'Nurses' self-management support to hospitalised patients: a scoping review

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REVIEW

'Nurses' self-management support to hospitalised patients: A scoping review

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Abstract

Aims and Objectives: To review the current literature to map and explore the interventions that have been considered or used by nurses to support adult patients' self-management during hospitalisation.

Background: Nurses can play an important role in supporting patients' self-management. Currently, however, it is unclear how nurses perform this task during a patient's stay in hospital. Traditionally, nurses take the primary role in managing patients' care during hospitalisation. Ideally, patients should have the opportunity to continue applying strategies to manage their health conditions as much as possible while in the hospital. This can increase patients' self-efficacy and decrease unnecessary readmissions.

Design: Scoping review informed by the Joanna Briggs Institute methodology.

Methods: A database search was undertaken using Pubmed, CINAHL, PsycInfo, Cochrane, Embase and grey literature sources. Data from the included studies were mapped and summarised in a narrative summary. To synthesise the information that was given about each intervention, we conducted a qualitative inductive content analysis. Results are reported in accordance with the guidelines for reporting Items for systematic review and meta-analyses extension for scoping review (PRISMA-ScR) (Supplementary File 1).

Results: 83 documents were included in this review. Based on the information about the interventions, three themes were identified: 'self-management support activities', 'focus of self-management support' and the 'intervention procedure'. Five self-management support activities can be distinguished: 'giving education', 'counselling and coaching', 'enhancing responsibility', 'engaging family-caregivers' and 'supporting transition from hospital to home'. The interventions focused on improving disease-related knowledge and on strengthening several self-management skills. Information about the procedure, development and the theoretical underpinning of the intervention was often limited.

Conclusions: Most activities within the nursing interventions to support adult patients' self-management during hospitalisation are the part of regular nursing care. However, the transfer of responsibility for care task to the patient is relatively new.

Further research could focus on developing interventions addressing all aspects of self-management and that are embedded in the patient's care pathway across settings. **Relevance to clinical practice:** Clinical nurses may improve nursing care by supporting all aspects of patients' self-management and facilitate patients as much as possible for taking responsibility for self-management tasks during hospitalisation.

KEYWORDS
hospital, nursing, scoping review, self-management support

1 | INTRODUCTION

In the past, health was seen as the absence of disease. More recently, a new definition is suggested, in which health is understood as 'the ability to adapt and self-manage' (Huber et al., 2011). Self-management, a concept aiming at persons' abilities to live with the consequences of a health condition, has received growing attention. Efficacious self-management encompasses the ability to monitor one's condition and to effect the cognitive, behavioural and emotional response necessary to maintain a satisfactory quality of life (Barlow et al., 2002; Richmond & Connolly, 2020) Self-management may be viewed as a subset of self-care, a broad concept referring to individual responsibilities for healthy lifestyle behaviours required for human development and functioning, but the differences between and the relationship among these two concepts are not clear (Richard & Shea, 2011; Richmond & Connolly, 2020; Wilkinson & Whitehead, 2009). Both terms are often used interchangeably (Coster & Norman, 2009; Wilson et al., 2006). There is no generally accepted definition for the term self-management (Coster & Norman, 2009; Richard & Shea, 2011; Wilkinson & Whitehead, 2009). For the purpose of this study, self-management is considered a part of self-care, specifically aimed at managing the actual and potential impact of a disease (Richard & Shea, 2011; Richmond & Connolly, 2020).

Nurses can play an important role in supporting patients' self-management (Coster & Norman, 2009).

In the context of long-term condition care, self-management support is described as 'a patient-centred collaborative approach to care that promotes patient activation, education and empowerment' (Jones et al., 2011; Leveille et al., 1998; Wagner et al., 2001), aimed at encouraging the patient to use their own skills, information and professional services to take effective control over life (Jones et al., 2011). The enhancement of self-efficacy, that is the confidence to carry out a behaviour necessary to reach a desired goal, is considered to be a key component of self-management support (Lorig & Holman, 2003; Pollack et al., 2016). Patients' self-efficacy can be enhanced by emotional and physical support during hospitalisation (Pollack et al., 2016).

Different programmes have been developed and tested to support patients' abilities to manage chronic illness at home (Coster & Norman, 2009; Lorig & Holman, 2003; Panagioti et al., 2014), but limited research has been conducted on programmes that support self-management in hospitalised patients. Traditionally, nurses take the primary role in managing patients' care during the course of a hospitalisation (Pollack et al., 2016), changing patients into passive consumers (Benham-Hutchins et al., 2017). Ideally, patients have the opportunity to manage their own health conditions and to develop necessary new self-management skills as much as possible under guidance of the hospital staff (Pollack et al., 2016). This may decrease unnecessary readmissions to hospitals, especially for older individuals (Hickman et al., 2010).

