

REVIEW PAPER

A realist review: what do nurse-led self-management interventions achieve for outpatients with a chronic condition?

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Abstract

Aim. The aim of this study was to examine how nurse-led interventions that support self-management of outpatients with chronic conditions work and in what contexts they work successfully.

Background. Self-management could be directed at goals such as quality of life, adherence or patients' empowerment. Self-management support is an increasingly important task of nurses. Many nurse-led interventions have been developed but it is not clear how these actually help improve patients' self-management capabilities.

Design. Realist review.

Data sources. Primary research studies on self-management support interventions conducted by nurses from January 2000 until March 2015 were retrieved from all relevant databases. The studies had a before–after design and used qualitative and quantitative methods.

Review methods. For each study, we described how the intervention was supposed to improve self-management and compared this with the empirical evidence. Next, we described the context–mechanism–outcome strings for each separate study, explored patterns and integrated the findings.

Results. Thirty-eight papers were included, evaluating 35 interventions concerning a diversity of conditions. Seven different context–mechanism–outcome strings were identified. Interventions focusing on patients' intrinsic processes were most successful. Least successful were interventions only providing education aimed at patient behaviour change. Various contexts can influence the success of the interventions: involvement of relatives, target group (i.e. chronic condition, motivation, being recently diagnosed or not), involvement of fellow patients and intervention group homogeneity or heterogeneity.

Conclusion. Successful interventions focus on patients' intrinsic processes (i.e. motivation or self-efficacy). This would guide nurses to decide what self-management support intervention they can best use in their specific setting and patient group.

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Keywords: chronic diseases, chronically ill, interventions, literature review, nurse led, nursing, realist review, self-care, self-management

Why is this research or review needed?

- The growing population of people with chronic conditions and the simultaneous increase in healthcare expenditures would benefit from effective self-management support.
- Self-management support is a core activity of nurses in outpatient settings. They are expected to know how a chronic condition impacts a patient's life and are therefore eminently suited to coach patients.
- The effective elements of nurse-led self-management interventions and the optimal circumstances have yet to be determined.

What are the key findings (what does it add to knowledge)?

- Seven mechanism-outcome strings of interventions were identified. Nurse-led interventions focusing on patients' intrinsic motivation and self-efficacy were most successful.
- Least successful were interventions providing solely education aimed at changing patients' behaviour.
- Contexts that influence the effectiveness of an intervention are family involvement, type of condition, patient's motivation, recently diagnosed or not, peer support and intervention group homogeneity or heterogeneity.

How should the findings be used to influence policy/practice/research/education?

- The influence of contexts on the effectiveness of an intervention should be taken into consideration when choosing or developing a self-management support intervention.
- Development of self-management support interventions should be based on theoretical concepts and proper selection of outcomes.

Introduction

The growing population of people with chronic conditions and the simultaneous increase in healthcare expenditures require effective interventions (WHO, 2005). Self-management is seen as a means to several ends: to improve patients' lifestyle or patients' adherence, to increase quality of life, or to empower patients (Wilkinson & Whitehead 2009, Kendall *et al.* 2011, Jonsdottir 2013). A much-used definition of self-management is: 'the individual's ability to manage symptoms, treatment, physical and psychosocial

consequences and life style changes inherent in living with a chronic condition and to affect the cognitive, behavioural and emotional responses necessary to maintain a satisfactory quality of life. Thus, a dynamic and continuous process of self-regulation is established' (Barlow *et al.* 2002 p. 178). This definition implies that self-management is not only a matter of medical or symptom management, but also of incorporating disease in one's life. This is important because people often struggle with the social meaning of the chronic condition (Atkin *et al.* 2010) and have to deal with practical consequences of the condition and the treatment in daily life. Self-management requires an active role of patients, since it implies a responsibility for *self* managing the condition (Lorig & Holman 2003).

Background

Although self-management is a task for the patients themselves, they may need support. Self-management support (SMS) requires a multidisciplinary approach (Wagner *et al.* 2001), but in practice is often provided by outpatient clinic nurses. Self-management support is a core activity of outpatient nurses (Elissen *et al.* 2013). They are expected to have insight into the impact of a chronic condition on a patient's life and are therefore designated to coach patients in their self-management (Schenk & Hartley 2002, Alleyne *et al.* 2011, Elissen *et al.* 2013).

Many self-management interventions are composed of multiple, interacting components and can therefore be regarded as complex (Campbell *et al.* 2000). Possible components are for instance the means of providing the content of the intervention, the theory on which it is built, the professionals executing the intervention and clinical guidelines (Clark 2013). Added to this complexity is the fact that different factors may influence the patient's self-management and consequently it is to be expected that there is no one-size-fits-all intervention that works for all patients and for all patient groups (Coster & Norman 2009, Bonell *et al.* 2012).

Although several recent reviews proved that certain self-management interventions were useful, it is not clear to what components success can be ascribed, for whom these interventions work and in what circumstances (Radhakrishnan 2012, Jones *et al.* 2014, Tu *et al.* 2015). Reviews often examine one specific type of intervention or one specific

chronic condition (Bonner *et al.* 2014, Kuo *et al.* 2014, Song *et al.* 2014). Besides, not all of these reviews are aimed at interventions specifically conducted by nurses (Bentsen *et al.* 2012, Radhakrishnan 2012, Bonner *et al.* 2014). Furthermore, the realist review methodology was developed precisely to examine what works for whom and why; on which theoretical assumptions interventions are based, how they are supposed to work and why they work or do not work in certain circumstances. A realist review provides explanatory rather than evaluative results, which is an added value of the evidence provided by traditional reviews. So realist reviews are also suitable for topics on which there is a certain amount of evidence (e.g. Kane *et al.* (2010), Kousoulis *et al.* 2014).

This is why the methodology is suitable for reviewing complex interventions aimed at people with different and often multiple conditions.

