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Teaching Self-Care:

Hospital Nurses' Participation in Discharge Planning

by

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THESIS

Submitted in partial satisfaction of the requirements for the degree of

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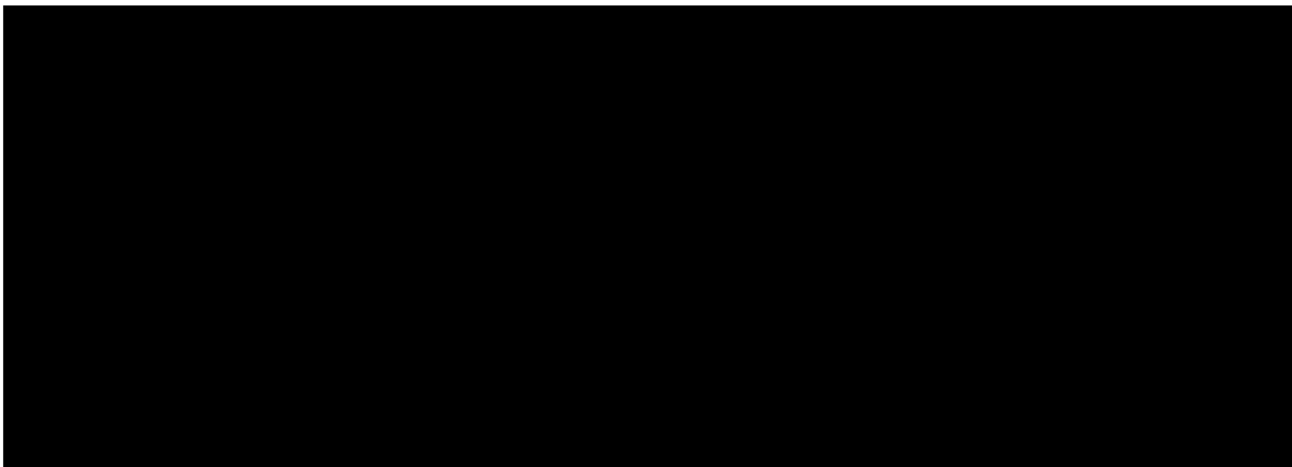

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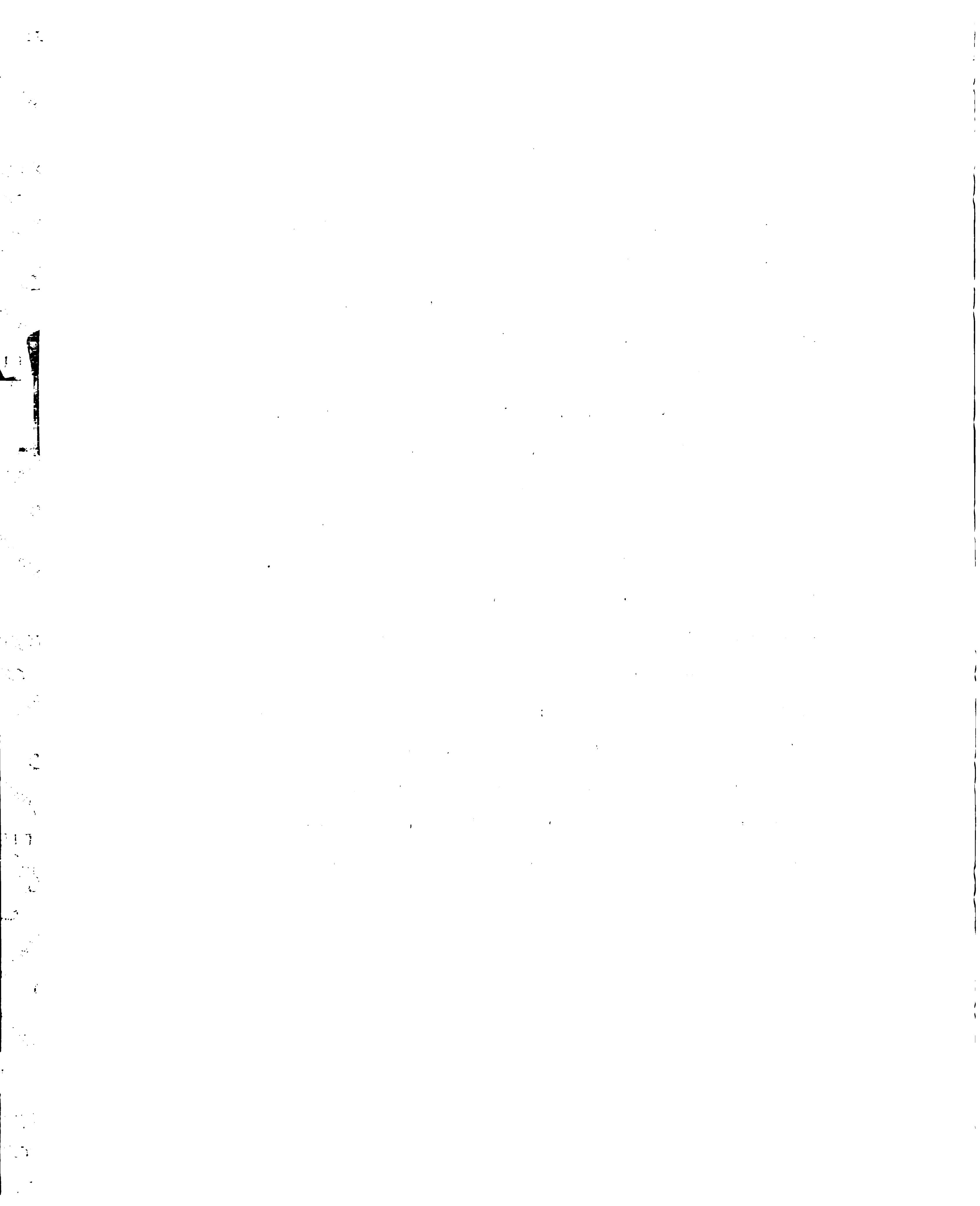
Abstract

This study examines nurses' perceptions of their involvement in discharge planning. Twenty-two registered nurses on two units at a university hospital were interviewed about time spent, activities carried out and difficulties commonly encountered in preparing patients for discharge. Additional data were collected through interviews with social workers and physical therapists on the units and through observations at team conferences during a two-month period. Nurses concentrate their discharge planning efforts on those patients going home. (Those going to another institution receive discharge planning from a social worker.) The largest expenditure of nurses' time was on teaching patients self-care, while very little time was spent locating or arranging services in the community. Nurses identified four major difficulties in discharge planning: 1) knowing when a patient or family had learned what the nurses had been teaching; 2) coordinating an informal support network for the patient; 3) knowing what other team members had planned or done; and 4) finding time for planning amid the priorities of acute care.



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These days when people leave the hospital for home they are far from well (Feldman, 1984). Some cancer patients have intravenous (IV) lines that go straight into their hearts. The patient keeps the line sterile and patient and receives medication at home or at a clinic (Dennis, 1985). Some patents with infections have peripheral IV lines through which they get antibiotics at home from visiting nurses (Wiseman, 1985). This may seem unsafe. If a patient or someone close to him doesn't properly care for the apparatus, he could bleed to death, or could become severely infected.

But, with proper care, people are recovering at home where they want to be, and they are saving thousands of dollars in hospital fees (Mitchell, 1978).

That a person is discharged from the hospital before he is well is really nothing new. Discharged patients have always left hospitals with less strength than they are used to, with changes in their bodies, with inabilities to do things they have always done for themselves. Somehow, they must relearn to care for themselves.

Discharge planning is the area of health care practice that anticipates the patients' post-hospital needs and arranges for community-based services to fill them. Good discharge planning would presumably move patients home at an optimum time in their recovery, avoid rapid rehospitalization, divert patients from nursing homes and other institutions, and facilitate recovery.

This paper explores the process by which hospital staff, particularly staff nurses, prepare people to leave the hospital after an acute illness.

PROBLEM

What is the Staff Nurse's Part in Discharge Planning?

As efforts to contain hospital costs lead to shorter stays for patients and higher levels of disability among patients at the time of discharge, it becomes increasingly important to adequately and efficiently prepare patients to go home (Wood, in press). Much of the literature on discharge planning has been prescriptive or descriptive based on clinical experience of the authors rather than systematic research on the effectiveness of various approaches. Very little is known about what actually is being done by hospital staff and how effective their efforts are. Few empirical studies of discharge planning have been conducted. Those that have been published focus largely on social workers. While nurses traditionally have contributed to discharge planning, there is little or no documentation of what parts of "ideal" protocols they actually carry out.

Objectives

This study examines nurses' perceptions of their involvement in discharge planning. Nurses were asked (1) how they spend their time and where they focus their efforts, (2) what planning they do, (3) what decisions they make, and on what criteria they base their decisions, (4) what aspects of discharge planning they

find difficult, and (5) what changes they would like to see come about. During the course of this study, the researcher examined what nurses record in the patient chart about their discharge planning activities as well as what they say about the extent of their involvement in the planning process.

Information gathered in this study: 1) documents the extent to which nurses participate in discharge planning activities, 2) indicates where there are gaps in planning, and 3) identifies difficulties in the process which, if ameoliorated, could ultimately benefit patients as well as staff.

REVIEW OF LITERATURE

There is a rather large body of literature on how to prepare clients for discharge (see Appendix A), but there is little or no empirical evidence that any of the recommended elements of discharge planning actually improve the outcome of the patients. There is evidence, through, that discharge to home care is a promising option. Mitchell (1978) found that patients placed in a home-care program improved their functional status more than those placed in either a community-based nursing home or a hospital-based nursing home. Stassen and Holahan (1980) and the Congressional Research Service (1981) found that when expanded home care services are provided, hospital use decreases. White (1972) showed that referring patients for home nursing care was cost effective.

Much of the programmatic literature on discharge planning frankly admits there are deficiencies in practice, and there is some emerging evidence that poor planning leads to serious negative consequences. Poor discharge planning has been connected with rapid rehospitalization (Schwartzberg, 1982; Barbaccia & Robinson, 1982), stress on family supports leading to breakdown of care (Cantor, 1979), extended hospital stays (Markson, Steele & Kane, 1983), and potentially dangerous lags between discharge and onset of community services (Lurie, Robinson & Barbaccia, 1984).

As these costly and sometimes personally tragic sequelae to poor discharge planning become part of the body of knowledge in social science, rather than just warnings from practitioners, it becomes critical to examine what works and what does not.

An essential part of discovering what works is understanding what is or is not being done in practice. There are several recent studies about discharge planners, all consisting of interviews of one or two people at each hospital who have administrative responsibility for this activity. Nichols and Feather (1984) and Reichelt (1980) looked at how the job of the discharge planner is structured. Markson (1983) focused on identifying the problems in placing elderly patients.

Two groups of researchers actually followed-up with patients to evaluate what planning had been done. Lindenberg and Coulton (1980) called 290 patients one month after discharge to determine

service needs and to find if services planned while in the hospital had been rendered. Lurie, Robinson and Barbaccia (1984) found that about half of the 170 patients they contacted had received no discharge planning. Yet more than two-thirds of these patients required supportive care at home. Furthermore, they found that only 32% of patients were linked with services, indicating that planning was often ineffective.

Though studies show there are gaps in care, there is, to date, little documentation of just where the gaps are and why they occur. Two British studies indicate there is inadequate communication between hospital and community agencies (Simpson & Leavitt, 1981; Parnell, 1982). In evaluating nursing's handling of discharge planning at a community hospital in the U.S., Dake (1981) found several problems: 1) late referrals, resulting in hastily-formed plans for post-discharge care and low-level comprehension among patients and families about community resources, 2) inadequate assessment by nurses of factors affecting post-discharge care, 3) scanty documentation on the patients' charts about what had been planned and what referrals had been made, and 4) inadequate communication among members of the staff about the options and plans for the patients.

There is agreement that staff nurses are in a prime position to do discharge planning because of their ability to assess functional level, mental status, and level of recovery of patients (McKeehan, 1981; Ratliff, 1981; Beale & Gully, 1981).

Schuman, Ostfeld & Willard (1976), in a study which documented discharge planning on one medical ward, suggested nursing service was the approach by which discharge planning could be improved. However, little attention has been paid to documenting and evaluating what parts of the planning process staff nurses do.

There is a study on quantitative aspects of activities of social workers in discharge planning (Vielhaber, 1975). The following study will confine itself to nurses' activies.

METHODOLOGY

Setting

The setting for the study was two nursing units: the orthopedics and oncology/general medicine units at the University of California, San Francisco (UCSF) Hospitals. Several aspects of these units made them appealing for study. Due to the nature of their illnesses, many patients on both units need help in preparing for discharge. By hospital policy, all patients receive discharge planning. On both units, it is generally accepted that staff nurses do discharge planning for patients bound for home. Both units have developed discharge planning protocols.

Some background on the administrative milieu for discharge planning: The responsibility for discharge planning is decentralized. On each unit, physicians, social workers and nurses share responsibility for this activity. There is an assistant director of nursing in charge of community nursing and

quality assurance who acts as a resource for head nurses and staff nurses. (She provides information on community resources and specific planning problems.) The units differ in that on the orthopedic floor, the physical therapist contributes a functional assessment prior to discharge, and on the oncology unit, a clinical nurse specialist does much teaching of technical skills to patients about to be discharged.