It is unclear what nurses do to support patients' self-management during hospital admission. For this reason, we conducted a scoping review to systematically map the research done in this area, to identify key components of nurses' support of patients' self-management during hospitalisation and to distinguish any existing gaps in knowledge.

What does this paper contribute to the wider global clinical community?

- Nurses can support patients' self-management while hospitalised by 'giving education', 'counselling and coaching', 'enhancing responsibility', 'engaging family-caregivers' and 'supporting the transition from hospital to home'.
- The transfer of responsibility for care tasks to the patient during hospitalisation is a relative new nursing activity that requires a different role for both the patient and the nurse.
- It is relevant to explore the possibilities of health information technology to support patients' self-management while in hospital.

2 | AIM

The aim of this review of the literature is to explore the interventions that have been considered or are used by nurses to support adult patients' self-management during hospital admission. The findings of this review will provide a starting point for the development of programmes supporting patients' self-management during hospital admission and for further investigation of this topic.

3 | METHODS

We conducted a scoping review because it incorporates a range of study designs in both published and grey literature and generates an intellectual overview of what is known around self-management support during hospitalisation (Davis et al., 2009; Levac et al., 2010). Scoping reviews are particularly useful for summarising literature about a topic area and for clarifying complex concepts (Levac et al., 2010). We used a methodological framework to guide the scoping review, involving the following five stages: identifying the research question; identifying relevant documents; selecting documents to include in the review; charting of information and data within the included documents and collating, summarising and reporting the results (Arksey & O'Malley, 2005, Levac et al., 2010, Peters et al., 2015). The optional sixth stage, a consultation with stakeholders, was not a part of the present review. For charting and analysing the information of the interventions described in the included documents, and to obtain a broad picture of what is reported about the interventions, we employed a qualitative inductive content analysis (Elo & Kyngas, 2008; Sandelowski, 2000). The research team consisted of researchers with different theoretical perspectives (psychology (JK), nursing (CO, JdM, LS), research methodology (JS)) and was supported by an experienced information specialist. The guideline published by the Joanna Briggs Institute (JBI) as well as the preferred reporting Items for scoping reviews (PRISMA-ScR) has been followed (Peters et al., 2017, Tricco et al., 2018). The PCC tool (population, concept and context) was used to structure the research question, the identification of relevant documents and the inclusion criteria (Peters et al., 2017, Tricco et al., 2018), see Table 1.

3.1 | Identifying the research question

The following research question was formulated: 'What interventions, presented in the current literature, do and can nurses use to support adult patients' abilities to self-manage during hospitalisation'.

3.2 | Identifying relevant documents

This stage consisted of two parts: the determination of the inclusion criteria and the search for relevant documents.

3.2.1 | Inclusion criteria

Documents were included in the review when they reported the interventions that can be or have been used by nurses, to support adult patients' self-management during hospital admission. A nursing intervention is defined as 'any treatment, based on clinical judgement and knowledge that a nurse performs to enhance patient outcomes' (Butcher et al., 2018). Qualitative, quantitative and mixed method study designs, as well as grey literature were included (Peters et al., 2015, Peters et al., 2017, Tricco et al., 2018). We have chosen to limit our study to documents published between 1 January, 2010, and 1 March, 2020. Nursing care in hospitals is changing rapidly due to the increasingly shorter hospital stay of patients and the higher complexity of care. How nursing care used to be more than 10 years ago is not considered relevant to answering the research question. Due to limited resources for translation, documents published in languages other than English were excluded.

3.2.2 | Search strategy

The electronic search strategies were developed by two researchers (CO, JK), supported by an experienced information specialist. The search for relevant documents consists of three steps, recommended in the JBI scoping reviews guidance (Peters et al., 2015). First, we conducted a limited search (n = 100) in the databases Pubmed and CINAHL to check the relevance and the completeness of the chosen keywords and to test the screening method. The first search string consisted of a broad list of terms related to self-management, such as 'patient empowerment' and 'patient participation' and yielded a large number of irrelevant hits that did not match the research question. We were specifically looking for interventions that nurses planned and/or performed with the aim of supporting patients' self-management, not with the aim of supporting patient participation or empowerment. It was therefore decided to focus the final search string on the term self-management. Because of the absence of generally accepted definitions for the terms self-care and self-management and the lack of consensus on the distinction of these two concepts (Richard & Shea, 2011; Richmond & Connolly, 2020; Wilkinson & Whitehead, 2009), we also used the term 'self-care' in the search strategy. Interventions reported to be aimed at self-care were verified to

TABLE 1 PCC framework with keywords search string

PCC framework	Keywords
Population: Nurses	Nurse(s) Nursing
Concept: Interventions to support patients' abilities to self-management	Self-management Self-care
Context: Hospital	Hospital(s) Inpatient(s) Hospitalised/hospitalized Hospitalisation/hospitalization

