

Promoting Self-Care in Individuals with Inflammatory Bowel Disease: A Scoping Review

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ABSTRACT

Background & Aims: Self-care has emerged as a pivotal component in the long-term management of inflammatory bowel disease, yet the literature remains fragmented regarding educational interventions supporting its implementation. This scoping review aims to systematically map existing educational strategies designed to promote self-care among individuals with inflammatory bowel disease and to identify barriers, facilitators, and implications for nursing practice.

Methods: Following the Joanna Briggs Institute methodology, a scoping review was conducted across five electronic databases (PubMed, Embase, CINAHL, Web of Science, and Scopus) with no date restrictions. Eligible studies focused on educational interventions targeting at least one of the following dimensions of self-care: maintenance, monitoring, or management. Data extraction and synthesis were guided by a theoretical model of self-care. Findings were narratively synthesized and supported by summary tables and conceptual mapping.

Results: Fourteen studies published over the past seventeen years were included. Interventions ranged from cognitive-behavioral therapy and digital health tools to structured group education programs. Most were implemented in high-income countries and delivered by multidisciplinary teams. Key barriers included time constraints, limited financial and human resources, and patient reluctance to adopt active roles. Facilitators encompassed the use of smartphone applications, teach-back methods, and communication tools such as patient passports. Reported outcomes included improvements in treatment adherence, psychological well-being, and patient engagement.

Conclusions: Educational interventions, particularly when grounded in self-care theory and delivered by nursing professionals, can enhance autonomy and quality of life in individuals with inflammatory bowel disease. Future programs should emphasize personalization, inclusiveness, and long-term behavioral change, supported by robust evidence and sustainable implementation models.

Key words: chronic disease – educational intervention – inflammatory bowel disease – nursing – self-care – self-management.

Abbreviations: CBT: cognitive-behavioral therapy; CD: Crohn's disease; IBD: inflammatory bowel disease; RCT: randomized controlled trial; UC: ulcerative colitis.

INTRODUCTION

Inflammatory bowel disease (IBD), including Crohn's disease (CD) and ulcerative colitis (UC), are chronic diseases characterised by alternating phases of remission and exacerbation, necessitating ongoing treatment [1]. The incidence of IBD is experiencing a marked increase in developing and newly industrialized countries. In high-income

countries, incidence continues to rise, particularly among pediatric and elderly populations, contributing to a progressive increase in overall prevalence and placing a growing burden on healthcare systems [2].

Inflammatory bowel diseases is characterized by chronic inflammation of the mucosa and intestinal wall, leading to symptoms such as abdominal pain, chronic diarrhea, rectal bleeding, weight loss, nausea, and other digestive disturbances. It frequently involves systemic manifestations (fatigue, low-grade fever, anorexia), extraintestinal features (arthritis, skin, and ocular inflammation), and severe complications like strictures, fistulas, abscesses, and toxic megacolon, which vary in severity and frequency among patients [1, 3].

The unpredictable and relapsing nature of IBD presents significant challenges for disease management, profoundly affecting patients' physical health, psychological resilience, and social functioning [4]. Beyond medical interventions, patients must contend with fluctuating symptoms, which can lead to emotional distress, social isolation, and a reduced quality of life. While pharmacological therapies and, in severe cases, surgical interventions aim to preserve and improve patient well-being while preventing long-term complications [1, 5], these approaches alone are insufficient to achieve optimal clinical outcomes. Effective IBD management necessitates a holistic, multidisciplinary approach that addresses clinical symptoms and empowers patients to participate in their care [6].

