



AMERICAN UNIVERSITY OF BEIRUT

DISCHARGE PLANNING FOR ADULT ONCOLOGY  
PATIENTS

by  
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DISCHARGE PLANNING POLICY FOR ADULT  
ONCOLOGY PATIENTS

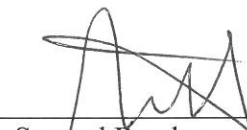
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## AN ABSTRACT OF THE PROJECT OF

Farah Walid Salhab

for

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Title: Discharge Planning for Adult Oncology Patients

Effective discharge planning is essential if oncology patients are to live an independent and confident life after inpatient treatment. The literature on discharge planning for adult oncology patients and the protocols used at leading international cancer centers were reviewed to develop an evidence-based policy and discharge plan for implementation at the American University of Beirut Medical Center.

The policy development framework developed by The UK Children and Family Court Advisory and Support Service was used to guide the preparation of the discharge policy and plan. Oncologist and oncology nurses were consulted during the development of the policy and plan, which were amended to take account of their comments and advice.

The discharge policy and plan developed as the outcomes of the project will be submitted for review and approval by American University of Beirut Medical Center administration.

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# CHAPTER ONE

## INTRODUCTION

By the year 2030, the number of older people suffering from cancer in the United States of America is predicted to double (Edwards et al., 2002). According to the American Cancer society almost 14.5 million Americans who have a history of cancer were alive on the 1<sup>st</sup> of January 2014. About 1,685,210 new cases of cancer are expected to be diagnosed in the year 2016, and about 595,690 Americans on the other hand are expected to die from cancer in 2016. According to the Centers for Disease Control and Prevention approximately 1.2 million patients with cancer are discharged from U.S hospitals every year. Almost all of these patients will require readmission in the future. However, it is important for the patients' quality of life that unnecessary admissions to hospital are to be prevented. Continuity of care outside the hospital but in the community at large is essential if unnecessary admissions of oncology patients are to be avoided.

Discharge planning is considered a main element in preventing avoidable admissions of oncology patients. The advantage of effective discharge planning brings benefits not only to the patients who are being discharged from the hospital, but to those patients who require further hospitalization following a recent diagnosis or return of symptoms.

In regards to safety education to be applied at home and post hospital discharge for oncology patients; the effects of discharge planning can be carried over for almost 1 to 3 years considering quality of life as a potential indicator for this project. While reviewing the literature it did not indicate the approximate effects of discharge planning

in relation with long term effects. An estimate of 65 to 71% of patient' level of comprehension of the discharge instruction was noted post discharge (Lee et al, 2005). Another indicator for the need of discharge planning would be any avoided cost due to unnecessary readmissions through the emergency room, frequent calls to the oncology unit for any unanswered question, poor symptom control management due to poor medication planning, and decrease in patient satisfaction due to inadequate information given upon discharge and lack of knowledge from the patients' side, and the improper preparation of the discharge instructions based on patients' needs and lack of follow ups.

In an environment of minimal resources, discharge planning has pushed to become more visible due to the urgent need for healthcare organizations to take control and manage bed occupancy rates which can only be achieved by decreasing the length of hospital stay. Discharge planning is a process that is correlated with risk on a dual level; first of all for the individual level in addition to the healthcare professional and healthcare organization levels simultaneously. The management of risk has been found to cause uncertainty and anxiety amongst health professionals (Atwal et al, 2012). As healthcare is proceeding forward it has become more and more essential to compile a straight to the point, easy access, limiting medical jargons discharge forms for oncology patients who are in dire need of strict home education to continue on their healing process while feeling more in charge of their own care plans.

Decisions come as a result of a combination of factors mainly influenced by the medical, environmental, financial factors not to mention the factor of personal preference. Although patients look forward to leaving behind their hospital beds and head home, they can still feel left alone with too much responsibility on their hands

(Norlyk et al, 2009). Transitioning from one setting to another may seem simple, however accomplishing a smooth transition from the hospital setting to ones' residence may face multiple issues including but not limited to medication errors, poor communication, inadequate transfer of information to continue care on an outside base, absence of a designated person fully responsible of the continuity of care and finally limited access to crucial medical services.

The phase directly after hospitalization has been noted to be one of the most 'tiring times' in cancer symptoms management (Hendrix et al., 2006). To promote the transition of care from the hospital setting to home while facilitating a lower risk of a readmission, different programs have been established around the world in various countries to aid keeping the rate of readmissions low as some governments pose a penalty on hospitals who have high readmission rates. In the United States of America, three programs have been established already to serve the hospitalized geriatric population. The first is The Transition Care Model (TCM) (Naylor et al, 2010), the second would be Project RED (Jack et al, 2009) and the Care Transitions Intervention (Coleman et al, 2003) all were developed to serve the older adult hospitalized community. A Japanese study done by (Tomura et al, 2011) showed that creating a blueprint of the patient and or family's day to day life while refining it to reach an agreed upon discharge plan based on patient's and family's personal preferences were crucial in the discharge planning process.

Recognition of the day to day problems and delays involved in discharging oncology patients led to the idea of developing a framework to build a policy based on its facts in order to help fasten the process of discharge while making it a smoother and more educational transition for both the patients and their direct caregivers or family

members involved in the care plan in addition to involving the responsible healthcare personnel in the process guided by preset guidelines. It is expected that by working closely with the inpatient oncology nursing team and the unit specific medical team the discharge process would enhance patient involvement in discharge process, cut down on possible delays related to discharge and length of stay, enhance communication channels between various healthcare members and the patients and their families respectively, and finally empower the patients by helping them gain the appropriate skills and knowledge to continue with the care on outside basis. The discharge plan for adult oncology patients will include: Home medication list, Managing side effects and the symptoms to be reported, how to maintain a well balanced diet, caring advice for caregivers, care at home, a detailed schedule for future appointments.