BOX 1 Search string Pubmed

((‘Nursing’[Mesh] OR ‘Nurses’[Mesh] OR Nursing[tiab]) OR Nurses[tiab]) OR Nurse[tiab]) AND (‘Self-Management’[Mesh] OR Self-Manage*[tiab] OR Selfmanage*[tiab] OR ‘Self Care’[Mesh] OR self-care[tiab] OR selfcare[tiab]) AND (‘Hospitals’[Mesh] OR Hospitals[tiab] OR ‘Hospitaliasation’[Mesh] OR Hospitalisation[tiab] OR Hospitalisations[tiab] OR Hospitalization[tiab] OR Hospitalizations[tiab] OR Hospitalized[tiab] OR hospitalised[tiab] OR ‘Inpatients’[Mesh] OR Inpatients[tiab] OR Inpatient[tiab])) Filters: Published in the last 10 years; English.

determine whether they focus on managing the actual and potential impact of a disease, in other words, whether they focus on self-management. If not, the intervention was excluded.

The final search strings were discussed and assessed by members of the research group (JdM, LS) on the basis of the peer review of electronic search strategies (PRESS) checklist (Sampson et al., 2009). Basis of the search string was the PCC (population, concept and context) framework (Peters et al., 2017, Tricco et al., 2018) (see Table 1 and Box 1). The final search (step two) was undertaken across the following databases of peer-reviewed and grey literature: Pubmed, CINAHL, PsycInfo, Cochrane, Embase, Google scholar, Open grey and Virginia Henderson Global Nursing, April 2020. The literature search using Google scholar was based on different combinations of keywords, the results sorted by relevance by Google, and, when relevant, limited to the first 20 pages, with the premise that relevance of retrieved articles would decrease after this point (Pham et al., 2014). At last, reference lists from included documents and all reviews of literature found were hand searched for suitable, additional documents.

3.2.3 | Document selection

The peer-reviewed database search (April 2020) identified 3719 potentially relevant documents (Pubmed ($n = 756$); CINAHL ($n = 1008$); PsycInfo ($n = 332$); Cochrane ($n = 736$) and Embase ($n = 887$). All identified documents were uploaded to the systematic review web app Rayyan (Ouzzani et al., 2016), and duplicates were removed ($n = 1244$). The main reviewer (CO) conducted an initial broad screening of all titles and abstracts for relevance on basis of the inclusion criteria and excluded 2174 documents. Global search of potentially relevant documents from Grey literature identified 71 documents, which also were uploaded in the web app Rayyan. Both reviewers (CO, JK) independently assessed the remaining 372 documents for eligibility, first on basis of title and abstract, then full text. Disagreements between the two reviewers were solved by discussing the relevant document, reaching consensus and, based on this, supplementing the criteria with the following reasons for exclusion: articles about pregnant women; psychiatric patients; patients with impaired cognition and palliative patients. We chose not to include these patient groups on the grounds that they have specific needs. Also, the inclusion criterion ‘during hospital admission’ was clarified with the following criteria for exclusion: patients admitted for one day, such as dialysis patients; Emergency Room patients; or patients hospitalised in a rehabilitation centre. If several documents were about the same intervention and study; then, the article with the best description of the intervention was included. This step resulted in 78 documents that were included in the review. In the final stage, five additional documents were included by hand-searching the reference lists of the included documents and reviews found, resulting in a total of 83 documents included (see Figure 1: The search decision flowchart).

3.3 | Charting the data

A data-charting form to record characteristics of the included documents and the key information relevant to the review question were developed and discussed within the research team (Peters et al., 2015, Peters et al., 2017). This tool included the following information about the document: title; author(s); year of publication; country of origin; journal of other information source; aims/purpose of the study; key concept; study design; context/setting; location; population; sample size; intervention type and comparator, duration of the intervention; outcomes and how outcomes are measured. The first reviewer/author (CO) extracted the data from the included documents registered the data in the Microsoft Excel Spreadsheet software program, and discussed the findings at several face-to-face meetings with the other reviewer (JK). During the data extraction process, the data-charting form was revised to include information on the theoretical underpinning of the intervention, as this is a relevant aspect when developing complex interventions (Craig et al., 2008). Consistent with the JBI approach for scoping reviews, critical appraisal of included documents was not undertaken (Peters et al., 2015).