Subjects

The orthopedic unit employs 20 registered nurses (RN's) for all three shifts, while the oncology unit has 34. Oncology has 12-hour shifts, and only nurses on the day shift (7 a.m. - 7 p.m.) are involved in discharge planning. On the orthopedic unit, which has 8-hour shifts, nurses on both the day and evening shifts, as well as some licensed vocational nurses (LVN's) do discharge planning.

The researcher interviewed all registered nurses on day shift on the oncology unit and on day or evening shift on the orthopedics unit, who had been employed at least two months and who consented to participate in the study (see Consent Form, Appendix B). Twenty-two nurses (40% of the two units' staff) were interviewed. Characteristics of the nurses were as follows: 4% were under 25 years old; 73% were 25-33 years of age; 23% were 40-46. All but one were female. Seventy-three percent had baccalaureate degrees, 23% had associate degrees and 4% had diplomas. Nine percent had bachelors degrees in subjects other

than nursing. Four percent had a masters degree. In terms of their clinical experience, these nurses had the following characteristics:

	1 year	1-3 years	4-8	9-12	12+
Years in nursing	4.5%	32.0%	36%	4.5%	23%
Years in specialty	18.0%	45.5%	32%	0	4.5%
Years in hospital	27.0%	41.0%	23%	4.5%	4.5%
Years on unit	27%	54.5%	14%	0	4.5%

Differences between nurses on the two units were remarkable only on two points: 1) No nurses on oncology were over 33 years old, though 23% of the orthopedic nurses were over 40. 2) Ninety-one percent of the oncology nurses and 55% of the orthopedic nurses had Bachelor's degrees. Years spent working in the specialty were remarkably similar on the two units.

In addition to the nurses, three social workers, two physical therapists and one clinical nurse specialist on the units were interviewed about the discharge planning process. Furthermore, the entire team was observed at 12 team conferences (eight on oncology and four on orthopedics).

Data Collection

Data was collected through interviews, observation, and chart review. This method was chosen because this was a small exploratory study that sought in-depth information from a small group of subjects. While observation of nurses' activities with patients would have provided valuable data on what elements of

the process are accomplished, this approach was not chosen since the presence of an observer would have been disruptive to nurses and patients, and might have effected nurses' behaviors, thus compromising the validity of findings. It might be argued that focussing on the nurses' perspectives might present a limited or biased view of the process. However, since nurses are the major implementors of discharge-planning protocols, their biases will affect how the plans are carried out. Therefore, understanding the discharge planning process from the vantage point of the nurse is crucial.

Nurse interviews were based on the guide in Appendix C. Interviews were one-half hour in length, were conducted in a private room on the hospital unit where the nurses worked, and were interrupted if patient emergencies occurred. Interviews with other team members were conducted with consent (Appendix D), in their offices and were based on the guide with Appendix E. Interviews were carried out in June and July 1984.

A convenience sample of 111 Kardexes and 63 completed patient charts were reviewed. The following data were collected: Information on the (1) family situation of patient (informal support); (2) environment at home (steps, proximity to help, etc.); (3) patient education done regarding discharge; (4) services planned on discharge; (5) referral information conveyed to service agencies; and (6) what discharge activities had been done.

RESULTS

Where Nurses Spend Their Time

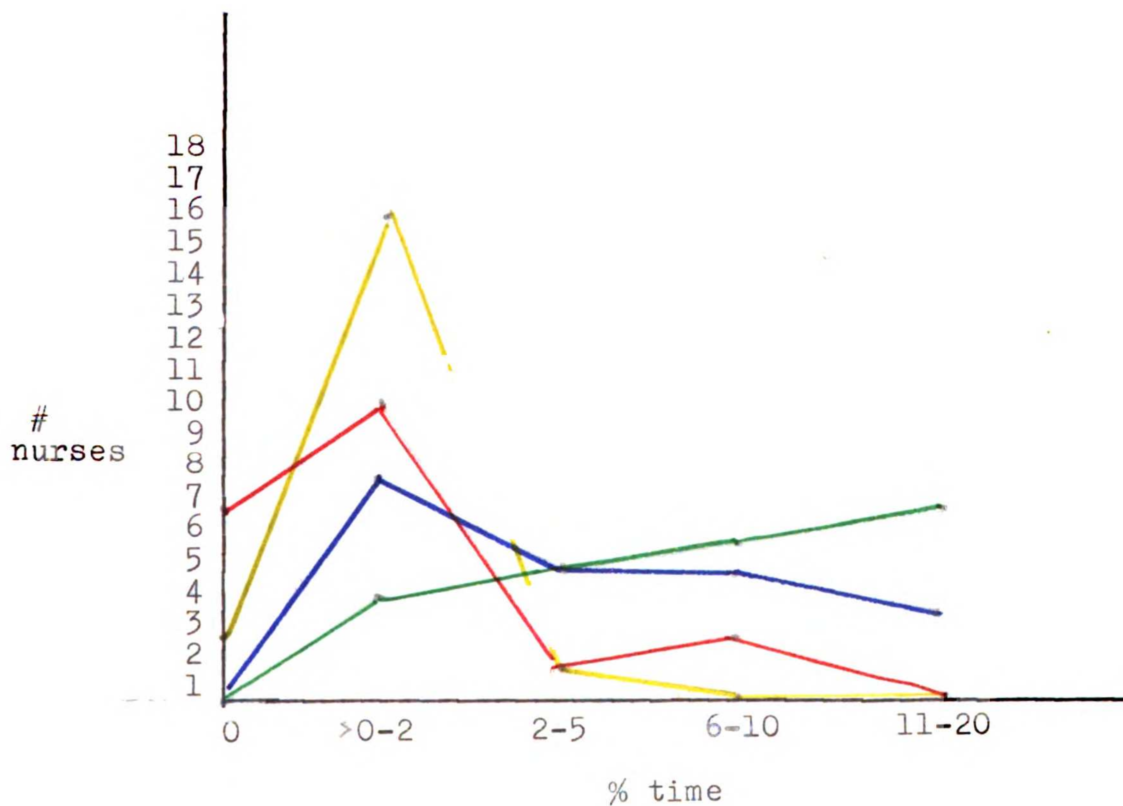
The literature on discharge planning focused on four categories of activities: assessment, education, locating of community services, and arranging of services.

During interviews with staff nurses it became clear that they spent the most time on education, specifically, teaching self-care--the transfer of skills for patient care from the nurse to the patient or to the patient's caretakers. Fifty percent said that they spend between 6% and 20% of their time on education, and 55% of these nurses spend 11-20% of their time on education (refer to Figure I).

Surprisingly, little time was devoted to locating or arranging community services, a task often thought to be heavily associated with discharge planning. Sixty-eight percent of the nurses interviewed said they spend less than 2% of their time locating services; 82% of the nurses said they spend less than 2% of their time on referral. Nurses located community services simply by looking up the home care agency nearest to the patient's home in a resource directory. They arranged services through a telephone call to the agency and a referral form. While the referral form was time-consuming, they saw that time expenditure as minor compared with time spent teaching self-care.

Figure 1

Time nurses spend on four discharge planning activities



Education
Assessment
Location of services
Referral to services

Note: Four subjects were unable to quantify time spent.

Not surprisingly, a large proportion of time was spent on assessment. All patients got an assessment of needs. Two nurses summarized how they assess a patient for the purpose of discharge planning:

> We start the day of admission, with the nursing history. We look at family support, if they have support, we ask how they get along. We look at how they progress. It is ongoing. You're always building rapport with the patient.
>
> I talk with the family--what are their needs, is the patient cohesive with the family, is there divorce or abuse going on. We see if there are other family members who can be caretakers--are they old, do they have health problems, are they reliable? I check on the home layout, ask what will be the situation when they go home.

The nurses clearly felt that teaching (based on a sound assessment) was the most valuable discharge planning service to be performed for patients, that nurses were responsible for performing that service in the hospital, and that referral was a safety measure (i.e., a check that what had been taught was being carried out at home). As one nurse said in an interview, "People are only about two-thirds of the way recovered when they go home." Nurses saw patients discharged to home as having to look out for themselves during that last one-third of recovery, and they saw nurses as having to prepare their patients for this self-care.

The Process of Teaching Self-Care: A Series of Decisions

Discharge planning for self-care requires that a series of decisions be made by nurses. The first decision to be made is whether the patient will go home or to an extended care facility

(ECF). The reason this is the first decision to be made is that it distinguishes patients who will be taught self-care (handled by nurses) from those who will need institutional placement (handled by social workers).

The home _vs_. ECF decision is made by the team--doctor, nurse, social worker. Fully 59% of the interviewees claimed that nurses play a major role in this decision. According to the nurses interviewed, the factors which carry the most weight in the decision are the following: 1) the patient's physical limitations (noted by 86% of the nurses), 2) availability of family to help at home (mentioned by 72%), 3) patient and family preferences (mentioned by 31%). Other circumstances which influence planning are the patient's age, finances, mental status and type of medical regimen (each mentioned by 13% of the nurses).

For those patients for whom an ECF is planned, the social worker becomes the primary discharge planner. He or she makes arrangements with the facility without much input from nurses.

If the patient is to go home, the nurse becomes the primary person responsible for discharge planning and its implemention. The social worker acts as a consultant, and is called upon only to help solve particular problems, counsel discordant families and patients, locate community resources which can supplement a visiting nurse, and answer questions about financial coverage.

Both the social workers and nurses agreed that this is the division of labor between professionals.

Nurses who were interviewed claimed that once the decision is made that a patient will be discharged home, the next step is to make a series of assessment decisions: 1) which patients need the most intensive teaching, 2) what should be taught, 3) who (patient or family) should be taught, and 4) how should the information be presented. In evaluating the progress of the patient, nurses had to evaluate when teaching is completed, and what formal community services need to be arranged.

Assessment

Who Needs Self-Care Teaching

The patient's personal characteristics and his medical regimen are the factors which nurses take into account when they are assessing a patient's need for being taught self-care. The majority of nurses interviewed agreed that elderly, more debilitated patients without families are most likely to receive attention prior to discharge. Young adults and those whose families are constantly at the hospital typically receive less attention. The following are examples of comments made by nurses who were interviewed:

> They may seem so independent in the hospital with family around that they don't get a whole lot of education.

> If they are our age they might get no discharge planning because we assume, right or wrong, they can fend for themselves.

Patients who need to continue complicated medical regimens at home receive extensive teaching from nurses prior to discharge. Patients with certain diagnoses get high priority for teaching because they require complex care and/or present serious safety risks. On the oncology floor, for example, leukemic patients usually receive the most extensive teaching because 1) they often go home with central lines such as Hickman or Broviac catheters that require complicated care; and 2) are immunocompromised, are candidates for infection, and therefore are potential safety risks. Patients less likely to receive teaching are those who are in the hospital for short stays for continuing chemotherapy. These patients have usually been under treatment for some time and are assumed to be more knowledgeable.

On the orthopedics unit, it is the patients who have had total joint replacements (hip or knee) who need the most attention prior to discharge. This is because of the safety precautions necessary to achieve proper range of motion of the joint, and because these patients have a greater potential for infection of the joint.

What Should Be Taught

Interviewees emphasized that what is taught is shaped by two things: home environment and medical regimen.

Nurses assess the home environment second-hand, through patient and family. Then the nurse decides what the patient needs to know so that his recovery can progress at home. This

might include, for example, teaching the patient how to stand or how to walk on stairs with crutches. One surse said:

> I check on the home layout. Is there a shower or a tub? Are their stairs? Are the bedroom and bathroom upstairs or down? How active is the patient? What does he do when he leaves the house?

Regarding medical regimen, nurses teach the patient to do tasks that nurses have been doing in the hospital. On orthopedics, this means monitoring for infection and proper circulation and helping to keep joints in proper alignment with activity. For example, total hip replacement patients need to be taught such maneuvers as how to put their shoes on without bending over. One nurse summarized the process:

> As they progress we observe them with the physical therapist, see their abilities, work with their exercises and range of motion. If they had a hip replaced and if they are not following their precautions, we reinforce it.

Oncology patients need to be taught to do dressing changes, to care for central IV lines and to monitor for infection.

<u>Who in the Family Should Be Taught</u>

Interviewees say that the nurse decides if the patient is able to oversee his own medical regimen and can manage activities of daily living, or if a family member or other caretaker needs to be involved. Nurses interviewed said that they may need to teach the more technical skills to the community health nurse if family members are undependable or unavailable. The clinical nurse specialist on the oncology unit does this occasionally.

How to Teach

Interviewees claimed that the nurse decides how each patient will best comprehend the information, and tailors teaching to the individual patient. For example, nurses felt one patient was not understanding what they were telling him about his cancer. Because he was a slower learner than average, they brought in teaching materials from pediatric oncology.

Evaluation

When is Teaching Completed?

