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Feature Article

The effects of mutual goal-setting practice in older adults with chronic illness

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ABSTRACT

Goal setting is a strategy that can enhance performance. The purpose of this study was to examine how engaging older adults with chronic illness in setting goals for their care would affect their performance in achieving those goals. This study employed a quasi-experimental design with repeated measures to evaluate the effect of an intervention, namely mutual goal-setting (MGS) practice, on elderly patients with chronic illness. Eighty such patients receiving nursing care at home were recruited for the study. Repeated measures showed that the intervention group achieved a higher percentage of their goals, though insignificant group and time interaction effects between groups were found in perceived functional disability, perceived functional health and self-efficacy in self-managing chronic illness. The findings of this study with a specific group, namely elderly patients with chronic illness, support the general premise that patients who participate in determining their care are more likely to improve in physical and mental well-being.

Introduction

Globally, the population is ageing. The proportion of the world's population aged 60 years and over is expected to increase from 11% to 22% by 2050.[1] More people are living into their 80s and 90s than ever before. As the risk of developing chronic health problems increases with age, the number of people living with chronic illness is therefore increasing as is the need for long-term care. The trend of self-management among older adults with chronic illness at home has been increasing to maintain their independence and reduce healthcare expenditure.[2,3] Older adults are often caring for themselves with community support.[4,5] In Hong Kong (a Special Administrative Region of China), Community Nursing Service (CNS)—the primary nursing service providing continued care for discharged patients at home—provides care predominantly for patients aged above 65 (more than 90% of the caseload).[6] Home is an environment where patients are more autonomous in making decisions regarding and in controlling their care.[7] If community nurses can help patients transfer this sense of power and autonomy to their own care, they may be better motivated to participate, to carry out the nurse's advice, and thereby achieve their goal, namely better well-being.

Involving patients in the care process has been advocated to provide individualized care by healthcare professionals.[8] Previous studies have shown that patient participation is associated with positive health behavior[9]; however, a systematic review showed that the outcomes of care were inconclusive in patients who were involved in the care planning process.[10] The active role of patients is suggested to be essential for self-managing chronic health problems. One such strategy—goal-setting—is considered to be an important motivational determinant which can promote their active role in care.[11] It is suggested that patients will adhere to treatment and care protocols if they are involved in setting the goals of those protocols.

Previous studies have shown that nurse and patient working together to set goals can improve the patient's quality of life and increase goal attainment.[12–15] Setting mutual goals requires explicit disclosure of the goals of care, as seen from both nurses' and patients' perspectives. The process of setting mutual goals encourages both parties to communicate openly and clearly, assessing care needs and strengths in meeting the needs and prioritizing resources to achieve the care goals. Mutual goal-setting enables both nurses and patients to understand their health priorities and beliefs, and identify effective interventions to affect health behavioural changes.[16–18] Most studies on goal-setting have been conducted in Western countries[13–18]; few have been done in Asia.[12] In particular, there is a lack of research on goal-setting among Hong Kong Chinese patients. To date, the effect of mutual goal-setting on Hong Kong Chinese older adults with chronic illness

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is unknown. There is a need to examine whether mutual goal-setting would improve the physical and mental well-being among older adults with chronic illness. Therefore, the aim of this study was to investigate whether older adults with chronic illness reported greater goal achievement and improved physical and mental well-being after a structured goal-setting practice. To investigate the effect of mutual goal-setting among older adults with chronic illness, two hypotheses were tested. First, older adults with chronic illness receiving mutual goal-setting would achieve their goals significantly faster and their goal achievement would be sustained longer compared with those who received the usual care. Second, older adults with chronic illness receiving mutual goal-setting would improve the perceived functional health and self-efficacy in managing their chronic illness and such improvement would sustain over time. Testing these hypotheses would provide evidence of the value of mutual goal-setting for older adults with chronic illness.

Methods

Design and sample size

A quasi-experimental design with repeated measures was used in this study. Power analysis was performed; a sample size of 66 was required for two groups with 33 subjects in each group to measure three times. These samples sizes were expected to achieve 95% power to test between factors (group), an effect size of 0.20, and a significance level of 5%.[19] Originally, we planned to over-sample by 20 patients (total n = 96), but we stopped recruitment when the control group achieved the required sample size (total n = 80) because of difficulties recruiting patients.