3.4 | Analysing and synthesising the data

The extracted data were mapped with results summarised in tabular form (See additional information) and by a narrative summary. To synthesise the information that was given about each intervention, we conducted qualitative inductive content analysis (Elo & Kyngas, 2008; Sandelowski, 2000). Codes were systematically applied, generated from the data instead of using a pre-existing set of codes to the data (Elo & Kyngas, 2008; Sandelowski, 2000). The qualitative data analysis and research software Atlas-ti (version 8) was used to support this analysis. Two reviewers/authors (CO, JK) independently coded the information regarding the interventions from the first 20 documents and met afterwards to discuss codes found and establish

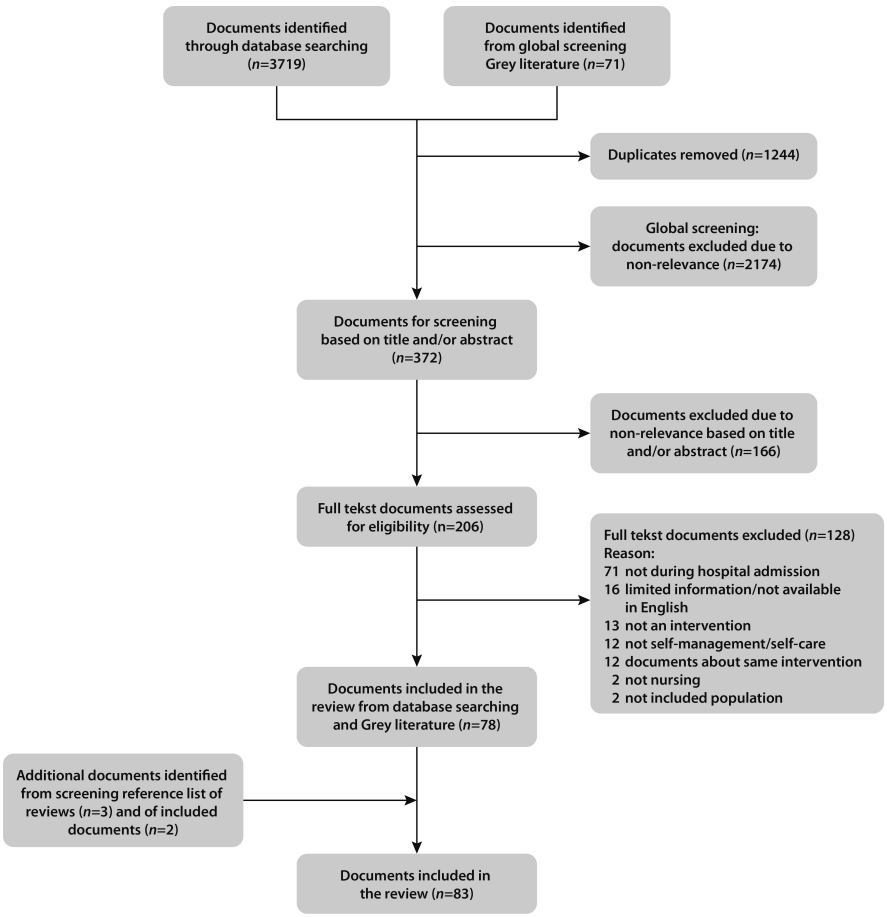

FIGURE 1 The search decision flowchart

consensus. For multidisciplinary interventions, as well as interventions across different care settings, only the part of the intervention performed by clinical nurses was included in the analysis, if this was clearly reported in the article. Subsequently, the other documents were coded by the first author, codes were grouped into categories with similar meanings and placed under themes. Finally, the mapping and summarising of data, the qualitative analysis and the development of themes were discussed within the research team and consensus was reached.

4 | FINDINGS

4.1 | General characteristics of documents

Documents found were journal articles (n = 59), conference abstracts or trial registrations (n = 21), or theses (n = 3). A large part of the documents originated in the USA (n = 30), 17 documents in Europe and 13 documents in China. Six documents originated in Canada. The other 16 documents originated from Australia, Brazil, Egypt, Iran, Japan, Lebanon, Korea, Singapore, Taiwan or Vietnam.

About half of the interventions were directed towards specific patient populations focusing on chronic conditions (See Table 2). Three interventions were directed to multimorbidity, two of them to both diabetes mellitus and cardiac conditions, and the remainder to diabetes mellitus and obesity. Samples sizes ranged from 1 patient to 3758 patients. Most of the included studies had a quantitative design (See Table 3). Details about the documents are available in the online Supplementary File 2.

TABLE 2 Patient populations targeted by an included intervention

Patient population	N
Chronic heart failure	38
Oncological illness	11
Diabetes mellitus	6
Orthopaedic	5
COPD	4
Having a stoma	4
Older patients	3
A liver disease	2
First-time acute stroke	2
Burns	1
Diabetes and chronic heart failure	2
Diabetes and obesity	1
Unspecified	4

TABLE 3 Design of the included studies

Design		N
Quantitative	experimental	36
	quasi experimental	11
	pre-experimental	4
	non-experimental	6
Qualitative		3
Mixed method		2
Not mentioned/relevant		21

4.2 | General characteristics of nurses' interventions to support patients' self-management during hospital admission

All interventions were aimed on supporting adult patients' self-management during hospitalisation. The interventions reported to be aimed at self-care were also focused on managing the actual or potential impact of the patient's disease. Nevertheless, distinctions can be made in the objectives of the interventions. Most of the interventions (n = 75) focused on preparing the patient for self-management after discharge, 11 of which also paid attention to patients' self-management during hospitalisation. Eight interventions focused only on patients' self-management while hospitalised.

