

# SUPPORTING SELF-CARE:

A SHARED INITIATIVE  
1999 – 2002



SUPPORTING  
SELF-CARE:  
A SHARED  
INITIATIVE  
PRENDRE EN  
MAIN SA SANTÉ :  
UNE INITIATIVE  
PARTAGÉE

Caregivers and Consumers Working  
in Collaboration for an Effective  
Health Care Approach



Canadian Association  
of University Schools of Nursing



L'Association canadienne  
des écoles universitaires de nursing



CANADIAN NURSES ASSOCIATION  
ASSOCIATION DES INFIRMIÈRES ET INFIRMIERS DU CANADA

The College of  
Family Physicians  
of Canada



Le Collège des  
médecins de famille  
du Canada



Health  
Canada

Santé  
Canada

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*Supporting Self-Care: A Shared Initiative* was based on the collaboration of four organizations and Health Canada: Canadian Nurses Association, The College of Family Physicians of Canada, Canadian Association of University Schools of Nursing, Association of Canadian Medical Colleges. However, the views expressed in this report do not necessarily represent the official policy of these groups.

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## ***Executive Summary***

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A committed and growing group of health care professionals and consumers in Canada has been working to describe and implement a more effective approach to health care, an approach involving the collaboration of health care professionals and consumers. Health Canada has funded and supported much of this work through the Supporting Self-Care Project, a multi-phase project initiated in 1994.

The project began with a study that explored how physicians and nurses stimulate and support self-care. A framework was developed providing a synthesis of the various approaches used by physicians and nurses to support self-care. In Phases 2 and 3, workshops for physicians and nurses, particularly physician and nurse educators, were held to identify ways of increasing knowledge and skills in promoting self-care practices through training and support. A network for physicians and nurses interested in promoting self-care was proposed, and three interdisciplinary pilot projects were funded.

The focus in Phase 4, the most recent phase, was on networking and partnership building. Reflecting the interdisciplinary nature of self-care support, a program entitled Supporting-Self-Care: A Shared Initiative, was implemented. Funded by Health Canada, the program involved a collaboration between the College of Family Physicians of Canada, the Association of Canadian Medical Colleges, the Canadian Nurses Association, the Canadian Association of University Schools of Nursing and Health Canada. The steering committee for the Initiative included consumers and representatives from all participating organizations. The steering committee selected and monitored nine projects across Canada that supported professional health care practitioners striving to foster a change in attitude and behaviour among their colleagues through education, mutual support or demonstration of new models of practice and professional development. The activities of the Initiative culminated in an invitational symposium in June 2001. The Symposium Report is included in Appendix B.

Phase 4 also involved the development of an interdisciplinary network of health professionals and consumers interested in the integration of self-care support in the education and practice of health care professionals. The network components include an electronic directory, a discussion mailing list, a quarterly newsletter and a web site.

Interest in the support of self-care in Canada has paralleled and grown with changing perspectives on health care, including the role of prevention and health promotion in “achieving health for all” and the emphasis on the broad range of health determinants in the population health approach. More recently, the focus of attention has shifted to the role of primary health care in improving access to and quality of health care. Through the ongoing study of the support of self-care, it has become evident that there is a strong link between

***A committed and growing group of health care professionals and consumers in Canada has been working to describe and implement a more effective approach to health care, an approach involving the collaboration of health care professionals and consumers.***

supporting self-care strategies and primary health care. By supporting the self-care efforts of their patients and clients, physicians and nurses encourage individuals to participate in making decisions about their own and their communities' health. Public participation is one of the key principles of primary health care.

Other trends and issues have emerged from Health Canada's long-term incremental approach to the study of self-care support. It became apparent that various principles related to the support of self-care applied regardless of whether the domain of interest was education, practice, research or policy. For example, the patient/client/consumer is always considered a partner in care, and the approach to supporting self-care is systematic and facilitated by interdisciplinary collaboration.

There are many challenges associated with educating health professionals in the support of self-care and in integrating self-care support into professional practice. These challenges have been identified and described in reports from the various phases of the Supporting Self-Care Project. In Phase 4, the projects demonstrated strategies to begin to overcome some of these challenges. Project teams developed tools such as self-care questionnaires for health care professionals and self-care manuals to assist older adults in practising self-care.

Many other health care professionals and consumers have now added their voices to those who value the opportunity to work together for an effective health care approach. The next steps in this work are under consideration. It is anticipated that mechanisms and strategies for further implementation of supporting self-care in practice will take place through a multi-centred program of activities based at several Canadian universities. Locating such initiatives within university learning environments will help to link theory and experience in education and practice, and through the research capacity of the universities, will generate evidence-based outcomes of self-care support by health care professionals. Consumers will continue to play an important role in these activities. A major objective will be to integrate supporting self-care into primary health care reform.

# Introduction

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## *Introduction*

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A committed and growing group of health care professionals and consumers in Canada has been working to describe and implement a more effective approach to health care, an approach involving the collaboration of health care professionals and consumers. This work has been supported and funded by Health Canada through the Supporting Self-Care Project, a multi-phase project initiated in 1994.

The Supporting Self-Care Project began with a small exploratory study and has progressed through several phases. In the most recent phase, Health Canada and four professional associations of physicians and nurses selected and monitored nine projects across Canada on supporting self-care. These projects were funded by Health Canada. An interdisciplinary network of health care professionals and consumers interested in integrating self-care support into the education and practice of health care professionals has also been established.

In each phase of the project, much has been learned about the philosophy of self-care, the support of self-care, the factors facilitating and challenging this approach and the changes that need to occur to expand interest in self-care support beyond the current small group of health care professionals and consumers. This document summarizes the various phases of the project and the resources created in each phase. Drawing from the discussions that took place during the most recent phase of the project, the Supporting Self-Care Initiative, this document positions self-care support within a primary health care framework. It also explores and highlights the major implications from the project for the education and practice of health care professionals, especially physicians and nurses.

For health care professionals and consumers whether familiar with or new to the concept of supporting self-care, it is hoped that this report will be a useful resource. It begins with a brief description of each phase of the project (see Appendix A).

# Evolution of the Self-Care Project

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## ***Evolution of the Self-Care Project***

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Through a long-term incremental strategy, Health Canada has been working, in collaboration with several key professional associations, to help professionals improve their support of self-care by linking practice, education and research.

### ***Phase 1 (1995-1997): The Foundation – A Framework for Supporting Self-Care***

The project began with a study to explore how physicians and nurses stimulate and support self-care. The study findings are based on three main sources of information: literature, clinical experiences recounted by physicians and nurses and information provided by people who have developed or used self-care programs and tools (Health Canada, 1997).

Guided by the literature and clinical experiences of physicians and nurses, a framework was developed that provides a synthesis of the various approaches used by physicians and nurses to support self-care. Five key components emerged: supporting the person, sharing knowledge, facilitating learning and personal development, helping the person build support networks and providing a supportive environment. The five key components and the main elements can be found in *Supporting Self Care: The Contribution of Nurses and Physicians, an Exploratory Study* (Health Canada, 1997).

The findings from the exploratory study also suggested that a variety of programs and tools<sup>1</sup> could complement professional practices that support self-care. To help physicians and nurses sort through the vast numbers of programs and tools available, a categorization scheme for programs and tools was proposed. Categories of self-care programs and tools include: integrated education and support programs, self-help groups, support groups, print and audiovisual tools, telephone help lines, computer-based tools and self-monitoring tools. Sixteen programs and tools are described in the report. The potential of these diverse programs and tools to enable people to be more active in their own care is highlighted. The programs and tools are concerned with a variety of topics including arthritis, cardiovascular disease and smoking reduction.

The report concludes with a discussion of the implications of this study for professional practice, education, research and policy.

### ***Phase 2 (1997-1998): Workshops for Physician and Nurse Educators***

In response to one of the recommendations of the first phase, Health Canada sponsored invitational workshops in Toronto and Montreal for physician and nurses educators. The workshop objectives were to identify ways of increasing knowledge and skills in promoting self-care practices through training and support and to foster the development of a network of physicians and nurses interested in promoting self-care.

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<sup>1</sup> A self-care program is an activity or initiative designed to enhance or support self-care practices in a specific audience. It involves leadership provided by laypersons, professionals or an extended health care team. It often involves an element of group interaction. A self-care tool is an aid to stimulate or enhance self-care, such as a computer program, book, video or questionnaire. Tools can stand alone or be used as a component of a larger program in self-care.

The bilingual document, *Supporting Self-Care: Perspectives of Nurse and Physician Educators* (Health Canada, 1998) resulted from these workshops. It presents the deliberations and recommendations from the group of experts – 66 physicians, nurses and consumers representatives – who participated in these two workshops. It identifies four main barriers to self-care support faced by physicians and nurses, as well as four promising avenues for action to help them become more successful in supporting self-care. This document has been useful to physicians and nurses, especially those responsible for the education of current and future practitioners. It has also been used as a networking tool and a resource for learning more about support of self-care.

### ***Phase 3 (1998-1999): Workshops and Pilot Projects***

In Phase 3, Health Canada supported two new activities that addressed recommendations of the workshop participants in Phase 2. First, one-day workshops were held in Vancouver, Toronto and Quebec that brought together approximately 100 physicians, nurses and consumer representatives. Each workshop was centred around a particular theme, namely heart health, stress management for women and a multidisciplinary initiative in self-care education. Secondly, three interdisciplinary pilot projects in clinical care, education and research were funded.

### ***Phase 4 (1999-2001): Networking and Partnership Building***

The most recent phase of the Self-Care Project included two main components, *Supporting Self-Care: A Shared Initiative* and the *Supporting Self-Care Network*.

In June 1999, the federal Health Minister Allan Rock announced funding over two years to a program entitled *Supporting Self-Care: A Shared Initiative*. The purpose of the Initiative was to help physicians and nurses support self-care in their practice and to promote mutual support among professionals. It solicited and selected projects from across the country that would promote self-care by striving to foster a change in attitude and behaviour among their colleagues – physicians, nurses and other health care professionals. Nine projects were funded and monitored through the Initiative. The projects were delivered through university, college or continuing education classes, mutual support among professionals or demonstrations of new practice models.

Reflecting the interdisciplinary nature of self-care support, the Initiative involved interdisciplinary collaboration between the College of Family Physicians of Canada, the Association of Canadian Medical Colleges, the Canadian Nurses Association, the Canadian Association of University Schools of Nursing and Health Canada. The College of Family Physicians of Canada and the Canadian Nurses Association co-chaired the Initiative's coordinating committee, whose membership also included two consumer representatives.

The activities of *Supporting Self-Care: A Shared Initiative* culminated in an invitational symposium held in Ottawa on 2-4 June 2001. Invited to participate were health care profes-

sionals and consumers involved in the various funded projects, stakeholders in health education, policy and community care and representatives from other interested organizations. The symposium report provides a brief outline of the presentations and highlights the plenary discussions including key messages, common findings, suggestions and recommendations (see Appendix B). Also it includes summaries of the nine funded projects and e-mail addresses from which full reports of the projects can be obtained.

The Supporting Self-Care Network, the other main focus of Phase 4, is an interdisciplinary network of health care professionals and consumers interested in integrating self-care support into the education and practice of health care professionals, especially physicians and nurses. The Network incorporates several components including an electronic directory, a discussion mailing list, a quarterly newsletter and a web site. The Network is briefly described in part three of the Symposium Report. Information on how to join the network is available at [www.supportingselfcare.ca](http://www.supportingselfcare.ca).

# Defining Self-Care and Supporting Self-Care

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## ***Defining Self-Care and Supporting Self-Care***

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Definitions of self-care vary depending on the context in which the term is used. As a result, different definitions have been used over the course of the project. In the initial exploratory study, self-care was considered to be “the decisions and actions taken by someone who is facing a health problem in order to cope with it and improve his or her health” (Health Canada, 1997, p. 1). This definition fit well with the framework of the study that focused on examples of self-care by individuals after a nurse or physician had been consulted. In other phases of the project and specifically in some of the funded projects, the definition was broadened to include decisions and actions taken to promote health and prevent illness. Such definitions are more in keeping with the comprehensive definition of self-care proposed by Dean (1986) in the early self-care literature:

***Self-care includes decisions to do nothing, self-determined actions to promote health or treat illness, and decisions to seek advice in lay, professional and alternative care networks, as well as evaluation of and decisions regarding action based on that advice.***

Self-care involves the range of activities individuals undertake to enhance health, prevent disease, evaluate symptoms and restore health. These activities are undertaken by lay people on their own behalf, either separately or in participation with professionals. Self-care includes decisions to do nothing, self-determined actions to promote health or treat illness, and decisions to seek advice in lay, professional and alternative care networks, as well as evaluation of and decisions regarding action based on that advice.

(p. 62)

The term “supporting self-care” has not been explicitly defined in most of the work associated with the project. However, it is generally considered to refer to the efforts of health care professionals to assist consumers in making decisions and taking actions regarding their health. Some people may not want to participate in self-care activities, and health care professionals must recognize this preference.

Recently, the Supporting Self-Care Network Development Committee agreed to the following working definitions of self-care and supporting self-care. Self-care refers to the decisions and actions taken by people to maintain and improve their health (Health Canada, 1997). Supporting self-care includes supporting the person (conveying acceptance, listening, etc.), sharing knowledge, facilitating learning and personal development, helping the person build support networks and providing a supportive environment. These practices and attitudes take place in the context of patient/client relationships with health professionals, and are grounded in a credible knowledge base.

# Changing Perspectives on Health Care

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## ***Changing Perspectives on Health Care: How Self-Care and Support of Self-Care Fit***

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Interest in support of self-care in Canada has paralleled and grown with changing perspectives on health care in this country. In 1974, the Lalonde Report, entitled *A New Perspective on the Health of Canadians* (Health and Welfare Canada, 1974), proposed that, besides the health care delivery system, three other factors influence people's health: human biology, environment and lifestyle. This work furthered the development of the field of health promotion. In 1986, Health Canada proposed self-care as one of three key mechanisms in a health promotion framework aimed at achieving health for all Canadians (Health and Welfare Canada, 1986).

In the 1990s, it was acknowledged that a broader range of health determinants must be addressed when considering strategies to influence the health status of Canadians. The Supporting Self-Care Project has revolved around three of these determinants: personal coping ability and skills, personal lifestyles and health care services (Federal Provincial and Territorial Advisory Committee on Population Health, 1994).

More recently, the focus of attention has changed to the role of primary health care in improving access to and the quality of health care in Canada (Rock, 2000). Primary health care is both a philosophy of health care and an approach to providing services (CNA, 2000). It seems logical and appropriate that a philosophy of patient or client-centred care, which is the foundation of supporting self-care, would be a key concept in the primary health care approach. The link between supporting self-care and primary health care is discussed later in further detail.