## CHAPTER II

### LITERATURE REVIEW

The number of new cases of cancer in Lebanon has increased and approximately an average of 5 percent yearly between the years 2002 and 2007 as data has suggested by the Lebanese Ministry of Public Health in their annual report in 2008. In 2007, a total of 8,868 new cancer patients were registered within Lebanese hospitals, around 484 more patients than the numbers registered one year before that in 2006. In 2006, 8,384 new cases were registered compared to 8,034 one year before that in 2005 according to the World Health Organization. The increase in numbers can be partially attributed to improved methods in registering patients, in addition to the new inclusion added by the Lebanese Ministry of Health to add non-melanoma skin cancer into their annual figures after it started be treated along like all other types of cancers.

Breast cancer was found to be the most common form of cancer in 2007, accounting for almost 2,729 of all new cases in 2007. Reaching 60 percent of new cases in women and composes 30 percent of all new reported cases in 2007. Prostate Cancer was ranked the second most common, with 761 newly registered cases in Lebanon in the year 2007, which composes 8.5 percent of all new cases. It should be noted that there has been a shortage of reliable data of cancer rates in Lebanon since 2006, when the Ministry of Public Health stopped releasing annual cancer registry figures to the public.

At the American University of Beirut, the Bassile In-patient cancer center had 2514 admissions of which around 1678 where oncology patients coming in for various reasons.

Studies have been conducted to identify the needs of oncology patients. The most important patient need identified by Dougherty (2010) was information about their medical care. Next in order of importance was the competence of caregivers of which can be their nurses or physicians. Hygiene and general cleanliness of the hospital environment was the third highest rated need. Pain management was only fourth in the patients' hierarchy of needs, which may be because pain was managed effectively for the patients in this study. The needs regarded as of less importance in Dougherty's (2010) study were directions to maneuver throughout the hospital, continuity of care by the same caregiver, support from indirect family members, with the same diagnosis and learning from their experiences. The needs expressed by families in Dougherty's (2010) study were similar to those expressed by the patients. However families ranked their needs differently from the patients. The most important need for patients was the information and the way of communication about their medical care, and the most important need for the families' side would be similar to what the patients have stated but had ranked them differently. Dougherty's (2010) study confirms the importance of patients to access their information.

Creedle et al. (2012) investigated the effectiveness of providing patients and caregivers with standardized plans to give them the information they need in order to help them improve health outcomes, while alleviating the burden of care. The patients and their caregivers indicated that standardized patient education helped to reduce the burden of care on caregivers, and helped patients achieve better outcomes such as forming certain levels of trust among their care providers and enhancing communication.

Slieper et al. (2007) has identified early preparation for discharge as an important factor for adult oncology patients. The issues requiring specific attention in early preparation for discharge reported by Slieper et al. (2007) are management of the psychological needs of patients and caregivers and the need to promote patient autonomy by discussing prognosis as early as possible. Slieper et al. (2007) emphasized the importance of responding to patients' psychological needs from the day of admission to help them access the services they need and a better way to facilitate discharge in a timely matter. The author mentions that usually discharge planning takes place at the end of the patients' stay at the hospital thus making it incomplete and difficult for both patients and their families to deal with its content alone on an outside basis. However with the patients' participation in the hospital with their discharge plans, the care is easily integrated in their daily routines.

Berry et al. (2014) discussed the oncology patients' knowledge on their discharge medications thus identifying one of the problems as having complex lists of medications for patients to deal with them on their own outside the hospital thus having the probability of jeopardizing their health due to lack of knowledge and or correct understanding, their cognitive status and the cost of the medications all contribute to failure in following their discharge medication plan. The method of using the telephone as a way of communication with the healthcare personnel involved was placed after the hospital discharge. Berry et al. (2014) mentioned that the method of continuation has led to a more accurate report of how patients are managing their medications at home. In addition, allowing patients to have full access to trained healthcare personnel helps fill in the missing gaps and ultimately improve patient medication outcomes. The findings are pertinent to current issues of obedience.



Wroblewski et al. (2014), focused on comparing the time needed to complete daily rounds and the utilization of health services to be done at the bedside versus in conference rooms while comparing quality of the rounds with respect to outcomes through looking at emergency room admission numbers, unplanned hospital admissions and telephone calls being placed to providers. Wroblewski et al. (2014) prospective, cross sectional study involved 120 participants admitted to one of three different surgical units of the same hospital. Results showed that the time needed in the conference room is the same time needed if rounds were being done at the bedside, in addition to having fewer readmissions and emergency room visits and phone calls as a result of groups rounding on the bedside thus allowing participation of both patients' and their families and that can be considered as a more feasible and effective matter of dealing with daily discharge necessary processes.

Korkmaz et al. (2015), studied the effectiveness of a discharge program with a focus on symptom management and quality of life in patients suffering from lung cancer. The results of this study done, recommended that a discharge program should be implemented to be used by patients with lung cancer since patients dealing with lung cancer suffer from the side effects of the disease progressively. Korkmaz et al. (2015) suggested creating a unit thus training healthcare professionals and nurses to manage the discharge program so that either patients or their families can call at anytime and get their accurate answers that they are looking for. It was emphasized that staff should be trained in order to improve symptom management information. Nurses need to be in charge of implementing the discharge program and to be able to guide both patients and their families to the adequate care needed for lung cancer population. The author focused on broadening this study to cover different types of solid tumor cancers.