Targeted outcomes of the interventions can be classified as follows: (1) patients' self-management or self-care (aimed at managing the actual or potential impact of a disease); (2) outcomes that influence patient's self-management, such as self-efficacy, knowledge or attitude; (3) outcomes that can be seen as a result of patient's self-management, such as adherence, clinical and functional outcomes, quality of life and readmission rates and (4) outcomes regarding the intervention, such as usefulness and cost-effectiveness.

Thirty-six interventions reported to be theoretically based. Most were based on theories of self-management or related concepts, such as self-care, self-efficacy, self-determination or self-regulation. Bandura's theory of self-efficacy was mentioned six times (Bandura, 1977). Four interventions were based on behaviour change techniques, two of which were referred to Michie's behaviour change model (Michie et al., 2011). Only one document reported that the intervention design was based on the Medical Research Council Framework for the development of complex interventions (Craig et al. 2008). The Donabedian quality assessment model (Donabedian, 1988), the Green's Precede model explaining health behaviour (Green et al., 1991) and Bloom's taxonomy (revised) of different levels of human cognition (Krathwohl, 2002) were also mentioned once. It is often stated that the intervention was based on previous research or guidelines.

A limited number (n = 22) of documents indicated how and by whom the intervention was developed. Involvement of a multidisciplinary team was mentioned sixteen times. Three documents reported that patients and other stakeholders participated in the development of the intervention.

More than half of the interventions (n = 51) were performed within the patient's care pathway across different settings. Intervention time varied from one short session while the patient is in hospital, to several sessions and/or to a follow-up regimen up to 12 months. Details about each intervention are available in the online Supplementary File 2. Occasionally references to individual papers are made to exemplify the results.

4.3 | Features of nurses' interventions to support patients' self-management during hospital admission

The description of the interventions found in this scoping review is diverse and often limited. The qualitative analysis enabled us to group the relevant features of nurses' interventions to support patients' self-management during hospital admission addressed in the documents into three themes. The first theme, 'self-management support activities', describes the different activities nurses perform to support the self-management of hospitalised patients. The second theme, 'focus of self-management support' describes which aspects of patients' self-management are targeted by the interventions. The third theme, 'intervention procedure', describes the information about the intervention procedure given in the included articles.

4.3.1 | Self-management support activities

Nurses performed various activities in order to strengthen patients' self-management.

Five activities can be distinguished: giving education; counselling and coaching; enhancing responsibility; engaging family-caregivers and supporting transition from hospital to home. The interventions found consisted of at least one of these activities, but usually a combination of several activities.

Giving education

Most interventions (n = 75) related to the transfer of information about the health condition and self-management and/or the acquisition of self-management skills. When this was not the case, the patient education was often mentioned as part of usual care. Some teaching sessions were clearly defined and structured with tools such as checklists as well as a standardised delivery method. Others have been described only to a limited extent. Patient education was delivered at the bedside, individually or in a group which allows participants to exchange experiences. The education varied from a session of one hour to extensive training with multiple meetings. Eleven interventions incorporated the Teach Back method, a method in which the patient is asked to repeat information just discussed to confirm the patient understands. Also, other methods for reinforcing the teaching were used.

Coaching and counselling

In some of the interventions ($n = 36$), patients received personalised assistance in learning to cope with the health condition. In individual conversations, and sometimes in the presence of family members, attention was paid to patients' situation, experiences, feelings, needs and capacity to change. These conversations took place in patient's room while in hospital, or after discharge by telephone, at patient's home or in an outpatient setting. The amount of information also varies on this subject. Motivational Interviewing techniques were used in five interventions to increase patients' motivation to change and to build confidence in the ability to do so.

Giving responsibility

In sixteen interventions, patients were actively involved in the provision of their own care and responsible for self-management activities, such as daily medication use, the administration of diabetes care, fluid input and output registration, mouth care, ileostomy care; nutrition input, diet, exercise, measuring and recording body weight or the prevention of complications while hospitalised. This transfer of responsibility is intended to teach the patients self-management skills so that they continue these activities after discharge. Nurses' assessment of patients' suitability to self-manage while hospitalised and drafting and signing an agreement for self-management while hospitalised were part of some interventions, in particular those aimed at medication self-management. It is reported that nurses check the patient's self-administrated medication list during each round of medication.