Deciding when teaching has been successfully accomplished is the next step in the process for nurses, according to those interviewed. It may be that the nurse decides that further teaching needs to be done outside the hospital if the discharge occurs before the nurse is comfortable with the patient's mastery of the skills. In evaluating the transfer of care skills an orthopedic nurse asks herself:

> Is the patient dependent or independent? If independent, how independent? Does he know his precautions? Has he learned what we taught him enough to function at home?

What Community Services are Needed

Fifty-nine percent of the nurses on both units stated that the service most need by patients at home is an assessment provided by the Visiting Nurse Association (VNA). Nurses on both oncology and orthopedics say they depend on the VNA to 1) double check how the self-care they have taught is being carried out at

home, 2) help the recently-discharged patient with tasks of living, and 3) reassure the patient at home.

Oncology patients are more likely to require a visit by a skilled nurse, whereas orthopedic patients most often need a home health aide or physical therapist, according to the nurses interviewed. These findings are not surprising, given that oncology patients go home with intravenous lines, and given that orthopedic patients frequently must deal with mobility problems.

Examples of comments made by nurses about VNA referrals follow:

> If a patient is well prepared in the hospital, he may not need much skilled nursing at home. Usually patients are debilitated and may need support like a home health aide.

> A patient's anxiety is high when he is about to be discharged and he needs someone to assess him at home. VNA may go a couple of times to see that he is OK. Sometimes the patients are afraid once they get home.

The Context in Which Nurses Do Discharge Planning: Complexities, Difficulties and Constraints

To fully understand what is going on with discharge planning in the hospital studied, one must consider not only what nurses try to do in preparing patients for discharge but the circumstances under which they work. To know the context is to know the difficulties and constraints under which nurses operate.

The context includes characters (patients, family or friends, community nursing agencies and members of the hospital team) and setting (the hospital work milieu). While it is

predictable that nurses will encounter complexities and difficulties in the interpersonal aspects of their work, it was the work milieu (with its demands on time, priority of acute care, decentralization of responsibility and large interdisciplinary team) that most constrained nurses' discharge planning efforts.

Difficult Characters

Patients: Teaching Self-Care

Teaching patients self-care is not difficult because of the content, but because of the characteristics of the patient as learner. The problems are similar to those any teacher encounters. Interviewees claimed that it is especially difficult for nurses to evaluate patients' grasp of the information:

> We try to make sure patients are good with precautions. They may say yes, but they may not do it.
>
> It's tough impressing on patients how important it is for follow-through, that they are not to exceed their activity limits, especially joint replacement patients.
>
> Sometimes they aren't ready to listen when you are ready to teach, or you aren't ready to teach when they are ready to listen. Some will just shake their head "yes" but they are not really listening.
>
> We have two categories of patients: the young, who don't care about what we tell them: they don't think anything is wrong with them, and the old, who because of memory problems, can't absorb what we tell them.

With some patients, the difficulty is in convincing them to let others help:

> I worry that they will be honest with me and the visiting nurse about needing someone. Some of them think

> it's charity, or it's an invasion of privacy. If they say they don't want help, I wonder if this is really true. Sometimes I almost insist they have a referral, especially if the family member is not reliable.

Families: The Complexities of Arranging Informal Support

When a nurse works with a patient's family or friends to set up care for the patient at home, the nurse hopes for an informal support network that is dependable, available, cohesive, and reliable. The interviewees talked about situations where these desirable qualities were absent. Family members may not be dependable:

> It can be hard to round up dependable people to take responsibility at home. They are the ones we need to teach.
>
> You teach them one thing here, find another happens at home. For example, a patient was instructed on decubitus care. The wife seemed cognizant, did a demonstration here. When VNA got to the home it hadn't been done for some time. Perhaps the patient decided he was terminal, so why bother. He also stopped the care of his colostomy, which he had been scrupulous about here. The VNA called us about it.
>
> We had an 80-year-old patient with an old husband who took care of her. I was concerned about his memory. You may have a home health aide for two weeks, but a couple of weeks may not be the answer. If you have a quasi-compliant patient and someone needs to harp on him, a family member may give up in a few days, whereas a nurse wouldn't.
>
> A family may say a sister who is a nurse is flying in to take care of the patient. Then it turns out the sister is really a nurses' aide. Or the family thinks that because a family member lives three blocks away, they can look in on the patient. It turns out the patient can't even get out of bed by herself, and the family who lives nearby has gone on vacation the week she is to be discharged.

The family may not be available for consultation with the nurse. They may visit at shift change, or rarely:

> It is difficult to find out who will be doing the care, and finding family or informal supports. If you can't teach the patient, you must find a family member to be there to learn.

The nurse may find herself involved in family disagreements:

> We have families in conflict and they are the most difficult. The family and patient give different messages.

The nurse may need to convince the family they can take the patient home:

> The most difficult thing is getting the patient or family to believe they can take care of the patient at home or that they realistically can't.
>
> The family may want to take the patient home, but they don't know what that involves. Hospice may be more appropriate but they have a bad feeling about hospices.

Families may want more help at home than nurses feel is warranted or possible:

> One of the hardest things is unrealistic family expectations. They want cleaning, shopping when you can't provide that kind of help.

The interviewees also noted that making arrangements with families becomes more complicated when the family speak a language other than English.

Community Health Agencies: Difficulties with Arranging Formal Help

For the most part, nurses didn't see it as difficult or very time-consuming to make the referral to a community service. But there were certain circumstances which several nurses recalled as problematic, two relating to the characteristics of the patient,

and one relating to aspects of the agency. Commenting on non-English-speaking patients, one nurse said:

> If the patient doesn't speak English, it is hard to get a VNA referral. A Vietnamese patient left, and we didn't think of it, but some agencies don't do Vietnamese.

Another nurse noted the problem she encountered with patients on complex regimens:

> If complex terminal care is needed--a morphine drip, for example--and the patient lives out of the city, it will not be covered (nurses will not perform the service). VNA here will do it. In the next town, there is no coverage for drips. Sometimes a patient will have a sister who is an RN who will do it, but otherwise it's a problem.

Noting the difficulties with agencies that have non-nurse intake workers, one interviewee commented:

> In one county, the RN's seem to take the calls, other places you may get a clerk who doesn't know much and you have to spell all the words. It's so much nicer if you talk to a nurse.

The Hospital: Constraints of Working Within the System

Perhaps the major source of difficulty with discharge planning was the hospital system itself, not just with patients, families and agencies. Problems arose from four sources: decentralization of responsibility, the priority of acute care, time constraints, and coordination of a large team.

Decentralization of Responsibility

By hospital policy, the responsibility for discharge planning is divided among team members. As a result, no one group of professionals bears heavier responsibility than any other. There is no charge to the patient (and thus no revenue

collected) for discharge planning. Since there is little incentive for any team member to undertake discharge planning, it is perhaps surprising that nurses take on as much of this responsibility as they do.

Priority of Acute Care

One aspect of the situation which obviously distracts attention from discharge planning is the high priority placed on acute care. One nurse with a background in home health commented:

> I should be aware of what is going on, have more control, but I don't have time to have more control. We need more coordination. At other hospitals I've worked at, there were nurses who did discharge planning--that was their job. But I guess the social worker is doing it here. I have done VNA and home health, so I should be oriented to home care. I know what I should be looking for, but somehow I don't even think of it here. I've wondered about what I'll do when I get a referral form put in front of me but so far I haven't dealt with it. Somehow it gets done but I'm not always aware of how it gets done. It doesn't seem like I'm doing much of it. I'm always stomping out fires.

Another nurse thought discharge planning was getting less attention that it should:

> I think discharge planning should be done by a team. It's half-assed. We tend to zero in on skin care and other acute problems. Then staff is inconsistent; not everyone is zeroing in on the same things. We had a patient going home and I knew something about him, but I didn't know enough to fill out the VNA form. Who wants to fill it out at 3:45?

Time Constraints

Not only is discharge planning overshadowed by acute care, it competes for nurses' time with a multitude of non-acute tasks. These tasks range from dealing with faulty equipment, to staff

meetings, to attending to patient hygiene. The list could go on. One nurse said:

> It's frustrating not having time to do teaching. You may see patients aren't absorbing it and you feel you are sending them home unprepared because you've got to go on to something else that day.

Of course, it is not only nurses but other members of the team who are pulled in many directions at once.

Coordination of a Large Team

With so many staff having discharge planning responsibility, there is an obvious need for communication among them, and for coordination of their efforts. One nurse recounted her difficulties with communication:

> Communication among the health care team is a major problem. For example, a patient will say so and so is checking on something for him. It turns out someone else is doing it and it takes a lot of time to sort it out. We rarely sit down and review the process together.

Interviewees noted problems with two major avenues of communication--formal conferences and written communication.

Formal team conferences. On each unit, there were regular team conferences of which discharge planning was a part. There were differences between the units in how these conferences were used, however.

The two units' approach to conferences differed in several ways: 1) number of conferences, 2) philosophy about who among the team needed to attend, 3) physical proximity of the

conference room to the nurses' station, and 4) orientation of the conference toward nursing concerns.

The two hospital units differed in the following ways:

Number of conferences: The orthopedics unit had two weekly conferences--management rounds, where all patients were discussed, and a patient conference where the focus was on an individual. In contrast, the oncology unit had patient management rounds three times a week, and nursing rounds once a week. Both oncology conferences addressed all patients.

Attendance: Staff nurses on orthopedics were expected and encouraged to attend both weekly conferences. Management rounds on orthopedics was also attended by the two residents on the service, physical therapist, social worker, pharmacist, psychiatrist and chaplain. The individual patient conferences were attended by the same group with the exception of the residents and physical therapist. On the oncology unit, staff nurses attended only nursing rounds. The only non-nurse team member at nursing rounds was the social worker. Patient management rounds, on the other hand, were attended by the head nurse, assistant head nurse, charge nurse, clinical nurse specialist, medical students, residents, attending MDs, social worker, dietician and pharmacists (but no staff nurses).

Proximity of the meeting room: Both orthopedic conferences were held in a room just steps away from the nurses' station. Oncology nursing rounds were held close to the nurses' station,

but management rounds were held in a room at a far end of the unit.

Orientation toward nursing concerns: Both orthopedic conferences addressed primarily nursing issues. Nursing rounds on oncology also centered on nursing concerns. Patient management rounds on oncology concentrated on medical management, however, with other aspects of care--psycho-social, nutrition, nursing, discharge planning--addressed if one of the team members had questions.

Staff nurses on oncology, then, despite their central role in discharge planning and other aspects of patient care, had no opportunity to meet with the other team members in a milieu where patients were reviewed systematically. Though no interview question addressed how the conferences served staff nurses communications needs, several spontaneous comments from oncology nurses indicated that they want to spend more time meeting with other members of the team:

> We staff nurses don't go to management rounds. I'd like an arrangement where the primary care nurse would sit with the MD and social worker. That may happen when we go to primary care.

> The most difficult thing about discharge planning is trying to coordinate the whole team--diatary, PT, clinical nurse specialist--and find out what the oncology team wants to do. With the medical team it's even harder to find out what they are doing, getting them to plan with us. They don't plan ahead.

It is not surprising, then, that nurses on oncology saw it as difficult to know what other team members had planned for patients.

Nurses interviewed said that contact with physicians was particularly important if they were to carry out discharge planning. This was necessary because it was the doctor who set the discharge date and needed to sign referrals in order for ensure third party payment. Interviewees made the following comments:

> Our biggest obstacle is communicating with the physicians. Ideally, we begin discharge planning at admission, but it doesn't always work that way. We're sometimes caught scrambling at the last minute.
>
> I just spent 15 phone calls trying to locate the MD who told a patient she could go home but didn't write it (and didn't tell the nurse).

Nursing shift changes: Lack of continuity. The large team may be a factor peculiar to university hospitals. However, a problem faced by all hospitals and that affects the carrying out of discharge planning is frequent changes in nursing staff due to different work shifts and the tendency for many nurses to work less than 40 hours per week. Two nurses made the following remarks:

> The hardest thing is that there are no consistent care givers. Getting adequate documentation of what has been done is difficult.
>
> We can be caught a day or two ahead of discharge and then the same nurse doesn't have him who had him the day before.

