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NURSING CARE FOR INDIVIDUALS WITH LONG-TERM ILLNESSES

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Abstract:

Context. Restoring and promoting self-management in individuals with chronic diseases or helping older adults maintain their independence are two strategies to improve health-related quality of life while potentially reducing costs. These kinds of interventions are frequently performed by nurses during follow-up home visits. Goals. to explain the effects of nursing interventions on individuals with a variety of chronic diseases during home visits. Approach. Using the databases from Medline, Embase, PsycINFO, CINAHL, and Cochrane as well as the terms chronic, diabetic, arthritis pain, and random, as well as [(nurses and care) or (nurse and interventions)], a systematic descriptive review was conducted. Results. The best results are obtained with older adults if "the younger-old" is the target population or if the intervention is specifically designed for older adults with known health issues. The length of the follow-up time, the quantity of follow-up visits, and the nurse's personality all affect the outcome. Patients with diabetes may benefit from follow-up nursing interventions that enhance their psychological and physical well-being.

Keywords: result, educational background, nursing, long-term care, chronic illness, chronic condition, older adults

Introduction:

and this compels healthcare providers to come up with innovative ways to cut costs. Restoring and promoting self-management in patients with chronic diseases is one strategy to preserve the autonomous function of the aging population. This has become crucial as the majority of individuals with chronic illnesses must "live with, rather than die from," their illness. The purpose of health policy is to improve efficacy. Effectiveness, though, could mean various things to different people. The most significant viewpoints for the patient are comfort, convenience, and the ability to lead a regular life; for the politician and the buyer, it signifies cost effectiveness; for the clinician, it signifies therapeutic outcome (Barriball & Mackenzie 1993).

One way to lower health care costs is through "substitution of care," a phenomenon wherein the most appropriate professional at the lowest possible cost provides care. For example, highly specialized nurses can be given tasks and responsibilities that would typically be performed by medical specialists (Temmink et al. 2000). Patients with chronic disorders are released from highly specialized departments to be monitored in the primary sector, where a patient's demands may not always be met by expertise about particular diseases. Numerous strategies have been developed to close this gap between the primary and secondary sectors, with the goal of keeping patients out of hospitals. One strategy is to hand off patient follow-up to specialized nurses in order to encourage self-care, enhance health-related quality of life, and save medical expenses.

Such cost-saving initiatives have drawn interest from large patient populations with chronic disorders like diabetes, heart and respiratory diseases, arthritis, and older adults in general. According to Becker et al. (1997) and 2000, chronic pain is also linked to patients' poor quality of life and high health care utilization. This article looks at the components and efficacy of nursing interventions by separating them from the treatment and care given to patients with chronic diseases by other health professionals.

The evaluation , Goals and objectives

The review's objective was to look into the specific long-term nursing interventions that are given to elderly patients or patients with chronic conditions when they are visited at home. The specific goals were:

- to outline the educational and therapeutic interventions that were given the nurses' history;
- to outline how the interventions have affected
- the individual receiving care,
- affordability,
- Clinical result.

The following search phrases were used: chronic, diabetic, arthriti*, pain, randomi*, and [(nurs* and care) or (nurs* and intervention)] in Medline, Embase, PsycINFO, CINAHL, and the Cochrane Database. The years of the hunt were 1993–2003. When appropriate, references from selected studies were given. The inclusion criteria were not met by any papers on chronic pain. The appendix displays the randomized controlled trials (RCTs). Patients with diabetes and rheumatoid arthritis, as well as older individuals in general without a documented chronic illness, were selected for further examination.

Qualifications for inclusion

The study focused on randomized controlled trials that examined nursing interventions offered to patients with chronic illnesses. Individualized long-term nursing treatments (lasting

longer than three months) with a minimum three-month follow-up period for older persons or adults with chronic diseases. Interventions needed to happen three times or more. Since doctors are frequently tasked with treating patients, articles about nurses working with doctors were included as long as the nursing involvement constituted the majority of the treatment plan.

Criteria for exclusion

This article excludes research involving minors, expectant mothers, or those with mental health disorders; it also excludes follow-up care following surgeries and hospital stays, specific nursing procedures (such as dressing wounds, giving medication), and using a nurse in place of a physical therapist (for the purpose of preventing falls). To exclude the acute phase of the disease, the RCTs with recently discharged patients or patients with heart and respiratory conditions were excluded. The exclusion of studies pertaining to patients with diverse illnesses was primarily done to ensure population homogeneity.

articles that were retrieved

There were seven articles about the elderly in there, including Twelve were disqualified due to inadequate intervention (3), lay workers doing some of the intervention (3), and multiple interventions pertaining to discipline (3), as well as other professions offering the assistance [physician (1) and physiotherapist (2)]. Seven papers involving patients with diabetes were accepted, while eleven were rejected due to group intervention (5) and six other grounds (inadequate intervention, in-hospital or multidisciplinary intervention, inadequate follow-up, or an excess of dropouts). There were two included publications regarding individuals with arthritis, and one was removed due to inadequate intervention and insufficient follow-up. Three articles were found, however two were removed due to group education and one due to cancer diagnosis. Neither of the articles was about chronic pain.

