Our growing and ageing population means the number of people living with long-term conditions (LTCs) is rising, further increasing the pressure on health services. By taking a step change in terms of practice and culture, can health professionals empower patients to make healthier lifestyle choices to reduce their dependence on NHS services and episodes of ill health?

This article explores health coaching and whether it has a place in nursing.

What is health coaching?
Health Education England (2015) defines health coaching as “a patient-centred process that is based upon behaviour change theory and is delivered by health professionals with diverse backgrounds”. In the last decade, it has emerged as a way of engaging patients to play a more active role in improving their health – evidence shows it can reduce costs and improve outcomes (Jonk et al, 2015).

Butterworth et al (2006) reported on the growing popularity in public health of motivational interviewing-based health coaching, a relatively new behavioural intervention. Its popularity was due to its ability to address multiple behaviours, health risks and illness self-management. Lafond and Charlesworth (2016) argued that growing demand for healthcare, increased healthcare costs and a rise in LTCs, against a backdrop of economic austerity, made it essential for people to actively manage their own health.

Informing and empowering patients increases their knowledge, confidence and skills in managing their own healthcare needs, thereby, enabling them to make healthier lifestyle choices, adhere to treatment regimens, and experience fewer setbacks and complications (Newman and McDowell, 2016). An essential part of patients’ health is their level of health knowledge, as this empowers them to take responsibility for their own health-related issues (Kesänen et al, 2014).

Health coaching differs from traditional patient education: instead of using the traditional approach of education that is directed ‘at’ the patient, it effectively motivates behaviour change through a structured and supportive partnership...
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between the patient and health professional (Huffman, 2007).

Applying health coaching to patient care
An example of how health coaching could be usefully applied is in tackling obesity, which is a major contributor to the rise in LTCs. Global obesity rates have almost tripled since 1975 and the UK has one of the highest rates in Europe (World Health Organization, 2020; NHS England, 2019). Obesity puts people at risk of conditions such as diabetes, joint problems, cardiovascular disease and high blood pressure (WHO, 2020), and costs the NHS £5bn a year (Royal College of Physicians, 2013). Growing rates of obesity suggest that obesity prevention and management strategies are, at best, slow and, at worst, ineffective. By applying a health coaching strategy, health professionals might help reduce this global health problem and the burden of LTCs, such as diabetes and cardiovascular disease.

As Goodrich (2016) argued, to deliver the best care, health professionals need to actively listen to patients to identify what matters to them and support them to set goals. This will encourage patients to take a more active role in their care and decision making, instead of being passive recipients of care with health professionals making all the decisions.

A literature review by Oliveira et al (2017) on the effect of health coaching on physical activity, mobility, quality of life and mood in older people showed that it increased physical activity at follow-up in patients with LTCs. Health coaching works on the core belief that people have a natural capacity to develop and grow; it focuses on empowering patients to construct solutions and engage in goal attainment (Boehmer et al, 2016). The idea is that encouraging patients to take a more active role in their health management not only helps them reach their goals, but also empowers them to make positive decisions about their health in future.

Asking patients what matters to them, and, most importantly, listening, can help them feel valued and confident that their needs are being met and allowed to develop. However, patients can also feel that health professionals do not see them as equals and that their perspectives and preferences are not heard.

Box 1. OARS model: examples

<table>
<thead>
<tr>
<th>Open-ended questions</th>
<th>Affirmations</th>
<th>Reflective listening</th>
<th>Summarising</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Can you tell me more about...?”</td>
<td>“It seems like you are really good at...”</td>
<td>“Some of what I heard you say...”</td>
<td>“So let’s go over what we talked about before...”</td>
</tr>
<tr>
<td>“What do you want to do next?”</td>
<td>“That’s a good suggestion”</td>
<td>“You seem...”</td>
<td>“Let me check that I understood your goals”</td>
</tr>
<tr>
<td>“How can I help you with...?”</td>
<td>“I can understand why you feel that way”</td>
<td>“I noticed tears in your eyes”</td>
<td>“Can I just go back over what we decided?”</td>
</tr>
</tbody>
</table>

Source: Miller and Rollnick (2012)

A health coaching model
One health coaching model that health professionals can use is Miller and Rollnick’s (2012) OARS model:

- Open-ended questions give insight into the patient’s experiences, thoughts, beliefs and feelings, which help to build a trusting, professional relationship;
- Affirming helps establish rapport and affirms the patient’s strengths, thereby allowing the health professional to build on the patient’s level of self-efficacy and encourage them to take responsibility for their own decisions;
- Reflecting on what the patient shares shows them they have been heard. This is not limited to what they say, but also includes their emotions and behaviour;
- Summarising the conversation allows the health professional to check they understand the patient’s goals and the patient understands the key elements of the plan that is developed together.

Box 1 shows the types of questions and responses involved in the OARS model.

Barriers to health coaching
All care should be patient centred, but how often do patients have the chance to challenge the advice they are given, even if that means they make decisions that are contrary to best practice? It is a tricky dilemma as health professionals aim to give advice based on the best evidence available: if a patient does not want to follow that advice, how does that make us feel? There is also the question of whether there is enough time during a patient’s admission to enable them to make informed decisions. Newman and McDowell (2016) divided the barriers to health coaching into three categories:

- Clinicians – clinicians’ tendency to see themselves as experts who are already delivering patient-centred care can prevent them from engaging with health coaching. They may also worry that health coaching will increase the consultation length and reduce their control over managing clinical risk;
- Patients – an expectation that they will be ‘fixed’ by health professionals can increase patients’ dependency on them and devalue their own ability to make decisions. Health coaching also requires psychological effort on the part of the patient;
- System – competing priorities, increasing workloads, short-term thinking and change fatigue can all hinder the implementation of health-coaching strategies.