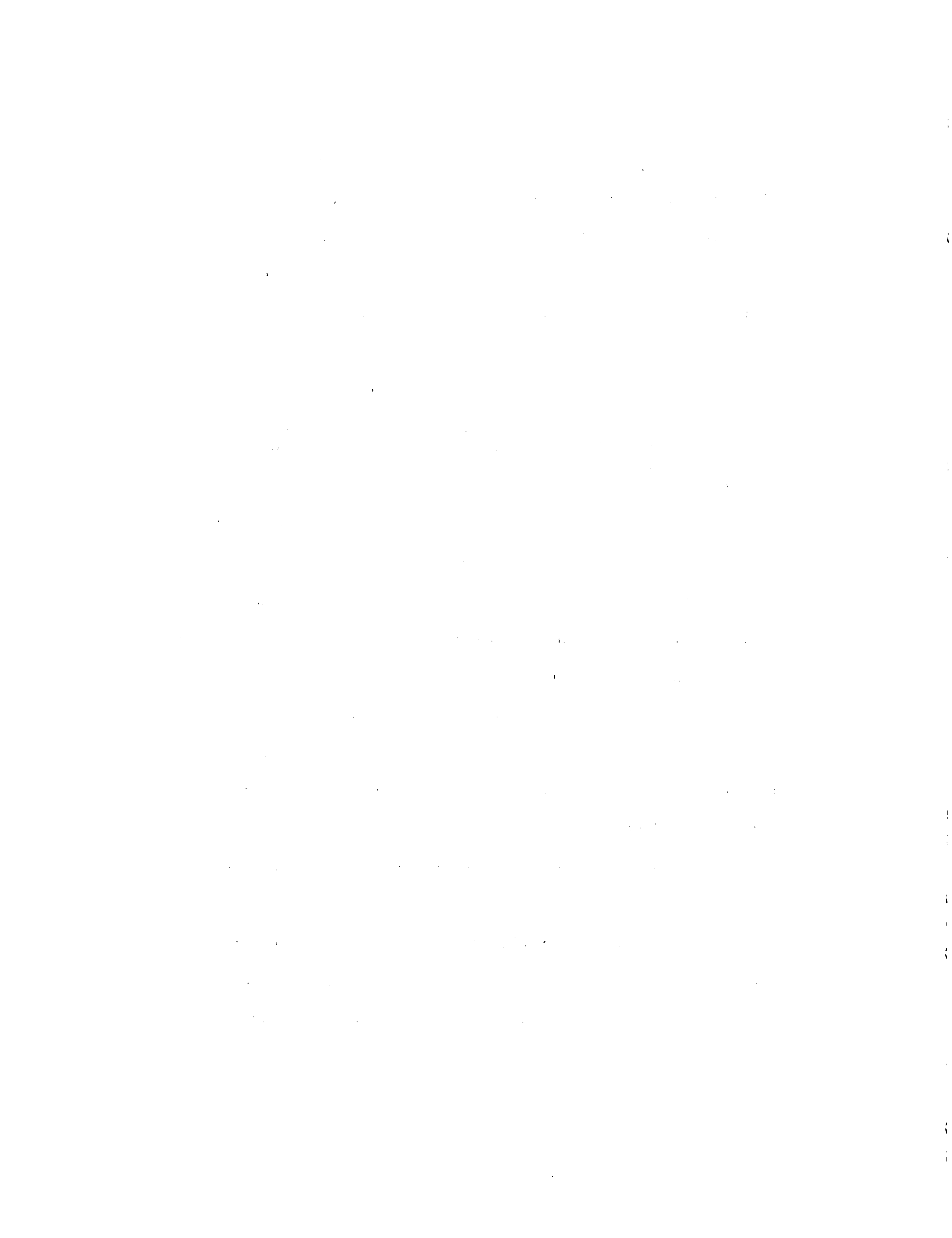
<u>Problems with written communication</u>. Both units had several mechanisms (among them, teaching protocols and Kardex notes) which attempted to combat the lack of consistent care-givers through written communication. Teaching protocols for specific nursing regimens (such as care of central lines, colostomy care and hip replacement precautions, see Appendix F) made the issue of what to teach clear-cut. One orthopedic nurse commented:

> Because of the protocols, we know <u>what</u> to teach <u>when</u>, and everyone reinforces the same things. We get on the patient's case and physical therapists are pretty consistent.

Nurses said their only difficulty with knowing what content to teach occurred when certain protocols were changed frequently.

If what to teach was clear-cut, how much teaching had been done was not. Though each unit's care plans contained check lists (see Appendix F) which would give an oncoming nurse an idea of how much of the discharge protocol had been completed, this type of charting was done in only 26% of the charts reviewed. Nurses' notes contained some mention of patient teaching in 45% of the 63 charts reviewed at discharge.

The oncology unit had gone a step farther and developed check lists, kept with the Kardex, for teaching patients with certain diagnoses (Appendix G). If used, the sheet would tell a nurse who was new to the patient just how much had been done. These sheets, too, were rarely filled out (4.5% of the 111 records reviewed).

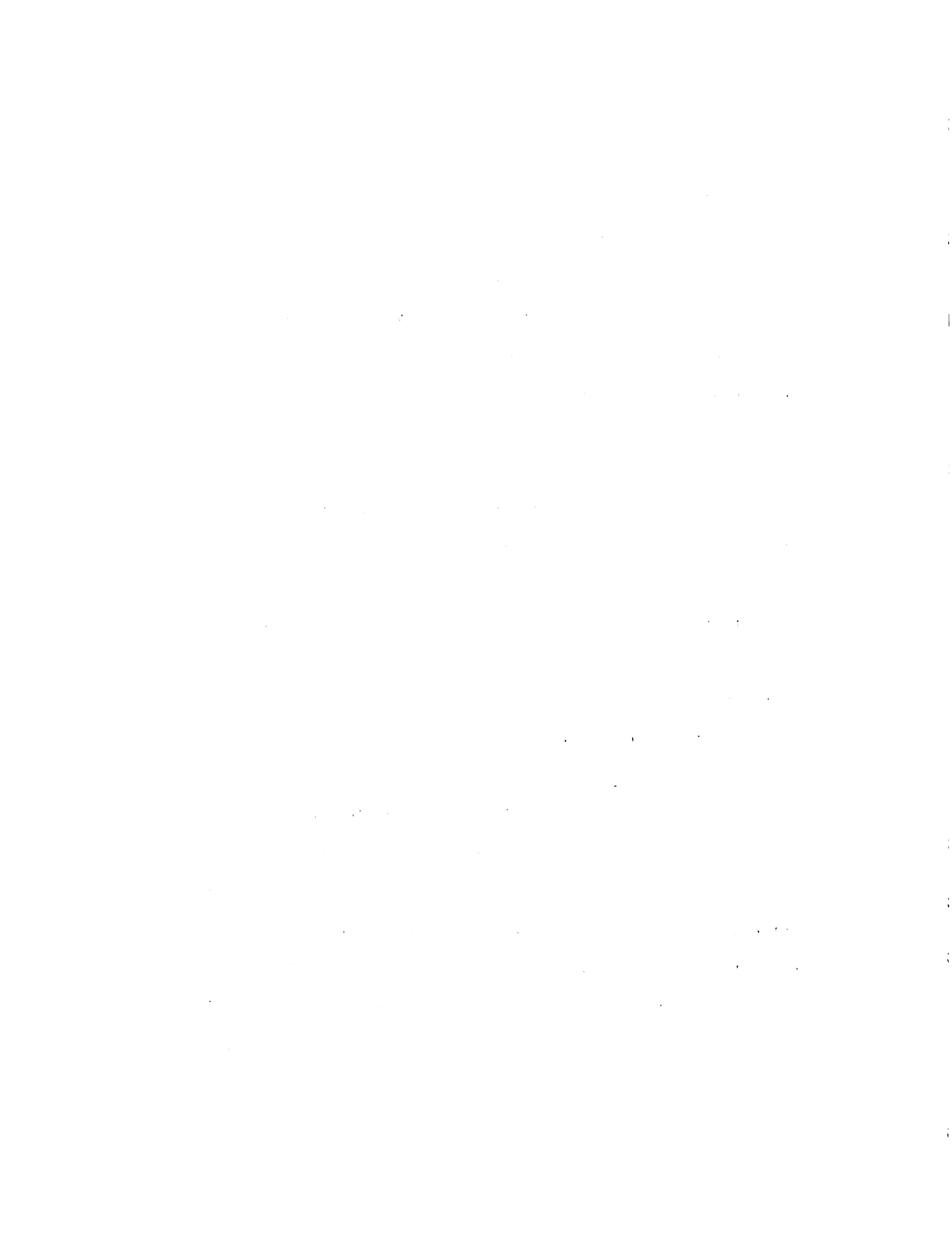


Kardexes also had a check list for notations about what aspects of discharge planning had been completed. This space was filled in on 16% of the 111 Kardexes reviewed. There were notes about some aspects of patient education on 9%. On 40% of Kardexes, there were notations of the services being considered for patients on discharge. On only one Kardex was any notation made about whether a referral had been made to the service agency.

It is important to note that assessment data were more often present in Kardexes than data on discharge planning. As part of their admission assessment, nurses made some brief notes about the home situation--who the patient lives with, whether there are steps to the house and inside the house. There were notes about whom the patient lived with on 88% of the Kardexes, and 38% showed mention of steps to or inside the house; however, 36% of these notations were on orthopedic patients.

What Would Nurses Change

When asked what changes they would make in the way discharge planning is done, 45% of the nurses pointed to a need for better communication of plans and activities completed. Twenty-seven percent of the interviewees say the process should be begun earlier. Eight percent said nurses needed more warning from doctors about the timing of discharge. Thirteen percent of the nurses interviewed said more attention should be paid to the referral.



Summary of Findings

Staff nurses focus on patients who will be discharged home, rather than those who will be placed in ECFs. Nurses do not focus their efforts on making referrals, as is often assumed. Instead, nurses focus on teaching the patients to care for themselves. In the process of teaching self-care, nurses assess which patients are most likely to need teaching, what they will need to know, whether the patient or family is the best candidate for teaching, how necessary information could best be conveyed, and when the patient is adequately prepared for discharge. Patients are often referred to the VNA, for safety checks, to be sure the patient is following through with self-care. The elderly, more debilitated patient, along with those with complicated medical regimens, get the most attention prior to discharge.

Difficulties for staff nurses center around evaluating patient comprehension of material, coordinating family back-up, communicating what has been done or what needs to be done to the hospital team, and finding time for discharge planning.

DISCUSSION

Implications for Nursing

Relationship of Theory to Practice

Discharge planning, as practiced on the nursing units studied, is consistent with the theory of Dorothea Orem, who said "Nursing's special concern is man's need for self-care action and

the provision and management of it on a continuous basis in order to sustain life and health, recover from disease or injury and cope with their effects." (Foster & Janssens, 1980)

Orem spoke of two kinds of self care--universal (in order to meet basic human needs) and health deviation (what is required when an individual cannot meet his own universal self-care needs). An ill person, Orem says, may need to 1) adjust ways of meeting universal self-care requirements, 2) establish new techniques of self-care, 3) modify the self image, 4) revise the routine of daily living, 5) develop a new life-style compatible with the effects of health deviation and 6) cope with the effects of the health deviation or the medical care used in the diagnosis and treatment of it. These adjustments may need to be made in order to cope with hospitalization and they may need to be made in new ways as discharge approaches.

As an ill person recovers, he or she progresses, according to Orem's theory, from a wholly compensatory system where nurses fulfill all the basic needs, to a partially compensatory system, where the nurse and patient both fulfill his or her basic needs, to a supportive-educative system where the "patient is able or can and should learn to perform self-care measures, but cannot do so without assistance." (Foster & Janssens, 1980). (See Appendix H.)

Discharge planning, when viewed as including the transfer of care skills from nurse to patient, is the mechanism for effecting

a transition from a partially compensatory system to a supportive-educative system.

Orem emphasized nursing's practical and intellectual aspects. In doing discharge planning, nurses are moving from their more practical to their more intellectual role. Perhaps some of the nurses' difficulties with discharge planning, such as lack of meeting time and sparse documentation of progress made, can be traced to their traditional image, in the hospital, as serving primarily in the wholly or partially compensatory system. That is, it is well accepted by administrators and nurses alike that nurses need time to help patients bathe, but perhaps less clearly accepted that they need uninterrupted time for planning, analysis and communication.

Suggestions for the Units Studied

Nurses are performing intellectual functions in discharge planning, but without much support. Their work could be sustained and facilitated by acknowledging this part of their role in several ways: 1) *Involve staff nurses more in interdisciplinary discussion*. Encourage them to attend team conferences. For example, arrange coverage so that at least one-half the staff nurses can attend each conference, while the other half answer patient calls. 2) *Clarify among team members what the discharge planning responsibilities of each professional are*. 3) *Reward nurses for their efforts by including objectives relating to discharge planning in promotional guidelines*. Send

one nurse a year on each unit to a discharge planning-related regional or national conference. 4) Increase nurses' knowledge of community services through inservices education programs or through use of educational leave to spend time with a home health nurse. 5) Allow staff nurses a period of time each day for planning and communicating. This time should be set aside, so they are completely free from other patient care responsibilities. 6) Improve continuity of the discharge planning process by a) increasing written communication among nurses (through use of flow sheets or check lists, for example), b) giving one nurse (perhaps the assistant head nurse) discharge planning as a primary focus, and have that person work Monday through Friday, 9 a.m. to 5 p.m.; and/or c) designating primary nurses who oversee patients' care for the entire hospital stay. 7) Include discharge planning in time computations so that it is considered in staffing. 8) Include discharge planning as a nursing service when calculating patient care charges.

Limitations of the Study

The findings of this study describe how discharge planning is handled in a university hospital with a large interdisciplinary team and without a centralized discharge planner. The findings cannot be applied to hospitals with dissimilar institutional structures and different mechanisms for accomplishing discharge planning functions.

Only <u>nurses</u>' perceptions have been explored. What is <u>actually being done</u> by nurses has not been verified.

Finally, the sample is small, and may be unrepresentative of nurses in general.