The assessment of the research methods' quality in the studies was conducted by a version of the Cochrane-reviewers' evaluation methodology (http://www.abdn.uk/hsru/epoc/). The papers were assessed in seven areas: design (was it clearly randomized?), randomization concealment, sufficient follow-up, blinded evaluation, baseline assessment, dependable results, and safeguards against cross-group contamination. Since nursing intervention does not allow for concealment, six areas were scored 0 for not done, 1 for unclear, and 2 for done, for a total of 12 possible method scores. Score allocations are displayed in the appendix.

assessing the RCTs' nursing interventions

Educational approach: Two methods were used to assess the content of the nursing interventions: an educational approach and (b) The duration of the patient's visit. Depending on

how much the patient participated in the learning process, studies were given a score of 1, 2, or 3. Interventions that primarily involved one-way communication, such as instructions, advice, or group education, received a score of '1'. A "2" was given to patient-centered interventions (encouraging, reinforcing, and discussing). A "3" was given to interventions that involved a significant level of patient participation, such as encouraging critical reflection, focusing on behavior and behavior changes (based on the patient's own decision), and using cognitive behavior methods.

The total duration of time spent with the patient during the study period was determined, if feasible, and categorized as follows: '1' for brief individual contact (less than an hour), '2' for intermediate individual contact (between one and six hours ± group contact), and '3' for the longest duration of individual contact (more than six hours). The study received a "NA" for not available when the amount of time spent could not be measured or quantified. The appendix displays the assigned scores.

The nurses' educational background

Using the educational descriptors found in the studies, the educational backgrounds of the nurses were categorized into three categories in order to look into whether the nurses' educational level affected the outcomes. Nurses in group one have only a minimum education in nursing and no indication of their experience. Nurses in group two were characterized as experienced, having worked in the field for more than five years, or possessing specialized training pertinent to the illness. Nurses with a master's degree or those who have completed advanced or specialized practice courses made up group three. Each of the groups received a score of 1, 2, or 3. The appendix displays the assigned scores.

The interventions' effects

. Three outcomes were used to assess the interventions' effects:

- The outcome for the patient (such as quality of life, patient satisfaction, well-being, self-reported regime adherence, self-efficacy, and knowledge and abilities related to self-care).
- Socioeconomic results (such as hospitalization rates, and duration of stay, admissions to nursing homes, usage of medical services, and financial savings).
- Clinical consequence, such as blood pressure, disability, or death evaluation, blood-glucose control, cholesterol-plasma level, and depression symptoms).

Being depressed-free may be a clinical goal as well as a patient outcome. The effect was assigned to the most relevant group based on how it was described in the text.

A score was assigned to each group (patient related outcome, economically and clinically associated outcome) that described the result. For a significant positive or negative outcome, the scores were þ3 or —3, and for a positive or negative outcome in few or few measures, they were ±1 and ±2. '¼' was allocated for no difference described, and 'NA' for no subject description. The appendix displays the assigned scores.

elderly individuals residing at home

According to six studies (Pathy et al., 1992, van Rossum et al., 1993, Stuck et al., 1995, 2000, Dalby et al., 2000, Hebert et al., 2001), a total of 3055 patients were included (intervention/control: nursing interventions Nursing interventions for older adults in these studies typically included a complete physical examination, discussion, and recommendations on pertinent areas of health care; nurses worked from a checklist, assessing physical, cognitive, emotional, and social functions and supporting patients with issues related to these areas; in four studies, visits were done every three months for three years; in three studies, the duration of the study was one to two years; and in one study, the duration was six months. The significance of the interpersonal differences among nurses was demonstrated in the study conducted by Stuck et al. (2000), in which three nurses carried out the'same' intervention. Compared to the control group, nurse C in this study discovered far fewer issues and avoided any nursing home admissions, but she also increased patient satisfaction. Cost reductions were achieved by nurses A and B in a subset of "low risk participants." In general, nurses had extensive educations. When measured, the quantity of time spent with the patient during the research period was "high," and when stated, the patients were heavily involved in the learning circumstances.

result for the patient. According to reports, patients reported feeling more satisfied and confident, and they thought their health was better (Stuck et al. 1995, 2000). In three of the publications, the patient's outcome was positive, and in three more, it was not mentioned. financial result. In two of the studies, the interventions appeared to be cost-effective, but in one, they weren't. The cost-effectiveness for the remaining research was not explained. clinical result. Stuck et al. (1995, 2000), Dalby et al. (2000), Pathy et al. (1992) and Dalby et al. (2000) reported improved vaccination frequency and delayed development of disability, respectively, as favorable effects on the intervention group.

