Case Study to apply CCSM principles and whole person health: an FCN supports Dan with self-management

Lee is a Faith Community Nurse who has been supporting Dan after his diagnosis of heart failure almost a year ago. Initially Lee helped Dan learn about heart failure by discussing with him the information supplied by the Heart Foundation and his doctor. He didn't understand his diagnosis and thought he would get better with rest. Lee listened as he expressed his fears and helped him to understand his condition and the impact good self-management could have on his quality of life. She connected him with a community nursing program with a cardiac rehabilitation nurse and a program. At Dan's request Lee accompanied him to his first session.

She reinforced the doctors care plan and explained the importance of a daily weigh to check his progress. They spent time problem-solving ways to ensure he maintained his care plan consistently. Lee created a chart for him to record his daily weight and a weekly blood pressure which he could do at home and she checked on her visits. Lee checked with Dan what he was learning at the cardiac rehab course to see how she could incorporate what he had learnt into his meal planning, shopping and general activities of daily living. Dan shared his concerns about the chronic nature of his condition, confiding in Lee that he had many fears, and great concerns about what lay ahead. Lee listened to him, encouraged him and prayed with him. He was also worried about becoming breathless during exercise and she urged him to continue the exercise noting that this was a good way to maximise his quality of life. She showed him ways to manage his breathlessness during exercise so it was more achievable, and how to know when he was over exerting himself.

Over recent weeks Lee noticed that Dan's feet were more swollen and he admitted that he was gaining weight but attributed this to eating too many Hot Cross Buns before Easter! His 6 monthly cardiac review was coming up, but he didn't want to 'bother' the doctor by discussing his swollen feet! Lee explained to Dan the importance of this information and the need for open and honest conversation with the doctor. She offered to attend the appointment with him, but after they wrote down the issues he needed to discuss with the doctor and discussed what the questions he would ask the doctor he felt confident to go alone, understanding the relevance of the recent changes in his wellbeing.

The specialist developed a management plan with Dan based on his weight changes and foot swelling, with instructions of how Dan could adjust his medication based on these. The doctor explained to Dan how and when he should do this and wrote this down as a plan as Lee had suggested. This enabled her to follow Dan up regarding his management plan at subsequent visits.

Can you see where Lee used the principles of chronic condition self-management to empower and support Dan to self-manage his heart failure?

- **K**nowledge: Dan's knowledge of his condition was growing
- **I**nvolvement: Dan was involved in his care and becoming more actively engaged with his doctors and getting help from Lee to navigate the system
- **C**are Plan: Dan was involved in his care and following the care plan and discussing it freely
- **M**onitor: Monitor symptoms associated with the condition(s)
- **R**espond: Dan was learning how to monitor and respond to changes in his condition and cope with his breathlessness.
- **I**mpact: Dan was recognising and discussing the impact of his condition on all areas of his life including his fear of dying and losing his independence.
- **L**ifestyle: Dan was becoming more aware of his need for nutrition and lowering salt and fluid intake, as well as managing activity that considered his whole health, connecting with church, family, praying and sharing openly with Lee.
- **S**upport: Dan was seeking support (he had connections with the Heart Foundation, a community cardiac rehabilitation nurse, and Lee – the faith community nurse. Lee also had connected Dan with others in the church's pastoral care team for ongoing social interaction, prayer support and help with his garden).

Lee supported Dan with more than his physical health. She provided spiritual care, emotional support and connections for social interaction.

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