Harrison et al. (2012), talked about following recommendations in order to discharge cancer survivors earlier from their hospital stay is most likely to become increasingly important as time is moving forward. Harrison et al. (2012) study explores cancer survivors' experiences of discharge after their hospital follow ups are done. 659 survivors were asked to complete a survey that involved questions regarding discharge status, information and time given for patients upon discharge and how did the discharge process go if it was satisfactory. The results of this study showed that of the patients discharged a minority reported having insufficient time and information given and adverse emotions as a result at the time of discharge. However the majority of the participants reported satisfactory results with their hospital discharge. Harrison et al. (2012), recommended that additional timing is to be added to the discharge process in order to improve certain conditions. In addition to more detailed information to be given to both the patients and their families and a stronger support system to be provided and maintained to ensure optimal care. Harrison et al (2012) mentioned that having a discharge plan summary on its own without clear explanation from the healthcare providers is as if the discharge plan wasn't presented, patients need to understand the content of the discharge summary in simple language without using medical jargons in order to decrease the fear of being independently responsible outside the hospital basis.

Nekhlyudov et al. (2012), talked about the benefits of having a survivorship care plan to all cancer patients that contains a summary of their treatment plan and offers help on post- treatment management. This survivorship care plan focused on improving communication channels between healthcare providers and their patients transitioning from the oncology setting to outside basis. Nekhlyudov et al. (2012), mentioned that there exists many similarities between discharge summaries and survivorship care plans,

however the survivorship care plan is considered to be a dynamic process requiring patients to be continuously updated and involved in its steps. Nekhlyudov et al. (2012), stated that the oncology community nowadays is continuously concerned about updating the quality and safety care being provided during clinical transitions. Long term discharge planning is emphasized while dealing with oncology patients since lifestyle changes accompany this certain disease, with survivorship care plans, patients can integrate their disease with their daily lives in order to manage symptoms and continue living in the community equally.

Wong et al. (2011), high-lighted the absence of neither a standardized hospital discharge plan nor a policy influenced approach in the public health sector in Hong Kong. Of the barriers mentioned is the absence of a standardized policy influenced discharge planning program, and misuse of communication channels and coordination between different healthcare providers and patients which are recognized as systemic failure issues mainly. In order to improve the quality of hospital discharge, the authors suggested having a multidisciplinary approach with a clear identity to each healthcare providers' roles, moreover healthcare providers should maintain a clear level of communication by being trained on communication skills and on the other hand for patients to fully acknowledge and understand their position in order to understand their psychological needs for them to be met. Wong et al. (2011) concluded the importance of developing the structure and key processes for the discharge planning system to be proposed to ensure the quality of care and maximize the efficiency of the organization.

Preen et al. (2005), used a randomized control trial of patients in order to find out the effect of a multidisciplinary hospital coordinated discharge plans on the length of stay, patient satisfaction with the discharge plan and their quality of life. Results from

this study showed that patients allocated in the intervention group were significantly more content with the process of discharge than patients in the control group. Results also indicated that the time needed to contact the attending physician was lower in the intervention group. Attending physicians mentioned that a third of discharge summaries provided to patients contained various errors, with notice that only 27 percent are received at all.

Paquette et al (2001) started using a new discharge prescription form, this form combines admission medications, any hospital medication changes and medications to be continued after discharge. Results after the implementation of this kind of discharge plan found a decrease in the number of medication errors that were started during the hospital stay. Also a decrease in the error of dosages of medication also showed. The results from this survey showed that both attending physicians and pharmacists were enthusiastic about the new medication discharge plan and they recognized its benefits while maintaining medication conformity.

Dudas et al (2001) did a randomized control trial about discharge planning with the help from a pharmacist to increase patient satisfaction and outcomes. Patients in the intervention group received a phone call as a follow up two days after they were discharged home for the purpose of discussing their medication management. This phone call gave the pharmacists a chance to figure and resolve any medication related incident in 15 out of the 52 patients participating. Dudas et al (2001) mentioned that the intervention group has a lower readmission rate within 30 days which forms a (10%) rather than the usual (24%) usually achieved.

Bull and Roberts (2001) discussed the four stages for a safe and complete hospital discharge plan which was formed of: 1) assessing of the patient, 2) formation of

an early discharge plan, 3) execution of the plan, and 4) evaluation of the transition back to society and post hospital discharge follow up. Additionally to the mentioned stages, expanding the assessment of the patient to contain perceptions of their strengths to go back home and resume being actively involved in the discharge planning process providing a smooth transition from the hospital to the home setting. The discharge process should have a multidisciplinary approach and to be tailored to “where the patient stands now” opposed to “where healthcare personnel think they should be” knowing the difficulty of the process.

Moher et al. (1992) found statistically significant patient satisfaction linked to improved discharge planning. Only in the past eight to ten years has there been an increase in research focusing on the discharge planning process solely.

Jack et al. (2009) did a randomized control trial of 749 patients and established that patients who were subjected to thorough discharge planning, which incorporated medication reconciliation forms, clear patient education and was followed up on the phone by a pharmacist after discharge was done, reported better preparedness for discharge in comparison to the control group. This patient focused discharge planning process highlighted the role of the multidisciplinary team responsibilities in the discharge planning process and rigorous education which decreased the rate of readmissions post hospital discharge.