# Key Findings

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## ***Key Findings***

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In 1997 at the conclusion of the exploratory study, a number of implications for practice, education, research and policy emerged. Most of these were generic in nature. It was noted that a larger number of physicians and nurses interested in professional support of self-care needed to examine the results of the study before more specific recommendations could be made. Since then, many more physicians and nurses, as well as a number of consumers, have been involved in studies and discussions related to the support of self-care. Some of this work, especially the projects funded through the Initiative, has generated specific recommendations that are available in the project reports. It is now also possible to address some general trends and issues that have emerged from the ongoing study of the support of self-care.

### ***Universality of supporting self-care principles***

Over the course of the Self-Care Project, it became apparent that various principles related to the support of self-care apply regardless of whether the domain of interest is education, practice, research or policy.

The supporting self-care approach includes the following principles.

- The patient/client/consumer is always considered a partner in care.
- The approach is both gender and culture sensitive.
- The climate between the health care professional and consumer is based on trust and confidence.
- The approach to supporting self-care is based on a systematic attempt to benefit from the motivation of the patient/client to improve his/her health.
- The approach is facilitated by interdisciplinary collaboration.
- Health care professionals require education, practice and support to improve their support of self-care.
- Evidence-based outcomes are needed to support the effectiveness of this approach.

The principles articulated here represent a beginning set of principles. Additional principles will likely emerge with further study and development of the supporting self-care approach.

### ***The link between supporting self-care and primary health care***

In 1978, the World Health Organization (WHO) acknowledged the importance of primary health care as a means of achieving health for all. WHO (1978) defined primary health care in part as “essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in a community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination” (p. 3).

Primary health care includes and integrates health promotion and preventive, curative, rehabilitative, supportive and palliative care. One of the key principles of primary health care is consumer participation. By supporting the self-care efforts of their patients and clients, physicians and nurses encourage individuals to take responsibility for and participate in making decisions about their health.

Linking the support of self-care with primary health care and other health care system reforms could open up opportunities for integrating support of self-care into the health care system. The views of professional associations representing physicians and nurses have affirmed the importance of the supporting self-care approach during this era of health reform. CNA (1996) called for adequate supports and opportunities for partnerships with providers to enable the public to play a greater role in health decisions. The most effective health care environment has been noted as one in which the patient can access all the assistance necessary to solve their basic health needs (Bowmer, 2001). The Futures Project, a recent initiative of the Canadian Medical Association (2000), summarized the actions that individual physicians and the profession can take to help create a future that is congruent with the profession’s values and vision. Referring directly to the support of self-care, physicians are called upon to encourage and support self-care and mutual aid. They are also asked to help increase self-care skills and capacity in the community.

### ***Awareness and education of health care professionals***

Through subsequent phases of the Supporting Self-Care Project, assistance has been added to the implications from the initial exploratory study for the education of physicians and nurses. There is general agreement that educational programs at the undergraduate, graduate and continuing education levels should incorporate content into their curricula about the attitudes, knowledge and skills necessary for supporting self-care. Through the Supporting Self-Care Project, educators have learned that it is easier to teach physicians and nurses about the concepts and strategies for supporting self-care by taking into consideration particular patient and client clinical situations. Rather than studying support of self-care in isolation from the context of care, health care professionals should focus on learning how to support the self-care efforts of people who may be facing certain health problems such as hypertension or who are wishing to make lifestyle changes such as increasing their exercise level.

There is also a consensus that an interdisciplinary approach to providing that education is necessary, and it is essential that the role of consumers in the education of health care professionals be strengthened. A culture that values self-care facilitates the education of health care professionals. Therefore, the concept of self-care needs earlier introduction into the general educational system.

*These workshops stimulated sharing and awareness among health care professionals of the many facets of self-care support.*

From 1998 to 2001, a variety of interdisciplinary workshops were organized involving both professionals and consumers. These workshops stimulated sharing and awareness among health care professionals of the many facets of self-care support. Several of these experimental workshops received tremendously positive participant evaluation, and therefore, constitute good models for further efforts in continuing professional development towards self-care support by primary health care professionals.

The challenges identified at earlier stages associated with educating health care professionals in the support of self-care still persist. These include difficulties inherent in changing curricula, as well as lack of: communication between learning institutions; funding for new programs; interest from some educators and students; interdisciplinary educational opportunities; adequate consumer input into curricula; and evidence-based results efficaciously supporting the self-care approach.

The projects funded through the Initiative have demonstrated strategies to help overcome some of these challenges. To illustrate these developments, highlights from some of the projects follow. Descriptions of all nine projects are included in the Symposium Report (see Appendix B). Project teams made specific recommendations for practice and future study. They also developed tools to assist in the education of health care professionals. Examples of these tools are included within the appendices.

The **University of Calgary** planned an educational activity to incorporate self-care theory into the clinical curriculum in an interdisciplinary model of learning. Three educational workshops for nursing students and residents in family practice focused on diabetes, palliative pain management and professional ethics. The project team developed a tool to survey participants about self-care aspects in these health areas (see Appendix C). Two lasting lessons from the project were acknowledgement of the importance of the patient as “teacher” and the need to identify and manage the interdisciplinary tensions in the management of care.

A project at **Université Laval** revealed that physicians and nurses do not always equally value supporting self-care and that implementing a culture of interdisciplinarity and self-care promotion among health care professionals requires concerted effort. The pilot project aimed to establish both an interdisciplinary partnership and a partnership with women experiencing menopause, thus promoting self-care in family practice units. Five training activities were developed for delivery using various tools such as informal presentations, group discussions, role playing activities, directed readings, practical workshops and a log book. The authors concluded that there is a need to challenge existing academic cultures to a greater extent and to call into question traditional practices.

The purpose of the project at **McGill University** was to develop an educational program that promotes a collaborative, self-care approach in the practice of nurses and physicians working in an out-patient family medicine unit. The focus of the program was on the development of learning partnerships between clients/families and their nurses and physicians. Another goal was to promote nurse-physician collaboration at all levels through the creation of new opportunities for interdisciplinary teaching, learning and research in the area of self-care. The eight-week program consisted of three main learning activities: interdisciplinary small group discussion, videotaping a clinical exercise and an interdisciplinary self-care learning module. The evaluation of the learning activities provided insight into strengths and weaknesses of each method. Among the tools developed for the project was a self-care questionnaire based on a variety of patient/family clinical scenarios (see Appendix D). The project resulted in positive interdisciplinary networking and new links between the School of Nursing and Faculty of Medicine.

Two other important barriers to educating health care professionals in supporting self-care are the discrepancy between educators' efforts to teach a supporting self-care approach and their inability to model self-care because of a lack of personal self-care practices. This dichotomy is also evident in practice when health care practitioners are unable to model self-care practices for their patients and clients. A funded project at the **University of Toronto** explored how to promote self-care in curriculum development. One important conclusion of this work was that the traditional culture in educational and health service institutions does not adequately support or foster a consistent focus on the care of self by health care professionals. For self-care initiatives to be supported at the individual level, they must be supported at the institutional level. To facilitate positive self-care concepts in students, academic health care professionals could adopt strategies such as encouraging self-reflection and self-awareness in faculty and students and better communication between faculty and students.

### ***Integrating support of self-care into professional practice***

Through the Initiative projects, physicians and nurses also learned about more specific strategies and tools for including support of self-care in their practice. **Nuu-chah-nulth Community and Human Services** on Vancouver Island conducted a pilot project to enhance the capacity of health care providers to promote self-care behaviours of clients in the community. In a collaborative process, nurses, physicians and community representatives prepared action plans to promote self-care behaviours. The project demonstrated the effectiveness of encouraging staff to develop action plans and identified factors that are barriers to and facilitators of self-care behaviours.

An outcome of the **University of Manitoba's** project is a self-care manual, developed to assist older adults practise self-care (see Appendix E). The manual is intended to emphasize the positive themes of self-care provided by participants in workshops attended by health care providers and older adults. It also provides potential solutions to some of the identified barriers to self-care (e.g., client's lack of motivation and provider's lack of time).

Another significant contribution from the pilot projects was the creation of a health calendar to encourage day surgery patients to take responsibility for their own health. Developed and validated at the **University of Moncton, Edmundston Campus** by day surgery patients, in conjunction with health care professionals, the tool provides service users with better preparation for dealing with the health care experience and helps health care professionals support the users' self-care efforts (see Appendix F).

To add to what was learned from the individual projects, the Coordinating Committee of the Shared Initiative commissioned Assessment Strategies Inc. to conduct a survey with the leaders and members of the various projects to identify the factors related to success or difficulties in developing the self-care projects and promoting self-care in general. Although responses to the factors varied, several factors emerged as being very important to success of promoting self-care. The most predominant factors or successful strategies were:

- adapting a program or intervention to the client's capacity, degree of motivation, ability and circumstances;
- involving, when appropriate, the members of the family and the support system;
- involving the target population in the development of the program or intervention;
- ensuring that resources are available in the community to ensure the continuation of self-care behaviours;
- involving multiple disciplines in the development of the intervention program or in the promotion of self-care approaches;
- ensuring that the practitioners are supported in their efforts to support self-care.

It is clear from the findings from the various phases of the project that support of self-care by health care professionals is occurring on an individual basis. However, both health care professionals and consumers have indicated that support of self-care is still not well integrated in practice within the health care system. Many barriers continue to stem from constraints in the work environment including lack of time, low staff complements and inadequate compensation. Other impediments relate to difficulties in changing attitudes and the approach to care from a disease-centered model to a patient or client-centered model. There has been little research on the impact of supporting self-care strategies on patient outcomes.

Other proposed strategies for reforming the delivery of primary health care also have the potential to reduce some of the challenges health care providers face in integrating support of self-care into their practice. For example, one solution planned to reduce the number of patients being assessed in emergency rooms at community hospitals by creating telephone triage services. In helping the people who call to address their health problems, nurses have the opportunity to support the callers' self-care efforts.

# Next steps



## *Next steps*

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In the exploratory study, physicians and nurses revealed that supporting self-care is professionally satisfying. Some spoke of the satisfaction that comes from seeing patients take charge of their health or from perceiving themselves as partners, with their patients, in the pursuit of health. Others spoke of the gratification of learning from their patients and the feeling of relief that the responsibility for the patient's health does not rest solely on the health professional's shoulders.

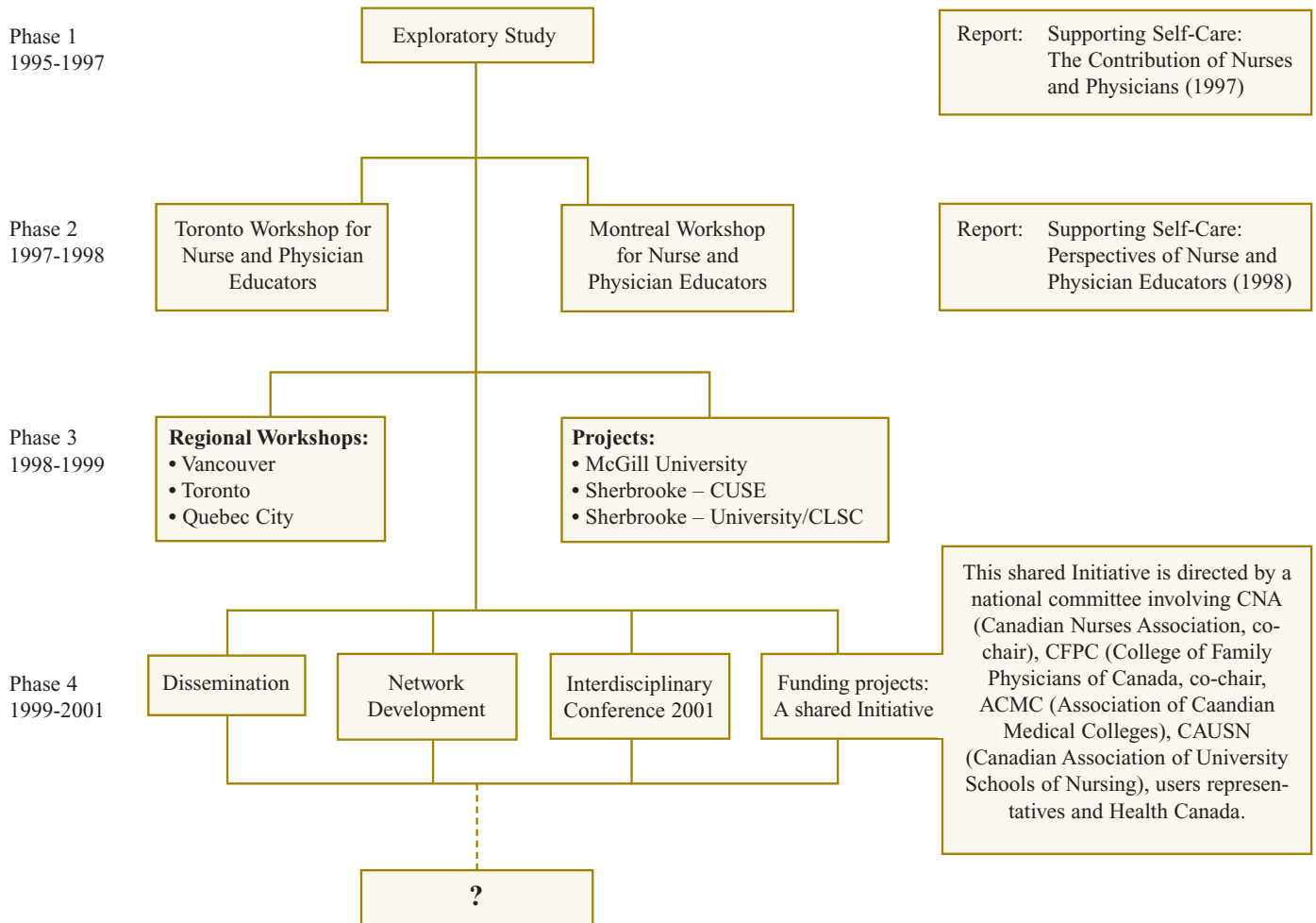
As the Project evolved, many other health care professionals and consumers added their voices to those who valued the opportunity to work in collaboration for an effective health care approach. They are convinced that the benefits of the supporting self-care approach are greater than the barriers. The Supporting Self-Care Initiative and the Supporting Self-Care Network have encouraged the participation of a critical mass of people who are eager to move this work forward.

It is anticipated that mechanisms and strategies for further implementation of supporting self-care in practice will take place through a multi-centered program of activities. A major objective will be to integrate supporting self-care into primary health care reform. The ultimate goal is to have a culture in Canada that creates an environment in which individuals feel motivated and supported to take care of their own health, as well as the health of those around them. It is recognized that implementation will have to link theory and experience in education and practice. Through the research capacity of the universities, evidence-based outcomes of self-care support by health care professionals can be generated through experimental approaches. Consumers will continue to play an important role in all of these activities.