The review

Aim

The objective of this realist review was to examine how nurse-led interventions that support self-management of outpatients with chronic conditions work and in what contexts they work successfully.

Design

The theory-driven realist review methodology can synthesize a diversity of evidence about the effectiveness of interventions in real life settings (Pawson & Tilley 1997, Pawson *et al.*

2004, Pope *et al.* 2007). Underlying theories and assumptions of an intervention are tested and give insight into how and why complex interventions do or do not work in a specific context (Pawson *et al.* 2004, 2005). In other words, a realist review identifies the pathways successful interventions follow (Pawson *et al.* 2004). An essential element is the description of a mechanism: defined as a reaction triggered by the intervention in a certain context and that leads to a certain outcome (Kane *et al.* 2010). The contexts, mechanisms and outcomes of an intervention are the cornerstones of a realist review. Linking these three elements leads to the so called 'context-mechanism-outcome strings' (CMOs), which articulate the interaction between the intervention, the context where the intervention is applied and the mechanisms that are set in motion by this interaction – leading up to an outcome (Pawson *et al.* 2005). In contrast to the traditional systematic reviews, the realist review methodology allows to include a variety of study designs, not only Randomized Clinical Trials. While conducting a realist review is an iterative process, the review was conducted according to sequential steps (Pawson *et al.* 2005) (Table 1).

Search methods

The Embase, Medline OvidSP, CINAHL, Web-of-science, PsychINFO, OvidSP, Cochrane central and PubMed Databases were searched from January 2000 until March 2015 for nurse-led SMS intervention studies. Various search terms for self-management, evaluation, chronic disease and nurses were used (Supplement File S1). The scope of our search was deliberately broad because many self-

Table 1 Steps in the realist review based on Mogre *et al.* (2014) and Yardley *et al.* (2015).

Step	Summary of approach
1. Clarifying the scope of the review	<ul style="list-style-type: none"> The objective of this realist review was determined. The scope involves nurse-led interventions for self-management support of outpatients with chronic conditions.
2. Determining the search strategy and	<ul style="list-style-type: none"> A search strategy was developed (Supplement File S1). Only studies using a comparison between 'standard care' and self-management support interventions (e.g. RCT, before-after design and qualitative and quantitative methods) were included Inclusion criteria were: self-management support interventions with a prominent role for nurses, outpatient clinic setting, adults with chronic condition, evaluation study and written in the English language. Studies were excluded if results were not measured at a patient level, if the setting was a palliative care, primary care, or psychiatric care
3. Ensuring proper article selection and appraisal of evidence	<ul style="list-style-type: none"> According to the realist review approach, studies were selected based on rigour and relevance. In addition, studies quality appraisal occurred with appropriate instruments (one for qualitative and one for quantitative studies).
4. Extracting of data	<ul style="list-style-type: none"> Data extraction forms were used to organize data. Information was obtained about: a) design of the study, b) characteristics of the intervention and c) the underlying theory (either implicitly or explicitly mentioned).
5. Synthesis of findings and drawing conclusions	<ul style="list-style-type: none"> Synthesis of the findings: underlying theories were compared with the empirical evidence. The context-mechanism-outcome (CMO) for each separate study was described, and patterns in the CMOs were explored. Conclusions were drawn about in what works for whom, in what circumstances.

management support needs are not disease-specific but generic in nature. They are mostly dependent on patients' subjective health perceptions and the availability of social support (Van Houtum *et al.* 2013, Dwarswaard *et al.* 2015).

Search outcome

The search yielded almost 4000 references. After removing duplicates, we screened 3022 abstracts, of which 314 full texts articles were assessed for eligibility (Figure 1). The exclusion of articles which did not meet the inclusion and exclusion criteria reduced the number of studies to 38.

Quality appraisal

Methodological quality of the qualitative studies was assessed with the Qualitative research review guidelines – RATS (Clark 2003). Methodological quality of RCTs was assessed with the Cochrane 'Risk of bias' tool (Higgins *et al.* 2011). Other quantitative studies were assessed with the rating system of Anderson and Sharpe (1991) adapted

by Huis *et al.* (2012) (Supplement File S2). In realist reviews, however, eligibility of studies is based on rigour and relevance for the objective of the review rather than on the established quality (Pawson *et al.* 2004).

Data abstraction

Titles, abstracts and subject headings of the retrieved citations were screened for relevance and full texts of potentially eligible studies were evaluated. In case of doubt, a third reviewer was consulted. Inclusion criteria were: SMS interventions with a prominent role for nurses, outpatient clinic setting, evaluation study, adults with chronic condition and written in the English language. 'Evaluation study' was defined as a study comparing 'standard care' with SMS interventions (e.g. RCT, before–after) design and/ or using qualitative evaluation. Studies were excluded if results were not measured at a patient level, if the setting was palliative care, primary care or psychiatric care. These exclusion criteria were chosen because the interventions should be targeted at people with somatic chronic conditions in an outpatient hospital setting.