In this context, promoting patient self-care is essential, enabling patients to independently implement interventions to meet their needs and maintain a high level of well-being. Barbara Riegel describes self-care as a "*process of maintaining health through health-promoting practices and managing illness*" through her middle-range theory, which encompasses three dimensions: self-care maintenance, involving preventive behaviors to maintain stability, during which individuals follow healthcare professionals' recommendations regarding lifestyle or therapeutic prescriptions [7, 8]. These behaviors may include lifestyle changes such as smoking cessation, following dietary recommendations, engaging in physical activity, and adhering to the medical regimen, including taking medication as prescribed. Self-care monitoring emphasizes attentive and conscious symptom self-monitoring to identify potential worsening. Participants actively monitor their symptoms, regularly assessing for any physical or emotional signs of complications. They are symptoms that may occasionally result from side effects of medications. Tools such as smartphone applications or daily symptom diaries are frequently utilized to track both physical and psychological symptoms.

Self-care management encompasses corrective actions that patients autonomously implement to recognize and address physical or emotional symptoms or exacerbations. These actions may necessitate consultation with healthcare providers, including IBD specialists such as nurses. Patients may also employ techniques for reducing anxiety and fear, including reading, listening to music, practising controlled breathing, or playing a musical instrument. Furthermore, exploring new tailored options that could provide further support is encouraged [7, 8]. It is essential to clarify the distinction between self-care and self-management, as they represent complementary yet distinct approaches. Self-care encompasses the autonomous, conscious, and goal-oriented activities an individual undertakes to maintain health and well-being. In contrast, self-management refers to a collaborative and structured process aimed at actively and consciously managing specific health conditions in coordination with healthcare professionals [9].

Promoting self-care helps patients manage their condition more effectively and maintain a higher quality of life. Preventive behaviours such as adherence to treatment recommendations, self-care monitoring, where patients learn to recognize early signs of symptom exacerbation, and self-care management, where they take corrective actions to mitigate the impact of disease outbreaks, can improve disease management. The integration of medical, psychosocial, and educational

interventions also helps patients gain the tools and confidence to cope with the complexities of living with IBD [8].

Central to self-care is engagement, defined as the ability and willingness to actively participate in one's care pathway. Engagement promotes greater responsibility, awareness, effective communication with healthcare professionals, and optimal use of available services. Engaged patients are better equipped to recognize and manage symptoms, leading to improved adherence and disease control [10].

However, inadequate engagement, limited access to consistent educational resources, and insufficient integration of psychosocial support intensify the challenges patients and healthcare systems face. These barriers underscore the urgent need for comprehensive, patient-centred management strategies to address the multifaceted nature of IBD effectively [11]. In this context, despite the growing recognition of self-care as a critical component of IBD management, the existing literature remains fragmented regarding how educational interventions support patients in developing and maintaining self-care behaviors. Thus far, the overall landscape of educational interventions to support self-care in individuals with IBD, including their characteristics, theoretical underpinnings, implementation strategies, and targeted self-care dimensions, has not yet been systematically mapped. This gap limits the ability of healthcare professionals and policymakers to identify evidence-informed strategies that should be adapted across diverse clinical settings. For these reasons, this scoping review aims to map the existing literature on educational interventions designed to support self-care in individuals with IBD. Specifically, this review addresses the following research questions: (DR1) What educational interventions currently exist for individuals with IBD? (DR2) What are the barriers and facilitators influencing the implementation of these educational interventions? (DR3) What are the implications of these interventions for nursing practice?

METHODS

Study Design

This study follows the scoping review methodology as outlined by Arksey and O'Malley, Levac et al., and Peters et al. [12-14]. This approach is particularly suitable for (a) clarifying key concepts and definitions in the literature, (b) identifying and mapping knowledge gaps related to the study topic, (c) offering a comprehensive synthesis to support nurses, researchers, and educators, and (d) informing and guiding future research directions.

The reviewed literature examines individuals of all genders and ages affected by IBD, with education as the central concept under investigation. In this context, education refers to the acquisition of knowledge resulting from a training or educational intervention. This study examines existing educational interventions in various healthcare settings, with a specific focus on promoting self-care and helping individuals manage their conditions more effectively.