Holland et al. (2006) created a screening tool to recognize users of hospital discharge planning services and concluded that patients' age, disability, home situation when living alone, and self proclaimed walking restrictions were more prognostic for patients needing post hospital discharge care which proves that there is some contradictory evidence in the literature regarding discharge planning.

Boughton et al. (2009) did a qualitative study to dwell on the patient's standpoint with interviews of 14 patients and their particular caregivers. Themes of patients' reciting fear associated from lack of information and the capability to take care of problems with self care prejudiced their perception of needing to return back home; staying in the hospital was supposed to be more secure. Therefore, there has been inadequate research to date tackling identification of individualized patient needs previous to discharge, patient satisfaction with the discharge process, and the formation of broad discharge criteria to aid a patient's potential for discharge.

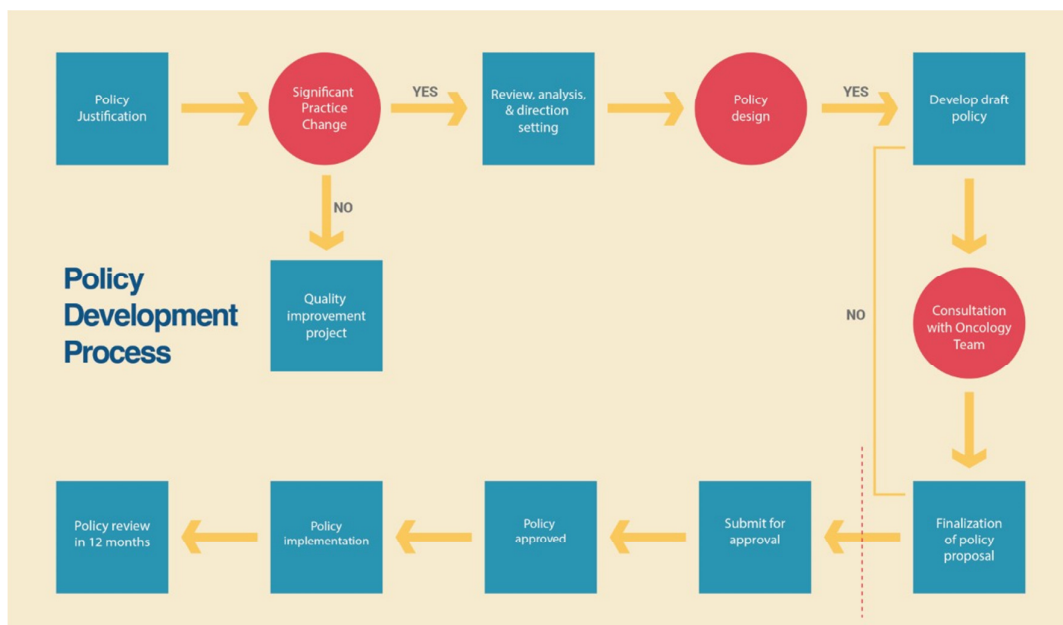
# CHAPTER III

## METHODOLOGY

### A. Policy Development Framework

This Policy Developmental framework has been adopted from the original documents of The Children and Family Court Advisory and Support Service (Cafcass). Cafcass (is a non-departmental public entity in England built up to encourage the welfare of children and families involved in family court. This Cafcaass policy framework is shown in Figure 1.

**Figure 3.1. The Cafcass policy development process**



This policy development framework was chosen since it acts as a good base to create a new policy from scratch; it contains tips on how to start considering all acting aspects that need to be included in order to form a well-rounded policy to serve

oncology patients effectively. This framework has been used by Cafcass for almost 10 years now since it was published in 2007 and it can be edited in order to serve the population we are aiming at.

## **B. Policy Development Process**

The Cafcass policy development process follows the following steps.

### ***1. Policy Justification***

A policy is crucial in regards to oncology patients since they specifically are considered a more vulnerable population group in regards to other situations. In the year 2006, 8,384 new cases were reported by the Ministry of Public Health in Lebanon and with this number being increased as we progress forward; hundreds of oncology patients visit the Bassile In-Patient Unit at AUBMC yearly. The removal of all possible cancer disparities is critical and needs to be learned, and for the information to be transferred properly from the medical and nursing teams respectively a policy needs then to be drafted to ensure equality in giving the patients their rights.

### ***2. Significant Practice Change***

When the preexisting policy is no longer satisfactory to both the patients and their families' various needs are in order to fully prepare for being discharged. Policies are uplifted sometimes when new studies show the need of adding or removing items from the discharge plan in order for it to be more concise and user friendly. Change in practice as well happens when the rules and regulations of either the country they are found in or when the hospitals change their internal laws to abide by what is allowed. Oncology patients and their families need continuous psychological support especially when they have to deal with their illness alone on outside basis this is manageable when



patients and their families understand and learn symptom management techniques in order for them to take control of their situation and alleviate their anxiety levels simultaneously. The Bassile In-Patient Unit alone includes 32 registered nurses and 8 attending physicians in addition to various medical team members that are constantly present and working actively on the unit. As the number of newly diagnosed patients are on the rise the volume of telephone calls received daily to the unit is rising as well with patients seeking information constantly and at various times. It's worthy to mention that standardizing the discharge planning process will have significant challenges to bypass because everyone follows their own way of work flow, so standardization will take a lot of effort and time to be unified amongst all staff.