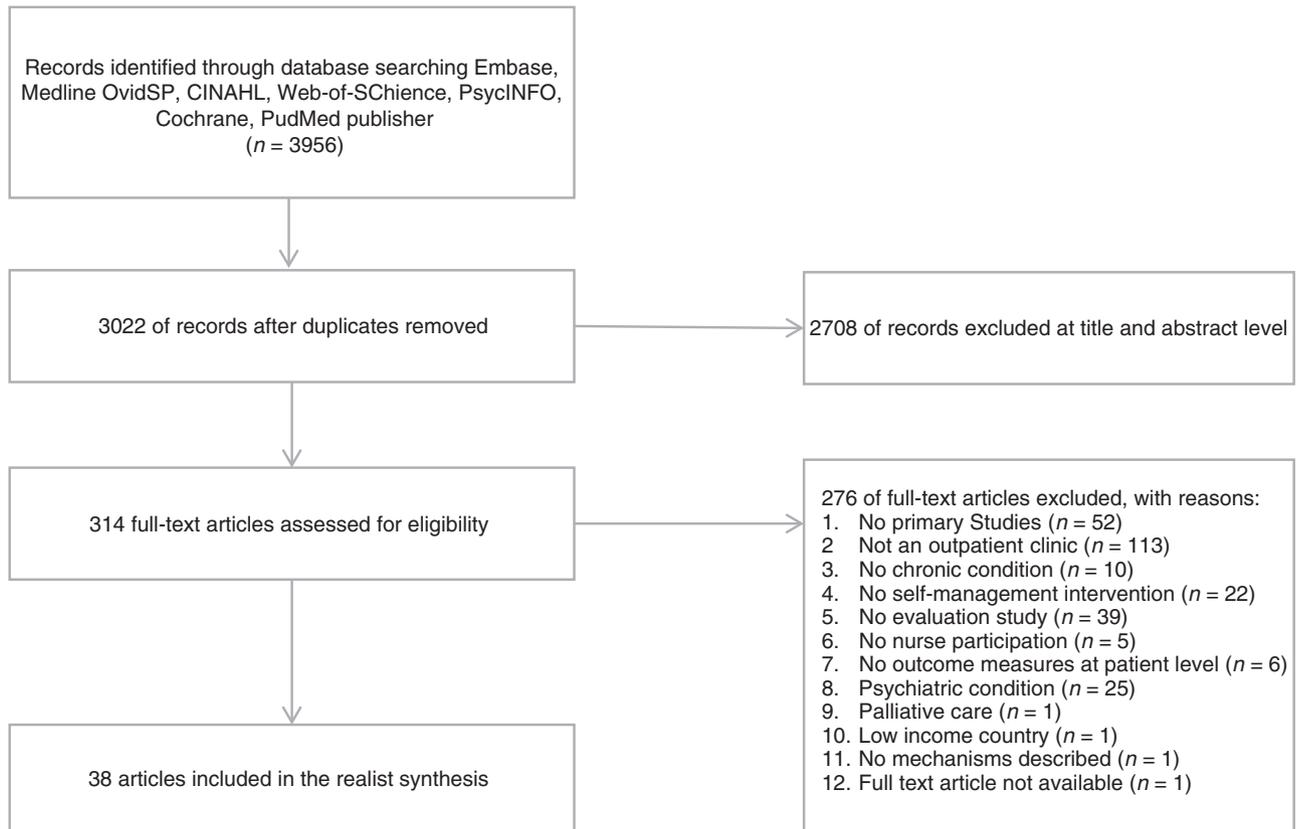


Figure 1 Flow chart of studies from identification to inclusion.

Synthesis

First, the full texts of included studies were reviewed and data were extracted. Information was obtained about: A. design of the study, B. characteristics of the intervention and C. the underlying theory. If theoretical assumptions were not provided, the corresponding author was contacted. Reporting effectiveness evidence, including estimates of precision, is not always done in realist reviews, although there are some examples of realist reviews that do (Leeman *et al.* 2010, Hoare *et al.* 2012). We also decided to report these effect sizes to enhance interpretation of the studies. If possible, effect sizes with the bias-corrected effect size Hedges (G) were calculated (Fritz *et al.* 2012) (Supplement File S3).

The research team reached consensus about the extraction and interpretation of the data in several rounds. A study's underlying theory, either implicitly or explicitly mentioned, was compared with the empirical evidence reported in the study. The CMO for each separate study was described and patterns in the CMOs were explored to explain what interventions worked in what settings.

Results

We included 35 different intervention studies reported in 38 papers. Two interventions were evaluated qualitatively, one was a mixed methods case-study, the other 32 interventions were evaluated with a quantitative design (of which 21 were RCTs). The 35 studies included a total of 3,490 patients, representing a diversity of chronic conditions (Table 2; a more comprehensive table with statistical outcomes is provided in Supplement File S3). Most interventions contained educational and counselling components; some involved physical exercises. Often, interventions were provided in group sessions, sometimes combined with individual sessions. Only few studies described a self-monitoring intervention.

Underlying theories

A study's underlying theory not always corresponded to the theory found in the empirical evidence. Therefore, we distinguish two types below: espoused theories (the theory mentioned as base for the interventions) and theories-in-use (how interventions had actually worked) (Argyris 1976).

Espoused theories

Based on the espoused theory we distinguished five categories of interventions, addressing respectively: (i) knowledge; (ii) behavioural change; (iii) coping; (iv) motivation;

and (v) self-efficacy. (i) Thirteen studies involved interventions with an emphasis on knowledge gain through the provision of education – with the (often tacit) assumption that education would lead to the desired behavioural change; (ii) Six interventions aimed at changing the patient's lifestyle and thus at behavioural change; (iii) Nine studies aimed at coping with the symptoms of the chronic condition. The focus lies primarily on re-interpretation of symptoms and dealing with stress; (iv) Two studies involved interventions aimed at increasing the patient's motivation (v) Six interventions focus on self-efficacy. The espoused theories are described in Box 1.

Theories-in-use: contexts, mechanisms and outcomes

We found three different mechanisms in the interventions: increase patients' knowledge, patients' skills enhancement and increase patients' motivation. Three different outcomes of the interventions were identified: behavioural change, increase in coping and increase in self-efficacy.

On the basis of the theory-in-use we identified seven different strings that linked the mechanisms and the outcomes (Figure 2). For instance, regarding an intervention aimed at explaining the risks of certain behaviour (knowledge) it is assumed that patients will effectively change their behaviour after learning about the risks. In certain contexts, the aim could be realized. The CMO-strings, we identified by comparing all studies are described below and presented in Supplement File S4.