Engaging family-caregivers

The included documents primarily described self-management support at an individual level, but in twenty-four interventions family caregivers were actively involved as well. Family members were invited to attend the educational sessions with patients about self-management knowledge; to discuss patients' support requirements and discharge plans; or to be instructed on skills like measuring blood pressure or daily weighing. In one intervention, the nurse would act as a role model for caregivers to help them adopt supportive attitudes and behaviours in their own interaction with the patient (Cossette et al., 2016). Family members were asked to assist the patients at home and track their adherence to the guidelines. Patients were encouraged to engage their relatives to provide social and psychological support.

Supporting transition from hospital to home

Nineteen interventions mentioned specific activities to ensure patients were prepared for discharge and understood the post-discharge plan of care. One intervention involved a visit to the patient in hospital by nurses who had the responsibility to oversee home care to introduce themselves as well as to arrange a suitable time to visit the patient at home (Negarandeh et al., 2012). Another intervention mentioned a Nurse Transition Coach who visits the patient prior the discharge and at home within 72 hours of discharge (Hoover et al., 2017). In seven interventions, it was stated that the patient was given a telephone number to contact the nurse with any question. Some interventions provided information about the transfer of care to the family physician or other primary care providers.

4.3.2 | Focus of nurses' self-management support

The focus of the interventions varied. In almost all interventions, an aim was to improve the patient's knowledge of the disease. This included information about the disease, risk factors, symptoms and/or treatment plans. In addition, the focus of the intervention was on one or more of the following aspects: (1) making lifestyle changes, such as quitting smoking, following a prescribed diet, exercise regularly or other instructions provided, (2) medication management and adherence, (3) physical self-management activities, such as daily weighing, correct inhalation techniques, wound care, correct tooth brushing techniques and personal hygiene when receiving chemotherapy, (4) dealing with stress and strong emotions, also clarifying the sources available for psychosocial support, (5) self-monitoring and symptom management, such as recognising the early signs of a COPD exacerbation and knowing what to do, identifying and managing complications related to stroke or controlling side effects of chemotherapy, (6) problem-solving, by encouraging patients to discuss concerns and problems and provide them with strategies to resolve problems, (7) navigating the health system, including keeping up follow-up arrangements, access to community programmes, information on patient groups and relevant websites and (8) goalsetting and the development and the implementation of a personal self-management plan, addressing patient's priorities, including realistic short and long-term goals.

4.3.3 | Intervention procedure

Information about the intervention procedure was often limited and insufficient to reproduce the intervention in a different setting. We found information about who performed the intervention, where the intervention took place, how the intervention was tailored to the individual patient and about the tools used.

Most of the interventions found were only performed by nurses. Five documents indicated that a multidisciplinary team was involved. Often, the nursing staff was given a training program to perform the intervention, to be well equipped to perform the intervention and to standardise the providing of the programme. Checklists have also been developed for this purpose. Some interventions were performed by part of the nursing team or by intervention nurses or nurses with an advanced degree. One intervention also involved peers, referring to individuals who have similar conditions and can use their own experiences to provide information and help to others (Wu et al., 2011).

More than half of the interventions were carried out within the patient's care pathway across different settings ($n = 51$). In this group, the intervention usually started during the hospital stay and

was continued after discharge. Three documents described interventions that started before hospitalisation to prepare the patient on performing self-management while hospitalised. The other 32 interventions only took place during hospitalisation.

Most interventions were standardised in terms of contents and mode of delivery, but often the procedure and/or contents were tailored to the individual patient needs, concerns, questions and priorities. Forty-two documents specifically stated that the intervention was individualised, personalised or patient centred. This was explained more concretely by for instance indicating that the teaching was adjusted to patient's educational level and knowledge of healthcare, by developing a personal plan for self-management after discharge or through an individually tailored and agreed time and duration of a telephonic follow up.

Various tools were used within the interventions. Often, the patient received written information or a textbook to take home after discharge. Sometimes training and instruction were supported by visual or audio aids. In addition, use was made of computer-aided learning, such as educational sessions on a computer, performed by a virtual nurse. Virtual reality was used to induce relaxation. At home, patients were given the opportunity to online chat facilities to discuss problems with nurses. Examples of self-help materials for patients included the following: a pillbox; a weighing scale; a heart rate monitor; reminders; a written traffic light method for symptom management; a diary to record behaviour and questions; chart for weight management or fluid intake and output. One article described a family caregiver checklist, including possible strategies to support patients without criticism (Cossette et al., 2016).