## Appendix A:

### Supporting Self-Care: Project overview

**Objective: Critical mass of health care professionals involved in supporting self-care**



Health Canada, Health Systems Division, October 19



**Appendix B:**  
**Symposium Report**



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**SYMPOSIUM  
REPORT**

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Many people contributed to Supporting Self Care: A Shared Initiative, phase four of the Supporting Self-Care Project.

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We also want to thank the organizations involved in the Initiative who were really supportive, not only by sending representatives but also by creating spaces in their conventions, web sites and newsletters to share information regarding supporting self-care with health professionals.

Finally, the Initiative benefited from the collaboration of health care professionals who participated in the nine funded projects and also from those who attended the June 2001 symposium held in Ottawa. Their participation was greatly appreciated.

We also acknowledge the support provided by the Canadian Nurses Association's staff throughout the project in various fields.

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# BACKGROUND & INTRODUCTION

Supporting Self-Care: A Shared Initiative was launched by Allan Rock, minister of health, on 18 June 1999. It is the fourth phase of the Supporting Self-Care Project, which was launched by Health Canada in 1995. The goal of Supporting Self-Care: A Shared Initiative is to assist health care professionals, especially nurses and physicians, to support self-care in their practice. It solicited, selected, funded and monitored interdisciplinary projects that took place in clinical practice or educational settings. In addition, a Supporting Self-Care Network is under development for the purpose of facilitating information sharing, support and connections among health professionals and interested users, in order for health professionals to support patient and client self-care.

The organizations participating in this initiative are: the Canadian Nurses Association (CNA), the College of Family Physicians of Canada (CFPC), the Association of Canadian Medical Colleges (ACMC), the Canadian Association of University Schools of Nursing (CAUSN) and Health Canada. The initiative is sponsored by CNA, directed by a steering committee and managed by a project manager. The steering committee consists of representatives of all participating organizations and consumers.

The symposium, held in Ottawa on 2-4 June 2001, was the culmination of this fourth phase of the Supporting Self-Care Project. Health care professionals and consumers involved in the various funded projects, stakeholders in health education, policy and community care and representatives from other interested organizations were invited to participate in an exchange of experience, ideas, approaches and recommendations. The main objectives of the Symposium were to:

- Produce concrete recommendations in education, professional practice and policy to enhance the concept of Supporting Self-Care among professionals and to bring it to reality in relation with a primary care approach.
- Disseminate current experiences in the various fields of Supporting Self-Care.
- Strengthen the Supporting Self-Care Network.

## FORMAT AND PROCESS OF THE SYMPOSIUM

The symposium was structured around table discussions, plenary reports, open forum discussions and brainstorming sessions. Brief presentations of the reports of the funded projects were provided to participants, grouped around three themes or streams related to the area of concentration of the project: Professional Practice, Education and Community Practice.

This report of the symposium provides a brief outline of the presentations (full reports are available through the e-mail address as provided) and highlights of plenary discussions including key messages, common findings, suggestions and recommendations.

# OPENING REMARKS

**Abby Hoffman, Director General,  
Health Policy and Communication Branch,  
Health Care Strategies and Policy Directorate,  
Health Canada**



This symposium is a critical step and an important milestone in the Supporting Self-Care strategy. The exchange of ideas and experiences among various health care professionals, health educators and health care users that has taken place since the inception of the program has been a key characteristic of the progress that has been made to date, and this collaboration is again evident at this symposium.

Through Supporting Self-Care: A Shared Initiative, nine pilot projects were selected and funded. They have produced a number of innovative ideas, approaches and recommendations, which we will have the opportunity to review and discuss over the course of the symposium.

Health Canada believes that the long-term objective of the Supporting Self-Care project – that is reinforcing self-care support in the practice of health care professionals – is a crucial aspect in the renewal of Canada’s health care system, particularly in the context of primary health care.

Our challenge over the next two days is to identify innovative but practical strategies, to influence the practice and training of health professionals in order to help them improve and extend their responsiveness to the needs of their clients and patients. We are looking for concrete, reasonable and doable recommendations and suggestions. Your experience, insights and constructive collaboration are important and appreciated as we work together to move the self-care agenda forward.



**Dr. Robert McMurtry, Assistant Deputy Minister  
Population and Public Health Branch, Health Canada**

Thank you for your invitation to join you here today. It is a great pleasure to take part in this symposium and to have the opportunity to discuss and to share information concerning the future role of self-care in Canadian healthcare.

This symposium has three key goals: to integrate the philosophy of self-care with primary care; to improve collaboration between physicians and nurses and other health professionals; and, to integrate health professional expertise and patient needs — that is, patient-centered care based on care, communication and common ground. Progress has been made on each of these goals.

On behalf of Health Canada, I am very proud of the projects that were funded by the Supporting Self-Care Initiative. Today, I would like to briefly highlight examples of the projects that offer many potential solutions and help to build community capacity:

The University of Calgary Project's focus on three health areas — diabetes, palliative pain management and professional ethics — was very appropriate and applicable at many levels. The McGill Project is impressive for its integration of cultures of the professions; for sharing information and resources; and, for adapting existing materials. The Laval Project noted the need for concerted efforts to come together in a synergistic way. The Manitoba Project focussing on older adults is a success story in how it got its message across to the health professionals and users who participated. The University Health Network Project sought to create a community of health learners, teachers and professionals — building community capacity may be the most important thing we can do. The New Brunswick Project overcame strikes when the project was underway and kept the project on target. As they stated in their conclusion “at the dawn of the new millennium, methods for delivering health care are constantly evolving and require new practices and changes designed to address the public's biophysiological, psycho-cognitive and socio-economic needs.” To integrate these needs is crucial and very much part of the project. “Promotion of self care by health care professionals and acceptance of responsibility for self-care by individuals are highly recommended and desired.”

This good work has to have the opportunity to make a difference. Accordingly, we need to not only build on these success stories and this symposium, we need to report, reform and network. We need to develop practical and concrete recommendations that look at education, professional practice and policy. We need to ensure that this information is disseminated and these ideas are shared, especially in the primary health care context. The Supporting Self-Care Network is one of the key ways to do this, and we all need to support it and ensure that it does succeed.

This group of people who are here today, can lead these efforts. The extent to which you believe that you can lead will correlate directly with your success in leading. You represent through your organizations nearly 300,000 Canadians. The issues related to health and health care are priorities for all Canadians. The evidence that you are able to produce is growing and further strengthens the claim that self-care works.

But who will define the future? If you have a unity of purpose amongst the people that you represent then you can define the future and I thank you for the efforts you have made to make the kind of difference that will help achieve your goals.



**KEYNOTE SPEAKER**

**5**



# EXPECTATIONS

Participants, in their table groups, discussed their expectations for the symposium. The following are some of the key common expectations as presented in plenary.

Many participants want to see the development of practical, concrete strategies for moving the self-care agenda forward. This would include recommendations and suggestions regarding relationships between health professionals and clients, discussions about systems and structures that support self-care, the identification of health care areas where the self-care concept is most needed and appropriate, strategies to educate and promote the concept of self-care with students and faculty, health professionals and consumers, and ways to apply self-care to meet diverse cultural needs. To achieve this, there is a need to be flexible and collaborative and to recognize the complexity of the issue and process. It will also be important to develop a clear understanding and definition of the term “self-care” and of the stakeholders involved.

There is a need to “embed the values of self-care” across the continuum of care providers and care recipients, and within educational facilities and curricula. It is a psyche that needs to be embedded in the social framework/system (culture, educational system, workplace, community, family, etc.). An understandable, “consumer-friendly” model of self-care will be needed for consumers in order to get their buy in. From the perspective of health professionals, there is a need for practical examples and answers to the question: How do we help our patients “live” self-care?

Sharing information and experiences, learning from each other and networking were other key expectations for the symposium noted by participants.

## STREAM 1 PROFESSIONAL PRACTICE



**Presentation: Self-Care Pilot Project Based on the Traditions of Various Cultures**  
**Françoise Moquin and Anne Véronneau, Maison d'Hérelle**  
**francoise@moquin.com**

This self-care pilot project used ancestral healing traditions in various cultures as part of a major change in our approach to dealing with AIDS. The project was designed to foster new attitudes and professional skills in caregivers in the area of self-care, through exploration and education initiatives. Six workshops (Traditional African Medicine and Herbal Medicine, Indian Ayurvedic Medicine, American Indian Medicine from the Mohawk Nation, Druidism, American Indian Medicine from the Vancouver Region, American Indian Medicine from the Algonquin Nation) were organized with multidisciplinary teams (physician, nurses, social workers) and service users. At each workshop, participants could draw on the experience of resource persons with expertise in holistic approaches to self-care based on ancestral healing traditions from specific cultures. The workshops were well-attended by service users, volunteers, family, friends and health care workers, and represented a variety of backgrounds and education levels.

A video was produced based on these workshops. With this tool, a wider audience will be able to benefit from innovative discussions and various concepts of self-care in the context of AIDS.



**Presentation: Relax! It's only stress-reduction training**  
**Dr. Donald Sproule, St. Mary's Hospital, Family Medicine Centre**  
**donald.sproule@mcgill.ca**

An eight-week stress reduction and relaxation training course was given with funding from the Supporting Self-Care Initiative. The main purpose of the project was to provide both healthcare professionals and patients with self-care tools designed specifically to reduce stress and enhance health and well-being. An innovative aspect of the program was the mixing of providers and users in the same group for the two-hour classes. Themes covered in the course included the symptoms or manifestations of stress, communication skills to deal with social stressors and the relationship between nutrition and chronic illnesses, as well as the practical teaching of the actual stress reduction techniques, such as breathing exercises, yoga, meditation and a technique called the "body scan", which involves visualizing the various parts of the body and relaxing them with the breath. Participants were provided with audiocassettes to help them practice at home.

The course was well-received by both the health professionals and the patients. The basis for a permanent stress reduction and relaxation program at the St. Mary's Family Medicine Centre has now been established. There are plans to expand the classes to 2½ hours, offer a one-day retreat at the end of the course, develop a workbook for participants and to provide a refresher course for "graduates."

## PROFESSIONAL PRACTICE

- Self-care is consistent with the patient-centred approach.
- There are positive results when the patient is viewed as an equal partner.
- The shared learning process demonstrated by the projects leads to a positive communication process.
- There is a need to value self-care before it can be effectively introduced into practice.
- Self-care is a value-system, a philosophy that must be incorporated by the health care professional to be effective in fostering and supporting self-care in our clients.
- If you believe in an intervention, you'll be more likely to apply it and recommend it. The attitude of the person providing care and of the recipient of care is important.
- Commitment to self-care must be governmental and organizational as well as individual.
- Self-care needs investment to happen: funding, time and education/promotion to achieve buy in.
- It is important to acknowledge and accommodate cultural diversity, for example, there is a need to define “family” in broader terms. One model for self-care may not fit for all.
- It is important to get the patient's full “story” and context.
- Do you have to experience self-care in order to practice it?
- There needs to be broad-based reflection (accountability for decisions) as one moves through self-care: self reflection, the reflection of other care providers, and reflection of the primary care giver.
- The terms “caregiver” and “recipients of care” need to be applied carefully – are these appropriate terms?
- Health care professionals can learn from lay people.
- It is still difficult to promote strategies for self-care.
- Self-care is a “need to know” not a “nice to know.”

## STREAM 2 EDUCATION



### **Presentation: Promoting Self-Care in Curriculum Development: A Workshop for Healthcare Professionals and Students**

**Vaska Micevski, MScN, PhD(c), Toronto Western Hospital, University Health Network  
Vaska.Micevski@uhn.on.ca**

This project looked at the importance of self-care in health curricula and the barriers and facilitators to introducing and integrating the concept to curricula development. The project invited health care professionals and students to participate in focus groups and to complete a questionnaire. A report of the study was presented in a workshop attended by members of the University of Toronto curriculum development committee in order to formulate recommendations for further research.

Key areas of discussion at the workshop included the role of academia in fostering/facilitating/promoting self-care attitudes; crisis prevention in health care professionals at the earliest possible stage; empowerment of health care professionals from training; and increasing health care professionals' credibility through positive self-care practices. One of the key conclusions from the study and workshop are that self-care initiatives must be supported at the institutional and educational levels in order for them to become incorporated at the individual level. However, the institutional culture of the health care fields does not adequately support or foster a consistent focus on self-care. Another key conclusion is that the single most important element to promoting self-care is self-awareness/self-reflection, and by extension better health care professionals. Overall, positive changes could be made at the academic institutional level, which would then facilitate better self-care concepts for health care professionals. There is a role for academic health care professionals to help facilitate positive self-care concepts in students.



### **Presentation: Supporting Self-Care Demonstration Project, University of Calgary Rodney Crutcher, MD, FCFPC, Associate Professor, Department of Family Medicine, University of Calgary, UCMC Sunridge crutcher@ucalgary.ca**

The project was designed around the following theory: self-care content and context needs to be made explicit to the healthcare professionals. The overall activity was an educational intervention planned to incorporate self-care theory into clinical curriculum in an interdisciplinary model of learning. The project sought to look at the principles, practices and ethics of self-care and focussed on three health areas: diabetes, palliative pain management and professional ethics.

The project provided opportunities for interdepartmental as well as interdisciplinary activities related to educational intervention with a self-care focus. The design of the projects allowed extensive community participation in the project delivery that ranged from patient dialogue, to family member retrospectives on illness, to community resource agency staff. The two key lessons learned of the project were the importance of the patient as “teacher” in care planning and the need to identify and manage the interdisciplinary tensions in management of care.




**Presentation: Training to Establish a Partnership between Physicians, Pharmacists, Nurses and Women to Promote Self-Care During Menopause**

**Louise Hagan, PhD Nursing, Professor, School of Nursing, University of Laval**  
**[louise.hagan@fsi.ulaval.ca](mailto:louise.hagan@fsi.ulaval.ca)**

The project's objective was to establish a more formal partnership between physicians, pharmacists, nurses and citizens in an effort to encourage citizens to take responsibility for their own health. Five training activities were developed for delivery using various tools such as informal presentations, group discussions, role-playing activities, directed readings, practical workshops and a logbook. Participants included medical students (graduate students completing residencies in family medicine and nursing), graduate students in pharmacy and community health care, family physicians, nurses working in family practice units and women experiencing menopause and one spouse.