Protocol and Registration

As directed by the Joanna Briggs Institute manual for scoping reviews, we developed a scoping review protocol [15]

utilizing the guidance of the Preferred Reporting Items for Systematic Reviews and Meta-analysis extension for Scoping Review (PRISMA-ScR 2020) [16]. The protocol was reviewed by the research team and was registered on OSF [17].

Eligibility Criteria

Reports written in all languages focusing on educational interventions for adults (≥ 18 years) with IBD were included. Reports that did not address the research questions or presented data on other intestinal pathologies without a clear distinction from IBD were excluded.

Search Strategies

A systematic literature search was conducted using major biomedical databases, including PubMed, Embase, CINAHL, Web of Science, and Scopus. The search was performed without time restrictions.

The search strategy is reported in the Supplementary File 1. Search strings were developed by incorporating the terms “inflammatory bowel disease,” “education,” and “self-care”, along with their synonyms. The search encompassed studies employing qualitative, quantitative, and mixed-method designs, along with literature reviews, editorials, and conference proceedings. The development of search strings was conducted according to the Joanna Briggs Institute (JBI) guidelines and guided by the Population, Concept, and Context (PCC) framework.

Study Selection Process

The screening of records retrieved through the search strings was conducted using the Rayyan online software [18]. Following the JBI guidelines [15], the screening process involved two independent reviewers (E.G. and S.R.C.), who initially selected relevant records based on title and abstract. Full-text articles deemed eligible according to the inclusion criteria were then assessed by the same reviewers (E.G. and S.R.C.). In cases of disagreement regarding study eligibility, a third reviewer (D.N.) provided a resolution.

Data Extraction

A comprehensive data-charting tool with predefined variables for extraction was developed prior to the review. A standardized Excel form was created and pilot-tested on a sample of five articles to ensure reliability and accuracy in data extraction. The table was independently completed by two reviewers and includes key details such as the first author, year of publication, country of origin, applied methodology, study focus, objectives, population/sample characteristics, professionals delivering the educational intervention, identified barriers and facilitators, and reported outcomes.

Synthesis of Results

The extracted data were synthesized and presented through a narrative approach, which allowed for a comprehensive and descriptive account of the characteristics, delivery modalities, and outcomes of educational interventions supporting self-care in individuals with IBD. This narrative synthesis enabled the integration of diverse study designs and intervention types, facilitating the identification of recurring themes, gaps, and

emerging trends across the literature. To enhance clarity and accessibility of the findings, the results were also organized and presented using a combination of visual formats, including summary tables, bar and pie charts, and conceptual maps. These visual tools were employed to highlight key aspects, including the geographic distribution of studies, population characteristics, theoretical frameworks underpinning the interventions, and the specific dimensions of self-care targeted (e.g., maintenance, monitoring, or management). Where appropriate, comparisons were made across different delivery settings (e.g., hospital-based vs. community-based interventions), types of educators (e.g., nurses, multidisciplinary teams), and modes of education delivery (e.g., face-to-face, digital platforms, or blended models). Conceptual mapping techniques were employed to illustrate the relationships between intervention components and intended outcomes, providing a structured understanding of the multidimensional nature of self-care in the context of IBD.

Risk of Bias

Scoping reviews aim to provide a broad overview of the available evidence without necessarily evaluating methodological quality or risk of bias. Consequently, the sources included in this review were not subjected to a detailed critical appraisal of bias risk [16]. Scoping reviews are not intended to provide synthesized effect estimates or draw conclusions about intervention efficacy; instead, they aim to identify key concepts, types of evidence, and gaps in the research landscape. Accordingly, the sources included in this review were not subjected to a systematic critical appraisal of methodological quality or risk of bias. Nonetheless, information regarding study design, sample characteristics, and outcome reporting was extracted to offer contextual insight into the strength and consistency of the available literature. Future systematic reviews focusing on specific types of interventions and outcome-focused meta-analyses may be warranted to rigorously assess methodological quality and the risk of bias.