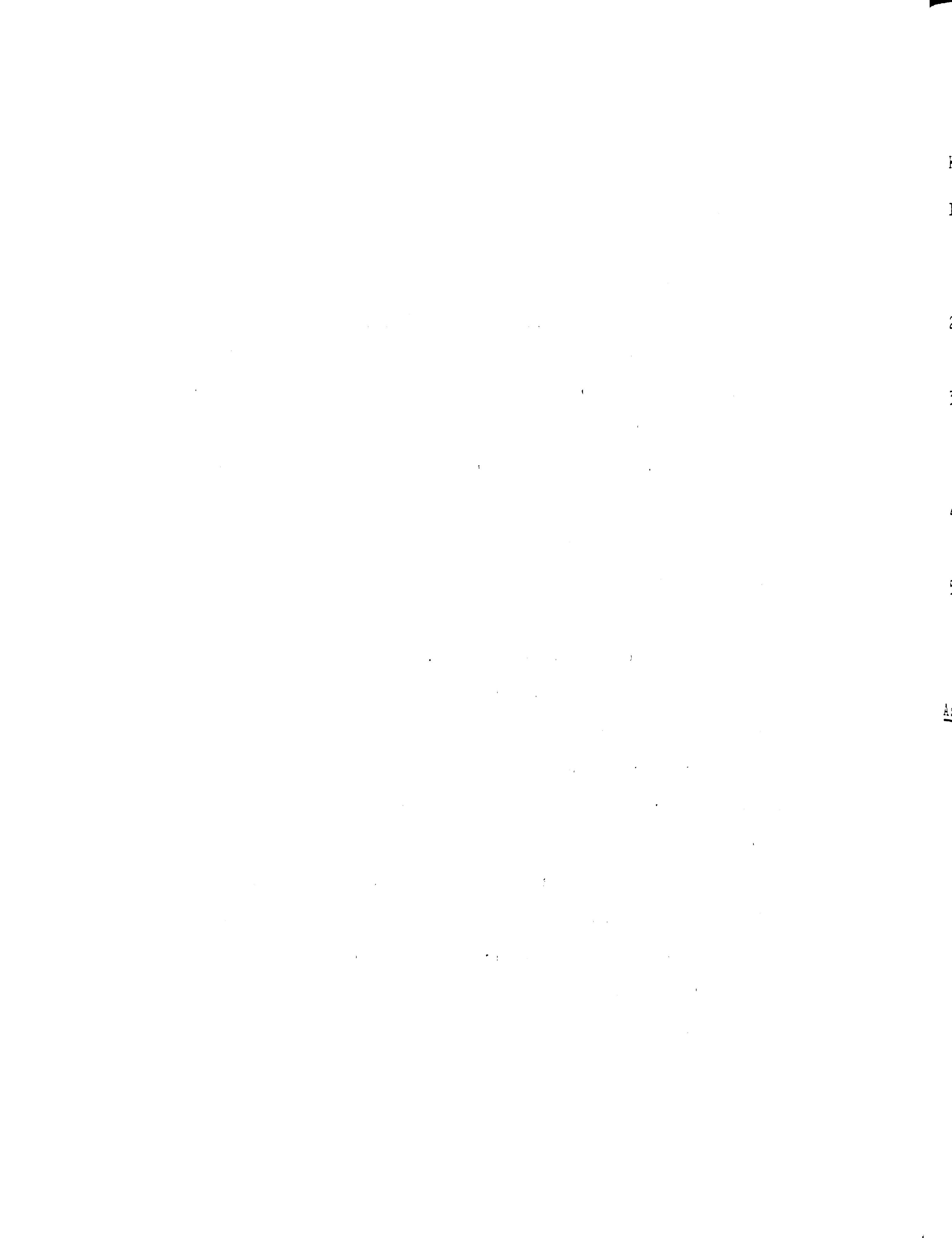
Suggestions for Future Research

The discharge planning process would benefit from studies conducted in other settings, with additional interview data. It would also be valuable to study actual behavior and measure the actual time spent by nurses and other staff members on discharge planning.

Data on the consequences of planning is also needed. Specifically, what actions or elements make for positive outcomes for discharged patients? It would be valuable to compare different models of discharge planning. One model might be to have a community nurse go into the hospital setting to prepare patients for their return home.

Finally, because nurses expressed such frustration with evaluating their teaching, research on a tool for evaluating patient and family comprehension of information is needed.

If the current trend toward earlier discharge continues, it will become more and more important for discharge planning to be effective, and particularly critical for patients to learn how to care for themselves. More research on how this can best be accomplished is crucial.



Appendix A

Keys to Good Discharge Planning According to Five Books:

1) National League for Nursing. (1974) _Discharge and patient referral planning_. (Papers presented at a workshop "Patient Discharge Referral Planning," held in Birmingham,Alabama, December 1973.)
2) Crittenden, F. (1983) _Discharge planning for health care facilities_. Bowie, Maryland: Robert J. Brady.
3) Fromstein, R. and Churchill, J. (1982) _Psychosocial intervention for hospital discharge planning_. Springfield, Illinois: Charles C. Thomas.
4) Steffl, B. and Eide, I. (1978) _Discharge planning handbook._ Phoenix, Arizona: Charles B. Slack, Inc.
5) American Hospital Association. (1974) _Discharge planning for hospitals_. Chicago, Illinois: author.

Assessment

Description: Correct assessment of patient as needing discharge planning[1]

Focussed on needs and goals[1,5]

Patient and family involved[4,5]

Provide for mutual awareness of what will face on leaving hospital[4]

Tasks: Assist patient and family to identify practical problems for discharge[2]

Establish function of discharge planning with patient and family[2]

Assist patient and family to identify psychological problems for discharge[2]

Evaluate physical and functional state of patient at discharge[3]

Evaluate patient's psychosocial status[3]

Consult with medical team re assessment of patient from point of view of other disciplines[3,4]

Factors which should be considered:

Who is at home to take care of patient[4]

How old is patient[4]

What problems will the diagnosis cause at home[4]

What is the capability of the family to assume responsibility, to understand and follow treatment plan, to be available for support and responsibility[3,4,5]

How available are resources in the community and how economically feasible is care at home[1,3,5]

What is the physical environment of the home in light of physical capabilities of patient[5]

Are the financial resources available to provide adequate food and to cover other expenses that the family may have to assume?[5]

What are the recommendations of the Utilization Review Committee[4]

Information that should be documented:[2]

Projected mental, emotional and physical states of patient at discharge

Day and time to leave

Where patient going

How going

What documents and information shall accompany patient

What referrals must be completed to community agencies and how they are to be communicated

What education or instruction has been given patient

What equipment, supplies and medicines are needed and who is responsible for providing

What appointments or arrangements have been made for ongoing care such as therapy, treatments or domestic help

Whether financial arrangements have been made for above

Whether patient's psychosocial status has been evaluated

Recommendations for ongoing care

Education

Prepare patient for visit by home health nurse--what fee to expect, how to take care of payment process, what equipment and supplies must be there, how to make contact[1]

Teach patient procedures he will have to do at home[4]

Teach family how they will need to participate in care[4]

Counseling

Assist family to meet psychological problems[2]

Assist family in meeting practical problems[2]

Linkages

Communicate plan

To staff[3,4]

Through patient record, updated as changes occur[4]

Through a conference with team members[4]

Through a transfer form, which should include:[5]

Patient identification

Length of stay

Where going

Responsible party

Disability

Impairments

Bladder and bowel hygiene

Personal effects

Social information--how well patient understands diagnosis, does family show interest, how patient has adjusted to disability, how patient is motivated to self-care, socializing ability of patient

Activity status with long-range potential

To Utilization Review Committee[4]

To caregiver[4]

Through narrative summary at case closing[3]

Implement plan

Match patient with correct services[1]

Transmit information correctly and adequately[1,4]

Make sure equipment and supplies are at home[1]

Establish a contact person at hospital for home health nurse[1]

Evaluation

Should be ongoing[4]

Should be follow-up of patient[3]

Appendix B

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

CONSENT TO BE A RESEARCH SUBJECT

Carolyn Knight, R.N., graduate student and Laura Reif, R.N., Ph.D., faculty member in the School of Nursing at the University of California, San Francisco, are doing a study on how nurses prepare patients and their families for discharge from the hospital. I have been invited to be in this study because I am a registered nurse working full-time on one of the floors of Long Hospital that will participate in this research.

If I agree to participate, I will be interviewed for about one-half hour by either Miss Knight or Dr. Reif. I will be asked to describe nursing activities related to discharge planning, and to identify which aspects of discharge planning are easy or difficult for nurses to carry out. The interview will take place during my regular work shift, in a private office near my hospital unit. Since nurses who participate in the study will be released from work during the interview, a meeting time will be arranged so it does not interfere with patient care or other important responsibilities.

In addition to the interview, Miss Knight will observe one or two telephone calls which I make to refer a patient for follow-up care. During this time, Miss Knight will take notes on the type of information which nurses commonly give to service organizations to acquaint them with patients and their circumstances.

The information obtained from interviews and observations will be kept confidential. Code numbers will be assigned to subjects, so my name will not appear on records of the interview or phone conversations. Subjects' names will be kept in a separate locked file so that confidentiality can be protected as much as possible under the law.

There will not be any direct benefits to me from being in this study. However, information obtained may, in the future, assist nurses to carry out discharge planning activities more easily and effectively.

I have talked with either Miss Knight or Dr. Reif about the study and they have answered my questions. If I have other questions, I may call Miss Knight at 282-2064 or Dr. Reif at 666-4658. I have been offered a copy of this consent form to keep.

Participation in this study is voluntary. I may refuse to participate or may withdraw from the study at any time without its affecting the evaluation of my work or my employment at this or any other institution.

____________________ Date

____________________ Subject's Signature

5/14/84

Appendix C

INTERVIEW GUIDE: HOSPITAL NURSES

1. Could you describe the kinds of activities you carry out in order to prepare patients and their families for discharge from the hospital?

   Could you give me a rough estimate of the amount of time you spend on these activities during any one shift? during any one work week?

2. Now I am going to list a few types of activities commonly associated with discharge planning. These activities are:
   - (a) assessment of the patient, home environment, family/friends who can help
   - (b) education of the patient and family to prepare them for discharge
   - (c) locating and arranging help for the post-hospital period
   - (d) giving information to service settings to which patient is referred

   Can you tell me which of these activities is most important for nurses to carry out? Which of these activities do you consider least important?

   Can you tell me which of these activities takes you the most amount of time?

   How much time would you say you spend on each of these activities in a work week?

3. Discharge planning can be a very complicated and time-consuming process. Can you describe for me some of the common difficulties you encounter when trying to prepare a patient and family for leaving the hospital?

   Probes: difficulty getting adequate information on patient, family, home?
   problems teaching patient/family so can manage when go home?
   trouble finding/assessing quality of setting to which refer patient?
   trouble knowing what services patient will need when goes home?
   trouble knowing what services will be paid for and how to get financial help for the patient and family?
   trouble communicating with other staff involved in planning?
   trouble getting adequate information to agency to which patient referred?
   trouble finding enough time to do adequate planning and education?

4. To what extent do you have a say in whether the patient goes home or to an extended care facility after discharge?

5. What sorts of things do you take into account when deciding whether a patient is able to go home or requires placement in an extended care facility?

   To what extent does the social worker and/or physical therapist supply information which helps you arrive at a decision?

6. What services do you find patients need most when they are discharged home?

7. Which of these services are most difficult to locate or arrange for patients?

8. When time is short, which aspects of discharge planning do you give priority to? Which activities tend to receive the least amount of attention when time is short?

9. When time is short, which patients are most likely to receive discharge planning? Which type of patient is least likely to receive planning when time is short?

10. Which other persons on this unit would you say are most involved in discharge planning?

    Probes: What about social worker?
    Physical Therapist?
    Clinical Nurse Specialist?
    Head Nurse?

11. To what extent do the activities carried out by these persons differ from those performed by you and other staff nurses on this unit?

12. If you could make two changes in the way discharge planning is currently done on your unit, what would those changes be?

Background information:

1. Age
2. Sex
3. Education (circle all that apply) diploma B.S. M.S. Nurse Practitioner
4. Years employed in nursing
5. Years employed in this specialty
6. Months/years employed at this hospital
7. Months/years employed on this unit

Appendix D

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO
CONSENT TO BE A RESEARCH SUBJECT

Carolyn Knight, R.N., graduate student, and Laura Reif, R.N., Ph.D., faculty member in the School of the Nursing at the University of California, San Francisco, are doing a study on how hospital staff prepare patients and their families for discharge from the hospital. I have been invited to be in this study because I am a professional who plays a key role in discharge planning on one of the floors of Long Hospital that will participate in this research.

If I agree to participate, I will be interviewed for about one-half hour by either Miss Knight or Dr. Reif. I will be asked to describe my role in discharge planning and how this differs from that of the hospital nurses. The interview will take place during regular work hours, in a private office near the hospital unit to which I am assigned. Since I will be released from work during the interview, a meeting time will be arranged so it does not interfere with patient care or other important responsibilities.