The project reported that there was a sense that supporting self-care was not necessarily equally valued in both medicine and nursing. Implementing a culture of interdisciplinarity and self-care promotion among health care professionals requires a concerted effort. The dialogue must extend beyond teachers and clinicians to politicians, administrators and researchers. Implementing support for self-care requires funding for activities and research projects and the participation of a broad range of "ordinary" citizens. It is important to not underestimate the "cultural" differences among professional groups but also between the professional world and the citizen. There is a need to challenge existing academic cultures to a greater extent, to call into question traditional practices, destabilize and challenge the status quo.



**Presentation: Phase II: Developing and Implementing Strategies that Promote a Collaborative, Self-Care Approach in the Practice of Nurses and Physicians**

**Catherine Gros, N, MSc(A), McGill University, School of Nursing**  
**[mpurden@wilson.lan.mcgill.ca](mailto:mpurden@wilson.lan.mcgill.ca)**

The purpose of the project was to implement and evaluate an educational program to support a collaborative, self-care approach in the practice of nurses and physicians working in an out-patient Family Medicine Unit. The main focus was on developing learning partnerships between clients/families and their nurses and physicians. Another key goal was to promote nurse-physician collaboration at all levels through the creation of new opportunities for interdisciplinary teaching, learning and research in the area of self-care. The resulting eight-week program consisted of three main learning activities: interdisciplinary small group discussion; a clinical videotaping exercise; and an interdisciplinary self-care learning module. A pre-test/post-test measure was developed to assess changes in clinical practice. In addition, the program was evaluated through a self-report questionnaire and a focus group. While half of the clinicians reported changes in their clinical practice as a result of the program, no clear pattern of change could be identified through the pre/post measure.

Without exception, the participants rated the videotaping exercise as the most helpful of the three learning exercises. However, the videotaping was hard to coordinate, requiring a substantial investment of human and material resources. As a result, this exercise would not be feasible for use with larger groups of learners and the development of less time-consuming and labour-intensive strategies are essential in order to successfully promote the practice of self-care concepts and skills with busy nurses and physicians. The use of clinical scenarios, included in the learning module and reviewed in the group discussion sessions, appear to provide a practical alternative for teaching concepts such as the person's readiness for intervention and for learning to implement responses that are appropriately tailored and timed to each unique situation. Findings indicate that this strategy, originally developed in Phase I of the project, is readily adaptable across acute and primary care settings and applicable for use by individual clinicians as well as interdisciplinary groups. Ongoing development of these scenarios and further research regarding their impact on learning is warranted. The project also resulted in positive interdisciplinary networking and served to forge new and important links between the School of Nursing and the Medical School. In addition, exposure to students from another discipline provided an important learning experience for faculty, expanding upon their current expertise.

## EDUCATION

- It is both surprising and disconcerting that multidisciplinary collaboration is considered a new idea.
- It is important to have role models to communicate self-care to students.
- The focus of clinicians is on acute care, and self-care has become a “nice to do” rather than a “need to do.”
- The promotion of self-care should take a cultural/social context.
- Interdisciplinary training is positive.
- “The patient as teacher” is powerful. It is important to listen to the stories of patients.
- We don’t always practice what we preach — there is a need for better role modeling.
- The use of appropriate terminology is important. For example, “patient” or “client”? Neither of these terms really suggest that the person is a partner in care. Similarly, there are problems associated with proprietary attitudes toward knowledge.
- An anthropologist may be a good source for insight in dealing with the cultural attitudes associated with self-care.
- There is a need to be cautious in making generalized statements based on a small sampling.
- The partnership model vs. the interdisciplinary model: what is the partnership? Is it created by the disciplines? Who is it for?
- Teaching about self-care (the “how to”) should not be confused with moving the concepts and values of self-care forward.
- The area that health professionals are especially good at is communicating knowledge to others — it is also important to communicate at other levels, for example the emotional level. Skills in this area need to be enhanced to support self-care.
- Education regarding self-care should start long before university — it needs to be rooted in our culture.
- Multiple strategies are most effective: one on one, group sessions, videos, etc.
- The change that must take place to facilitate the multidisciplinary collaboration needed for self-care will be applicable and beneficial to many other areas of the health care system.
- Self-care is counter-cultural to health care professionals (i.e. it is not valued or promoted in the culture of health care professionals, as evidenced by long hours and self-sacrifice).
- Patient integration is an important driver to the learning process, but the choice of patient representative is key.

## Questions for Clarification

- Are there strategies in place for campuses of only undergraduate nurses? Is there a strategy that puts undergraduate and graduate nurses together?
- Are there strategies to deal with differences in attitudes, especially in terms of control and power both between health care professionals and between health care professionals and their patients?
- What are some of the barriers to self-care, other than the historical tensions between doctors and nurses?
- At what point in the patient’s care is it important to facilitate self-care?
- How do we promote self-care when self-care is counter-cultural to health care professionals? How do we change attitudes about self-care among health care professionals and how do we sustain these changes?

## STREAM 3

# COMMUNITY PRACTICE



**Presentation: Promoting Self-Care in Nuu-chah-nulth Communities**  
**Jeannette Watts, Nursing Supervisor, Nuu-chah-nulth Community and Health Services**  
**[jnetwatt@island.net](mailto:jnetwatt@island.net)**

The major objective of the project was to enhance the capacity of health care providers to promote self-care behaviours of clients in the community. The project encouraged intersectoral collaboration between the Nuu-chah-nulth Community and Health Services as an employer of nurses, local community physicians and the community health representatives from the First Nations communities. Project activities included: workshops to develop action plans; implementing action plans in the work setting; evaluating the effectiveness of the action plans; and disseminating the findings. The action plans that were developed by participants were used in various ways, including to provide focus and direction, to guide and organize, as reminders and with clients.

The project demonstrated the effectiveness of encouraging staff to develop action plans promoting self-care in clients. This was easily accomplished because self-care is a major characteristic of the Nuu-chah-nulth nursing philosophy and framework. The consensus at the completion of the project was that self-care practice needs to be continued and implemented in all training and orientation activities.



**Presentation: Supporting Self-Care for Older Adults: Building upon a Self-Care Framework**  
**Malcolm Doupe, MSc, BPE, Research Associate, Department of Family Medicine, St. Boniface Research Centre**  
**[mdoupe@srbc.mb.ca](mailto:mdoupe@srbc.mb.ca)**

The objective of this project was to complete a series of focus groups and educational workshops to investigate the effective strategies for health care professionals to promote and assist older adults to practise self-care and older adults to become more educated about the daily practice of self-care. Participants in the project included older adults, family physicians, nurses, social workers, pharmacists, occupational therapists and dentists. Activities in the project included questionnaires, focus groups and participant-mediated workshops.

According to participants, the most important parameters of self-care practice include physical health, social health, cognitive health, safety and adaptation as well as education. The most important themes for health care professionals to consider when supporting self-care include empowerment and education, developing relationships, comprehensive assessments and collaborating with other health care professionals. Barriers to self-care noted by participants include lack of motivation, non-compliance, dependence on the health care system, lack of time for health care professionals to fully understand the important community life aspects of the older adult and lack of community services and resources (or the lack of knowledge about existing resources). A self-care manual is being developed by the project team to assist older adults to practise self-care.





**Presentation: Health Calendar**

**France Marquis, BS Nursing, MSc Nursing, Professor, University of Moncton**  
fmarquis@cuslm.ca


Project goals were to determine the impact of a perioperative program encouraging day surgery patients to take responsibility for their own health and a perioperative program for health care workers on supporting self-care. People who have undergone day surgery and health care professionals participated in the development and validation of the Health Calendar. The tool encompasses the activities and information related to the three stages of the day surgery process: the preoperative, perioperative and postoperative stages. It provides service users with better preparation for this health care experience and helps health care professionals support the users' self-care efforts. It also helps health care professionals standardize their actions for supporting self-care.

The tools developed for this project, especially the Health Calendar, could potentially be used by service users in other health care contexts, with potential links to health promotion, prevention, recovery and rehabilitation. Promotion of self-care by health care professionals and acceptance of responsibility for self-care by individuals are highly recommended and desired.

**PLENARY DISCUSSION:**

# **KEY MESSAGES & LESSONS LEARNED**

## **COMMUNITY PRACTICE**

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- It is important to incorporate the needs and expectations of both the community and individuals (patients) when designing tools and resources. Including the community will help build community buy in. Including individuals will help build a sense of security in patients and contribute to buy in.
  - There is a need to recognize the cultural context in which tools will be applied/used. The cultural context will often include an element of spirituality.
  - The resources and services outside health care settings (such as community groups, clubs, churches, etc.) may provide insights and assistance. These resources can also assist in helping to change attitudes and behaviours.
  - It is important to address the motivation factor: how do we build motivation for self-care? There is often a great dependence on the health system. There is a need to communicate the benefits of self-care, as they will be strong motivators.
  - The whole support system needs to be examined, beyond the health system. For example, often workers' compensations systems restrict or discourage self-care practices. Collaboration across sectors is needed.
  - How can health care professionals learn to work within other cultures? It is important to engage members of a culture or community in partnership.
  - There are many approaches and many tools that are effective.
  - Wisdom, sensibility, empathy and support are key words to remember.

## PART TWO

# FOCUS ON WHAT WORKS BEST

Participants were invited to select one of the streams (Professional Practice, Education or Community Practice) for in-depth break-out group discussion.

The discussions started with a period of personal reflection, in which each participant thought about an event, project or situation that had been fulfilling and effective and gave them a sense of well-being and accomplishment. Participants reflected on the aspects that were of value to them, what they valued about themselves at the time, and how the experience enabled them to achieve balance. Participants then shared their experience and thoughts in a “storytelling” session with a partner. Each participant then described the *powerfully positive* aspects of his or her partner’s story with the table group. Participants were asked to consider the values and behaviours that were enlivening in each story.

In plenary, each group presented their key findings in response to the following question:

**What are the core factors that enliven and sustain activity in your stream?**

### Education

The group presented a motto: “One for all and all for one!” The educational experiences of participants that had been the most positive were ones that related to that motto. To be effective, learning or education must be meaningful to the learner and, therefore, should include the client. The learning does not necessarily need to be easy – the more challenging the experience, the more meaningful it is in many cases. The information or learning (the “what”) has to also be relevant, timely and meaningful. The educational activity (the “how”) and the educational environment are also important. An environment where everyone, including the patient/client, is supported, equal, respected and valued helps set the stage for a meaningful experience.

Positive educational experiences are allowed both through the acquisition of new knowledge and through sharing knowledge with others. The external environment is also important and influences the way we learn and work. Support from colleagues, from family and friends and support from clients/patients all create a positive learning environment. In a self-care context, you have to achieve balance, take time for reflection and have a level of self-discipline.





## Community Practice

The personal relationships and the connections with the people on your team help build positive experiences. There needs to be a “chemistry” between all the partners that creates trusting, effective, productive relationships. Teams may be small or large — either way they provide an environment of support, a framework for positive communication and human connections. The common goals and common messages of the team are important. There must be a non-judgemental attitude and acceptance of people and their situations. Flexibility is another core aspect — especially around options for care and the roles of those involved (despite the preconceived ideas of others).

Like the team, partnerships are core to effective networks. This includes personal partnerships, team partnerships and partnerships with other professionals. In partnerships, each partner influences the other in the way and content of what we practice and the context in which we think. It is a give and take process of ideas, attitudes and methods.



We need to be aware of external influences (budgets, values in the system, bureaucracy), and sometimes we will need to work to overcome them. We need to understand and find a balance in terms of what we can change, and what we cannot change. Balance is also needed in terms of local capacity and centralized control. Time is another core factor — change takes time, energy, a shared vision and commitment.



## Professional Practice

When you have a team of experienced, capable professionals who are motivated; have energy, a sense of spirit and a shared vision; and are all heading in the same direction, you have a positive, effective team that will reach their destination.

Autonomy and independence as well as respect for others are key values that sustain us. It is important to feel comfortable in your functions and to be in a working context that is consistent with your values. You must begin with your patient’s or client’s needs before your own. It is important to maintain balance and to respect the rhythm, functions and capacities of others. One of the key balances is to be sure to give ourselves the freedom and time to think and the means to operationalize — in other words, the possibility and the right to dream.

## PART THREE

# THE SUPPORTING SELF-CARE NETWORK

Members of the Supporting Self-Care Network Development Committee were introduced to participants by Alain Vanasse:

- Hector Balthazar, Representative for Seniors, Ottawa
- Laurie Potovsky-Beachell, Consumer Representative, Manitoba
- Juliette “Archie” Cooper, School of Medical Rehabilitation, Manitoba
- France Marquis, Professor, University of Moncton, New Brunswick
- Wayne Weston, Byron Family Medical Centre, Ontario
- Lynne Young, Registered Nurse, Vancouver

France Marquis provided participants with a brief overview of the Network’s goals and processes.

The Supporting Self-Care Network is the result of a number of recommendations from previous workshops and meetings that have taken place since the launch of the Supporting Self-Care Project, and it is a key part of Phase 4.

The mission of the Network is “to facilitate sharing, support and connections among health professionals and interested users and in order for health professionals to support patient self-care.”

### **The Network has five key objectives:**

1. To connect health professionals who are interested in and committed to supporting self-care with like minded professionals and users.
2. To facilitate the sharing of information, knowledge and experience among health professionals and users.
3. To provide credible sources of information about supporting self-care.
4. To encourage and improve competencies among health professionals related to knowledge, skills, attitudes and values toward supporting self-care.
5. To advocate changes in the education systems for health and social services that will help overcome systemic barriers to supporting self-care.

The Network is based on a number of values: credibility, professionalism, commitment and respect, enablement and empowerment, interdisciplinary collaboration, inclusiveness and diversity.

The elements of the Network include an electronic directory, a discussion mailing list, a quarterly newsletter and an interactive web page.

Why should you join the Network? We will connect you with people who share your values, people who could provide moral support when needed. You will be able to exchange ideas with others to help you fulfill the expectations of your clients and patients. By joining the Network, you get access to credible information that is practical and useful, including information on best practices that will help you improve your practice or your teaching.

To join the Network or to obtain more information, visit our web site at [www.supportingselfcare.ca](http://www.supportingselfcare.ca).

# FOCUS ON WHAT WE WISH FOR

Participants worked in their table groups to identify their top three wishes for stakeholders so that they can embrace and realize what is best about self care in Professional Practice, Education and Community Practice. Participants were directed to be “bold and audacious” in their wishing.