RESULTS

Study Selection and Descriptive Summary

A total of 14 documents were deemed eligible after screening 1,356 titles and abstracts and 98 full-text documents as outlined in Fig. 1, which displays the PRISMA 2020 flow diagram.

The publications were all from within the last 17 years (Table I) and were mainly from Europe (42.8%), North America (28.2%), and Asia (21.4%) (Fig. 2). Notably, the majority of included documents were journal articles (100%). The country economy of origin for the included papers was predominantly constituted by high-income nations (92.8%). The documents were classified into four types: reviews (50%), randomized clinical trials (RCTs) (21.2%), quasi-experimental studies (7.2%), observational studies (7.2%), mixed-method studies (7.2%), and pilot studies (7.2%). All included results are synthesized in a table derived from the pilot testing phase (Supplementary Table II). Following the data abstraction process, the results were further synthesized using thematic analysis, starting from the dimensions of self-care identified by Riegel’s middle-range theory (self-care maintenance, self-care monitoring, self-care management).

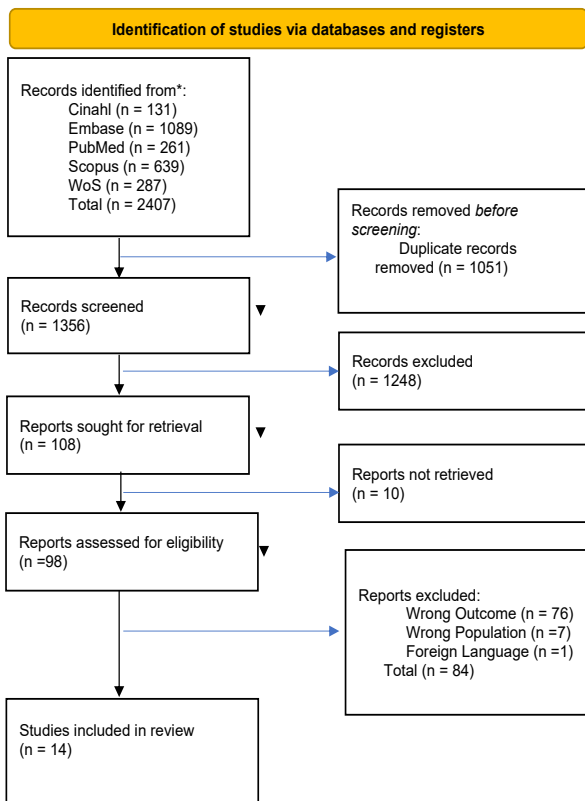


Fig. 1. PRISMA 2020 flow diagram for new systematic reviews which included searches of databases and registers only.

Table I. Characteristics of included documents

	Count	%	Reference
Years of publication			
2007-2014	3	21.4	22, 29, 31
2015-2025	11	78.6	19-21, 23-28, 30, 32
Geographic region			
Africa	0	0	
Asia	3	21.4	24, 27, 28
Australia and New Zealand	0	0	
Europe	6	42.8	19-22, 30, 31
Middle Est	1	7.2	26
North America	4	28.6	23, 25, 29, 32
South America	0	0	
Country economy			
Lower middle income	1	7.2	26
Upper middle income	0	0	
High income	13	92.8	19-25, 27-32
Type of publication			
Journal article	14	100	19-25, 27-32
Journal discipline			
Nursing discipline	4	29	22, 23, 28, 31
Other	10	71	19-21, 24, 26-27, 29, 30, 32
Study design			
Review	7	50	22-25, 27-29
Observational	1	7.2	30

Table I (continued)

Mix Method Study	1	7.2	20
Randomized Controlled Trial	3	21.2	19, 21, 26
Pilot study	1	7.2	32
Quasi sperimental study	1	7.2	31