The information obtained from interviews will be kept confidential. Code numbers will be assigned to subjects, so my name will not appear on the record of the interview. Subjects' names will be kept in a separate locked file so that confidentiality can be protected as much as possible under the law.

There will not be any direct benefits to me from being in this study. However, information obtained may, in the future, assist hospital staff to carry out discharge planning activities more easily and effectively.

I have talked with Miss Knight or Dr. Reif about this study, and they have answered my questions. If I have other questions, I may call Miss Knight at 282-2064 or Dr. Reif at 666-4658. I have been offered a copy of this consent form to keep.

Participation in this study is voluntary. I may refuse to participate or may withdraw from the study at any time without its affecting the evaluation of my work or my employment at this or any other institution.

________________________ Date

________________________ Subject's Signature

5/14/84

Appendix E

INTERVIEW GUIDE

SOCIAL WORKER / PHYSICAL THERAPIST ROLE IN PLANNING

1. Could you describe for me the activities you carry out to be sure that patients and their families are prepared for their discharge from the hospital?

2. To what extent do your activities differ from that of the nurses on this unit?

3. Do you initiate discharge planning for some patients? What types of patients?

4. To what extent do you become involved in discharge planning because the nurse or physician have referred a patient to you? What types of patients are referred?

5. To what extent do you have a say in whether the patient goes home or to an ECF following discharge?

6. What sorts of things do you take into account when deciding whether a patient is able to go home or requires placement in an ECF?

   To what extent do the nurses supply information which helps you arrive at this decision?

7. What services do you find that patients need most when they are discharged?

8. Which of these services are most difficult to locate or arrange?

9. If you could make two changes in the way discharge planning is currently handled on your unit, what would those changes be?

BACKGROUND INFORMATION:

Age Sex Highest degree Specialty training

Years Employed as Professional Years at this hospital Yrs. on unit

Appendix F

MASTER PROBLEM LIST

Date	No.	ACTUAL PROBLEM CLOSED/OPEN REDUCTION, INTERNAL FIXATION ~~OF UPPER/LOWER EXTREMITIES~~	Charting Frequency	Date in-active
	1.	Anxiety and fear		
	2.	Discomfort		
	3.	Immobility		
	4.	Decreased GI mobility		
	5.	New walking gait/upper extremity		
		limitations		
	6.	Need for discharge planning and teaching		

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N. Munasnes, J. Gerstner
Rev. 6/80

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NURSING PROBLEM LIST AND CARE PLAN

DIAGNOSIS:			AGE:
RN:	M.D.:		SERVICE
Initial	Name	Initial	Name

DIRECTIONS:

This is a general Model of Practice for CLOSED/OPEN REDUCTION, INTERNAL FIXATION OF UPPER/LOWER EXTREMITIES

1. To individualize the nursing care plan circle the problem number and the nursing orders that apply to the patient.
2. Add and number additional problems as needed.

Date	No.	Patient Problem/ Expected Outcome	Deadlines & Charting Freq.	Nursing Orders
	1.	Anxiety and fear due to: impending surgery - possible complications - treatment - complete understanding of procedure - unexpected hospitalization		1. Spend time with patient to determine b understanding of surgical procedure. Refer appropriate questions to MD. 2. Explain importance of ROM exercises in unaffected extremities and have patient demonstrate. 3. Instruct in use of trapeze. 4. Explain post-op positioning, e.g., pillows, sand bags, elevation, turning, possibility of balance suspension. 5. Explain importance of pulmonary toilet including coughing and deep breathing, Incentive Spirometer. 6. Inform re: pain, availability of meds, alternative ways to relieve it. 7. Inform re: a.) Schedule of OR day (pre-op meds, what to expect, time and length of procedure). b.) PAR until stable c.) Information for family 8. Explain possible after-effects of anesthesia - sore throat from intubation - diet progression
		Expected outcomes: - Verbalizes fears and concerns - Expresses understanding of what to expect post-op - Demonstrates ability to cough, deep breathe and do post-op exercises		

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Date	No.	Patient Problem/ Expected Outcome	Deadlines & Charting Freq.	Nursing Orders
				CLOSED/OPEN REDUCTION, INTERNAL FIXATION OF UPPER/LOWER EXTREMITIES
	2.	Discomfort due to: - fracture and corrective procedure - cast, constricting drening - muscle spasm - edema - numbness and tingling		1. Maintain position of comfort and alignment/MD order 2. Offer back rubs, massage, PRN 3. Instruct patient in alternative methods of pain relief. 4. Check CMS and pulses with V.S. notify MD of changes. 5. Check cast for pressure points q 2 while drying, then q shift.
		Expected outcomes: - Verbalizes relief of pain with medication or position change. - Able to feel pressures in effected fingers and toes. - Denies numbness and/or tingling.		

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Date	No.	Patient Problem/ Expected Outcome	Deadlines & Charting Freq.	Nursing Orders
				CLOSED/OPEN REDUCTION, INTERNAL FIXATION OF UPPER/LOWER EXTREMITIES
	3.	Immobility due to fracture and corrective procedure. Problems can include; a.) ↓ lung expansion b.) poor skin integrity c.) high risk for pulm, fat or air embolus		1. Change position and massage boney prominences q 2 - 4° w/a and prn at noc 2. Use egg crate, sheepskin and heel/ elbow protectors prn. 3. Check perineum, coccyx and linen. q void for dryness. 4. Auscultate both lungs and assess resp. with V.S. 5. Pulmonary toilet 10 x / hr W/A and prn at noc. Include ICS, DB & C. 6. Assess for c/o chest pain/discomfort q 4° x 3 d, then q sh x 7 d. Then QD til D/C. 7. Assess ability to dorsiflex foot q 4° x 3 d, QS til D/C. Notify MD of calf pain present. 8. Antiembolism stockings/MD order, remove BID at 9 - 9.
		Expected outcomes: Skin intact and clear or rashes and /or reddened areas. Lungs clear to aurecultation Afebrile Able to dorsiflex foot without calf pain.		

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CLOSED/OPEN REDUCTION, INTERNAL FIXATION OF UPPER/LOWER EXTREMITIES

Date	No.	Patient Problem/ Expected Outcome	Deadlines & Charting Freq.	Nursing Orders
	4.	Decreased GI mobility due to anesthesia, pain med, immobility, and diet changes.		1. Review nursing history for patient's own pattern. 2. Assess for bowel sounds q shift. 3. Have patient use toilet when ambulatory. 4. Help patient to choose high fiber foods in diet. 5. Increase fluids to 2 - 3 liters/day 6. LOC prn/MD order.
		Expected outcomes: - Has re-established baseline normal bowel pattern		
	5.	New walking gait/upper extremity limitations due to surgery, weight bearing limitations, presence of cast on immobilization device		1. ✓ Drs. order for weight bearing status. 2. Consult with PT to determine appropriate walking aid. 3. Evaluate ambulatory progression q day including stamina, distance amb., amt of assistance needed. 4. After ambl. for 3 days discuss goals for discharge 5. Have patient demonstrate ability to perform ADL, including getting in and out of bed, on and off toilet seat, in and out of chairs 3 consecutive times. 6. Have patient verbalize his understanding of activity restrictions and demonstrate exercise regime to be followed at home.
		Expected outcomes: - Ambulates safely and independently with crutches or walker including stairs. - Performs essential ADLs getting in and out of bed, on and off toilet seat, in and out of chairs. - Verbalizes understanding of activity restrictions and willingness to follow exercise regime		

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Date	No.	Patient Problem/ Expected Outcome	Deadlines & Charting Freq.		Nursing Orders PAGE 5
					CLOSED/OPEN REDUCTION, INTERNAL FIXATION OF UPPER/LOWER EXTREMITIES
	6.	Need for discharge planning and teaching due to lack of knowledge re: home care needs.			1. Talk to pt., family & if necessary S.W to determine home sit. & to eval. need for ECF, NVA or home care services. Make necessary referals to appropriate agencies
					2. Instruct in meds. including purposes, routine of admin. and side effects. Include family/prn.
					3. Have patient verbalize knowledge of meds.
					4. Instruct patient in cast care including: need to keep cast dry, do not introduce objects into cast for scratching. Can use hair dryer to break surface tension, signs and symptoms of circulatory impairment pressure sores, tingling, numbness and need to report to MD. Have patient verbalize the above.
		Expected outcomes:			
		- Verbalizes understanding of arrangements for care after discharge including MD office or clinic appointment.			
		- Verbalizes knowledge of discharge meds including side effects			
		- Verbalizes knowledge of cast care.			

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CLOSED/OPEN REDUCTION, INTERNAL FIXATION OF UPPER/LOWER EXTREMITIES

Nursing Criteria for Discharge or Maintenance (overall expected outcomes):

1. Ambulates safely with crutches, non-weight bearing or touch-down weight bearing as indicated, including stairs if necessary.
2. Verbalizes understanding of activity restrictions and willingness to follow exercise regime.
3. Demonstrates independence in ADL consistent with physical limitations existing pre-op, including use of aids as necessary in high rise toilet seat.
4. Verbalizes understanding of arrangements for care after discharge. Make extended care, VNA, home care service, PT referrals if necessary.
5. Verbalizes knowledge of discharge meds, to include name, time, and dose of each.
6. If still in cast when discharged:
   a.) Verbalizes understanding of cast care.
   b.) Reiterates signs and symptoms of circulatory impairment and pressure sores -- need to report to MD.

Home Care Coordinated Activities:

Make extended care, VNA, home care service, patient referrals if necessary.

M. MUNASWES, J. GERSMEYER

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APP. 6180 EW

University of California San Francisco
Hospitals and Clinics
San Francisco, CA 94143

UNIT NUMBER

PT. NAME

BIRTHDATE

LOCATION DATE

MASTER PROBLEM LIST

ACUTE LEUKEMIA

DATE	NO.	ACTUAL PROBLEM	CHARTING FREQUENCY	DATE INACTIVE
	1.	↑ susceptibility to infection		
	2.	Thrombocytopenia		
	3.	Fatigue/weakness		
	4.	Nausea, vomiting, anorexia		
	5.	Pt/family anxiety, anger, depression or regression		
	6.	Lack of knowledge re home care		

Appendix F-6

NURSING PROBLEM LIST AND CARE PLAN

DIAGNOSIS:			AGE:
RN:	M.D.:		SERVICE
Initial	Name	Initial	Name

UNIT NUMBER

PT. NAME

BIRTHDATE

LOCATION DATE

DIRECTIONS:
This is a general Model of Practice for ACUTE LEUKEMIA

1. To individualize the nursing care plan circle the problem number and nursing orders that apply to the patient.
2. Add and number additional problems as needed.

Date	No.	Patient Problem/Expected Outcomes	Deadlines & Charting Freq.	Nursing Orders
	1.	↑ susceptibility to infection due to: a) neutropenia b) incompetent WBC		1. Establish procective environment (i.e., protective isolation, no cut flowers or plants, no visitors with infectious diseases, limit number of personnel who enter the room, private room, damp mop room by Environmental Services. 2. Wash hands before and after each pt contact.
		Expected Outcomes: - Pt afebrile. - No S/S of infection - Pt achieves a recovery of normal WBC and polys.		3. Provide pt with individual equipment. 4. Use medical aseptic technique with all procedures. Avoid any invasive procedure. 5. Daily physical assessment of all body sites with a high potential for infection (lungs, mouth, urine, stool, skin). Culture as appropriate when indicated. 6. Notify physician for temp over 38° po or 37+ ax. Do not take rectal temps. 7. Avoid skin and mucous membrane trauma. Use toothettes for mouth care when platelet ↓50K. Mouth care and hs with saline or ½ str H_2O_2. Remove dentures when not eating. 8. Perineal care: Perform BID for females. Teach proper wiping technique after BM, avoid rectal meds or enemas, stools softeners prn, sitz bath qday with pHisoHex or pHisoHex wash after BM. 9. Avoid use of bladder cath: If necessary, during insertion avoid contamination, use smallest possible cath, use sterile closed drainage system. Cath care BID with Betadine. 10. Pulmonary care: Assess pulmonary status q AM. Teach proper C&DB technique and insure it is done q 4 hrs. Suggest use of incentive spirometer to physician when indicated. Chest PT when ordered (consider platelet count when performing PT). Sputum production. 11. Fever: Take temp q 4 hrs ATC, control as

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Date	No.	Patient Problems/Expected Outcomes	Deadlines & Charting Freq.	Nursing Orders
				ordered: antipyretics, alcohol or tepid sponges, cooling blanket, light clothes, cool room, force fluids. Indicate parameters for calling physician and for doing cultures. Observe for S/S of shock. 2. IVs: Avoid peripheral venipunctures. If necessary, see IV procedure. Date and change all IV tubing q 24 hrs. Date and change all IV bottles q 24 hrs. Change Hickman dressing per protocol. Change peripheral IV site q 3 days - dressing changes per procedure. Assess for S/S of infection q AM.
	2.	Thrombocytopenia due to marrow involvement, chemotherapeutic agents Expected Outcomes: - Pt demonstrates techniques to prevent trauma. - No S/S of active bleeding. - No bruising/pathechiae. - No C/O headache, change in CNS. - Gradual ↑ in plt count to normal values approx. 2 wks after nadir.		1. Teach pt to avoid bodily injury, ambulate with assistance, use electric razor, no toothbrushes when plt ↓ 20 K, soft toothbrush if ↓ 50 K. Side rails up, pad if necessary. 2. Careful daily assessment of all body sites for bleeding petechiae, bruising, or echymosis. 3. Test urine, sputum, and stool for OB as appropriate. 4. Avoid IM injections, suctioning, or/NG tubes. 5. Treat temps to prevent plt destruction. Transfuse plt after lowering temp. 6. Monitor menstrual flow with pad count. 7. No ASA or ASA compounds. 8. Monitor bowel function to prevent diarrhea/constipation. 9. Mechanical soft diet if necessary. 10. Apply pressure for 15 min following venipunctures and bone marrows. 11. Take BP BID unless pt condition requires more frequent monitoring. Pump up 10mmHg above last reading - go up by 10 as needed. 12. When plt ↓ 10 K, keep HOB elevated 30 , neuro signs q 8 hrs. Bedrest. 13. Teach pt to avoid excessive nose blowing. 14. If O_2 ordered, administer with mist mask rather than nasal prongs. 15. Review plt status with physician prior to all invasive procedures, i.e., bone marrows, LPs.

