
- Dealing with common psychological responses
- Promoting exercise and activity in a realistic manner
- Self-monitoring of progress and condition changes
- Maintaining behaviour change
- Dealing with setbacks appropriately

The Heart Manual teaches the patient, as early as possible following their event or intervention, how to manage their own health needs. This not only reduces the possibility of secondary events but also lowers the demand placed on health services.

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