### ***3. Quality Improvement Project***

This step is needed to maintain what is positive about the existing policy about discharge planning while focusing on the areas that need improvement. This step:

- Decreases post discharge adverse events by asking patients verbalize their understanding of post hospital discharge treatment continuation after education is given and reinforced while still inside the hospital. Moreover, increases patients' satisfaction rates since they will be well aware of what they should be doing on an outside basis.
- Increases exposure to discharge teaching and constant quality improvement updates, this step can be reassured by collecting baseline data on both patients and their families' satisfaction and then recollecting at a 6 month interval for a year or two to see how the new implemented process is being received and understood and implemented correctly.

#### ***4. Review, Analysis, & Direction Setting***

When only change is needed for the policies at hand, the task force in charge of change will gather up the most recent and relevant literature found in order to analyze and compare it to what's happening on the ground and setting its direction straight. The task force is formed of various healthcare members of which physicians, nurses and other healthcare members who can positively contribute and affect its outcome.

Attending physicians and nurses are constantly busy as oncology patients continue to rise in numbers, with this increase happening therefore I took on this project on behalf of all the staff working at the Bassile In-Patient unit in order to form a new discharge planning policy and plan after consulting with them and editing and testing it before implementation and if it succeeds then it can be expanded to cover other specialties.

#### ***5. Policy Design***

Identify key characteristics to be used

##### **a. Quality / Accuracy / Objectivity**

- Refers to the accuracy of the evidence found in the literature and on the ground if possible with constant updates to the latest evidence in order to assure compliance to the latest standards being used worldwide.
- The evidence retrieved and the material collected from John Hopkins Hospital with addition of information gathered via internet were reviewed from the perspective and were fit with the Lebanese adult oncology patients.

##### **b. Credibility**

Credibility is needed in order to ease the process of approval by the Hospital administration and the various task forces responsible for it, by having credible information the policy on discharge planning would be a good reference to rely on for

both the patients and their families on one hand and the staff using this policy on the other. The policy will be credible because it's developed from the best available evidence and adopted from policies being applied at top performing hospitals including the Johns Hopkins Hospital.

#### c. Relevance

For the policy on discharge planning to be relevant, the literature review should be done in a timely matter and extracting literature to be used as a base source from recent years. This step is crucial to have a well rounded policy that can stand out between what is usually used and is considered a norm. The studies reviewed for this project were published in international peer reviewed journals in the past.

#### d. Practicalities

Relates to the extent to which the evidence is accessible to the policy makers, with this said this step needs to be obtained in order for the policy to be categorized as universal and can be used and understood by various staff members in order to relay the messages to the patients correctly. Care plan has been taken to consult both medical and nursing colleagues on the practicalities of introducing a discharge planning policy for oncology treated at the Bassile In-patient Unit.

#### e. Developing the Draft Policy

The first draft of the proposed discharge planning policy for adult oncology patients treated at the Bassile In-Patient unit will be developed from recent literature, from observations made at the oncology center at the Johns Hopkins Hospital. In addition to following an internet searches for similar policies done at various leading cancer centers worldwide.

### **C. Consultation on a Draft Policy for AUBMC**

Selected medical and nursing teams were consulted on a draft policy which was amended to take into account a complete policy. Then after the draft is done we consult other oncology team members (Registered nurses, medical team members, attending physicians, Dietician etc.) to add their remarks on the draft based on both subject and objective observations and adjusting the policy accordingly to cover the majority of deficiencies found after many collaborative sit downs have occurred to reach one concise decision on the content of the policy to be drafted.

### **D. Preparation for a Final Draft for AUBMC**

#### ***1. Finalization of the Policy Proposal***

Following amendments of the draft policy based on feedback from both physicians and nurses at the Bassile In-Patient unit, the revised version was checked with the nurse manager. In addition consulting with patients and their families about the final draft of the policy in this section the patients and their families are referred to me by the treating physicians at the unit.

#### ***2. Submission for approval***

Following further consultation with the treating team, the revised policy will be submitted for approval by the Clinical Practice Council (CPC) at AUBMC. The policy that will be submitted for the approval of AUBMC administration is presented as Appendix A.

#### ***3. Policy Implementation***

Once approved by the Clinical Practice Council (CPC) a memorandum will be disseminated. Moreover the clinical educator will devise with the author of the paper

and accordingly provide various training sessions to all the staff that are required to start using the new discharge policy in order to reassure that the training was done and that staff are comfortable disseminating and managing the new policy so that the patients can have full benefit of what the new policy on discharge can provide to them and their families.

#### ***4. Policy Review in 12 months***

The policy is to be reviewed and updated every 12 months in order to keep it with the latest evidence on hand to remain efficient and reflect positively in patients' daily lives. In addition to taking feedback from both the patients and their families about the discharge plan at hand in order to understand their view point either positive or negative and build on it for it to become more user friendly and increase compliance and patient satisfaction. Affective symptom management, number of readmissions on the unit, number of attendances in the emergency room for symptom management and pain control can all be considered as indicators for the efficiency of the discharge policy.

#### ***5. Discharge Planning Checklist***

The development of the discharge policy plan was complemented with preparation of an evidence-based discharge planning checklist compiled the literature reviewed and best practice at world renown cancer centers, including Johns Hopkins, Tufts Medical Centre, and Memorial Sloan Kettering. The Discharge Planning Checklist proposed for use at AUBMC is presented as Appendix B.

### **E. Ethical Consideration**

The reason for developing a discharge planning policy was to assist both patients and their families post discharge to better manage cancer associated pains, associated symptoms, and how to support patients by meeting their psychological needs. All members of the treating team will be involved in implementing the policy especially the nurses. Thus consulting both physicians and nurses on preparing the draft and the final policy is crucial.