Date	No.	Patient Problems/Expected Outcomes	Deadlines & Charting Freq.	Nursing Orders
	3.	Fatigue/weakness due to: a) anemia from bone marrow involvement and chemotherapeutic agents and b) ↑ metabolic demands of illness/fever Expected Outcomes: - Demonstrates ability to perform ADL independently without fatigue, SOB, weakness. - Pulse 100/min.		1. Plan activities within limits of pt's tolerance. More assistance may be needed during nadir and febrile episodes. 2. Consider a referral to PT. 3. Modify environment for pt's convenience and to encourage as much independence as possible. 4. Assure pt that it is normal to feel this way and that their energy level will ↑ when their marrow recovers. 5. Bedrest with minimal energy expenditure during dyspnic phase.
	4.	Nausea, vomiting, anorexia due to chemotherapy, depression, electrolyte imbalances, etc. Expected Outcomes: - Weight remains constant, I&O balanced. - No nausea, vomiting. - Taking in adequate calories for body size and physical condition. - No S/S electrolyte imbalance.		1. Explain the importance of maintaining good nutrition to pt/family. 2. Dietary consult. 3. Administer antiemetics 1 hr before meals and prn. Pre-med for chemo administration. 4. Promote good environment for meals, clean, calm, free of odors. 5. Offer small, frequent meals. 6. Maintain fluid intake of 2L/day -- ↑ if febrile. 7. I&O, wt qod. 8. Calorie counts if pt is having continued N,V, anorexia. 9. Consider need for supplementary vitamins, minerals, hyperal with physicians. 10. Perform S/As qid while on hyperal. 11. Observe for S/S of electrolyte imbalance.

NURSING PROBLEM LIST AND CARE PLAN

DIAGNOSIS:		AGE:
RN:	M.D.:	SERVICE

Initial	Name	Initial	Name

UNIT NUMBER

PT. NAME

BIRTHDATE

LOCATION DATE

Date	No.	Patient Problem/Expected Outcomes	Deadlines & Charting Freq.	Nursing Orders
	5.	Pt/family anxiety, anger, depression, or regression due to: a) fear of the unknown b) fear of dependence c) fear of abandonment d) fear of loss of control e) fear of loss of identity f) masking fear, hate, shame, or guilt g) frustration of separation from ego-enhancing aspects of outside life NOTE: Anger provides energy for coping, so the pt may: - recover - fight the disease - deal with interpersonal issues - or choose to die. Expected Outcomes: - Focuses on reality about which things can be known and acknowledges that there are questions for which there are no answers. - Expresses need and chooses times to be alone and times to be with others. - Expresses anger in a style that is normal for the pt. - Preserves self-esteem by balancing some regression with continuing efforts at mastery.		1. Ask on admission how the pt/family normally expresses anger; review with them that feeling angry is very common in pts with leukemia and their families. 2. Establish a relationship of confidence and trust with the pt in which the pt can question and receive reliable answers. Share with the pt your willingness and the time you have available to listen and discuss these needs and feelings. If time is limited, arrange to return to talk later or make referrals appropriate to aid pt's discussion, i.e., chaplain, physician, social worker, and apprise your resource with what has gone on with the pt. 3. Encourage pt and family to discuss matters together, e.g., "Is this something you can talk about with your wife?", and insure that they have time alone and time with appropriate staff, if needed. 4. When pt demonstrates previously identified patterns of anger, ask specifically "Are you feeling angry today?" Provide opportunities for the pt to express anger in own style. Remind pt that feeling angry is common in hospitalization, illness, and that if pt can allow self to get angy, pt will have more energy to cope and to fight the disease. 5. If appropriate for pt's physical condition, encourage pt to do more for self. There may be opportunities in the course of his physical care for the pt to express anger over minor issues, to release the energy in small increments that the pt can manage (safety valve). NOTE: Know your patient and his physical condition well. A leukemic at the nadir of his bone marrow hypoplasia does not have the energy to deal with these issues. Intervention is more appropriate during recovery when the pt's initiative lags behind his physical recovery. 6. Consider referral to resources mentioned in N.O. #2. It may be easier for the pt to express anger with those not directly

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Date	No.	Patient Problems/Expected Outcomes	Deadlines & Charting Freq.	Nursing Orders
				performing his care. 7. After the pt has gotten angry, view it in a positive light. Make an effort to be with the pt as much as you were before. Assist the pt to distinguish between those issues that can realistically be changed and those that cannot be changed. Restate or reteach any information the pt may not have been able to hear due to selective perception during the angry episode.
	6.	Lack of knowledge re home care		1. Instruct pt/family in the following with implications after discharge.
		T = Taught R = Returned		A. Hickman line and dressing care:

T	R	Nursing Orders (continued)
		1. General guidelines: Catheter function/potential problems Use only the blue plastic clamp. Do not sit in water that covers the catheter or dressing. Call physician immediately for any swelling, drainage, redness, or tenderness. Do two-minute Betadine handwash before doing anything with your line.
		2. Povidone-Iodine Hand Wash: Setting up to wash (supplies, remove jewelry, etc.). Wash hands and nails. Rinse. Do not touch anything outside of catheter-related activities or you must rewash. Time yourself for two minutes. Always hold hands up toward ceiling to rinse and dry off. Dry with paper towels or clean, reusable towel. Dry hand first, then forearm. Use separate towel for each hand (with reuseable towel, use a different portion). Turn off the faucet using the towel as a barrier.
		3. Dressing change: Change q 24 hrs or if becomes loose, wet, or soiled. Clean area with alcohol and paper towel.

Expected Outcomes (for problem 6):
- Demonstrates ability to care for Hickman line.
- Verbalizes knowledge re susceptibility to infection, bleeding; preventive measures, and resource people to call should these occur.
- Verbalizes realistic plans for the future.

NURSING PROBLEM LIST AND CARE PLAN

DIAGNOSIS: | AGE:

RN: | M.D.: | SERVICE

Initial	Name	Initial	Name

UNIT NUMBER

PT. NAME

BIRTHDATE

LOCATION | DATE

Date	No.	Patient Problem/Expected Outcomes	Deadlines & Charting Freq.	T	R	Nursing Orders
						Gather supplies.
						Wash hands for two min.
						Remove old dressing.
						Inspect site.
						Squeeze acetone alcohol Sepp with tip down. Push container towards yourself while holding top edge. Do not touch cotton tip.
						Hold catheter about 6 inches out from site btwn. 4th & 5th finger of non-dominant hand. Never touch the part of the catheter that stays under the dressing.
						Place tip of acetone alcohol Sepp on skin next to exit site. Clean from exit site outward in a circular motion for about two inches. Never return to the area you previously cleaned. Drop the catheter.
						Repeat with PVP iodine Sepp.
						Let iodine sit for two min.
						Meanwhile, open the 2x2.
						Place Betadine ointment on the wrapper.
						Open sterile cotton swabs. Do not let the ends touch anything but the ointment.
						Place a small amount of ointment on the exit site.
						Pick up the 2x2 and pull apart. Touch only the outside of the gauze.
						Place one 2x2 under the exit site folded under itself.
						Place another 2x2 over the site with the part you touched facing out.
						Repeat previous steps with Benzoin Sepp.
						Cover entire dressing with 3 inch paper tape.
						Curl catheter loosely on top of the dressing with the tip pointing up at least as high as the exit site. Tape in place.
					4.	Heparin Flush:
						Vials should be punctured no more than 10 times.
						Clean area with alcohol and paper towel.

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Date	No.	Patient Problems/Expected Outcomes	Deadlines & Charting Freq.	T	R	Nursing Orders
						Wash hands for 2 min. with Betadine.
						Swab Heparin and Saline bottles with Betadine. Let sit 2 min.
						Draw up 1cc Heparin.
						Draw up 1 cc of air.
						Draw up 1cc of Saline. Replace needle cover.
						Turn syringe over to mix. Expel air.
						Clamp catheter.
						Remove tape form cap junction.
						Hold catheter 2 inches down from cap between 4th & 5th finger. Open Betadine swab fully, touching only the outside, wrap it around the catheter/cap junction. Rub it. Let sit 2 min.
						Remove cap. Open alcohol wipe. Touch only corner. Place center of wipe over catheter end and rub.
						Remove needle from Heparin flush.
						Insert end. Remove clamp.
						Slowly inject. Stop injecting when last 0.2cc of Heparin is still in syringe. Clamp catheter.
						Open new cap. Remove syringe. Place cap on.
						Tape securely with ½-inch plastic tape.
						Remove clamp.
						Curl catheter loosely, secure with tape.
					5.	Line Break:
						Always know where your emergency catheter kit is.
						If you notice any leaking, immediately clamp your line closer to you then to the leaking area.
						Do 2-min hand wash.
						Mix Heparin flush as usual.
						Replace syringe needle with blunt needle (#18 for Broviac, #16 for Hickman).
						Open Betadine wipe and wrap around leaking area on the line. Let sit 2 min.
						Open sterile scissors. Do not touch blades. Cut the line just below (closer to the skin) the leaking area.
						Insert blunt needle into the new end of the catheter all the way up to the hub.
						Unclamp the catheter and heparinize.
						Clamp the catheter.
						Secure the needle to the catheter with plastic tape.

NURSING PROBLEM LIST AND CARE PLAN			
DIAGNOSIS:			AGE:
RN:	M.D.:		SERVICE
Initial	Name	Initial	Name

UNIT NUMBER

PT. NAME

BIRTHDATE

LOCATION

DATE

Date	No.	Patient Problem/Expected Outcomes	Deadlines & Charting Freq.	T	R	Nursing Orders
						Remove the syringe and place a cap on the end of the needle. Secure cap with plastic tape.
						Notify your physician immediately so arrangements can be made to repair your catheter.
					B.	↓WBC:
						Taking/recording temperature.
						Call physician if temp 38 for 12 hr.
						Avoid crowds and people known to have infectious diseases.
						Call physician for sore throat, mouth tenderness, or white lesions, chills, sweating, productive cough, skin infection, painful rectum, burning with urination.
						Take care of any cut/scrape immediately. Report any swelling, redness, or poor healing.
						Females to use only peri pads (no tampo
						Exercise scrupulous peri care.
						Mouth care pc and hs. Inform dentist of medical history before having any work done.
					C.	↓RBC:
						Notify physician if any ↑ fatigue, weakness, ↑ HR, HA or SOB.
						Do not donate blood.
					D.	↓Platelets:
						Notify physician if ↑bleeding/bruising (bleeding gums, ↑ menses, black stools, hematuria).
						No ASA or ASA-containing substances.
						Avoid enemas, suppositories.
						Limit use of alcohol.
						Prevent injuries to yourself.
				2. Check with physician before using any new medication (over-the-counter).		
				3. Discuss resources before discharge:		
				A) VNA referral - pt desires services yes or no ?		
				B) Will have follow-up with:		

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12-12D-7/81 Leukemia

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NURSING PROBLEM LIST AND CARE PLAN

Date	No.	Patient Problems/Expected Outcomes	Deadlines & Charting Freq.	Nursing Orders
				Clinic LMD Other
				4. Determine whether the pt's expectations for cure/future treatment are realistic. Pt may not be ready to discuss these issues. Inform Social Worker, clinical nurses of pt's level of understanding/ acceptance.
				5. If going home on medications - write out drug names and dosage instructions. If possible, have pt demonstrate administration day before discharge.

Nursing Criteria for Discharge or Maintenance (overall expected outcomes):

1. Demonstrates ability to care for Hickman line.
2. Verbalizes knowledge re susceptibility to infection, bleeding, preventive measures, and resource people to call should problems arise.
3. Verbalizes realistic plans for the future (see Problem #6).

Home Care Coordinated Activities:

Appendix G

Discharge Questionnaire
11L

The following is a discharge planning questionnaire to make your return to home and to the community as easy as possible. Although you may have just been admitted to the hospital, we feel that it is not too early to begin planning for changes in your life. This questionnaire is to help you and your family meet these changing needs through awareness of potential problems and mention of available resources to assist with health care at home.

