6 'A's – Tip Sheet For Self Management Support

Here is a quick guide to some of the techniques explored in the Advanced Development Programme for Clinicians. Please don't feel you have to touch on all 6 A's at each patient-clinician engagement. Although the examples are for Respiratory Patient's remember these skills can be used to support self management skills with all people living with a long term condition.

NHS Ayrshire & Arran

ASSESS - assess the work that needs to be done

Explore patient's concerns/agenda
Use the 'bubble' diagram (see "Health Concerns of Respiratory Patients" panel) to explore patients concerns
Use a pre-visit or waiting room questionnaire to focus the interaction

Explore patient's views on behaviour change:
Ask your patient questions that focus on health behaviours.

What are you currently doing that is contributing to your health?

What have you heard about living with COPD that you think might help you stay healthy?

Is there anything you have been thinking about doing to improve your health?

How important on a scale of 0-10 is it for you to (stop smoking, loose weight, exercise more, etc.)? Why is it a 3 and not a 0?

AGENDA SET - triage patient's agenda to get a feel for urgency

Clarify patient's concerns/agenda

I am hearing you say you have concerns about more frequent chest infections, and increased breathlessness. You are also considering increasing your activity levels. What else? What are your priorities? What do you want to make sure happens before you leave hear today? Are you sure?

Set clinician's agenda.

While we have this opportunity to be together I would like to check your oxygen level, review your medications etc.

Negotiate final agenda.

We have the time we need today to do justice to our highest priorities. Let's focus on those and try and answer your key concerns.

The Health Foundation

ADVISE - provide brief information without medical jargon

Find out what your patient understands about their COPD or treatment, this will save time by increasing your understanding of what your patient already knows and allow you to clarify on his or her misunderstandings.

Ask before advising

Do you know what causes you to feel breathless? What do you already do to control your breathlessness? Can I offer you some advice? Other patient's have found ways to help with their breathlessness; can I share these with you?

Make sure the source of information (medical literature, your opinion, other patients you work with) is clear.

Ask your patient to repeat what you told them so you know if you have made your advice understandable.

AGREE – collaborate to agree goals and actions plans, e.g:

GOAL:

Become fitter to be able to enjoy time playing with grandchildren.

How important is it for you to achieve...on a scale of 0-10.....

ACTION PLAN:

What will you do before we next speak?

Do some walking?

How much time will you spend walking?

20min.

Where will you walk?

To the local paper shop.

When will you walk?

After lunch.

How often will you do this?

3 times a week.

ASSIST - help you patients when they have problems until they learn to help themselves

That sounds like a great plan. But making a change can often be difficult. If you consider a scale of 1 – 10, where 10 means you are you are very confident and '1' means you are not at all confident, where do you see yourself? About a 5

That's great that your feel a confidence level of 5. That's a lot higher than 1. I wonder if there is a way you could modify your plan to increase your confidence? What is stopping you feeling more confident?

I am worried I might get to the shop but struggle to get back. Maybe if I walk half way to begin with that would allow me to feel more confident.

If you walked half way three times next week, how confident do you now feel on the same scale of 1 -10. 8.

ARRANGE – follow up to check progress, problem solve and sign-post patient to the most appropriate local services, resource or clinician

Great, let's make arrangements for me to follow up with you to check how things are going. Would you like to come into see me, e-mail you or give you a call on the telephone?

You could call me; it would save me having to come back.

(Via telephone on agreed date)....How did you get on with your action plan?

I only managed it once as the weather was bad, I don't go out when it's wet and windy.

Have you any ideas on ways around this problem?

I used to go to an exercise class, but that's too much for me now. I could wrap up well, but the wind would still make me breathless. I really don't know a way around this.

Is it ok if I make a suggestion? Yes

I could refer you to our Physiotherapist for some advice about exercise, she actually runs some exercise and education programmes for people living with COPD. How does that sound?