String A Knowledge leads to behavioural change

Interventions that follow this string are based either on the espoused theories emphasizing knowledge and cognition (Balk *et al.* 2008, Rootmensen *et al.* 2008, Trappenburg *et al.* 2008, Huang *et al.* 2009, Van der Meer *et al.* 2009, Rønning *et al.* 2011, Yıldız & Kurcer 2012, Gonzalez 2014, Goossens *et al.* 2014, Howden *et al.* 2015, Yu *et al.* 2014, Grilo *et al.* 2015), on the one aiming at behavioural change (Wilson *et al.* 2008, Moriyama *et al.* 2009, Otsu & Moriyama 2011, Choi & Lee 2012, Otsu & Moriyama 2012) or on the one aiming at self-efficacy (Yu *et al.* 2014). Education was offered about the disease, its symptoms, medication and the importance of adherence. Also, (self-) monitoring was applied to provide patients feedback about their knowledge gain and behavioural change (Balk *et al.* 2008, Trappenburg *et al.* 2008, Huang *et al.* 2009, Moriyama *et al.* 2009, Otsu & Moriyama 2011, 2012, Grilo *et al.* 2015). In one intervention, the patients' families were involved (Moriyama *et al.* 2009).

Table 2 Overview of selected studies (in alphabetical order by first author).

Author(s); year of publication; country	Intervention characteristics	Design	Patient group characteristics (<i>n</i> ; diagnosis)
Akyil & Ergüney (2013), Turkey	Education Individual	Quasi experimental design with control group	<i>n</i> = 65 Chronic Obstructive Pulmonary Disease (COPD)
Bakan & Akyol (2008), Turkey	Counselling Group & individual Self-monitoring Family involvement	RCT	<i>n</i> = 43 Chronic Heart Failure (CHF)
Balk <i>et al.</i> (2008), The Netherlands	Education Individual Self-monitoring	RCT	<i>n</i> = 214 CHF
Carrieri-Kohlman <i>et al.</i> (2005), USA	Education Individual Physical exercises	Prospective, randomized single- blind trial	<i>n</i> = 103 COPD
Choi and Lee (2012), Korea	Education Counselling Group & individual	RCT	<i>n</i> = 61 Chronic Kidney Disease (CKD)
Donesky <i>et al.</i> (2014), USA	Education Individual Physical exercises	RCT	<i>n</i> = 115 COPD
Gonzalez (2014), USA	Education Individual	Single-group before–after design	<i>n</i> = 30 Venous ulcers
Goossens <i>et al.</i> (2014), Belgium	Education Individual	Descriptive, cross-sectional study	<i>n</i> = 317 Congenital heart disease (CHD)
Grilo <i>et al.</i> (2015), USA	Education Counselling Individual Self-monitoring	Pilot clinical trial	<i>n</i> = 28 Uncontrolled hypertension and comorbid Diabetes Mellitus (DM) type 2
Hagberth <i>et al.</i> (2008), Sweden	Education Group	Qualitative descriptive study	<i>n</i> = 13 Asthma
Howden <i>et al.</i> (2015), Australia	Education Counselling Individual Physical exercise	RCT	<i>n</i> = 83 CKD
Huang <i>et al.</i> (2009), Taiwan	Education Individual Self-monitoring Family involvement	RCT	<i>n</i> = 148 Asthma
Jiang and He (2012), China	Education Counselling Individual	RCT	<i>n</i> = 96 COPD
Kara & Aşti (2004), Turkey	Education Groups & individual Physical exercises Family involvement	RCT	<i>n</i> = 60 COPD
Kaşıkçı (2011), Turkey	Education Individual Physical exercises	Case-study	<i>n</i> = 1 COPD
Lee <i>et al.</i> (2014), South Korea	Counselling Individual	RCT	<i>n</i> = 151 COPD
Lindskov <i>et al.</i> (2007), Sweden	Education Individual Groups for family	Naturalistic non-randomized waiting list controlled trial	<i>n</i> = 48 Parkinson's Disease

Table 2 (Continued).

Author(s); year of publication; country	Intervention characteristics	Design	Patient group characteristics (<i>n</i> ; diagnosis)
Monninkhof <i>et al.</i> (2003), The Netherlands	Education Exercises Groups Family involvement	RCT	<i>n</i> = 248 COPD
Moriyama <i>et al.</i> (2009), Japan	Education Counselling Individual Self-monitoring Family involved	RCT	<i>n</i> = 65 DM type 2
Otsu and Moriyama (2011), Japan	Education Counselling Individual Self-monitoring Family involvement	RCT	<i>n</i> = 102 CHF
Otsu and Moriyama (2012), Japan	Education Counselling Individual Self-monitoring Family involvement	RCT	<i>n</i> = 94 CHF
Rönning <i>et al.</i> (2011), Sweden	Education Counselling Individual	Single-group before– after design	<i>n</i> = 55 Congenitally malformed hearts
Rootmensen <i>et al.</i> (2008), The Netherlands	Education Individual	RCT	<i>n</i> = 191 COPD
Sarian <i>et al.</i> (2011), Canada	Education Groups Family involvement	Single group before after test	<i>n</i> = 10 Peritoneal dialysis patients
Schreurs <i>et al.</i> (2003), The Netherlands	Education Counselling Groups	Single group before–after design	<i>n</i> = 83 Asthma, DM, and CHF
Smeulders <i>et al.</i> (2010a,b), The Netherlands	Education Groups	RCT	<i>n</i> = 317 Congestive heart failure
Trappenburg <i>et al.</i> (2008), The Netherlands	Education Individual Telemonitoring	Non-randomized controlled multicenter study	<i>n</i> = 115 COPD
Tsay <i>et al.</i> (2005), Taiwan	Education Counselling Groups	RCT	<i>n</i> = 57 End-stage renal disease
Van der Meer <i>et al.</i> (2009), The Netherlands	Education Groups Telemonitoring	RCT	<i>n</i> = 200 Asthma
Van Os-Medendorp <i>et al.</i> (2007a), The Netherlands	Education Counselling Individual	Mixed methods	<i>n</i> = 65 Chronic pruritic skin disease
Van Os-Medendorp <i>et al.</i> (2007b), The Netherlands	Education Counselling Individual	RCT	<i>n</i> = 65 Chronic pruritic skin disease
Williams <i>et al.</i> (2012), Australia	Education Counselling	RCT	<i>n</i> = 78 CKD, DM, and cardiovascular disease
Wilson <i>et al.</i> (2008), Ireland	Education Counselling Individual & groups	RCT	<i>n</i> = 91 COPD

Table 2 (Continued).