Please complete the parts of this questionnaire which applies to you as soon as you feel able. Return it to your nurse when you are done.

I. When you get home:

a. With whom will you live?

b. Who will assist with your care if necessary?

c. Will you and your family require assistance with care?

d. Will you have difficulty with any of the following at home:

___ stairs ___ bathtub/shower ___transfering into bed (ht. of bed, other furniture

e. Will you need any of the following equipment at home?

___ wheelchair, walker

___ bedside comode

___ bathroom safety equipment

___ oxygen or suction machines

___ dressing supplies for changes

f. Will you have any problem obtaining any of the following:

___ transportation (shopping)

___ child care, pet care

___ medications

___ adequate accomodations

___ food

g. How much of the following will you be able to do?

	independant	with assist.	unable
Eating			
Dressing			
Bathing			
Positioning in bed, sitting, standing			
Transfer to tube and tolier			
Walking			
Dressing Changes			
Other medical treatments/procedures			

II. Please circle any of the following that you would like to know more about:

a. Your disease/Illness:
   1. What caused it?
   2. Signs/symptoms of a relapse or recurrence of problems
   3. What could be done to prevent recurrence, complications?
   4. How might the side effects of treatment and the disease affect me?

b. Medication:
   1. Its purpose, what it does
   *2. How much to take
   *3. When to take it
   4. Side effects to be aware of
   5. Ways to reverse or help minimize side effects

c. Treatments, procedures, and exercises: (ie. Hickman dressing changes, colostomy, ileostomy care, etc.)
   1. Their purpose
   2. How to do them
   3. How often to do them

d. Supplies/equipment used at home:
   1. Their purpose
   2. When and how to use it (i.e. walkers, braces, etc.)
   3. How to obtain more or repairs
   4. Cost

e. Nutrition
   1. Special diets:
      how much to eat or drink
      how often
      what foods to avoid or what foods to concentrate on (ie. alcohol, coffee, etc)
   2. Which foods might cause drug interactions if taken with drugs

f. Preventative health practices:
   1. Breast examination
   2. Pap smears
   3. Birth control and sexual practices
   4. Dental health
   5. Exercise and its affect on your illness

III. Referrals: Which of these agencies do you forsee needing involvement with or more information about them?

____ VNA (Visiting Nurse)/Home Health Aid ____ Meals on Wheels

____ Senior Citizens ____ Mental Health Agency

____ Planned Parenthood ____ Insurance Groups (Medicare, medical)

____ American Cancer Society ____ Social Welfare

____ Hospice ____ Other

Would you like to see any other members of the health care team while in the hospital?

____ Chaplain (priest, minister, rabbi,etc) ____ Social Worker

____ Physical/Occupational Therapist ____ Dietician

____ Financial Representative ____ Nurse Clinical Specialist (psych, et

Thank you for taking the time to complete this form. We are eager to assist you in planning for your discharge. Please continue to call upon us for help.

*These will be covered on your discharge medication sheet given to you before leaving

Terminal Patient Discharge Checklist

Notified: ____ Chaplain ____ Physical Therapist
____ Social Worker ____ Dietician
____ Clinical Specialist ____ Pharmacist

Symptom Management:	Demonstrated	1st return	2nd return
Medications: (List) w/ instructions 1. 2. 3. 4. 5.			
Mouth Care:			
Sking Care:			
Bowel/Bladder Care:			
Pain Control:			
Activity Needs:			
Wound/Stoma Care:			
S/S Infection:			
Other (List): 1. 2. 3.			

Diet Instructions: ____ reg ___ soft ___ liquids ___ NPO

Type, frequency, foods to avoid:

In-Home Help

Name of responsible friend/family member ____________________ phone number __________

Agencies involved (list)/notified?	Date	Initials
1. ____________________	____	______
2. ____________________	____	______

Equipment needed (List)/ordered?	Date	Initials
1. ____________________	____	______
2. ____________________	____	______

Discharge Checklist: General

Notified: Chaplain ____ Physical Therapist ____

Social Worker ____ Dietician ____

Diet Instructions:

	x1	x2
1.		
2.		

Medications:

	Instructions: x1	x2	Side effects x1	x2
1.				
2.				
3.				

	demo	1st return demo	2nd return demo
Bowel/Urinary Control:			
Mouthcare:			
Wound Care Instructions:			
Pain Control:			
Other Treatment:			

Home Health Service:

	Needed	contracted	already followed
1.			
2.			

Equipment Needed: Ordered:

1. ____
2. ____
3. ____

Discharge Checklist: Leukemic

Notified: Chaplain ____ Physical Therapist ____

Social Worker ____ Dietician ____

Diet instructions:

x1	x2

1.

2.

Medications:

Instructions: x1	x2	Side effects: x1	x2

1.

2.

3.

	demo	1st return demo	2nd return demo
Bowel/Urinary Control:			
Mouthcare:			
Hickman Teaching:			
Dressing -			
Flush -			
Emergency repair -			
Signs and Symptoms of Infection:			
Taking Temperature:			
Pain Control:			
Other Treatment:			

Home Healyh Service:	needed	contracted	already followed
1.			
2.			

Equipment:
Needed

Ordered:

1. ____

2. ____

3. ____

Chemotherapy Patient Discharge Checklist

Notified: ____ Chaplain ____ Physical Therapist

____ Social Worker ____ Dietician

____ Clinical Specialist ____ Pharmacy

	Demonstrated	1st return	2nd return
Medications: (list) w/instructions 1. 2. 3. 4. 5.			
Prevention of Complications of Chemotherapy			
Mouth Care			
Infection Control (Taking temperature)			
Bowel Care			
Wound/Stoma Care			
Pain Control			
Other: (List)			

Diet Instructions:

Home Help:

Name of family friends ______________________

and phone number ______________________

Agencies involved (list)	Date Ordered	Obtained	Initials
1. ____________	________	________	________
2. ____________	________	________	________

Supplies needed (list)			
1. ____________	________	________	________
2. ____________	________	________	________

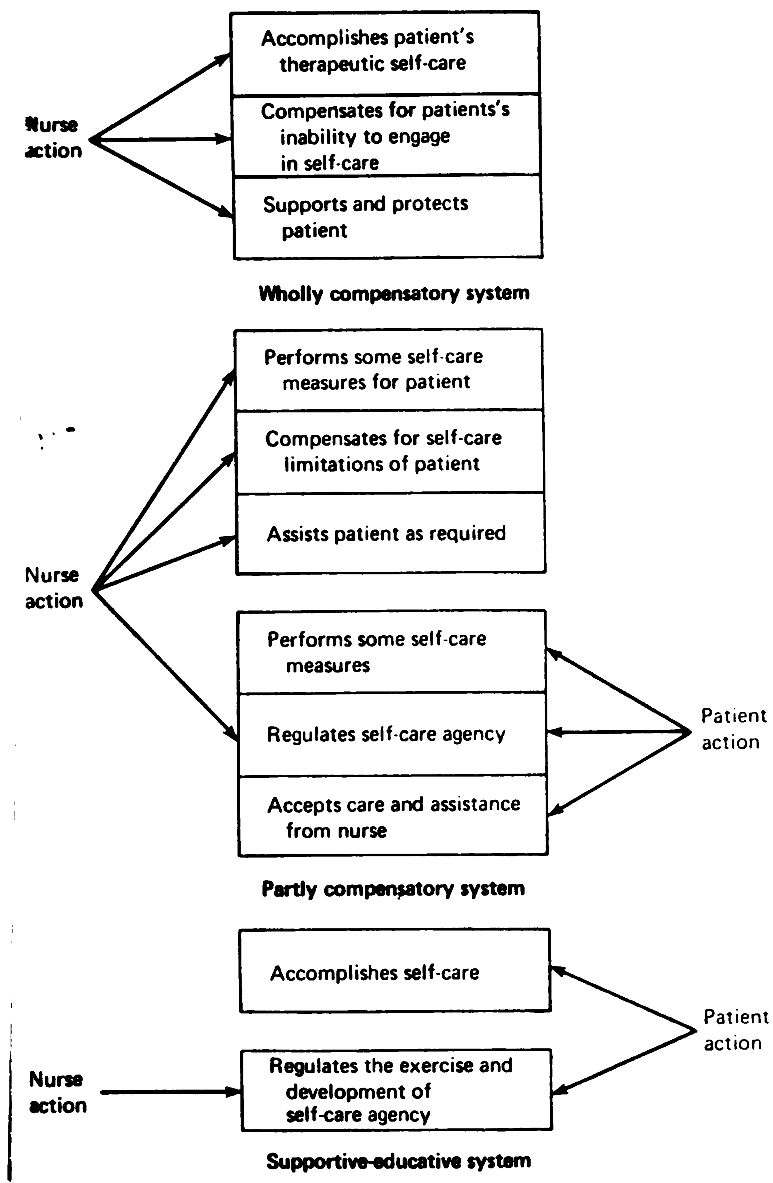
Special Pt/Family Education Needs: Circle when appropriate, check when completed

____ Use of bedpan	____ Injections (SC/IM)	Other (List)
____ Bed Bath	____ NG Feedings	____________
____ Making Occupied Bed	____ Temperature	____________
____ Turning Patient	____ Hickman Care	____________

List Unresolved Problems from Nursing Care Plan:

Problem	Status	Plan
1.		
2.		
3.		

Appendix H



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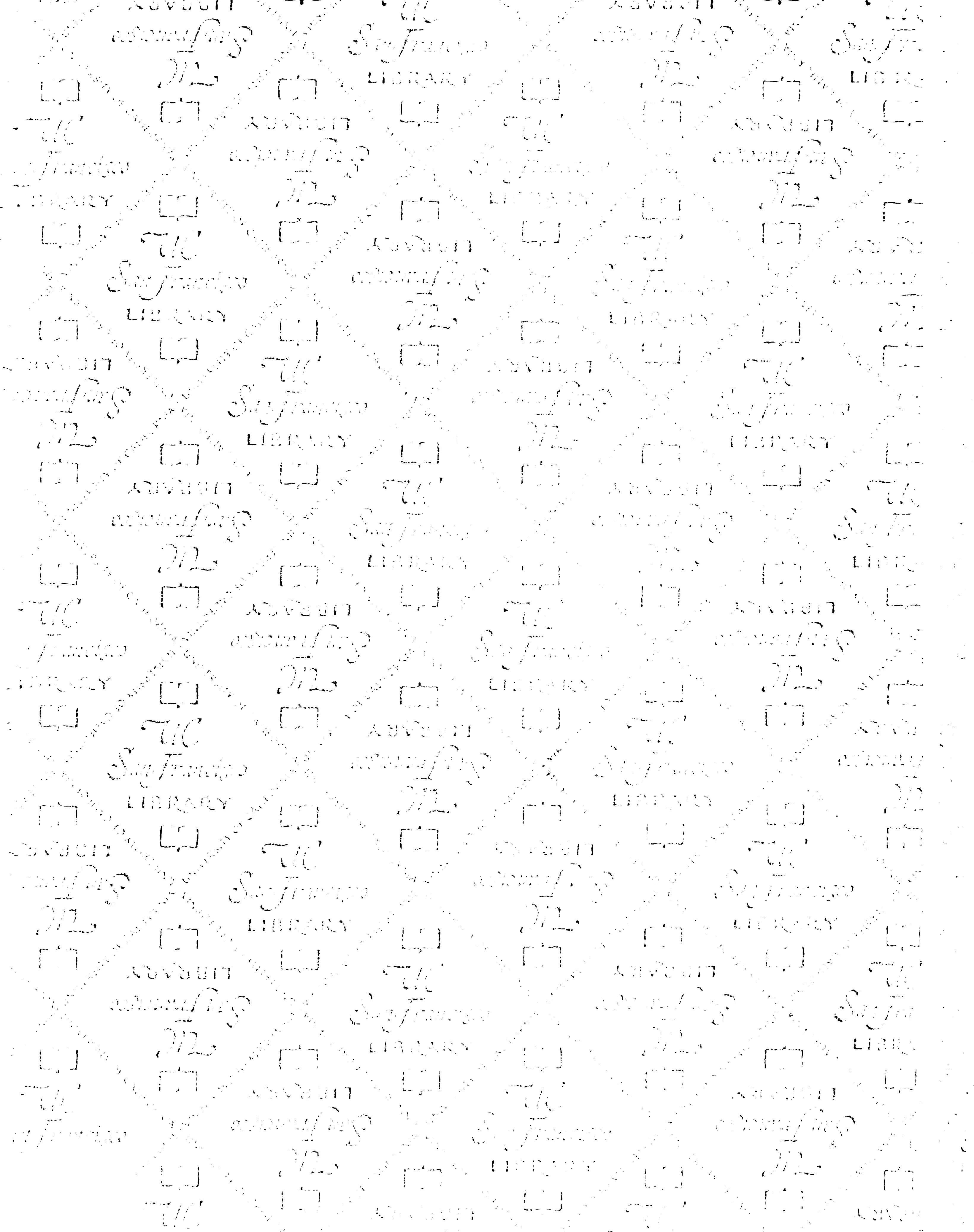

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