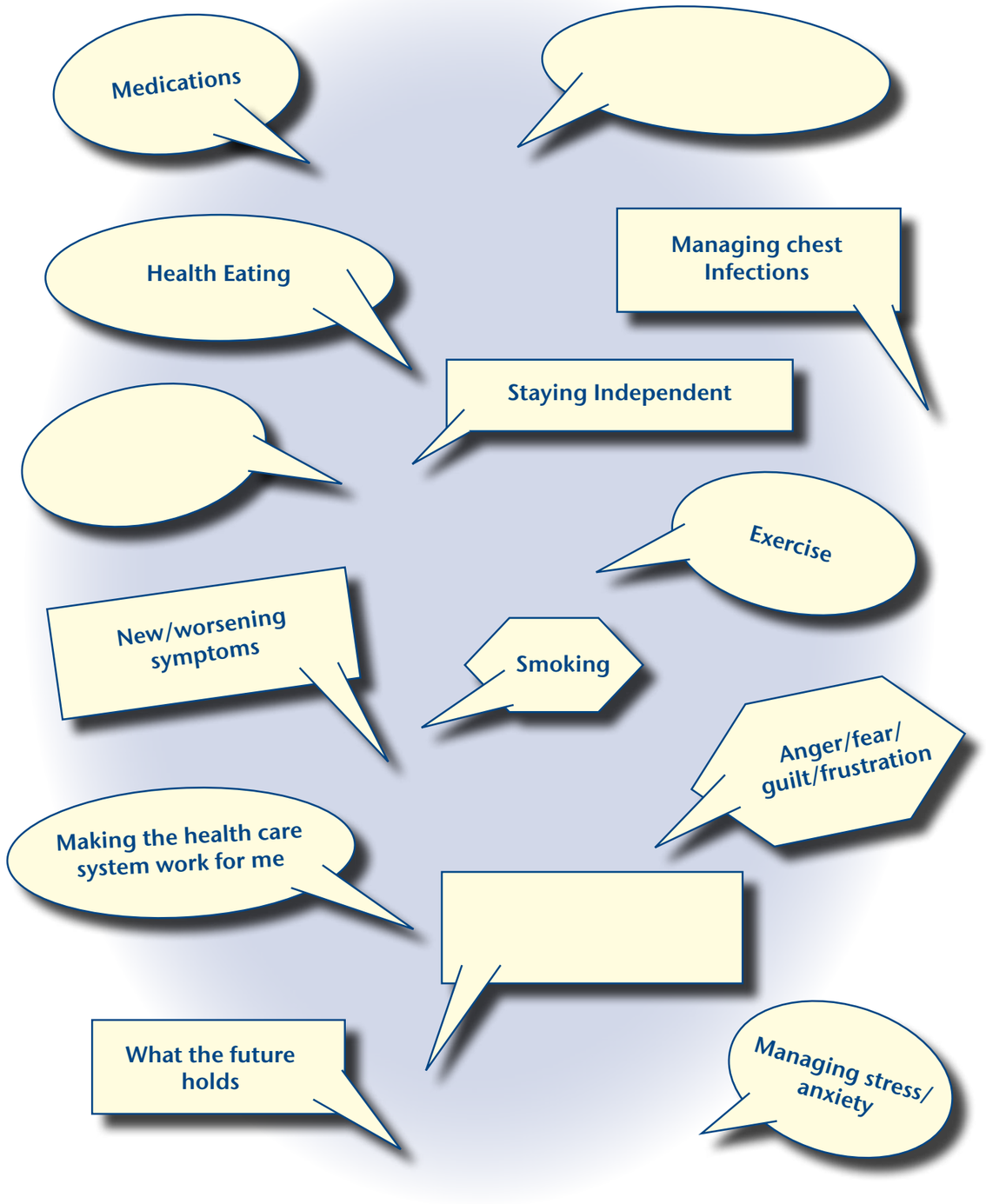
Yes I think that would make me feel more confident about exercising and would get round the problem of the weather.

Great, I will refer you. Would you be happy for the Physiotherapist to now support you with your goal of getting fitter?

Yes, that seems sensible. I'll look forward to hearing from the Physiotherapist

Health Concerns of Respiratory Patients

Here are some things that respiratory patients have told us that they think about. Maybe some of these things concern you. You may add your concerns in the empty bubbles. Would you like to talk today about the one that matters to you the most? Would you like to make a change in one of them?



Goal setting sheet

My goal / the health change I want to make in the next 3-6 months is

.....

.....

.....

This week/ month I will (WHAT e.g. walk)

.....

.....

.....

HOW IMPORTANT? (Please circle. If less than 7 start over)

1 2 3 4 5 6 7 8 9 10

1= not important 10= very important

HOW MUCH (e.g. 15min) .....

WHEN (e.g. before lunch) .....

HOW MANY DAYS (e.g. on 3 days) .....

CONFIDENCE

When you see yourself completing this action during the next week, how certain are you that you will accomplish it? (Please circle, if less than 7 start over)

1 2 3 4 5 6 7 8 9 10

0= no confidence 10= totally confident

I would like this goal to be followed up by: .....

Via: telephone **YES / NO,** follow up appointment **YES / NO,** in class **YES / NO**

In (please circle):

1 week **2 weeks** **3 weeks** **4 weeks** **2 months** **3 months**

Follow up on week beginning: .....

Follow up notes.....

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