Other factors they identified included:

- A poor correlation between patient and clinical expectations;
- Patient dissatisfaction with the quality of clinician-patient communication.

They concluded that a change was needed in the expert clinician-patient relationship, as this can create dependence.

The role of communication
Good communication skills are vital for effective health coaching, and are “central to the provision of compassionate, high-quality nursing care” (Bramhall, 2014). The Nursing and Midwifery Council’s (2018) Code states that nurses should “listen to people and respond to their preferences and concerns”. Good communication is also integral to the nurse-patient relationship, which is created through nurse and patient interactions (Bramhall, 2014).

Effective communication between health providers and patients can improve patient outcomes, and is especially pivotal in areas such as patient health, education, adherence to treatment regimens and satisfaction with care (O’Hagan et al, 2014). Nurses have a key role in meeting patients’ communication needs and effective nursing communication skills are critical to providing high-quality care (O’Hagan et al 2014). Skillful, effective nursing communication is patient centred, which is important in rapport building and other behaviours associated with a positive
attitude towards patients (O’Hagan et al, 2014). Lotfi et al (2019) have proposed that improving patient satisfaction increased patients’ involvement and adherence to individual care plans; this supports the idea that to be an effective health coach, a nurse must be an expert communicator.

Numerous models and frameworks can be used for health coaching, common successful strategies include solution-focused goal setting and motivational interviewing techniques (Oliveira et al, 2017). The aim is to teach patients self-management strategies and encourage behaviour change, as illustrated in the case study (Box 2).

**Case study**

Susan Perkins, aged 57, had a spinal cord injury (SCI) caused by spinal infarct at T10 (neurological deficit below the tenth thoracic nerve causing impaired movement and sensation). She was admitted from her referring hospital with an indwelling urinary catheter (IDUC), which she ‘clamped and released’ on urge. Long-term use of IDUCs is not recommended for people with SCI, largely due to the associated increased risk of infection. Best practice is to remove the catheter and start a programme of self-intermittent catheterisation (ISC); this will achieve sufficient emptying and low-pressure urine storage and drainage (Afsar et al, 2013), and is the most suitable and safest way to avoid complications (Afsar et al, 2013; El-Masri et al, 2012).

Hospital policy was to start the ISC regimen as soon as possible. The day after her admission, to learn about Ms Perkins as a person, rather than seeing her as a SCI case, I spoke to her about her patient journey to the ward and what she hoped to achieve during her admission. We discussed her bladder management and removing the IDUC; Ms Perkins was happy about this as she disliked having the IDUC. I explained she might have to start on an ISC regimen as, despite having the sensation that she needed to pass urine, she may not have the motor control to be able to empty her bladder.

When I described the procedure and showed Ms Perkins some examples of catheters, she became quiet, and appeared anxious and tearful. I gently told her I had noticed her distress and we discussed why she was feeling like this. She explained she had expected to be able to empty her bladder once the catheter was removed, as she still experienced the urge to urinate; she had never considered that this might not be possible. We spent some time going through the pros and cons of ISC compared with ISC, so Ms Perkins could fully understand everything, and make an informed choice and a plan. As we needed to change the IDUC anyway, we discussed a trial without catheter to see whether she was able to pass urine on urge. If she could not, she agreed she would try ISC with support from nursing staff; if this did not work, she would have an IDUC reinserted.

We decided to remove the catheter the following day after breakfast. Unfortunately, Ms Perkins was unable to pass urine, so she agreed to try an ISC as planned. With support to do this and the aid of a mirror (in which she initially did not want to look at her urethral opening), she managed very well. As the procedure had gone well, she agreed to continue with this bladder management and, as she grew in confidence, she was able to do it independently – and eventually without the mirror.

Allowing Ms Perkins to take control of her care encouraged her to try this new procedure, as we had an agreed back-up plan and she understood what was going to happen and why. Her initial expectation was that she had come to the specialist spinal centre to ‘recover’; switching to a form of catheterisation she had to do herself was not her idea of recovery. Spending time with her to explain the procedure and talk it through allowed her to voice her fears, and we were able to work out a plan to address them. Overcoming these difficulties, and learning why bladder management is so important, should hopefully help Ms Perkins make effective health decisions in the future following her discharge from hospital.

*This case scenario is based on the author’s clinical experience*

**Conclusion**

New ways are needed to empower patients to make and sustain healthy lifestyle choices. Health coaching engages patients in managing their own health and has proved beneficial in the care of people with LTCs; effective communication is vital.

A shift of mindset is needed among patients, health professionals and care providers to enable health coaching to become an everyday part of nursing. Introducing health-coaching techniques to a ward environment – with the organisation encouraging staff to get involved and patients to make informed, positive decisions about their health and care – can lay the foundations for people to make healthy choices throughout their lifetime, thereby, reducing the burden on the NHS and the chances of future episodes of ill health.

**References**


World Health Organization (2020) Obesity and Overweight. WHO.net 1 April.