Author(s); year of publication; country	Intervention characteristics	Design	Patient group characteristics (<i>n</i> ; diagnosis)
Yıldız and Kurcer (2012), Turkey	Education Counselling Individual	Single-group before–after design	<i>n</i> = 84 CKD
Yu <i>et al.</i> (2014), China	Education Individual Family involvement	Non-randomized controlled trial	<i>n</i> = 84 COPD
Zoffmann and Kirkevold (2012), Denmark	Counselling Individual	Qualitative evaluation study	<i>n</i> = 50 DM type 1
Zoffmann and Lauritzen (2006), Denmark	Counselling Group	RCT	<i>n</i> = 30 DM type 1

Box 1. Espoused theories: Underlying theories within the categories of intervention.

Knowledge

Theory of constructivism (Bodner 1986)
Chronic Care Model (Wagner 2001)
Orem's theory of self-care (Orem 1983)
No theory mentioned

Rønning *et al.* (2011)
Grilo *et al.* (2015), Sarian *et al.* (2011)
Gonzales (2014)
Rootmensen *et al.* (2008), Trappenburg *et al.* (2008), Balk *et al.* (2008),
Van der Meer *et al.* (2009), Yıldız and Kurcer (2012),
Lindskov *et al.* (2007), Huang *et al.* (2009), Goossens *et al.* (2014),
Howden *et al.* (2015)

Behaviour change

Theory of cognitive behaviour (Lindeman 1989)
Theory of Planned Behaviour (Ajzen 1991)
Health Belief Model (Becker & Maiman 1975)
Trans-theoretical model of stages of change
(Prochaska *et al.* 1985)
No theory mentioned

Otsu and Moriyama (2011, 2012), Moriyama *et al.* (2009)
Wilson *et al.* (2008)
Williams *et al.* (2012)
Wilson *et al.* (2008), Zoffmann and Lauritzen (2006)

Choi and Lee (2012)

Coping

Vifladdt & Hopen model (Vifladdt & Hopen 2004)
Self-Regulation Model (Leventhal *et al.* 2003)
Proactive coping theory
Transactional Model of Stress and Coping (Lazarus 1993)

Roy's Adaptation Model (Whittemore & Roy 2002)
No theory mentioned

Hagberth *et al.* (2008)
Schreurs *et al.* (2003)
Schreurs *et al.* (2003)
Tsay *et al.* (2005), Jiang and He (2012), Van Os-Medendorp *et al.*
(2007a,b)
Akyil & Ergüney (2013), Bakan & Akyol (2008)
Lee *et al.* (2014), Monnikhof *et al.* (2003)

Motivation

Self-determination theory (Zoffmann 2004).

Zoffmann and Lauritzen (2006), Zoffmann and Kirkevold (2012)

Self-efficacy

Social Cognitive Theory (Bandura 1991)

Donesky *et al.* (2014), Kaşikçi (2011), Carrieri-Kohlman *et al.* (2005),
Smeulders *et al.* (2010a,b), Kara and Aşti (2004), Yu *et al.* (2014)

Most interventions used a mixture of means (Supplement File S5). These interventions did not always lead to the desired behaviour; for example, in the context of recalcitrant smokers who lacked symptoms of dyspnoea and had little confidence that another attempt to quit smoking would be successful (Wilson *et al.* 2008) or in the context

of food-insecure patients with uncontrolled hypertension and comorbid diabetes type 2 (Grilo *et al.* 2015). Interventions employing re-enforcement education were more successful, that is, when the nurse repeated the information in the next consultations or in telephone calls and answered individual questions (Huang *et al.* 2009, Choi & Lee 2012).

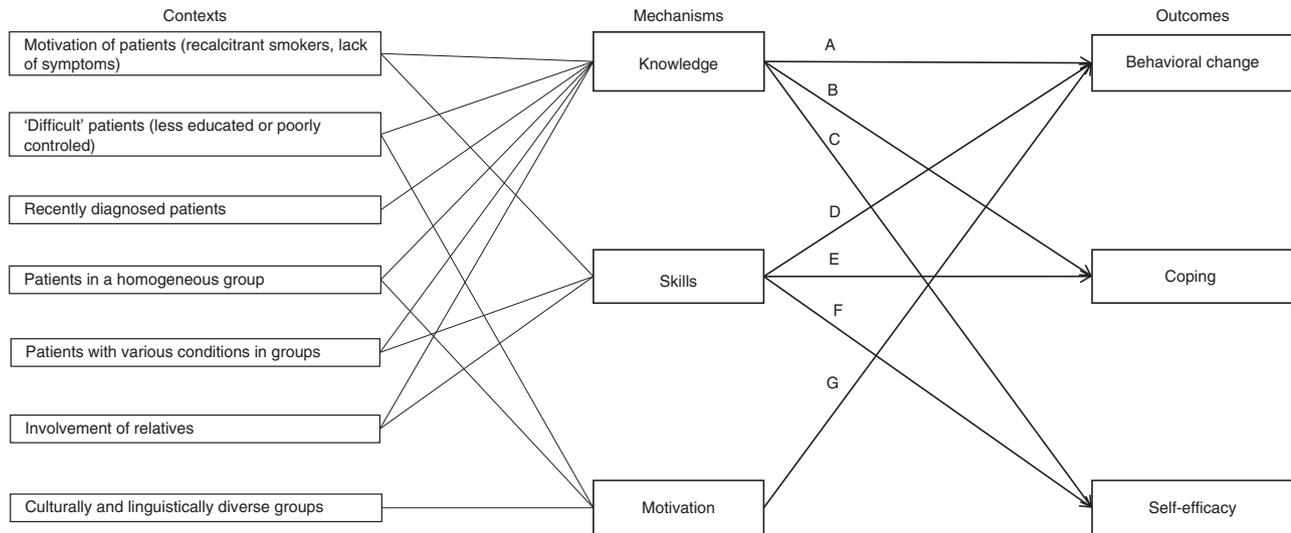


Figure 2 (A–G) strings between Mechanisms and Outcomes.