## Education

The first group on Education presented four themes:

1. **Scholarly work:** To do good work in self-care, there is a need for scholarly work to ensure common understanding on the theory and definitions related to self-care. The scholarly work requires sound and understandable research and evidence and “stories” that have been adapted to the scholarly level.
2. **How we learn:** This goes hand-in-hand with scholarly work — but we don’t have to wait for the research to be in to begin. Curriculum, learning itself, the building blocks of learning and the excitement of learning are all part of how we learn. It is important to “park our disciplinary turf” at the curb and focus on what is of benefit to the client or patient. In order to do this, we have to be confident in who we are and comfortable relinquishing some of the roles that we thought were only ours to do. The earlier we start teaching and learning about self-care the better. The issue of collaboration with other health care disciplines and with health care consumers when putting curriculum together has to be at the forefront of what we do from now on.
3. **Interprovider/Partners:** In addition to interdisciplinary collaboration around how we learn, the concept of partnerships — that communities can be partners and that disciplines can be partners — is important. Above all, we need to recognize that the client/patient is a full partner in the learning experience. The interprovider collaboration also has to be done in the bigger environment — we need to realize that federal, provincial and local practices, politicians and health consumers are really our partners and we have to engage them in the excitement of the concept of self-care. We also have to redefine what we do, from disciplinary tasks to our disciplinary and partnership responsibilities.
4. **How we practice:** It is important that we “walk the talk.” We need to translate our theory and our learning into practice. There is a need to create model settings, and these will likely look much different than practice settings have traditionally looked (for example, student physicians and student nurses looking after the same families). We need to build in recognition of care for self in all we do — not just caring for ourselves as professionals, but caring for our patients in a different kind of way. There is a geographical factor — self-care is not just limited to rural or semi-rural settings. There are also “head and heart” issues to consider. In practice, how would you know if you are doing a good job? There need to be ways to measure outcomes and to identify evidence that matters. There is a need to create a theoretically-solid, practical, partnership-based educational “facility” that is self-care centred.

**The other group on Education noted three key dreams or challenges:**

1. To solve tensions between nurses and doctors and encourage support between the two groups.
2. To change the health culture in Canada. Currently, one's health is put in the hands of other people. People need to take charge of their own health.
3. A National Research Institute for the Promotion of Self-Care. This would provide a place for research, education and clinical practice and would also analyze the results. Another dream would be to have community research centres, well-supported by funding.

To help ease tensions between nurses and doctors, the health structure must support self-care. Nurses should be at the same level as doctors, and to do so they require good training (baccalaureate education). The idea of doctor/nurse teams should start early in the medical education process, with common projects, common goals and values, and also include continuous training. The regrouping of health care disciplines to facilitate self-care must be a condition of funding.

To help change the health culture, an awareness campaign targeted to both adults and children to promote self-care should be launched.



## Community Practice

The first group felt we should develop in our dreams a wide vision of a culture of self-care. The concept of self-care should be integrated in the larger context of community — not as a separate concept but rather within a global vision of health.

Participants see a triangular partnership based on equal collaboration among the team and the patient. There is a partnership between the team and the client or patient and among the members of the health care team itself — with no one person or discipline in control.

Education should be targeted to the community. It is important that people be well informed on health matters, and they need access to accurate information. People have a responsibility to inform themselves and care for themselves, but they need the information tools and the ability to access understandable information in order to do so. Health care professionals have a role to play in helping people receive the necessary information and education, but ultimately the user should feel and be responsible for obtaining the information and the care required.

Goodwill is not enough to make these dreams happen — there needs to be partnerships in place and structures that support those partnerships. Administrative and financial resources are also needed to operationalize these dreams.

The second group expressed a need for an overall systems change. Participants have a dream that the whole health care system and the other systems that support wellness (such as housing, water, etc.) are viewed with an holistic approach — mind, body and spirit. Government policy for all areas is put through the “prism of health” to ensure consistency with health goals. Cultural sensitivity is embedded across the system. The systems are not parallel, but people are working in an interdisciplinary way to support health care. As part of the overall systems change, there is a need for a major rethink of the goals and financing of the health system. The system change will support a shared-care model. There must also be a people focus: there needs to be more ownership of the health care system by persons rather than by bureaucracy. There is a need to empower the general public.

The development of new local community programs will be part of the overall system change. This will lead to a greater sense of trust between the public and health professionals. There is a need to acknowledge the demographic changes that are taking place and provide more programs and services for people over the age of 65. At the same time, it is important to introduce the concept of self-care at the elementary school level by involving students, teachers and others. The community programs can distribute health information, such as information about self-care, for both users and health professionals.

There are a number of values that would be embedded in the system: it would be portable, universal, accountable, more inclusive. There would be sufficient health care professionals to meet the needs of the population and sufficient resources to train health care professionals. Self-care is valued. People have access to their own health information. There are flexible work hours for health care professionals. Overall, the system must maintain the principles of universal health care.

We need to relearn about caring — about how an individual feels about their health; we need to involve families in health care, and we need to focus on the “caring” part not the “dollar” part.

**Other dreams expressed by the group included:**

- Health care is delivered, and health care professionals work in pleasant physical environments.
- The media looks positively at health services.
- There is a values-based approach to self-care that brings us closer to the human processes including death.
- There is greater openness to and acceptance of alternative and complementary therapies, both by individuals and as part of the health care system.
- There is more emphasis on experiential evidence at all levels.





## Professional Practice

The first group felt that there is a need to develop a systems model to support self-care practices. This would be used to develop and assess programs, to evaluate practices, etc.

There is a need to address the “new spirit of self-care” by moving beyond the knowledge and the “how to” stage. We need to have a philosophical lens with which we address our relationships with patients.

The incentives and tools to support change need to be in place, such as rewards and the infrastructure necessary to make self-care practices happen.

### **The dreams of the second group fell under five themes:**

1. Creativity: A weekly draw, for example, where the winner would be DG for a day. A wild dream — but the point is that everyone should understand other people’s jobs.
2. Education.
3. Values.
4. Organization: Self-care is fully integrated in the system. We take better care of ourselves in order to take better care of others. There should be meetings and exchanges amongst the health care team. There should be mandatory meal and rest times for health care professionals (part of our own self-care).
5. Policies: We use our own power to change things, to influence the organization toward self-care. We have the power to do it.

*“We have the freedom to dream and the power to act to change things.”*

## Common Themes Across the Streams

- **Early education is important to develop the concept of self-care into our culture.**
- **Partnerships between the different interveners, health professionals, patients and nurses are vital.**
- **Government departments have to speak to each other and focus on the prism of health care.**



## PART FIVE

# FOCUS ON THE FUTURE

From these dreams and wishes, participants were asked to focus on the ones that they feel are most important and to discuss and develop the elements that would need to be in place for them to become a reality.

Participants identified three key themes for further discussion:

1. Overall systemic or societal change, including both organizational change and culture change.
2. Education issues in broad terms and with a focus on research and scholarly work.
3. Local and community programming.

Participants selected one of the themes to explore in-depth in order to develop a description of the future, the steps required to achieve that future and recommendations to institutions or individuals (including recommendations to oneself) to move forward.

The group then presented their key findings in plenary.

## Education

### Group I:

#### ***What do we look like in the year 2036?***

As a society, as health care professionals, as academic leaders, we value models for practice. We support self-care practice in education and in practice settings. Faculty value opportunities for self development and provide opportunities for others for self-development. Politicians are well educated on the value of self-care.

Self-care values have a presence in the whole continuum of education — from toddlers on. Self-care itself does not slot into only one area of the health system — it is evident and practised along the continuum. Transdisciplinary courses are available along with multidisciplinary fieldwork that places teams in the community. Patients and the community are involved in curriculum development and evaluation. Demonstration projects provide guidelines for curriculum development. Education standards are built within accreditation standards as well as curriculum evaluation standards.

Funding is available for the transdisciplinary collaborative work around self-care projects. Funding is also available for the “art” part of health services and practices as well as for the sciences.

#### ***How do we achieve this vision?***

Everyone in the health care system needs to be involved in making this happen. But most important, the clients, patients and the public must be involved. The development of core competencies and the incorporation of self-care values in curriculum and multidisciplinary courses requires common language and definitions. This requires collaboration and dialogue.

We need to have dedicated funding for curriculum development. Each discipline has an association or accreditation body (both at the national and provincial levels) that needs to be involved. There must be dedicated links that go from academia to practice and vice versa.

In the research area, we need to develop evaluation criteria – what are we trying to measure? – and research specific to the area of multidisciplinary care and the concept and practice of self-care.

We need to look at and evaluate our teaching and ensure that we are effective. The focus needs to be on both the “art” and the “science,” and efforts must be made to better incorporate the two together. Key funding sources include: SSHRC, CHSRE, CIHR (specifically the health services area).

The overall key aspects are the definitions, language and understanding that we are all on the same page – “Mobilize, collaborate and include.”

**Group 2:**

**Designing the Future**

Educational programs: There are formal and informal interdisciplinary self-care programs for health care professionals and for students during their training and fieldwork. There is a multi-layer evaluation system in place, supported by the CIHR, to track health outcomes. There is equality throughout the health education system.

Curriculum programs: Self-care is part of the core competencies, embedded in the learning process. There is a need to develop ways to assist health care professionals in taking “spiritual histories” of their clients/patients. There is a need to include other cultures in the development of the curriculum. There is a role for mentors.

Policy making: Bureaucracy is decreased. Policies are based on care and caring, rather than cure. The media should be involved to help promote these concepts.

*“Put the passion back into compassion.”*

## Local and Community Programs

**Philosophy of the Model**

The model needs to be interdisciplinary, across the age span, encompassing all levels of health, from wellness to aging and death. Within the model there has to be trust with those who are providing and those who are practising self-care. There has to be ownership and empowerment and a willingness of the individual to buy in. The model must be inclusive, multicultural and support diversity. There has to be continuity of care. There have to be linkages within the community and within the health care system. The model must be tailored to the community’s needs – what works in an urban centre may not be suitable in a rural community. There needs to be a monitoring system in place.

The group noted that before developing community programs, needs assessments must be done. It is important to educate all members of the community about self-care, beginning at the elementary school level. There needs to be continuity of services, including home services, health promotion, curative, protective, transportation, rehabilitation and outreach programs linked with health professionals.

Participants wondered what a multidisciplinary “community centre” might look like – would it be a building? A virtual network? Resources need to be accessible and understandable to be applicable. People must also be aware of the resources, so there is a need for promotion. Administrative support must also be in place. Resources – human, material, expertise, time, money – are required.

Overall, the model needs to be inclusive, multidisciplinary and interdisciplinary. It must foster buy in in people by ensuring they can get the services they need to meet their specific needs.

## Systemic Change

### Group I:

The groups noted four key areas for focus:

#### 1. **Person-centred change:**

- It is necessary that any systemic change begin at the user-driven level and that there is user-driven involvement in the criteria. The group recommended that all government-funded agencies have criteria in place that facilitate and ensure user involvement.
- Early education for self-care is important, so there will need to be collaboration with ministries of education.
- Mechanisms for measuring results need to be in place.
- Promoting an accreditation system for self-care is another way to move the agenda forward.

#### 2. **Government supports in place to support self-care:**

- Incentives and rewards: such as changing provincial fee schedules to include supporting self-care; governments including supporting self-care as one criteria when providing grants to hospitals or research initiatives.
- Prism and focus for public policy: all public policies, at all levels of government, should be evaluated for the implications that they have on health.
- Evaluation: government incentives for health care professionals to evaluate the supporting self-care programs that they have in place.
- Support for partnerships: governments should increase the support for partnerships with other sectors for self-care, and between other government departments and other levels of government. Private sector initiatives should also be encouraged through tax incentives. Government departments at all levels should ensure that they are communicating with each other.

### **3. Business fueling a momentum for self-care:**

1. Promoting awareness and lobbying: the development of government and industry awards to businesses that promote and engage in healthy practices in the workplace.
2. Partnerships: community, business and government partnerships promote self-care awareness.
3. Incentives and standards: tax credits or tax penalties for businesses that do or do not engage in practices that promote self-care and healthy practices in the workplace; support for business cases that demonstrate ways to promote and achieve healthy choices.

### **4. Leadership must be shared, ongoing and lead to concrete results:**

There has to be a coming together of government, citizens and professionals. It is too great a burden, too complex and too risky politically for any one person. The shared leadership must be sustainable, ongoing and partnered, with ongoing monitoring, evaluation and “quality assurance.” Above all, it must be concrete with real initiatives, priorities, standards, policies, public campaigns and funding to match our requirements.

### **Group 2:**

The group proposed a number of strategies:

- A Communication Strategy that is transparent and multi-level and directed to governments, professional associations, consumer associations, unions and individuals. The strategy must be done by the professional associations. Health Canada should hire a publicity specialist to communicate the idea of self-care to the public, for example pointing out the quality of care and money saved and alleviating negative feelings about self-care. Concrete initiative: the partner professional associations integrate the promotion of the concept of self-care within their own action plans and communications vehicles.
- A strategy for the financing of projects that could come from the public or the private sector and that the supporting self-care concept be integrated into the criteria for funding.
- Research Strategies in the self-care field, especially for the collection of data and evidence.
- A reform of practice strategy to encourage development of a supporting self-care model and demonstration projects in various areas, with a patient-centred focus along the continuum of the health care system and an emphasis on an interdisciplinary approach. The model must also embrace various cultures and not exclude alternative practices.
- A political strategy to operationalize the changes needed by having a system with adequate resources, empowering the public. It is important to ensure that the family is empowered and given the opportunity to be a part of the care team.

Participants felt that an Operationalization Committee should be established following the symposium to maintain the momentum of the supporting self-care agenda. Participants offered a slogan for the promotion to the public of the concept of self-care: I am the main actor of my care.

RECAP

# KEY MESSAGES & THEMES

## Education

1. Involve the public.
2. Develop core competencies.
3. Develop multidisciplinary courses.
4. Dedicated funding that supports both the “art” side and the “science” side.
5. Promote self-care in academia and practice.
6. Develop evaluation criteria. Evaluate and research.
7. Include other cultures.
8. Focus on care and caring (not on cures).

## Local and Community Initiatives

9. Do a needs assessment.
10. Focus on education.
11. A centre/network.
12. Outreach.
13. Continuity of care.



RECAP

# KEY MESSAGES & THEMES

## Systemic Change

### Person-centred

14. Governments seek user involvement in funding decisions.
15. Early education in schools.
16. Evaluation and selection in accreditation.

### Government supports

17. Incentives and rewards.
18. Public policy focus on health — across disciplines.
19. Evaluation.
20. Support partnerships.

### Business

21. Promotion, awareness.
22. Partners.
23. Incentives and standards.

### Shared leadership

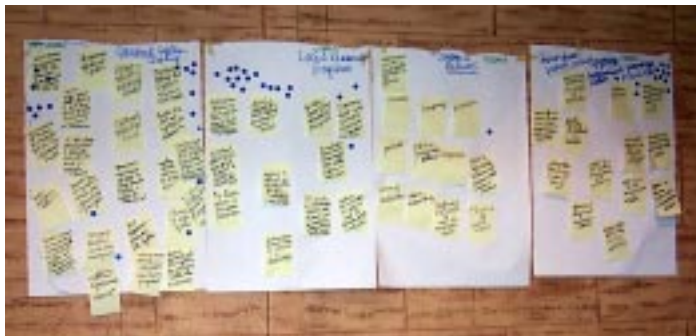
24. Government, citizens, professionals.
25. Continuous.
26. Partnerships.
27. Concrete ideas, funded.