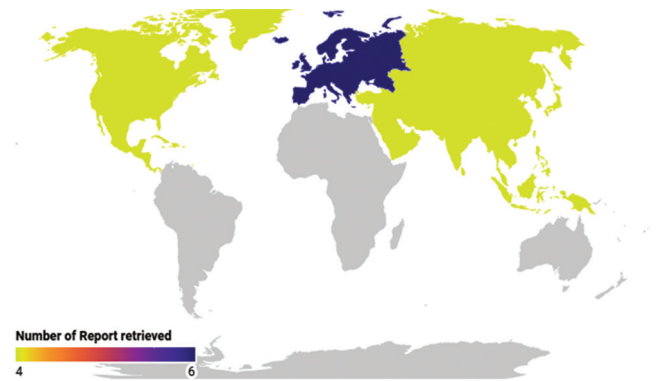


Fig. 2. Heat map of study distribution across the globe.

RQ1: What Educational Interventions are Available for Individuals with IBD?

The 14 studies included in this review describe educational interventions aligned with the three dimensions of self-care identified in Barbara Riegel’s theory: self-care maintenance, self-care monitoring, and self-care management [8]. Notably, Artom et al. [19] reported on a RCT using a cognitive-behavioral therapy (CBT) manual designed to address IBD-related fatigue. Similarly, Sweeney et al. [20] developed a CBT-based intervention targeting fatigue, pain, and urgency. This program promotes skill development in activity regulation, sleep hygiene, cognitive restructuring, emotional regulation, and interpersonal communication, with tailored content specifically designed for individuals with IBD.

Educational content varies across studies, but all focus on symptom management. A comprehensive review by Berding et al. [21] identified interventions that target coping strategies and emotional management through relaxation techniques and group therapy, which were more common than individual formats. Other programs aimed to improve doctor-patient communication and promote illness recognition and management [22].

The systematic review by Conley et al. [23], which included only RCTs, highlighted interventions promoting autonomous medication use (for example, prednisone during flare-ups) and strategies for accessing care. One such program involved self-management through self-hypnosis to reduce stress and improve flare-up detection and response [23].

Iizawa et al.’s review [24] focused on interventions addressing symptom monitoring, lifestyle, communication, social and spiritual support, and pharmacological management. The literature also emphasizes the importance of educating patients on problem-solving skills to support medication adherence, enhancing the patient-provider relationship, and ensuring adequate social support [25].

Several studies highlight the importance of health technologies in patient education, particularly in the areas of self-medication and disease management [26-28]. The study by Rohde et al. [32] described a digital messaging intervention focused on validation, counseling, and support, targeting physical symptoms, mental health, and nutrition-related aspects of IBD.

Regarding communication tools, Saibil et al. [29] highlighted the benefits of a “patient passport” for tracking medical exams and the use of email as an effective medium for managing test results, prescriptions, and non-urgent communications. Similarly, Squires et al. [30] examined the use of flash cards to provide patients with quick, accessible information for IBD self-management. Stansfield et al. [31] developed an outpatient educational program covering diagnosis, treatment options, flare-up management, and health promotion, supported by printed materials and ongoing follow-up via clinic or telephone.

RQ2: What Factors Facilitate or Hinder their Implementation?

Several barriers to implementation emerged, including time constraints, financial limitations, and inadequate training [19, 20]. Patient-related barriers were also identified, such as reluctance to take an active role in care, favouring a provider-led decision-making model [22].

Smartphone-based applications were viewed as promising due to their adaptability to the chronic nature of IBD, enabling ongoing updates, peer interaction, and experience sharing [26, 27]. However, tools such as the patient passport require patient commitment and consistency. Similarly, the use of email may face practical limitations linked to data security and IT system integrity [29].

RQ3: How Do these Interventions Impact Nursing Practice?

The educational intervention described by Artom demonstrated potential for improving both fatigue and quality of life over the medium to long term (3, 6, and 12 months) [19].