Thus, the information was tailored to individual needs, enabling patients to relate it to their own situation.

Self-monitoring (by receiving feedback via a TV-channel or computer program about the accuracy of their answers to questions) was successful in that it stimulated learning. Thereby, patients who were recently diagnosed learnt to recognize warning signs that required behaviour change (Balk *et al.* 2008, Huang *et al.* 2009). However, self-monitoring had no added value for people who had received the diagnosis long ago.

In spite of the prominent role of education in these interventions, knowledge gain was often not measured (Trapenburg *et al.* 2008, Wilson *et al.* 2008, Moriyama *et al.* 2009, Otsu & Moriyama 2011, 2012, Yıldız & Kurcer 2012, Gonzalez 2014, Howden *et al.* 2015, Lee *et al.* 2014, Yu *et al.* 2014, Grilo *et al.* 2015). The effect evaluation of most of the studies that did measure knowledge gain showed that patients' knowledge had increased, irrespective of context and education programme (Balk *et al.* 2008, Rootmensen *et al.* 2008, Huang *et al.* 2009, Choi & Lee 2012, Goossens *et al.* 2014). But change in behaviour was only achieved if re-enforcement and repeated education sessions were provided (Huang *et al.* 2009, Choi & Lee 2012). The involvement of family did not seem to affect effectiveness.

In summary, re-enforcement education and tailored knowledge gained from answers to individual questions led to behavioural change in recently diagnosed patients. This string was less successful for target groups with little confidence in their ability to change behaviour and for patients who fail to see any effect of behavioural change on their symptoms.

String B Knowledge leads to coping

Some interventions following this string are based on the espoused theory emphasizing knowledge and cognition (Lindskov *et al.* 2007, Sarian *et al.* 2011), but most are based on the one emphasizing coping (Monninkhof *et al.* 2003, Schreurs *et al.* 2003, Tsay *et al.* 2005, Van Os-Medendorp *et al.* 2007a,b, Bakan & Akyol 2008, Hagberth *et al.* 2008, Jiang & He 2012, Akyil & Ergüney 2013). Their common feature is teaching patients how to re-interpret the symptoms of their chronic condition. This was usually done by the nurse, but in some studies disease-related information and experiences were discussed with fellow patients and/or family (Bakan & Akyol 2008, Hagberth *et al.* 2008, Sarian *et al.* 2011).

In many interventions patients played an active role: e.g. keeping diaries, doing homework or using a self-help manual (Supplement File S5). Sharing experiences and, by doing so, learning from fellow patients helped patients feel understood and made it easier for them to adapt the knowledge to their own situation than when a professional provided information. However, patients mentioned that this was not useful for all topics (Hagberth *et al.* 2008).

In several interventions, information about symptoms was given by professionals, which enabled patients to re-interpret the symptoms (Monninkhof *et al.* 2003, Van Os-Medendorp *et al.* 2007a,b, Bakan & Akyol 2008, Hagberth *et al.* 2008, Jiang & He 2012, Akyil & Ergüney 2013). Through this re-interpretation, patients were more successful in dealing with these symptoms (Van Os-Medendorp *et al.* 2007a,b, Jiang & He 2012, Akyil & Ergüney 2013). Learning from fellow

patients usually made it easier to adapt the knowledge to the own situation than when a professional provided information. Some interventions consisted of goal-setting (Monninkhof *et al.* 2003, Bakan & Akyol 2008), activating the family (Monninkhof *et al.* 2003, Bakan & Akyol 2008, Sarian *et al.* 2011), or keeping a diary so as to raise awareness of how they dealt with symptoms (Schreurs *et al.* 2003, Tsay *et al.* 2005, Van Os-Medendorp *et al.* 2007b). The latter was not always successful, because the patients participating in these interventions did not appreciate the home work, which accompanied the diary keeping, before the consultations with the professional.

Although interventions and contexts differed, most interventions following this string seemed to improve coping strategies. Knowledge gain – the starting point of this string – was demonstrated in only two interventions (Hagberth *et al.* 2008, Sarian *et al.* 2011). The other eight studies, though, had not included this in the effect evaluation.

To sum up, interventions using this string were successful in various chronic conditions when experiences and disease-related information were shared with fellow patients or relatives and when information was personalized. This enabled patients to re-interpret the information and the symptoms – and thus to better cope with the disease. Less successful were interventions asking patients to keep a diary (Supplement File S4).

String C Knowledge leads to self-efficacy

Interventions following this string are based on the espoused theory emphasizing self-efficacy (Kara & Aşti 2004, Carrieri-Kohlman *et al.* 2005, Smeulders *et al.* 2010a,b, Kaşıkçı 2011, Donesky *et al.* 2014).

Education was provided about managing day-to-day disease-related problems – via telephone interviews, brochure or group sessions (Supplement File S5). In some interventions patients were encouraged to share experiences with fellow patients or experienced laymen (modelling) (Kara & Aşti 2004, Smeulders *et al.* 2010a,b). This provided ready-to-use information and made patients feel acknowledged and more self-confident.