Diabetes

Long-term follow-up was conducted in-person in four of the included RTCs involving diabetic patients, and three additional studies satisfied the inclusion requirements as long as phone conversations were approved as nursing interventions (Rettig et al. 1986, Boehm et al. 1993, Kirkman et al. 1994, Campbell et al. 1996, Fosbury et al. 1997, Thompson et al. Piette et

al. (2000), 1999). The following describes the interventions and their impact on this group, based on seven trials including 1465 participants (954/511):

nursing interventions

Two studies (Boehm et al. 1993, Campbell et al. 1996) with four study groups used a range of interventions, from regular care to applying cognitive behavioral methods to facilitate compliance or behavior changes.
Interventions were defined as follows: telephone calls by a nurse stressing comprehension of – and adherence to – the prescribed medical regimen (Kirkman et al. 1994); discussions about the significance of appropriate self-care and about reported problems, followed by strategies for solutions (Piette et al. 2000); instructions/teaching in diabetes self-care according to patients needs (Rettig et al. 1986); throughout assessment followed by an educational plan (Fosbury et al. 1997). According to Thompson et al. (1999), nurse interventions involve regular telephone consultations with patients to provide advise about adjusting diabetic therapy. The nurses adhere to established protocols while utilizing their discretion when making individual decisions. When describing educational methods, time spent differed as well. The educational backgrounds of nurses were characterized as either basic or as diabetes specialists.
result for the patient. The patient perspective was examined in three trials. Positive outcomes were reported in two studies: higher self-efficacy (among the group speaking English) and increased patient satisfaction (Campbell et al., 1996; Piette et al., 2000). According to Kirkman et al. (1994), there was no discernible difference in patient-related outcomes between the control and intervention groups. financial result. According to Campbell et al. (1996), no economic gains were identified or mentioned.

clinical result. All but one of the studies produced positive results in terms of therapeutic benefit. The majority of trials revealed reduced blood pressure, cholesterol, and plasma glucose levels. They also found behavior changes, increased self-care knowledge and abilities, and self-reported regimen adherence (Campbell et al. 1996). Less depressive symptoms and fewer days spent in bed were observed by Piette et al. (2000).

Rheumatoid arthritis RCTs

Drawing from two trials including 280 patients (106 ÷ 174), the impact of extended-term specialized nursing intervention is contrasted with findings from a multidisciplinary team or a specialist rheumatologist (Hill et al. 1994, Tijhuis et al. 2002).

The nursing group's interventions were referred to as a "programme of care." The program had no set procedure, but interventions included patient education and counseling, referrals to paramedical colleagues, supervision and day-to-day management of patients with a range of

rheumatic conditions, and monitoring patients on disease-modifying anti-rheumatic drugs. A consultant rheumatologist was directly available to the nurse for medical guidance (Hill et al. 1994). According to Tijhuis et al. (2002), the interventions included information about rheumatoid arthritis and, if necessary, the prescription of joint splints, adaptive equipment, and house adaptations in consultation with a rheumatologist. If necessary, referrals to other medical specialists were made. The time spent was considered to be medium/low, and the nurse was an educated practitioner or specialist with a high/moderate degree of education. The interventional method's description lacked clarity.
result for the patient. When compared to the group that saw a rheumatologist, nurse interventions showed significantly reduced levels of discomfort, greater levels of knowledge, and more satisfaction. In comparison to the multidisciplinary team (inpatient or outpatient care), the nurse-specialist group's patient satisfaction was noticeably lower.

financial result. No computations.

clinical result. The two examined studies demonstrated comparable gains in all groups, as evidenced by increases in functional status and quality of life as well as a decrease in disease activity.

conclusion:

When an intervention is designed specifically for older adults with identified health issues, or when the target population is "the younger-old," the best results are achieved in these populations. The length of the research and the number of follow-up house visits appear to have an impact on the outcome. The impact is also based on the individual nurse. The goal of the treatments is frequently to assist the patient in actively participating in matters pertaining to their health. Typically, this involves a multifaceted examination, which is followed by counseling, advocating, and negotiating. Interventions are rarely explained in full.

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