Other studies have also supported these findings, highlighting similar positive impacts on fatigue and quality of life [22, 23, 25, 28]. However, Barlow et al. [22] reported that only 3 of the 14 studies reviewed showed significant improvements in quality of life. Several studies also documented a reduction in disease flare-ups and a consequent decrease in hospital visits [24,31].

Two studies showed significant reductions in participants’ fears and worries, with additional benefits in terms of anxiety and depression relief [21, 23]. The use of teach-back methods and smartphone applications improved treatment adherence [26], while messaging systems contributed to a reduction in IBD-related distress [32].

Communication tools such as the patient passport and email enhanced the patient–provider relationship by offering a clearer overview of patient status. For physicians, email was perceived as an efficient and traceable form of communication that reduced unnecessary in-person visits [29]. Flashcards also showed positive effects on medication adherence (31% of cases), symptom reduction, and patient engagement in care [30].

Mind Map of the Results

A comprehensive mind map depicted in Fig. 3 delineates the multifaceted relationship between self-care behaviors and educational intervention, illustrating how diverse strategies, from CBT focused on fatigue, pain, and emotional regulation [19, 20], to structured programs emphasizing symptom monitoring, medication adherence, and doctor–patient communication [23-25], collectively foster patient autonomy. Educational interventions incorporate techniques such as relaxation, group therapy, digital health tools, self-monitoring, and tailored communication aids [22, 29, 30, 32], reinforcing the role of structured knowledge delivery in empowering individuals with IBD to effectively manage their condition.

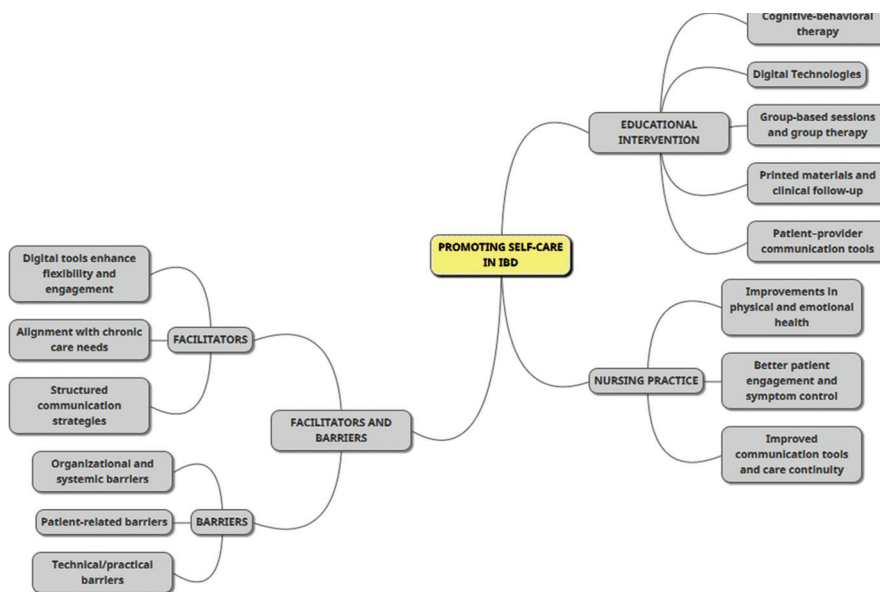


Fig. 3. Mind map of results.

Several barriers emerged, including systemic factors such as organizational and systemic barriers [19, 20]. Patient-related barriers were also identified, particularly the reluctance of some individuals to adopt an active role in their care, favoring instead a provider-led decision-making model [22].

The map further illustrates how technology-enhanced interventions, such as smartphone-based applications, offer promising solutions due to their adaptability to the chronic and fluctuating course of IBD. These tools facilitate continuous education, peer support, and experience sharing [26, 27]. Structured communication strategies, including patient passports, follow-up emails, and educational tools, complement these technologies by supporting continuity and clarity in patient engagement [29].