### Clear, focussed research

28. Multicultural.
29. Before and after.

### Communications

30. Positive.
31. Organizational work plans.



# FOCUS ON OUR COMMITMENTS

Participants were asked to consider where do we go from here? Are there personal or institutional commitments to move forward on any of these ideas that can be made today? And if so, who will you need to ask for help?

## **Betty Gourlay**

The Board of the Canadian Nurses Association is meeting next week and will be discussing primary care. I invite all the nurses here today to stand guard and be aware and ready to mobilize in terms of joining our designates to help us advance our primary health care agenda, particularly its self-care component. CNA's Specialty Groups are also meeting, and we will be sharing information from this symposium with our colleagues from across the country.

## **Edith Côté**

I feel a call from this discussion here today, and so I am committing CAUSN to putting self-care on its agenda, to seeing how it could be part of the accreditation process of our program and to developing a position statement on self-care. Ian Bowmer, of ACMC, is committed to doing the same thing at his organization.

In my role as a professor at Laval University, we are looking at a pilot project with the group from Family Medicine to help implement self-care.

## **The Manitoba Group**

We have committed ourselves to four things:

- To promote and contribute to the Self-Care Network. We will ensure that everyone in our professional domains know about the Network, signs-up and contributes to it.
- We are committed to talking to the universities who educate health care professionals about moving forward on interdisciplinary health education with a self-care component.
- We are committed to moving ahead with the self-care manual that has been developed in Manitoba to start building the evidence about self-care.
- We are committed to trying to move researchers towards doing a community needs assessment that is consumer based.

## **Alain Pavilanis**

I represent the whole committee when I say that we are committed to taking this process forward, first with a report of this meeting. On a more personal level, I have a desire to see something happen — I am committed to using this Networking opportunity that we are developing and making sure that some concrete projects come from what we have done. The concrete link that has emerged at this meeting between the associations of physicians and the associations of nurses is something that I am committed to fostering further.

**Jean-Marie Romeder**

The two commitments from Health Canada that I would like to share are as follows:

- We will continue the work on the Supporting Self-Care Network for the next nine months to facilitate its viability and to help build its various components. We want to work on finding long-term financing for the Network, and we are confident that we will be successful.
- As soon as we know the criteria to be met for the funding of the primary health care projects, we will share that information with all the organizations represented in the Network.

**Ellen MacFarlane**

I sit on the Education Advisory Committee for the Registered Nurses Association of Nova Scotia (the committee responsible for developing nursing standards in education). I commit that I will use my skills to influence that group to ensure that the competencies and standards associated with self-care are included in the requirements for accreditation and licensure. I also belong to a university nursing faculty, including professors, associate professors, lecturers and clinical associates, and I commit that I will encourage at least 95% of them to sign up for the Network. I will also work with CAUSN to ensure that the mandates that you are trying to implement there are carried out at our level.

**Joni Boyd**

The Canadian Nurses Association has also enjoyed the collaboration with the College of Family Physicians, the Association of Canadian Medical Colleges and CAUSN over the course of this project and is committed to continuing this kind of work. It has been very interesting, very informative, and very fruitful.

**Hélène Patenaude**

Personally, I will invite the community into my classroom, not only the clinical and professional experts as I do. I will include reflection on self-care and activities about self-care in the student's life, include specialty and alternative approaches, open space to diversity and spirituality and create a self-care environment in the faculty. I will share my experiences with the Network, and I hope to receive feedback and guidance from the Network. I believe that even the small steps are important.

**France Marquis**

New Brunswick is committed to continuing the partnerships and expanding our health centres. I commit to register as a member of the Self-Care Network, and I invite all my colleagues in the province to do so as well.

**Patrick McGowan**

For the past 15 years I have been researching, implementing and evaluating self-management programs, a strategy to bring about people engaged in self-care behaviour. In all my research so far, I have been looking at the health status of people who participate as well as the impact on their lives — I haven't ever really focussed on self-care behaviours. My commitment is that I will deliberately seek mechanisms and resources needed to investigate whether or not people at the end of self-management strategies are actually engaged in self-care behaviours.



## **Catherine Gros**

This is not a new commitment, as it was outlined in the final report of our project, but formal collaboration and experience around curriculum development between the School of Nursing at McGill and the School of Medicine was an extremely positive and enriching experience for us, and we have every intention to not only continue the relationship, and the dialogue and the networking, but to expand on it as well.

## **Wayne Weston**

I have a number of ways that I hope to promote what I have learned at this symposium. I will relay what we have done here to my Dean at the University of Western Ontario and ask her how we can promote this at Western. I sit on a number of committees involving undergraduate education, and I will tell other committee members all about it. I will meet with members of the nursing faculty to also relay what we have learned here. I am Chair of the Directors of Undergraduate Education for the 16 medical schools with regard to family medicine, and I will be taking the information to that group. I have formed connections with people from Windsor and Thunder Bay in the nursing faculty at this meeting and hope that as medicine expands in those areas we will be in concert. In addition, the book that I was a co-author of, *Patient Centred Medicine*, is in the process of revision — and it will be infused with ideas about self-care.

## **Harold Dion**

As President of the Quebec College of Family Physicians, I will include the information from this symposium in our next newsletter so our members are aware of this. I am on the scientific advisory board of multiple medical journals, and I'll recommend that we integrate the concept of self-care into the writing of articles and in the creation of future workshops.

## **Rodney Crutcher**

At Calgary we will further develop the collaboration that we started between the faculty of medicine and nursing and explore working with Montreal and Sherbrooke and others in making self-care real in education.

## **Françoise Moquin**

I cannot commit my organization, but on a personal level I will promote the new Network to my friends and colleagues who work in the domain of HIV/AIDS and to the residents at the home. And I would be happy to offer my bilingual brainstorming services.



## CLOSING COMMENTS

### **Alain Pavilanis**

Thank you to all of you for coming to the event and for taking part so capably and enthusiastically. Thank you for your interest, your intelligence and your participation. Thank you as well to the members of the organizing committee and the four organizations that have taken part in this initiative with Health Canada: the College of Family Physicians, the Canadian Nurses Association, the Association of Canadian Medical Colleges and the Canadian Association of University Schools of Nursing. I would like to thank Alan Sobel and his team; Antoinette and Pierre who did a great job of organizing the conference; Jean-Marie Romeder and Bob Shearer; and the whole team at Health Canada, Isabelle Caron. Thank you all.

We must not underestimate the power of the work that we have done here and the power of our ideas. We must not forget that we are being listened to — as was clearly evidenced by the presence of Dr. McMurtry. We are being listened to. We have a powerful point of view, and we have to continue our work.

The Steering Committee will follow up on this symposium. First, we will be meeting on the 17th of August, and we will distribute the minutes of that meeting to you. Second, we will publish a report of the symposium, and this will be sent to you as well.

I hope that we will all continue to work together on this clear path that we have embarked on, with the commitments that we have just gathered. They really point the way for moving us forward.

### **Lynnette Leeseberg Stamler**

One of the things that I heard so often over the past two days, and certainly something that was personal for myself, was the opportunity to meet, to listen to and to learn from so many people — some of whom I have never heard of before, some of whom I had talked to on the phone or who had written reports that I had read and some of whom I already knew. And I think that was a real strength of this conference. So my challenge is to everyone to continue those ties, to maintain and strengthen them.

A huge thank you to Health Canada for extending Phase Four so that we could have this symposium as the closure to the phase. And in the words of Bob McMurtry: “Report, reform and network!”

See you on the Network!

## **Appendix C :**

### **Supporting Self-Care Demonstration Project, University of Calgary**

#### **Self-Care Items for Questionnaires**

##### *Workshop Session 1: Diabetes Mellitus*

*Presented in same format as rest of questionnaire*

Individuals are capable of determining what is important in their lives and health professionals such as nurses/doctors are able to help them realize their personal goals.	1--2--3--4--5
Health systems features such as time and workload do not encourage support of self-care.	True      False
Standard care plans are supportive to self-care.	1--2--3--4--5
There is a difference between self-care in the hospital and the community.	1--2--3--4--5
Motivational interviewing can be a way of listening and communicating which supports self-care.	1--2--3--4--5
Consumer knowledge and shared expertise are resources to nurses and physicians.	1--2--3--4--5
Wider access to multidisciplinary consultation would be an important step to true collaborative medical treatment.	1--2--3--4--5
Acute and chronic illnesses are different, and this may impact on when you are an expert and when you are not	1--2--3--4--5
Self-care involves managing complex lives, not just diseases.	1--2--3--4--5
Self-care and compliance with treatment regimes are sometimes mutually exclusive.	True      False

*Workshop Session 3: Assessment and Management of Pain in Palliative Care*  
*Presented in same format as rest of questionnaire*

- 1) In promoting self-care, an accurate report of pain is essential. The clinician takes all of the following into account **except**:
  - a) The use of a pain rating scale.
  - b) The patient's self report.
  - c) The clinician's personal opinion and beliefs about the truthfulness of pain.
  - d) The patient's preference to the type of rating scale used.
  
- 2) Teaching the patient and family to use a pain rating scale includes all of the following **except**:
  - a) Explaining the scale in detail describing the parts of the scale (10 = worst pain, etc).
  - b) Explaining that the word "pain" is a broad concept including a variety of hurts.
  - c) Teaching the family to use the scale, only if the patient is not able to understand the scale.
  - d) Allowing the patient to determine what an acceptable pain rating would be.
  
- 3) To enhance the likelihood of the patient and family adhering to a prescribed analgesic regimen, the clinician can teach the patient and family all of the following **except**:
  - a) There are harmful effects to unrelieved pain.
  - b) Around the clock (ATC) dosing twice daily is most effective at 10am and 2200 hrs p.m.
  - c) That taking several analgesics (with the same dosing intervals) at the same time is not dangerous.
  - d) That "rescue" doses of medication should be taken before the pain becomes bad.

## ***Appendix D:***

### ***McGill University, School of Nursing and Faculty of Medicine***

#### ***The Self-Care Questionnaire***

(clinical scenarios for clinicians practicing in family medicine)

A variety of patient/family situations are described below. Each is followed by a set of possible responses. Please indicate the extent to which you agree or disagree with each of the proposed responses by marking your answer along the 5-point scale. The extent to which you agree or disagree with an option should be determined by considering whether or not the response is one that you believe you would actually implement in your own clinical practice. There are no right or wrong answers. For each situation, you may agree with all, some or none of the options presented. Explain the rationale behind your choices. You may also include alternate responses to the situation that you think would be appropriate to implement. Please be prepared to share your ideas with your colleagues in the group discussion sessions.

### SITUATION 1

Mr. B., a successful writer, is being seen in the clinic for the first time following his discharge from the hospital where he was treated for his second myocardial infarction (MI). Mr. B. is 66 years old. He is 5'10" tall and is 75 pounds overweight.

As he enters the examining room, you observe that Mr. B. is smiling and appears happy. You introduce yourself and ask him how he's feeling. Surprisingly, Mr. B. does not mention his illness. Instead, he says he feels "fine," adding that he has recently completed his second novel, which he boasts, "has a good chance of making the Best Seller list." When you ask him to tell you about what brought him to the clinic, Mr. B. explains, "I've been having a bit of trouble with my heart again.... Sitting at the computer all day hasn't helped me keep my weight down." Based only on this information, your health care approach to working with Mr. B. at this time would include:

	<b>Strongly Agree</b>	<b>Agree</b>	<b>Neither Agree nor Disagree</b>	<b>Disagree</b>	<b>Strongly Disagree</b>
1. Asking Mr. B. To tell you more about his level of daily physical activity.					
2. Getting Mr. B. to implement a program of regular, moderate exercise.					
3. Helping Mr. B. to lose weight by getting him to follow a low fat, calorie-reduced diet.					
4. Finding out from Mr. B. what his current priorities are.					
5. Helping Mr. B. understand the seriousness of his situation by providing relevant information on heart disease.					
6. Expressing interest in Mr. B.'s work and listening as he tells you about his latest novel.					

**SITUATION 2**

Mrs. J., age 72, has breast cancer, which has metastasized to the bone and brain. Mr & Mrs J. were informed of the poor prognosis during a recent hospitalization at which time the couple decided that Mrs. J. would receive palliative care at home.

During your visit to the J.'s home, you note that Mrs. J. appears calm and comfortable, and she tells you that the medications are effectively controlling her symptoms and her pain. You observe that Mr. J. is sitting at the bedside, holding his wife's hand. In a soft and loving tone of voice, Mr. J. tells his wife not to worry and that, "everything's going to be OK," adding he will take her back down to their home in Florida as soon as she gets better. Based only on the above information, your health care approach to working with Mr. & Mrs. J. at this time would include:

	<b>Strongly Agree</b>	<b>Agree</b>	<b>Neither Agree nor Disagree</b>	<b>Disagree</b>	<b>Strongly Disagree</b>
1. Reminding Mr. J. that his wife has entered the terminal phase of her illness, and helping him understand that she is not going to get better.					
2. Being honest with Mr. J. by taking him aside and telling him that his goal to return to Florida with his wife is not realistic.					
3. Asking Mr. & Mrs. J. what they think you can do to help at this time.					
4. Reflecting to Mr. J. the dedication, caring and concern that he shows toward his wife.					
5. Asking Mr. & Mrs. J. to tell you more about their home in Florida.					

### SITUATION 3

Mr. F., age 85, was admitted to hospital three weeks ago following a stroke (CVA). While Mr. F. has been receiving physiotherapy regularly and making good progress, he has been refusing to participate in his physiotherapy for the past few days. No other changes in his mental health or physical status are apparent. Based only on this information, your health care approach to working with Mr. F. at this time would include:

	<b>Strongly Agree</b>	<b>Agree</b>	<b>Neither Agree nor Disagree</b>	<b>Disagree</b>	<b>Strongly Disagree</b>
1. Asking Mr. F. to tell you more about how he is feeling.					
2. Getting Mr. F. to participate in this aspect of his care by reinforcing the health benefits of physiotherapy.					
3. Reminding Mr. F. of his upcoming discharge, and informing him that he won't be able to go back home if he doesn't get back to his baseline level of functioning.					
4. Empathising with Mr. F.'s feelings, while clarifying that physiotherapy is not a negotiable part of his care plan.					
5. Intervening to prevent further decline by requesting a consult with psychiatry.					