## CHAPTER IV

### DISCUSSION

#### **A. Force Field Analysis**

Force Field Analysis is a useful decision making tool, created by Kurt Lewin in the 1940s it was originally used in Lewin's work as a social psychologist. This tool was developed to help users come up with decisions by analyzing the forces driving and restraining a certain change, with helping users communicating the reasons behind the decision they conclude. Force Field Analysis is used for two purposes, first to select whether to proceed with the change being suggested, the second purpose would be to increase the chances of success by strengthening the forces backing up change and weakening the forces playing against it Tools, M. (2013).

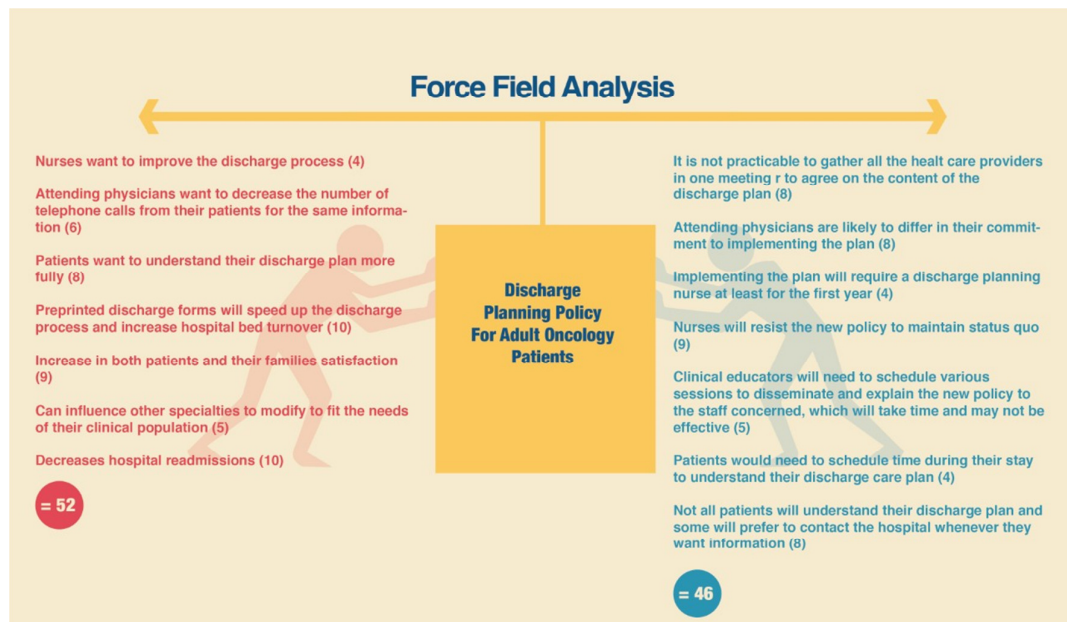
#### **B. Restraining Factors - Possible Solutions**

The restraining factors can be addressed by involving physicians, nurses, and patients in the implementation of the plan. An agreed on plan of implementation is needed if the new policy is to succeed. A discharge planning nurse may not be required if there is consensus among physicians and nurses that the discharge plan is needed. A high level of involvement of the stakeholders in finalizing the discharge planning policy will increase the likelihood it will succeed. The plan will be trialed in its draft form to explore the cooperation of patients and families. If necessary, the plan can be implemented for the patients of one of the treating physicians before extending the process to other patients. However, this might make it more difficult to implement the

policy for all the patients in the unit. The Force Field Analysis for the implementation of the discharge policy is shown in Figure 2.

### C. Evaluation

**Figure 4.1. Force Field Analysis of the Discharge Planning Policy for Adult Oncology Patients**



#### 1. Evaluation of the Policy

A group of volunteer nurses at the Bassile In-Patient unit would undertake a review about the discharge policy by talking to the patients and their families and attending physicians by reviewing the log of telephone calls to check the frequency and content and would discuss results with the team to propose changes to the policy being addressed. If the policy is amended it would be submitted as a revision two to the relevant Clinical Practice Committee (CPC).



## ***2. Review of the Need of a Discharge Planning Nurse***

The discharge planning nurse would be asked to write a report on the first twelve months of the policy addressing issues as:

- 1) Number of patients discharged
- 2) Waiting time for admission to the unit
- 3) Number of education session decided on using the policy
- 4) Number of nurses attended
- 5) Evaluation of usefulness and practicality of the policy
- 6) Breakdown of how nurses used their time
- 7) Advantages and the disadvantages of the role from the perspective of the discharge nurse

All those steps would then be reviewed by the Clinical Practice Committee (CPC), when the comments are in then the nurse manager of the oncology In-Patient unit and the nursing director would add their comments to the edited version, this edited document would be submitted to the administration. The outcome of the discharge nurse position is retained and that the role has fulfilled its purpose and is no longer required. Here the role should be continued but revised depending on the comments and impressions left from the previous year.

## CHAPTER V

### SUMMARY, LIMITATIONS AND RECOMMENDATIONS

#### **A. Summary**

The discharge planning policy being implemented here started as an answer to patients needs to have adequate knowledge on how to continue taking care of themselves considering oncology patients as a vulnerable population. This systematic approach started as an idea taken from the various complaints both nurses and their patients have about the available discharge plan being used, after consultation with stakeholders at various levels have occurred a draft policy was executed following amendments given from the consultants.