Nurses play a critical role in the implementation and continuity of these strategies. Current evidence demonstrates that educational interventions contribute substantially to improved quality of life and clinical outcomes in individuals with IBD [19, 21-23, 25, 28-30, 32].

DISCUSSION

This scoping review systematically mapped the educational interventions aimed at promoting self-care in patients with IBD. The included studies, predominantly recent, methodologically diverse, and conducted in high-income countries, underscore the growing interest in person-centered approaches that go beyond traditional pharmacological treatments. Anchored in Riegel's middle-range theory of self-care [33], the interventions reviewed span the three core dimensions of self-care: maintenance, monitoring, and management, thereby offering a multidimensional lens to support patients in managing their illness trajectories.

One of the most prominent findings is the emphasis on psycho-emotional aspects of care. Interventions that incorporated CBT, mindfulness, relaxation techniques, and self-hypnosis proved effective in reducing stress, anxiety, and emotional distress [34-36]. These findings are consistent with those observed in other chronic diseases, such as type 2 diabetes, cardiovascular conditions, and chronic kidney disease, where psychological support has been shown to improve treatment adherence and coping abilities [37, 38]. While these findings originate from conditions other than IBD, the parallels in disease chronicity and self-care demands make them highly relevant to IBD care models. These findings confirm that emotional regulation should be considered a key therapeutic target in chronic illness management. Importantly, the role of resilience as a facilitator of self-care emerged strongly. As demonstrated, resilience enhances patients' engagement and self-efficacy, forming a protective buffer against the psychological burden of IBD [39]. Educational programs that incorporate resilience training, such as narrative medicine, peer support, or structured group exercises, could further enhance patients' psychological preparedness to manage disease-related stress [40,41]. Interventions that integrate coping strategies and emotional self-regulation, therefore, hold promise for strengthening long-term disease self-management [42, 43].

Patient engagement and health literacy are critical prerequisites for the successful implementation of educational

interventions. The use of tools such as the "patient passport" [44], teach-back methods [45], and flashcards [46] demonstrates how structured information delivery can enhance patient autonomy. However, a true shift toward a patient-centered model requires more than just information transfer; it also requires motivational components and personalization [47].

Health literacy is not merely the ability to read and understand medical information, but also to apply it in daily decision-making. Low health literacy has been correlated with reduced adherence, increased hospitalization, and lower satisfaction with care [48, 49]. Tailored strategies, including co-designed educational programs and culturally adapted materials, can support a deeper understanding of treatment regimens, symptom monitoring, and lifestyle modifications. Moreover, validated instruments such as the Health Literacy Questionnaire (HLQ) or the eHealth Literacy Scale (eHEALS) may be integrated into future programs to personalize content and assess the efficacy of interventions [50]. Digital health solutions are increasingly featured in IBD self-care education. Mobile applications, SMS-based interventions, and asynchronous communication platforms such as email have been shown to improve treatment adherence and reduce distress [27, 51]. These tools also support peer exchange and real-time feedback, aligning with current trends in patient-centered digital health [52]. However, while digital tools offer convenience and scalability, they may inadvertently widen disparities if not designed with accessibility in mind. The digital divide remains a key issue, particularly for older adults, individuals with low health literacy, or patients living in underserved regions. Future interventions must ensure inclusiveness by offering hybrid educational models (combining digital and in-person elements) and support mechanisms for individuals less familiar with digital platforms. Implementation science approaches may help identify best practices for adapting technology to the real-world context of IBD care [53]. A recent scoping review on digital nursing interventions suggests that the need exists to align technological innovation with patients' preferences and socio-demographic characteristics to optimize its impact [52].