Two of the six studies, both in COPD patients, showed significantly increased self-efficacy (Kara & Aşti 2004, Kaşıkçı 2011). The other studies had either not measured the effect on self-efficacy (Carrieri-Kohlman *et al.* 2005, Donesky *et al.* 2014), or reported that patients' self-efficacy did not increase (Smeulders *et al.* 2010a,b). Although providing and discussing knowledge was key to all interventions in this string, none of the studies described whether patients' knowledge had increased. This string was successful in the

context of COPD in both individual and group counselling sessions focusing on day-to-day problems.

String D Skills enhancement leads to behavioural change

The interventions following this string are based on the espoused theory emphasizing knowledge and cognition (Rootmensen *et al.* 2008, Huang *et al.* 2009) and on the one emphasizing behavioural change (Wilson *et al.* 2008, Moriyama *et al.* 2009, Otsu & Moriyama 2011, 2012). All interventions aimed at learning 'how-to'-skills, such as inhalation (Rootmensen *et al.* 2008) and relaxation techniques (Wilson *et al.* 2008), abandoning smoking (Rootmensen *et al.* 2008, Wilson *et al.* 2008, Moriyama *et al.* 2009, Otsu & Moriyama 2011, 2012), or alcohol use (Otsu & Moriyama 2011, 2012), preventing exacerbation (Rootmensen *et al.* 2008) or using a peak flow meter for monitoring of the condition (Huang *et al.* 2009). Usually the nurse provided support, but sometimes also family members, who received the same instructions (Moriyama *et al.* 2009, Otsu & Moriyama 2011, 2012). Other means of these interventions include check-and-correct skills, daily exercises, personal targets, record keeping and motivational interviewing.

All interventions following this string also followed string A. In one study, this proved to be a successful combination, because patients learnt how to monitor their asthma and received feedback about their self-management by rating the symptoms on a scale and using a peak flow meter (Huang *et al.* 2009). This study showed significant positive effects on both skills and change in behaviour. The other studies either not measured these outcomes (Moriyama *et al.* 2009), or were not entirely successful (Rootmensen *et al.* 2008, Wilson *et al.* 2008, Otsu & Moriyama 2011, 2012). For instance, this combination of strings was less successful in the context of poorly motivated patients and reluctant smokers (Wilson *et al.* 2008, Moriyama *et al.* 2009). Some interventions did not take skills achievement into account in the effect measurement, but could be regarded as successful in terms of better clinical outcomes (Moriyama *et al.* 2009, Otsu & Moriyama 2011, 2012).

In short, this string was not successful in the context of poorly motivated patients, nor was the additional instruction of family members effective. However, it was successful in the context of patients with asthma, who learnt to effectively monitor their condition.

String E Skills enhancement leads to coping

All interventions following this string are based on the espoused theory emphasizing coping (Monninkhof *et al.*

2003, Schreurs *et al.* 2003, Tsay *et al.* 2005, Van Os-Medendorp *et al.* 2007a,b, Jiang & He 2012, Lee *et al.* 2014). The interventions aimed to improve coping with symptoms through education on practical self-management tasks, such as peak flow monitoring, but also skills for stress reduction. Means of these interventions were diary records, instruction booklets, self-help manuals and peer groups. In two studies, skills were practiced in a group with fellow patients and this approach appeared to be successful (Schreurs *et al.* 2003, Tsay *et al.* 2005). These patients also set personal goals, kept diary records and discussed these with fellow patients. Eventually, they could better cope with stress- and health-related problems caused by their chronic condition. All studies but one combined teaching skills with the provision of knowledge (via string B). In the exceptional study, when information was needed nurses referred patients to educational material they had received earlier (Lee *et al.* 2014). This approach was not successful. However, the combination of strings B and F seemed to be successful in improving coping strategies. In one study, patients with COPD were reminded through telephone calls to practice distraction and relaxation skills (Jiang & He 2012). This approach considerably improved coping skills.

In sum, this string was successful if realistic goals were set and skills were practiced in either individual sessions or homogeneous patient groups.

String F Skills enhancement leads to self-efficacy

All interventions following this string are based on the espoused theory emphasizing self-efficacy (Kara & Aşti 2004, Carrieri-Kohlman *et al.* 2005, Smeulders *et al.* 2010a, b, Kaşıkçı 2011, Donesky *et al.* 2014). All interventions combined this string with string C '*Knowledge leads to self-efficacy*'. They included 'mastery experiences', 'verbal encouragement', 'modelling' and 'adverse emotional or physical arousal' (Kara & Aşti 2004, Carrieri-Kohlman *et al.* 2005, Smeulders *et al.* 2010a,b, Kaşıkçı 2011, Donesky *et al.* 2014), to be achieved by supervised training, record keeping, setting personal targets, home exercise and group support. Two interventions used group-training sessions, among other things to increase patients' confidence and thus their self-efficacy (Kara & Aşti 2004, Smeulders *et al.* 2010a,b). Newly learnt behaviour was sustained through encouragement from the healthcare professional or fellow patients and thereby improved self-efficacy (Kara & Aşti 2004, Kaşıkçı 2011). This approach was not successful in all studies. In one study, the effect on self-efficacy was not sustained. The researchers explained this by the short duration of the intervention (1 year) (Smeulders *et al.* 2010a,b).

Overall, this string was successful in the context of patients with COPD who received feedback from either healthcare professionals or peers and who saw other patients performing exercises.

String G Motivation leads to behavioural change

Interventions following this string are based on the espoused theory emphasizing behavioural change (Williams *et al.* 2012) and the one emphasizing motivation (Zoffmann & Lauritzen 2006, Zoffmann & Kirkevold 2012). Several interventions made use of motivational interviewing, phone calls, interpreters and personal targets (Supplement File S5). In two studies involving patients with poorly controlled diabetes, patients reflected on their problems with the aid of reflection worksheets (Zoffmann & Lauritzen 2006, Zoffmann & Kirkevold 2012). Qualitative data showed that patients became internally motivated to follow lifestyle adjustments and were more capable to integrate the chronic condition into their lives. The intervention groups showed a substantial level of behavioural change.