#### **B. Limitations**

This study if implemented can face various obstacles first of all it will require the oncology staff to add an extra task to their daily schedules, by having a well balanced discharge plan means more time needed from the nurses to sit down with their patients to explain the content based on the notes they have about their patients and families needs as of the first day that they have been admitted. Second of all, the discharge plan will need to be explained in Arabic for those who do not understand the English language which can lead to misinterpretation of information if not trained well. Third of all would be the idea creating a discharge planning nurse and the possibility for it to become a permanent role which will require an increase in the unit's budget.

### **C. Recommendations**

As a result and based on the above issues addressed for discharge planning as well as evidence based literature review on the significance of discharge planning the author of this paper is even more convinced that discharge planning is essential for better patient outcomes post discharge.

Patients necessitate a well built discharge planning that takes apparent barriers to discharge in order for the patients to succeed as they are ready to return home.

Healthcare education should be taken more seriously, our patients require us to put in more effort in order to understand them and their needs instead of leaving them in vain.

The shortage of nurses does not allow for timely follow ups during the admission to know the material that needs to be emphasized on upon discharge.

Health care institutions need to establish follow up phone calls after discharge to foresee potential problems before they happen in order to shun costly re-admissions. Investing in a well tailored discharge plan to the concerned individual while having evaluation of discharge obstacles, timely reply to resolve those obstacles and a continuation on education and participation of the multidisciplinary team with patients and their families helps them to feel more confident and well prepared for discharge home.

It is recommended that more work should be done in regard to how the health care industry can resourcefully circulate the fundamental information that patients need.

The discharge planning nurse role can positively affect practice in the area of discharge planning through promoting for sufficient, close follow up after discharge which can in return offer the needed educational, emotional, support that patients require when they are discharged home.

Health care institutions can perform better by bridging the space and enhancing the quality of care by investing in useful, comprehensive discharge planning through involving the patients and their families in the plan as well as starting the discharge process early in the hospital stay.

## APPENDICES

## APPENDIX A

# DISCHARGE PLANNING POLICY FOR ADULT ONCOLOGY PATIENTS



### Nursing \_Discharge Planning Policy for Adult Oncology Patients

Title:	<b>Discharge Planning Policy for Adult Oncology Patients</b>	Index Number:	<b>QPS-NSG-003</b> (Func. - Categ. - Sr.No.)
Scope of application:	<b>All Nursing Staff</b>	Original Date:	Reviewed on: Next Review:
		<b>January 2016</b>	<b>26.03.2016</b> <b>26.03.2018</b>

#### 1. Policy

Discharge planning policy specific to the adult oncology population

#### 2. Purpose

- For all oncology patients who are admitted to the Inpatient unit (Long stay)
- To be initiated within the first 24 hours of the admission to promote the preliminary risk assessment screening and consulted to the various disciplines for deeper assessment of the patient's nutritional, physical, psychosocial and financial needs.

#### 3. Definitions

- **Assessment:** the initial step in identifying client's familiarity to set meaningful learning goals and strategies.
- **Client education:** the course of influencing behavior and teaching the patient self-care techniques so that they can take accountability for certain aspects of health care following discharge from the hospital.
- **Discharge:** To let go, as in discharging a patient from the hospital.
- **Discharge planning:** Systematic processes of planning for patient care after discharge; which includes patient needs, goals, and strategies for implementation.
- **Readiness to learn:** an element of the learning process; refers to the psychological state of being accepting to new information and the learning process.

#### 4. Procedures

1. Responsibility/ Assessment/ Procedure
  - a) Attending physician and or medical team in charge are responsible for:

1. Developing a discharge plan in collaboration with patient/family
2. Documenting the plan in the medical record
3. Continuous update of the medical plan in the medical record with any changes and or modifications to the plan
4. Consulting physical and rehabilitation medicine (therapy) as indicated

**b) Registered Nurse**

1. Finalize the admission screening note while identifying any patient needs to be addressed during the hospital stay
2. Identify patient's potential needs for home care services post discharge
3. Commence discharge planning process using the adjusted Medicare discharge planning checklist
4. Review discharge plan and instructions with the patient and their families prior to discharge

**II. Reportable conditions**

- a. Need for physical medicine (Therapy)
- b. Need to revise discharge plan
- c. If any delay in patient's discharge
- d. Patient is not insured

**III. Documentation**

- a. Nurse completes admission screening note within her shift upon admission
- b. Nurse documents patient education given in the medical record
- c. Attending physician/ medical team in charge document discharge plan and any modifications done to the plan
- d. Nurse is present upon discharge for a final revision of the plan for any modifications with patient and their families

**5. Signatures**

Revised by	Name	Signature	Date
NQI Manager	_____	_____	_____
Reviewed and Concurred by	Name	Signature	Date
NQI Manager	_____	_____	_____
NQI Manager	_____	_____	_____
Nursing Policy & OPD Coordinator	_____	_____	_____
Approved by	Name	Signature	Date
Director of Nursing	_____	_____	_____

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## APPENDIX B

# DISCHARGE PLANNING CHECKLIST FOR PATIENTS AND THEIR CAREGIVERS




Label Here

**NAME:** \_\_\_\_\_

**REASON FOR ADMISSION:** \_\_\_\_\_

*During your stay, your doctor and your nurse will work with you to plan for your discharge. You and your caregiver are important members of the planning team. You and your caregiver can use this checklist to prepare for your discharge.*

**INSTRUCTIONS:**

- Use this checklist early and often during your stay.
- Talk to your doctor and your nurse about the items on this checklist.
- Check the box next to each item when you and your caregiver complete it. 
- Use the notes column to write down important information (like names and phone numbers).
- Skip any items that don't apply to you.