Educational interventions have demonstrated measurable outcomes, including reduced fatigue, improved quality of life, decreased flare-ups, and fewer hospitalizations [34, 47, 54]. However, the magnitude of these effects remains variable. Only a few studies showed statistically significant improvements in QoL, suggesting that educational content alone may be insufficient unless accompanied by emotional, behavioral, and motivational support [55]. This variability may be attributed to several factors, including the heterogeneity of study designs and outcome measures, limited follow-up duration, and a lack of standardization across educational interventions. These methodological differences can hinder comparability and dilute the observed effects, underscoring the need for more rigorous and harmonized evaluation strategies. In this context, the nurse plays a pivotal role as both educator and emotional facilitator, capable of integrating clinical education with psychosocial support tailored to patients' needs [56, 57]. By fostering trust, continuity of care, and individualized guidance, nurses can enhance the effectiveness of educational interventions and

promote meaningful improvements in self-care and quality of life [58, 59]. Moreover, the nurse-patient relationship plays a central role in promoting engagement, empowerment, and continuity of care, especially when nurses receive specific training in communication, coaching, and behavioral change techniques. From an organizational standpoint, barriers such as a lack of time, inadequate staff training, and limited financial resources hinder implementation [60, 61].

These findings mirror challenges identified in other contexts, such as cancer care and heart failure [38, 62]. Overcoming these barriers requires structural investment in nursing education, protected time for patient teaching, and institutional support for innovation. Policy-level changes may be necessary to formalize educational interventions as a reimbursable component of chronic disease care, thereby ensuring sustainability and equity.

Despite the growing body of literature, significant knowledge gaps persist. Few studies have systematically assessed patient satisfaction with educational interventions, and the measurement of behavioral change over time is rarely addressed. Moreover, comparative studies between different educational formats (e.g., individual vs group, digital vs face-to-face) are lacking. Additionally, no study to date has explored the long-term maintenance of self-care behaviors following the completion of educational programs, nor has it examined the specific challenges faced by patients with varying disease severities or socio-cultural backgrounds.

In terms of implications for practice and research, the review emphasizes the importance of integrating and personalizing educational interventions that consider individual patient needs. Although educational strategies were identified across all self-care domains, significant gaps remain in the existing literature. These include the need for more qualitative and quantitative research to assess the effectiveness of interventions and patient satisfaction. Future studies should focus on specific self-care behaviors and explore their impact in greater depth. To address these gaps, future studies should prioritize: (a) the adoption of long-term follow-up designs to assess sustained behavioral change; (b) the development and testing of culturally tailored educational interventions; (c) the inclusion of caregiver roles and dyadic approaches, particularly given the interpersonal dimension of chronic illness management; (d) the evaluation of cost-effectiveness and implementation feasibility in real-world settings; and (e) the validation and widespread adoption of IBD-specific self-care measurement tools, which are currently lacking in many studies. These directions are crucial for strengthening the evidence base and ensuring that educational interventions are both clinically effective and contextually relevant. Altogether, these recommendations may inform the development of more effective, inclusive, and sustainable self-care educational strategies for individuals with IBD.

Finally, while this scoping review offers valuable insights into educational interventions for IBD patients, it is limited by the nature of the included studies and the methodology employed. As is typical for scoping reviews, no formal quality assessment of the studies was performed [63]. Therefore, findings must be interpreted with caution, as some studies may be limited by factors such as small sample sizes, selection bias,

or methodological flaws. Further robust studies are needed to confirm and expand upon these results.

CONCLUSIONS

Promoting self-care in adults with IBD, supported by digital tools, enhances autonomy and improves symptom management. Nurses play a key role in empowering patients. Ongoing training and adequate resources are essential to ensure effective, person-centred educational interventions.

Conflicts of interest: None to declare.

Authors' contribution: I.M., D.N. and R.C. conceived the study and designed the methodology. All the authors contributed to data collection and analysis of data. I.M., D.N. and M.P. drafted the manuscript. All the authors revised and edited the manuscript. R.C. supervised the study and revised the manuscript for important intellectual content. All authors read and approved the final manuscript.

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