### SITUATION 4

Mme. L. is a 23 year old unemployed single mother with three children; Luc, 4 years; Martine, 3 years; and Eric, 6 weeks old. The L. family was identified as “high risk” by the hospital at the time of Eric’s birth, and the case was referred to you for follow-up care. Since that time, Mme. L. has repeatedly failed to come to the clinic for her scheduled post-natal appointments. The secretary contacted Mme. L., and a home visit was arranged. You have not met this family before. As you enter the apartment, you observe a number of safety concerns in the environment, including household cleaning products that are within the children’s reach. Mme. L. is in the midst of preparing a bottle of formula while trying to calm the infant who is crying in her arms. Meanwhile, you note that Luc and Martine have been left unattended in the bath. On greeting her, Mme. L. tells you that she feels “really tired” and “stressed-out”... “I’ve reached the end of my rope with these kids!” she adds in an angry, frustrated tone of voice. Based only on the above data, your response to Mme. L. at this time would include:

	<b>Strongly Agree</b>	<b>Agree</b>	<b>Neither Agree nor Disagree</b>	<b>Disagree</b>	<b>Strongly Disagree</b>
1. Providing direct assistance by offering to help with the children’s bath.					
2. Asking Mme. L. to tell you who is available to support her.					
3. Highlighting to Mme. L. that she should keep all poisons and cleaning products safely locked away.					
4. Exploring Mme. L.’s knowledge of the measures, which can be taken to prevent bathtub-drowning accidents in children under five years old.					

**SITUATION 5**

Mr. A., age 72, presents as a very private and reserved man. He has just been diagnosed with cancer and has shown little emotion in response to the news. In working with Mr. A., which of the following strategies would you implement?

	<b>Strongly Agree</b>	<b>Agree</b>	<b>Neither Agree nor Disagree</b>	<b>Disagree</b>	<b>Strongly Disagree</b>
1. Maintaining eye contact and remaining silent.					
2. Getting Mr. A. to open up to you and talk about his feelings.					
3. Giving Mr. A. information on how to cope with his new diagnostic in a healthier way.					
4. Ensuring Mr. A. has a sense of mastery and control over the situation.					

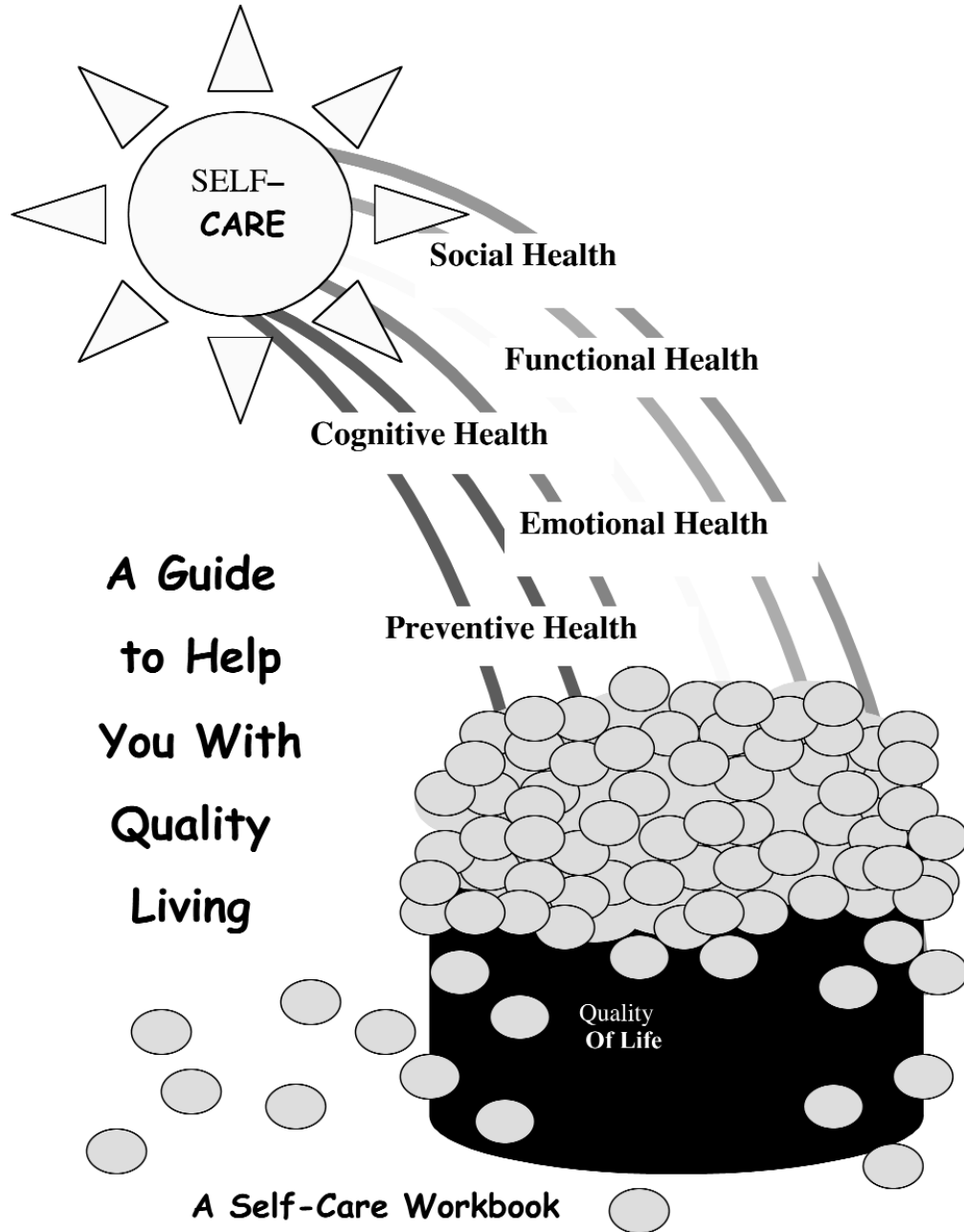
**SITUATION 6** (In reference to Mr. A. above)

Just as you begin to terminate your visit with Mr. A., he mentions that he does not want his wife to know about his diagnosis. You respond by:

	<b>Strongly Agree</b>	<b>Agree</b>	<b>Neither Agree nor Disagree</b>	<b>Disagree</b>	<b>Strongly Disagree</b>
1. Helping Mr. A. getting insight into his own behaviour by highlighting that reluctance to inform his wife is probably tied to his current inability to deal with his own feelings about the diagnosis.					
2. Promising <u>not</u> to reveal the diagnosis to his wife, even if she should ask for this information directly.					
3. Asking open-ended questions in order to understand further Mr. A.'s desire not to inform his wife.					
4. Reflecting to Mr. A. that he should learn to communicate more openly with his wife, and scheduling another appointment in order to begin working with him toward this goal.					

**Appendix E:**

**Excerpt from University of Manitoba's  
A Guide to Help You With Quality Living**





**Self-care** is about people learning to improve their health in as many areas as they wish, so life can be enjoyed to the fullest. **The purpose of this manual** is to enable **seniors** to learn about some self-care activities and to guide you through the process of self-care.

The section titled **exploring self-care** will explain all of the different areas of self-care.

The section titled **thinking about your self-care** will assist you with making decisions about your self-care.

The **resource guide** will assist you in finding the right people to talk to.

The section titled **helping you with self-care** will assist you in making your self-care practices easier.

**Your self-care calendar** will help you keep track of your self-care.

## **EXPLORING SELF-CARE**

The purpose of this section is for seniors to become more familiar with self-care in the many different areas of your life.

### **A. Self-Care:**

*“You, the individual, can do more for your health and well-being than any doctor, any hospital, any drug, and any exotic medical device.”*

*Joseph Califano*

Self-care is what you do to improve your health in whatever manner you choose. The most important point about self-care is that **YOU MAKE THE DECISION** to improve your health. This does not mean that you must practice self-care by yourself. Assistance from family, friends and the community is a very important part of self-care.

### **B. Self-Care and Your Life.**

We have divided overall health into the following major areas:

- Social health
- Functional health
- Cognitive health
- Emotional health
- Preventive health

We will now define these health areas, and provide some examples of how to remain healthy or become healthier in each area.

***Appendix F:***

***University of Moncton, Edmunston Campus:  
My Health Calendar***

# Mon Calendrier Santé / My Health Calendar



Nom / Name : \_\_\_\_\_



SUPPORTING SELF-CARE:  
A SHARED INITIATIVE

PRENDRE EN MAIN SA SANTÉ :  
UNE INITIATIVE PARTAGÉE



UNIVERSITÉ  
DE MONCTON  
Campus d'Edmundston



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# My Journey Toward the Self-management of My Health

## Introduction

People who have experienced day surgery as well as health professionals have participated in the creation of the *Health Calendar*. This tool helps the individual to be better prepared regarding the steps involved in day surgery. What's more, self-care support interventions by health professionals have all been standardized.

*Self-care* includes all activities that people do to prevent illness, to assess their discomforts, as well as to recover, improve and maintain their health. Self-care means that people are capable of making decisions and taking action for their own health; they may choose to manage their health-related challenges by themselves, to consult health professionals or support groups, or they may choose to do nothing at all.

As part of *self-care support*, health professionals become partners with the individual by recognizing his needs and abilities to care for himself. By their interventions, the health professionals support the individual in his process towards autonomy.

## Objectives

**During the day surgery process, my *Health Calendar* enables me:**

- ◆ to be better informed about the various steps involved in day surgery;
- ◆ to be able to manage my health care more efficiently;
- ◆ to know the available resources;
- ◆ to use the resources which are appropriate for my needs;
- ◆ to follow the advice received.



# Day Surgery

The **day surgery program** means that I am admitted, operated, and discharged on the same day of the surgery.

Activities surrounding day surgery are divided into three steps:

1. The presurgery process (visit with the surgeon, communication with the operating schedule service, and visit to the preanesthesia clinic);
2. The day before and the day of surgery (day surgery, operating room and recovery room);
3. The return home (recovery).



## What I need to do:

My collaboration is very important for my well-being and for the success of the surgery. So:

- I carefully read the information contained in this document;
- I make a check mark (✓) in the ;
- I write down my questions in the area provided “Notes”;
- I share this information with close family members or friends so that they may help and support me.



# 1. The Presurgery Process

## 1.1 My visit with the surgeon

The surgeon:

- explains my health problem and the reasons for the surgery;
- explains the surgery;
- tells me about the possible complications;
- tells me for how long I will be absent from my work, if necessary;
- gets my consent for the surgery;
- gives me my *Health Calendar*, if not, it will be mailed to me by the secretary from the operating schedule service.

## 1.2 The operating schedule service

The secretary:

- Sends me the information by mail or calls me to confirm the date and time of my appointments for:
  - my tests and examinations;
  - my visit to the preanesthesia clinic;
  - the day of the surgery.

*Notes*

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**What I need to do:**

- I write down the date and time of my appointments in my *Health Calendar*;
- I read the information regarding the preparations for the tests;
- I **confirm or cancel** my appointments, by calling as soon as possible, at the following number:



**Edmundston** (506) 739-2725  
**Grand-Falls** (506) 473-7551  
**St-Quentin** (506) 235-7300 \*  
\*(for tests and examinations only)



### 1.3 My visit to the preanesthesia clinic

The purpose of the preanesthesia clinic is to help me prepare for the surgery. This visit is necessary because it allows me to remain at home until the day of the surgery. The duration of this visit is about 60 to 90 minutes.



#### What I need to do:

The day before my visit to the preanesthesia clinic, **if necessary**, I:

- do not eat or drink, according to the instructions received from the operating schedule service;
- ask someone to come with me and tell them the expected time and duration of the visit.

In the morning, I bring:

- my medications in their original containers;**
- a list of my known allergies;**
- my medicare card or other health insurance card;**
- my hospital card;**
- my *Health Calendar*; and**
- all the documents received concerning the surgery.**

When I arrive at the hospital, I go:

- to the admission service to register and a secretary will tell me where to go;
- to the specimen collection service where the necessary tests are done (blood samples and other tests);
- see the nurse at the preanesthesia clinic.

#### Notes

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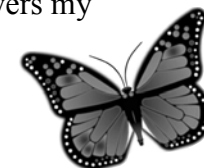
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#### Important

*I understand that if I do not go for this visit, the surgery will be cancelled.*

#### The preanesthesia clinic nurse:

- fills out the health questionnaire with me;
- gives me information on the types of anesthesia and on the specific surgery;
- takes my vital signs (temperature, blood pressure, pulse, breathing), my weight and gives me the appropriate information;
- forwards the request(s) for consultation(s) with the other professionals (anesthesiologist, internist), if necessary;
- explains the steps to follow for my preparation;
- gives me the soap for the shower or bath before the surgery;
- tells me which medications to take or to stop taking the morning of the surgery;
- goes over the *Health Calendar* with me and answers my questions and concerns;
- makes sure that someone stays with me for the first 24 hours after the surgery.



## 1.4 The waiting period before the surgery



### What I need to do:

- I notify:
  - ◆ my babysitter, if necessary;
  - ◆ my employer about the duration of my work interruption, if necessary;
  - ◆ the person who will accompany me about the date and time of the surgery.
- I ask a family member or friend for help in performing the expected activities after the surgery;
- I prepare my meals in advance for a few days following the surgery;
- I ask about the services offered by the Canadian Red Cross Society, as well as the cost of these services, if necessary:
  - ◆ Home help (babysitting service, housekeeping);
  - ◆ Meal service;
  - ◆ Rental of equipment and material.

At the following number:



Edmundston	(506) 736-0050	Mrs. Ginette Collin
Grand Falls	(506) 473-5897	
St-Quentin*	(506) 759-8521	Mrs. Evelyne Beaulieu
	*(same services except for meals)	

### Notes

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- I get the orthopedic equipment (crutches, cane, etc.) prescribed by the health professionals, from the pharmacy or from the Canadian Red Cross Society, in order to prepare for my return home. It is recommended that I practice using this equipment in advance;
- I get assisting devices for my personal care (chair to put in the bathtub, long-handled brush), if necessary;
- I adjust my home environment to make it easier to move about, if necessary;
- I practice the exercises suggested on page 12;
- I make sure that I have a thermometer and bandages;
- I make sure that I have medications on hand for pain, acetaminophen (Tylenol<sup>®</sup>), and for nausea, dimenhydrinate (Gravol<sup>®</sup>), in tablets and suppositories.



## 1.4 The waiting period before the surgery (continued)

**Warnings !**

- At least one week before the surgery, I cut back on my consumption of alcohol and tobacco;
- At least 2 weeks before the surgery, I stop all consumption of non-prescribed or illegal drugs (they may alter the effect of the anesthesia);
- If I suffer from diabetes, I do not take my diabetes medication (insulin and oral medication) on the morning of the surgery, but I bring them with me;
- As requested by the anesthetist or the surgeon, the nurse tells me when to stop taking certain medications or which ones I should take that morning with a small amount of water (ex.: Aspirin<sup>®</sup>, anticoagulant, some antidepressants or others);

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- Because the date of the surgery may sometimes change, I make sure that I am ready ahead of time.

