Executive summary

Supporting self-management in heart failure patients with diabetes
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The aims of this project were to understand current self-management in heart failure patients with diabetes to identify any potential gaps in current practice and to explore patients' experiences of self-managing these two conditions. These issues were explored by using mixed research methods.

A total of 118 heart failure patients with diabetes participated in stage 1 (questionnaire survey) of this project. Of them, 29 (24%) were female, the remaining 89 (76%) were male; they had average duration of heart failure for 8.5 years ranging from 1 to 59 years and majority of them were classified wither NYHA class II or III while they had longer average duration of diabetes which were 14.6 years ranging from 1 to 63 years. The majority of them were elderly (>65 years) and more than half of them were obese. They reported less adequate self care capacity for their diabetes: age, weight and severity of heart failure were found negatively related to diabetes self-management while only a small number of the participants reported that they self-cared heart failure adequately, which suggests more support needed for this group to adequately self-care their multiple conditions.
Seventeen participants were invited to stage 2 (the interviews) of this project with views of exploring their experiences of living with heart failure and diabetes. Most of them reported that living with multiple morbidities could be challenging and the main barriers for sufficient self-care were old age, living with other conditions e.g. complications of diabetes or/and heart failure, limited physical capacity. More than half of them reported that they experienced confusion or contradiction in receiving the advice/information from different health care teams, also travelling to different places to attend clinics was considered as an extra burden to them. Some of participants believed they would benefit from joined clinics with all relevant care team members as information related to them could be shared/exchanged between teams.

Findings from this project suggest that more support from health care professionals is needed for those living with multiple conditions and more integrated advice or information from health care teams could help them better with self-managing their conditions.

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