Another study described an intervention using culturally adjusted information provision. An interpreter translated the messages of the nurse into the patients' own language. Although patients perceived the sessions as helpful, actual change in behaviour could not be proven (Williams *et al.* 2012).

This string was successful in the context of patients with poorly controlled diabetes who worked with reflection sheets (Zoffmann & Lauritzen 2006, Zoffmann & Kirkevold 2012). Deploying interpreters in the context of culturally and linguistic diverse patient groups was less successful.

Discussion

This realist review aimed to explore how nurse-led interventions that support self-management of outpatients with chronic conditions work and in what contexts they work successfully. The theories-in-use were determined and accordingly, seven strings of interventions were identified.

Interventions that focused on patients' intrinsic processes (self-efficacy and motivation, in strings C, D and G) were the most successful ones (Kara & Aşti 2004, Carrieri-Kohlman *et al.* 2005, Zoffmann & Lauritzen 2006, Kaşıkçı 2011, Zoffmann & Kirkevold 2012). This focus appealed to patients' internal perceived locus of control, which is important for persistence and performance of new behaviour (Ryan *et al.* 1995). Overall, least successful was string A where education was assumed to lead to behavioural change behaviour. Our review demonstrates that when

patients are not confident of their power to change their behaviour or if they do not immediately see positive results of their efforts, education alone will not result in behavioural change. This is in agreement with previous systematic reviews which concluded that education is not sufficient to incite behavioural change (Coster & Norman 2009, Barlow *et al.* 2010). Our review adds that behavioural change could be successfully achieved by re-enforcement of education, tailoring the information to the individual patient's need and by combining knowledge transfer with skills enhancement.

Various contexts were found to influence the effectiveness of interventions. Relatives were involved in the strings with knowledge as a starting point (A, B, C) and this seemed to have a surplus value, as patients felt more supported in daily life. This is in line with findings from a qualitative synthesis of patients' self-management needs, which concluded that relatives' support is essential (Dwarswaard *et al.* 2015). Other relevant contexts are the target group (condition, extent of motivation, recently diagnosed or not), the use of peers and group homogeneity or heterogeneity. In all strings, most interventions were developed for homogeneous groups of patients and the homogeneity mostly had a positive impact on recognition and confidence.

Limitations and strengths

This review represents interventions concerning a variety of chronic conditions but is not exhaustive in this respect; for example, rheumatic disorders are lacking. Studies on this condition were retrieved in the initial search, however, but did not meet the selection criteria. Some were not an empirical study (Lagger *et al.* 2010, Faradji *et al.* 2012); others were outdated (Sinclair *et al.* 1998). It is also possible that, due to our 'nurse-led' and 'outpatient ward' criteria, we might have missed other relevant studies.

Due to the broad approach of our search strategy, many different diseases and different types of interventions were included in our review. This complicates the comparison between interventions. In van Houtum's study among a large sample of Dutch patients with different chronic conditions, self-management tasks and support needs were only partly determined by disease-related factors. While the methodology of realist review has been well described (Pawson *et al.* 2004), realist reviews differ in the way they are executed or documented (Kane *et al.* 2010, Wong *et al.* 2010, Higgins *et al.* 2012). Identifying mechanisms and the corresponding contexts and outcomes, may require a long, continuous process of abductive thinking, reflection and debating (Jagosh *et al.* 2013). In the current review, we worked cyclically to

discover what each decision in the study meant for the steps yet to come. Close collaboration between all team members was beneficial to finding creative solutions as a component of abductive thinking and for reflection.

Practice implications

The insights of this review may help nurses decide what self-management support intervention they can best use in their specific setting and patient group. Preferably, they should select interventions aimed at increasing patients' motivation and self-efficacy, instead of focusing solely on education. Involving peers or relatives could be helpful in achieving these goals.

Different espoused theories were found in the primary evaluation studies. In thirteen studies (34%), no clear underlying theory was mentioned but they could implicitly be linked to existing theories. To evaluate properly the mechanisms that make an intervention 'work', a clear theoretical base underlying the intervention is crucial (Clark 2013, Pawson & Tilley 1997). A theoretical framework provides not only suggestions of how to measure the effects but also appropriate targets for the intervention (van Meijel *et al.* 2004, Michie & Prestwich 2010).

In complex interventions, the role of the healthcare professional is of great influence on the outcomes (Disler *et al.* 2012, Clark 2013). Nurturing relationships with healthcare professionals may stimulate patient's self-efficacy to manage a chronic condition (Disler *et al.* 2012). Although suitable training offers resources to support patients effectively (MacDonald *et al.* 2008), only few authors of the reviewed papers described how healthcare professionals were trained prior to the intervention. This aspect deserves more attention in the description of the intervention in forthcoming studies.

Conclusion

Until now, it was not known what elements of nurse-led SMS interventions were effective. This realist review discusses some of the working elements and shows that interventions focusing on patients' intrinsic processes were most successful. It clarifies in what context nurse-led interventions in supporting self-management of outpatients with chronic conditions will be effective or not. These insights may help nurses choose the appropriate SMS intervention for their target group. The specific context (the involvement of family or relatives, the target group of chronic ill patients, the involvement of fellow patients and intervention group homogeneity or heterogeneity) should be taken into account, because not all interventions work for all

patients in all circumstances. When developing an intervention, using an underlying theory is recommended because this provides guidance as to what outcome the intervention should be aimed at.

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Conflict of interest

No conflict of interest has been declared by the author(s).

Author contributions

All authors have agreed on the final version and meet at least one of the following criteria [recommended by the ICMJE (<http://www.icmje.org/recommendations/>)]:

- substantial contributions to conception and design, acquisition of data or analysis and interpretation of data;
- drafting the article or revising it critically for important intellectual content.

Supporting Information

Additional Supporting Information may be found in the online version of this article at the publisher's web-site.

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