Setting and sampling

The study was carried out in 13 CNS Centres across different districts of Hong Kong. Of these, 7 CNS Centres were randomly allocated as intervention centres and 6 as control centres. Inclusion criteria were: (a) diagnosis of at least one chronic disease, (b) age over 65, and (c) admission to CNS within 48 h. Exclusion criteria were: (a) living in residential home, (b) unable to communicate or express discomfort, and (c) admission to CNS for one-off service, for example, taking a blood sample. The community nurses of each CNS Centre involved in the study were instructed to screen for eligible older adults with chronic illness. Convenience sampling was performed on all patients admitted to each of the 14 CNS Centres until the required sample size was met. Oral and written information describing the study was given to eligible patients by the community nurse during the first home visit before they consented to participate in the study. The study was approved by the Ethical Committee of Hospital Authority, Hong Kong.

Study intervention

Apart from the usual care, a structured goal-setting practice—Mutual Goal-Setting (MGS) was delivered to the intervention group. The MGS is a structured and collaborative goal practice involving both the community nurses and patients in planning care through using a goal menu, namely, the Goal Register (GR), which was specifically developed by the author—who had been working as a Nurse Specialist in CNS for more than ten years—to facilitate dialogue between nurses and patients in setting care goals. The GR (Fig. 1) is a list of care goals commonly encountered in home care. Each care goal was constructed as a series of goal statements to specify the levels of outcome expectations for a particular health problem. An individual care goal which specifies a series of outcome levels was named a “goal scale”. A sample of a goal scale, “Awareness of Home Accidents”, is shown in Fig. 2. A panel composed of three experienced community nurses and one professor in nursing was invited to assess the content validity of the GR. The panel evaluated the relevance of the GR in relation to the usual practice in CNS, and the practicality of the outcome levels for all goal scales. In assessing the content validity of the GR, the four experts rated the relevance of goal areas as 0.97 and the practicality of the outcome levels as 0.98. In addition, seven community nurses were asked to assess the reliability of the GR using a single case scenario in identifying care goal and outcome levels of a pseudo-patient. The nurses reached an overall agreement of 95.3% that the GR could do this.

Seven visits were scheduled within the study period: two visits during the first week of the study, one visit in weeks 2, 3 and 4; and one visit in weeks 6 and 8. A study protocol was also developed to guide implementation of the MGS. The steps in goal-setting for the nurses were listed as follows:

1) Explain the process of mutual goal setting;
2) Identify the goal of care from the GR in collaboration with patient;
3) Identify the current health situation with reference to the goal statements;
4) Engage the patient to discuss the expected level of outcome;
5) Sign a goal-setting record to actualize the agreement of care;
6) Review the progress of goal achievement during follow-up visits

Seven community nurses who naturally worked in the intervention centres provided the study intervention—MGS. The author provided three 3-h training sessions on how to use the GR to set care goal with patients. The nurses’ competence in setting care goals using the GR was evaluated using case scenario to ensure the community nurses accurately identified relevant goal types from the GR and assigned goal levels according to the criteria of the case scenario. The author also provided on-site coaching to each community nurse who provided the study intervention to ensure consistency in goal-setting. Training was stopped when all community nurses had demonstrated competence in using the GR. The training described above was one of the measures used to ensure treatment fidelity. Further, the author ensured the reliability and authenticity of the goal-setting intervention by random comparison of the goal-setting record used for research purposes with the actual patient record. The consistency of information between the goal-setting record and the patient’s record indicated whether the study intervention was being carried out properly. The author was available for consultation if/when needed.

For the control group, six community nurses who worked in the control centres received briefing on the study schedule and logistics only. Patients in the control group received usual care only—health advice and nursing care from the community nurses. The community nurses set the goals of care but did not necessarily involve patients in making decisions. Both the community nurses and patients in the control group did not have access to the GR.

Assurance of quality of the study intervention

To ensure the study intervention was delivered as intended, steps were taken according to the recommendations of National Institutes of Health (NIH) to address treatment fidelity in five aspects: study design, training, delivery of treatment, receipt of treatment, and enactment of treatment skills.[20] The study design practices were intended to ensure that the “dose” of study intervention provided to the patients was consistent and reliable. The