*Notes*

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## 2. The Day Before and the Day of Surgery

### 2.1 The day before surgery



#### What I need to do:

- I stop smoking after 6:00 p.m.;
- I do not eat or drink after midnight, according to instructions received at the preanesthesia clinic;
- I take a shower or a bath with half the soap received from the preanesthesia clinic;
- I do not apply any moisturizing cream or perfume;
- I take off nail polish and jewelry;
- I prepare my personal belongings (slippers, facial tissue, sanitary pads, toothbrush and toothpaste, case for eyeglasses or contact lenses and denture container);
- I make sure that the person accompanying me knows the time at which I must be at the hospital;
- I rest and relax.

#### Notes

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**If I have a fever, come down with the flu or develop any other symptoms, I notify the hospital at:**



**Edmundston** (506) 739-2725

**Grand Falls** (506) 473-7551





## 2.2 The day of surgery



### What I need to do:

- I take a shower or a bath with the remaining soap given to me at the clinic;
- I do not wear any** makeup, perfume, moisturizing cream, jewelry and nail polish;
- I bring:
  - ◆ my personal belongings;
  - ◆ my medicare card or other health insurance card;
  - ◆ my hospital card;
  - ◆ **my medications in their original containers (pumps, insulin, etc.);**
  - ◆ **my *Health Calendar*;**
  - ◆ a moist washcloth in a plastic bag in case of nausea on my way back home.
- I have someone accompany me at the scheduled time;
- I register at the emergency counter before 7:00 a.m., and I register at the admission service after 7:00 a.m.

## 2.3 Day surgery

### The nurse:

- ◆ checks my personal information, my allergies and my medication;
- ◆ takes my vital signs (temperature, blood pressure, pulse, breathing);

### Notes



### The nurse (continued):

- ◆ shaves the surgery site, if necessary,
- ◆ disinfects the surgery site;
- ◆ installs an intravenous solution (IV) (serum);
- ◆ applies a cream to numb the area where the IV is inserted, if necessary.



## 2.3 Day surgery (continued)



### What I need to do:

- ◆ I put on a hospital gown to make the preparations easier;
- ◆ I sign a legal consent form;
- ◆ I take off my dentures, glasses (contact lenses) and other prosthetic devices;
- ◆ I ask for a tranquilizer if I feel nervous;
- ◆ I go urinate just before I leave for surgery;
- ◆ I relax while I wait to leave for the operating room.

## 2.4 The operating room

During the surgery, the team consists of the anesthesiologist, the surgeon and two nurses. They:



- ◆ prepare me for surgery (electrodes ♥, blood pressure device, finger clip sensor to measure the percentage of oxygen);
- ◆ proceed with the anesthesia and the surgery.

## 2.5 The recovery room

As soon as the surgery is over, I am taken by stretcher to the recovery room.

The length of stay in the recovery room is about one (1) hour.

### Notes

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### The nurse:

- ◆ checks:
  - \* my vital signs (temperature, blood pressure, pulse, breathing);
  - \* my incision (my dressing);
  - \* my IV (serum);
  - \* my degree of consciousness by asking me questions.
- ◆ gives me medication for the pain or nausea, if necessary;
- ◆ assists me to do exercises for my breathing and my circulation.



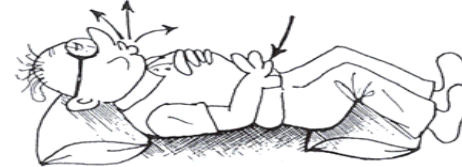
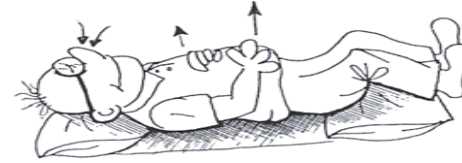
## 2.5 The recovery room (continued)



### What I need to do:

#### For breathing:

- ◆ Deep breathing: I inhale as deeply as possible. I hold for 5-10 seconds. I exhale all the air. I repeat 5 times.
- ◆ Coughing: I bend my knees; I inhale deeply. I hold my incision (abdominal) with my hands or with a pillow. When exhaling, I contract the belly muscles and I cough.



#### For circulation:

- ◆ Changing position: I bend my leg for support; I hold on to the side of the bed to lift my buttocks and roll over to the other side.
- ◆ Legs: I bend the hip and the knee while sliding my foot on the bed. I hold for 5 seconds and release. I repeat 5 times for each leg.
- ◆ Feet: While lying on my back, without moving the hip or the thigh, I move my ankles in a back and forth motion, pulling my toes towards me, then away from me.



All these exercises **must be practiced before the surgery** so that they may be easily done after the surgery. I understand that I am responsible for practicing those exercises. The nurse remains available to assist me or to correct my movements.



## 2.6 My return to the day surgery unit

The length of my hospital stay is on average from 1 to 4 hours, or the time it takes for me to completely recuperate.

### The nurse:

- ◆ monitors my vital signs (temperature, blood pressure, pulse, breathing);
- ◆ asks me questions to check my degree of consciousness;
- ◆ gives me medication for pain or nausea, if necessary;
- ◆ checks my incision (my dressing);
- ◆ removes my IV (serum);
- ◆ gives me instructions for my return home (prescriptions and instructions to follow);
- ◆ gives me a discharge form which indicates my next appointments (with the surgeon, family physician, clinics or others);
- ◆ gives me my medical certificate (work stoppage period), if necessary;
- ◆ evaluates whether or not I am ready to be discharged.

### Notes

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### What I need to do:

- ◆ I explain clearly the degree of pain I am feeling so that I may receive the medication prescribed by the doctor;
- ◆ I drink liquids to make sure that I don't have any nausea;
- ◆ I tell the nurse if I feel nauseated and if I start vomiting;
- ◆ I get help from the nurse the first time I get up after the surgery:

- ◆ I turn on my side, lean on my forearm on the same side, bend my legs and let them slide down over the edge of the bed at the same time as I raise myself with my other hand;



- ◆ I take the time to breathe deeply and I remain seated on the edge of the bed for a few minutes while I move my legs;



- ◆ I get up slowly while looking straight ahead to avoid becoming dizzy;
- ◆ I tell the nurse if I feel dizzy and I lie down again.



## 2.6 My return to the day surgery unit (continued)

**At this stage, there are 3 possible scenarios:**

**A. Usually:**

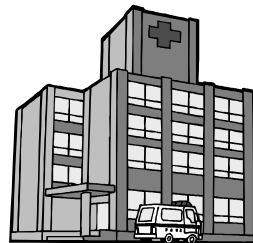
- ◆ I ask someone to drive me home from the hospital and stay with me for the first 24 hours;
- and**
- ◆ the day surgery nurse calls me during the first 24 hours.

**B. Sometimes:**

- ◆ I ask someone to drive me home from the hospital and stay with me for the first 24 hours;
- and**
- ◆ I receive a visit from health professionals of the Extra-Mural Program as requested by my surgeon.

**C. Rarely:**

- ◆ I remain in the hospital for a longer period, if my condition requires it.



*Notes*

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# 3. The Return Home

## 3.1 Instructions



What I need to do:

For the **first 24 hours**, a responsible adult stays home with me.

For the **first 48 hours**, for my own safety:

- ◆ I do not drive a motor vehicle or use power-driven tools (may be more than 48 hours if advised by the surgeon);
- ◆ I do not make any important decisions; it is recommended that I postpone them for later;
- ◆ I do not drink alcohol or take illegal drugs.



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## 3.2 Advice on possible discomforts

After a surgery, it is **normal** to feel pain (burning sensation, tightness) in the area of the surgical wound. I may also have a sore throat, difficulty swallowing as well as muscular pain. I may get chills and feel cold, have a headache, have difficulty sleeping, and feel nauseous due to a fever. My temperature (by mouth) may remain high (38° C or 100.5° F) for the first 48 hours while **my body is healing**.

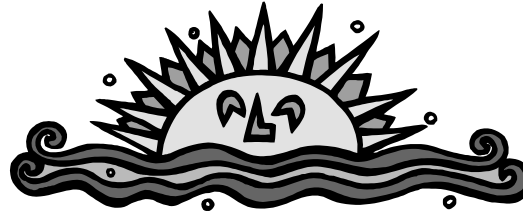
I rest and consult my *Health Calendar* to get answers to my questions.



### 3.2 Advice on possible discomforts (continued)



What I need to do:



1<sup>st</sup> day

2<sup>nd</sup> day

- I take an analgesic (pain reliever) **regularly**, especially during the first 24 hours including night-time, if necessary. There is no risk of dependency;
- I do not wait until the pain is severe to take an analgesic (pain reliever) because pain is easier to relieve before it becomes severe;
- I take 1 or 2 acetaminophen tablets (Tylenol<sup>®</sup>), every 4 hours, if I have the following symptoms:
  - ◆ headache; or
  - ◆ chills, feel cold and my temperature (by mouth) is higher than 38° C or 100.5° F.
- I call my surgeon's office if the pain relievers do not provide relief. If he's not available, I call day surgery;
- I take throat lozenges or ice chips to relieve my sore throat;
- I do the recommended exercises when my pain is relieved;
- I take dimenhydrinate (Gravol<sup>®</sup>) in tablets or suppositories, every 4 hours, if I am nauseous;
- I lie down and rest if I feel dizzy;
- I make myself comfortable by:
  - ◆ having liquids (water, juice) within my reach;
  - ◆ placing a cold washcloth on my forehead.



- I start to gradually cut down on the analgesics (pain relievers). If I take an analgesic (pain reliever) according to the prescription, I can replace one out of two doses with acetaminophen (Tylenol<sup>®</sup>), according to the dosage indicated for my age. This means that I take the analgesic (pain reliever), then 4 hours later, I take the acetaminophen (Tylenol<sup>®</sup>). I can repeat this for 24 hours;
- Usually, the pain gradually wears off 48 hours after the surgery.

*Notes*

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### 3.3 In case of complications



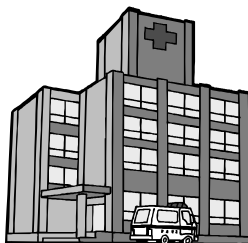
What I need to do:

I call day surgery if:

- ➔ a blood stain increases in size on my dressing, (I add another dressing without removing the original one);
- ➔ after 48 hours, my temperature by mouth does not come down, (remains at 38° C or 100.5° F);
- ➔ I experience vomiting that is not relieved by dimenhydrinate (Gravol®).

I immediately go to the nearest hospital emergency room if:

- ➔ I have difficulty breathing, I feel pressure in my chest;
- ➔ my wound dressing quickly becomes soaked with blood;
- ➔ I experience calf pain, along with redness, heat, tenderness, and swelling;
- ➔ I am unable to urinate 8 hours after my return home, if my belly becomes hard and swollen, if I frequently urinate in small quantities without feeling a sense of relief;
- ➔ I worry about my condition and I cannot reach the day surgery or my surgeon.



**Important**

I may call **911** if I need to be taken by ambulance.





# 4. Practical Advice



## What I need to do:

### ◆ Driving a car and making decisions

The use of medication during anesthesia and those used for pain relief may impair my reflexes. I do not drive my car during the first 48 hours following the surgery or according to my surgeon's advice. I can buckle up my seat belt. For the same reasons, I delay making important decisions and I do not sign any important papers. If I was under general anesthesia, I may experience difficulty with my concentration for as long as 2 weeks after the surgery.



### ◆ Medication

Unless otherwise advised by my physician, I may start taking my usual medication as soon as I return home. I should not take any medication containing acetylsalicylic acid (Aspirin<sup>®</sup>, Advil<sup>®</sup>). If I am already taking an aspirin tablet for my heart or my carotids, I can continue. During the first 24 to 48 hours following the surgery, to avoid the risks of bleeding, I should take medication containing acetaminophen (Tylenol<sup>®</sup>) instead.



### Notes

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### ◆ Care of my wound

- With absorbable suture (invisible), I keep my dressing (small tapes) for a period of 7 to 10 days;
- With suture clips, I keep my dressing on for a period of 2 days.



When the dressing is removed, the wound must be exposed to the air. If I have clips (which may hook onto things), I may cover the wound with a small dry bandage.

Suture clips are generally removed after 7 days or according to the appointment I received when I left the hospital.

If my wound has a small discharge:

- I clean it with a saline solution\* (available at a pharmacy) and I place a small dry bandage. **I do not use peroxide or alcohol.**

### \*Saline solution recipe

Mix one heaping teaspoon of salt in 4 cups of water (1 liter);  
Boil for 15 minutes and refrigerate.  
Place at room temperature before using.



◆ **Personal hygiene**

Unless otherwise advised by the nurse, I may take a bath or a shower 24 hours after the surgery.  
I do not rub the wound, I sponge it softly. I do not use soap or perfumed products on the wound itself.  
If I have a dressing, I cover it with a piece of plastic which I tape at the edges to keep the dressing dry.

◆ **Eating and drinking**

I eat lightly on the first day, and I start eating gradually to avoid nausea. Here are some foods suggested as I start eating again : bouillon, soup, jello, etc. Unless otherwise instructed by the doctor, I may start eating as usual.



◆ **Elimination**

A good hydration (drinking liquids) fosters a good urinary (urine) and intestinal (stools) elimination. Certain medications for pain may cause constipation; for this reason, it is important to drink plenty of liquids (water, warm liquids, lemonade, cranberry juice, prune juice). If I find urination difficult, I may sit on the toilet seat and run tap water in the sink, or pour a small amount of lukewarm water on the perineum (genital organs).

◆ **Resting**

I have to rest because it is normal to feel tired during the days following the surgery. I use relaxation techniques (music).



**Notes**

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◆ **Exercise**

After the surgery, it is important to return gradually to physical activities, such as walking. Walking outdoors helps to activate the blood circulation in my legs, especially if I had general anesthesia.



◆ **Sexual activities**

Generally, except for a few gynecological and perianal surgeries, there are no restrictions for sexual activities. If I have any questions, I may talk to a nurse about it.



# 5. Useful Information



## After the surgery,

### A. I will receive a follow-up phone call:

The day surgery nurse will call me during the first 24 hours following my surgery if I received general or regional anesthesia (epidural, spinal, intravenous block).

### B. I may consult:



Resources	Telephone
Office of the surgeon or family physician	
Tele-Care (where a nurse is available 24 hours a day)	1-800-244-8353
Pharmacist Where I got my prescription	
Web site ♦ Virtual Hospital	www.vh.org/patients

## Notes

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***I recover and maintain my health !***



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