5 | DISCUSSION

The large number of identified documents ($n = 83$) shows that this topic is an important area of interest. The qualitative content analysis of the information given about the interventions led to the emergence of three themes, which indicate self-management support activities, the focus of the support and the procedure to implement the support. The review revealed five activities nurses can undertake to support the self-management of hospitalised patients. Some activities, such as patient education or involving family care-givers, have been performed by clinical nurses for quite some time, but the aim on supporting patient's self-management is fairly new and may change the content of these activities. Making patients responsible for self-management activities during hospitalisation seem to be a rather new nursing activity. Nurses are used to involve patients in activities of daily living (ADL), but less so in activities aimed at managing the impact of a disease, such as fluid input and output registration or measuring body weight or preventing complications. Not all patients are able or willing to be actively involved. Patients' preferences and capacity to engage in their care while in hospital should be assessed to tailor patients' involvement to each patient's unique wishes, circumstances and condition (Jerofke-Owen & Dahlman, 2019).

Most interventions found were aimed at improving patients' skills for self-management their chronic disease at home. There are few interventions that stimulate the patient's active self-management while in the hospital. The latter is increasingly important because hospital stays are becoming shorter, which means that more and more is expected of patients. Patients' understanding and managing their own health while hospitalised, will help them to maintain self-confidence and give them the ability to develop new self-management (Pollack et al., 2016). Normally, patients do not perform self-management while in hospital, as they consider it inappropriate and want to adhere to, what they consider to be, hospital procedures (Otter et al., 2019). Encouraging and inviting patients to have an active role and control over personal care can change this (Otter et al., 2019). This calls for a different professional role for nurses. Nurses need to recognise patients as equal partners in care, responsible for their own health. Previous research showed that nurses find it difficult to share or transfer professional control and lack confidence in patients' abilities to properly self-manage (Otter et al., 2021; Wilson et al., 2006). Nurses are uncomfortable with the idea of being challenged by expert patients (Wilson et al., 2006). It is suggested that an unclear role definition of nurses and the difficulty to clearly articulate their specific expertise within a multidisciplinary team, influenced their responses to knowledgeable patients (Wilson et al., 2006). Describing the area of nurses' expertise and their specific role regarding self-management support, clearly assigning this task to nurses and teaching nurses to share or transfer control to patients can enable them to accept their changing roles.

It is debatable whether every intervention that was identified can be regarded as a self-management support intervention. The core objective of self-management support is to influence the patient's health behaviour and to increase the patient's skills and confidence in managing their health condition(s). However, some interventions do not seem appropriate to achieve this because they focus on only one aspect of self-management or because they are limited in duration and do not appear to be sufficient to generate a permanent change in health behaviour. Self-efficacy, although considered an important part of self-management support (Lorig & Holman, 2003; Pollack et al., 2016), has been mentioned only a few times as the theoretical basis for developing an intervention or as the intended outcome of the intervention. Nevertheless, all activities found can be seen as a way to increase patients' knowledge and confidence in managing their own health. Previous research identified a generic set of skills to be successful for effective self-management, including problem solving, decision-making; resource utilisation, forming a patient-health care provider partnership and taking actions (Lorig & Holman, 2003, Van de Velde et al., 2019). All these skills were mentioned in this review, but not all skills are addressed in every intervention.

More than half of the interventions took place over a longer period and consisted of activities across settings. These interventions, focusing the continuity of care and designed to bridge the institutional barriers between the acute care setting and the care in the patients' community context, are good examples of self-management

support interventions as they have been found to reduce readmission due to exacerbation, especially in older persons (Hickman et al., 2010). In view of the increasingly shorter hospital stay and thus, the reduced ability to support patients' self-management while in hospital, it is important to develop self-management support programmes that will be implemented in different care settings.

Only a few interventions were aimed at patients with an acute illness, such as a first-time stroke, or at patients with a planned surgical procedure. These patient groups need more attention as self-management is also important for patients with acute health problems. They also need to monitor their condition and have to deal with the cognitive, behavioural and emotional consequences of their health problem. It is striking that most interventions are aimed at dealing with the consequences of a single disease, while most of the hospitalised patients older than 65 have two or more acute and chronic diseases (Buurman et al., 2016). Acute conditions can complicate treatment of other conditions (Buurman et al., 2016). It is important for both the healthcare professional and the patient to be aware of this. Self-management support should also focus on patients with complex needs due to multimorbidity.

One of the challenges hospital nurses faced in supporting patients' self-management is the lack of time (van Hooft et al., 2016; Otter et al., 2021). Given the prognosis of future nurses shortage (World Health Organization, regional office for Europe Nursing and Midwifery, data and statistics, 2020), the lack of time will only increase; so, we need to look for interventions that respond to this. Some interventions found in this scoping review used health information technology to support patients' self-management, which reduced the time spent by nurses. These types of interventions have great potential for engaging hospitalised patients in their care (Roberts et al., 2017).

Scoping reviews are not intended to assess the quality of the literature scoped (Arksey & O'Malley, 2005). Nevertheless, several aspects were noted with regard to the quality of the information in the documents. Interventions to support patients' self-management are considered complex interventions, interventions with several interacting components that impact the length and complexity of the causal chain from intervention to outcome and the influence of the local context (Craig et al., 2008, Bleijenberg et al., 2013). Best practice to design a complex intervention is to act systematically, use the best available evidence and theory (Craig et al., 2008), basing the intervention on both the needs of recipients and providers and on the delivery context (Bleijenberg et al., 2018). The lack of any of those elements reduces the chances of success (Bleijenberg et al., 2018). Our study showed that information about the development of an intervention is often lacking or limited. This makes it difficult to understand how the intervention works, what the ingredients are and how they have an effect. The quality of most descriptions of the interventions found was also poor, making it difficult to replicate the interventions or to build on research findings (Hoffmann et al., 2014). A suggestion for further research is to use a systematic method for the development of interventions, such as the Medical Research Council Framework, and describe the intervention in sufficient detail to allow others to reproduce the intervention (Hoffmann et al., 2014; Tong et al., 2007). A recent concept analysis of self-management, identifying ten attributes delineating self-management, may provide a basis for the development of new self-management programmes (Van de Velde et al., 2019).

We have performed this review of the literature systematically, using the framework of Arksey and O'Malley (Arksey & O'Malley, 2005). This framework suggests an optional sixth stage with stakeholders' consultations, although it is unclear when, how and why stakeholders should be consulted, and how these data should be analysed and integrated with the findings (Levac et al., 2010). We plan to present the findings of this scoping review, along with results of previous research (Otter et al., 2019; Otter et al., 2021) to experts in a Delphi study with the aim of reaching consensus on the way nurses can support patients' self-management during hospital admission. This can also be seen as a first step in disseminating the research findings.

6 | LIMITATIONS

Despite the comprehensive database search, it is possible that potentially relevant documents were missed because only English language documents were included. Our review is further limited by the lack of detailed information about the interventions in many of the documents. Due to restricted resources, the process of data extraction was largely performed by one reviewer (CO). To limit the possibility of reviewer bias, all questions and doubts were discussed with the second reviewer (JK) and eventually within the research group.

7 | CONCLUSION

This scoping review demonstrated the interventions that nurses (can) use to support adult patients' self-management during hospitalisation. Most activities within these interventions are part of regular nursing care, but the focus on patients' self-management is relatively new and may change its content. The actual involvement of patients in their care and the transfer of responsibility for care tasks to the patient are a new activity within the nursing care for hospitalised adult patients. Some interventions focus on only one aspect of self-management, usually the patient's knowledge of the disease and its treatment. More aspects of patients' self-management need to be addressed to influence patients' health behaviour and to increase patients' skills and confidence in managing their health condition(s). Interventions that take place over a longer period and are carried out in different settings within the patients' care pathway, seem suitable for increasing the patients' skills and confidence in managing their health condition.

Based on our analysis, we suggest that further research could focus on (1) reviewing the literature on the effectiveness of the different activities mentioned, or, if limited research is available, conducting studies to determine the effect of the various activities on

patients' self-management; (2) developing and testing interventions that focus on empowering patients to be actively involved in their own care and responsible for (parts of) their self-management during hospitalisation, including methods for assessing patient's capacity to self-manage while in hospital; (3) developing and testing self-management supporting interventions embedded in the patient's care pathway across settings, targeting both chronic and acute health problems and patients with multimorbidity and (4) with specific attention to the possibilities of health information technology. We also propose to use a systematic method for the development of interventions, based on both the needs of recipients and providers, and to describe the interventions in publications in sufficient detail to allow others to reproduce. Nurses need information on how to support patient's self-management in an evidence based, structured manner and how this can be integrated into clinical practice.

8 | RELEVANCE TO CLINICAL PRACTICE

By performing a scoping review, we did not investigate the effectiveness of the interventions found. As a result, we cannot give evidence-based recommendations for practice (Peters et al., 2015). The findings can be considered a first step in developing conceptual clarity regarding nurses' support of patients' self-management during hospitalisation and can be used by clinical nurses to improve nursing care through developing interventions that address all aspects of self-management and make the patients as responsible as possible for self-management task while hospitalised.

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CONFLICT OF INTEREST

None.

AUTHOR CONTRIBUTIONS

Each author contributed to this manuscript and take responsibility for the work reflected in this analysis. The authors' contribution is as follows:

1. Caroline E.M. Otter involved in conceptualisation, methodology/design, project administration, formal analysis and writing—original draft, review and editing.
2. Joost C. Keers involved in methodology/design, formal analysis, and writing—reviewing and editing, supervision.
3. Jakobus Smit involved in methodology/design and writing—reviewing and editing.
4. Lisette Schoonhoven and Janneke M. de Man-van Ginkel involved in methodology/design and writing—reviewing and editing and supervision.
5. All authors read and approved the final manuscript.

DATA AVAILABILITY STATEMENT

Data available in the article supplementary material. More data available (in Dutch) on request from the authors.

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