ACTION ITEMS	NOTES
<div style="background-color: #00796b; color: white; padding: 5px; margin-bottom: 10px;">Your Discharge Destination</div> <ul style="list-style-type: none"> <li><input type="checkbox"/> House</li> <li><input type="checkbox"/> Apartment               <ul style="list-style-type: none"> <li><input type="checkbox"/> Availability of electricity 24 hours</li> <li><input type="checkbox"/> Availability of Elevator</li> <li><input type="checkbox"/> Living alone</li> <li><input type="checkbox"/> Living with immediate family members</li> <li><input type="checkbox"/> Living with extended family members</li> </ul> </li> </ul>	<div style="border: 1px solid black; height: 200px; width: 100%;"></div>
<div style="background-color: #00796b; color: white; padding: 5px; margin-bottom: 10px;">Your health</div> <ul style="list-style-type: none"> <li><input type="checkbox"/> Ask your providers about your health condition and what you can do to help yourself get better.</li> <li><input type="checkbox"/> Ask about problems to watch for and what to do about them. Write down a name and phone number of a person to call if you have problems.</li> </ul>	

Source; amended from: [www.medicare.gov/Pubs/pdf/11376.pdf](http://www.medicare.gov/Pubs/pdf/11376.pdf)

## ACTION ITEMS

## NOTES

- Use "My drug list" to write down your prescribed medications.
- Tell your nurse what medications you took before you were admitted. Ask if you should still take these after you leave.
- Write down a name and phone number of a person to call if you have questions.

### Recovery & Support

- Ask if you'll need medical equipment at home. Who will arrange for this? Write down a name and phone number of a person you can call if you have questions about equipment.
- Ask if you're ready to do the activities below. Circle the ones you need help with, and tell the staff:
  - Bathing, dressing, using the bathroom, climbing stairs
  - Cooking and paying bills
  - Getting to doctors' appointments
  - Picking up your medication
- Ask the staff to show you and your caregiver any other tasks that require special skills (like changing a bandage or giving a shot). Then, show them you can do these tasks. Write down a name and phone number of a person you can call if you need help.

### Rest, Relaxation and Mindfulness

UNLESS YOU HAVE BEEN ADVISED OTHERWISE BY YOUR PHYSICIAN

#### **PRACTICE SIMPLE AND MILD YOGA EXERCISE (You can practice with or without an instructor)**

- An instructor can guide you to focus your attention systematically on parts of your body.
- This technique helps participants relate to their bodies with greater kindness and awareness.

#### **SITTING MEDITATION PRACTICES**

- Focus on your body, breathing, ambient sounds and thoughts.
- Bring your attention back to the present moment if it wanders

#### **WALKING MEDITATION**

- Be attentive to your sensations as you walk.
- Attend to your breathing, ambient sounds, the rhythm of your movements

Source; amended from: [www.medicare.gov/Pubs/pdf/11376.pdf](http://www.medicare.gov/Pubs/pdf/11376.pdf)

## Exercise

- Let regular physical activity be a part of your daily routine
- Avoid inactivity and return to normal daily activities as soon as possible after diagnosis
- Aim to exercise at least 150 minutes per week

### PRECAUTIONS FOR CANCER PATIENTS WHO WANT TO EXERCISE

- Check with your doctor before starting any exercise program. Make sure you understand what you can and can't do
- Check your blood lab results during your treatment. Ask them about them, and if it's good for you to exercise
- Do not exercise if you have a low red blood cell count, called anemia
- If you have low white blood cell counts or if you take medications that make you less able to fight infection, avoid public gyms and other public places until your counts are back in range
- If you feel very tired and don't feel up to exercising you can try doing 10 minutes of light exercises every day.
- Stay away from any weight-bearing exercises that could cause you to fall and hurt yourself.

### THINGS TO THINK ABOUT WHEN PLANNING AN EXERCISE PROGRAM

- Speak to your doctor before you start any type of exercise
- Start slowly. Even if you can only do an exercise for a few minutes a day it will help you. Exercises will increase slowly when your body starts enduring more. Your muscles will tell you when you need to slow down and rest.
- Try short periods of exercise with frequent rest breaks.
- Always start with warm-up exercises for about 2 to 3 minutes. Remember to breathe when you stretch.
- Exercise as you can. Don't push yourself while you are in treatment. Listen to your body and rest when you need to.

## Sleep

- The amount of sleep a person needs varies from person to person. During cancer treatment, the need for sleep may sometimes increase, as the body repairs itself. Most people need from 7-9 hours of sleep.
- It is important to talk with your doctor about any sleep concerns. It is especially important to inform your doctor if your lack of sleep is interfering with daytime activities and ability to function.

## Diet and Nutrition

- Cook meat, chicken, turkey, and eggs thoroughly to proper temperature. Meats should not have any pink inside. Eggs should be hard, not runny
- Do not eat raw food, such as sushi or meats
- Do not use foods or drinks that are past their freshness date
- When eating in restaurants, avoid foods that may have potential bacterial contamination like raw food, avoid buffets and salad bars
- Do not eat foods that show signs of mold like French cheese
- Do not eat fruits and vegetables before pasteurizing them

### WAYS TO MANAGE APPETITE

- Eat 5 to 6 small meals or snacks each day instead of 3 big meals
- Drink juice, or soup if you do not feel like eating solid foods. Liquids like these can help provide the protein, vitamins, and calories your body needs.
- Use plastic forks and spoons. Some types of chemo give a metal taste in the mouth. Eating with plastic can help decrease the metal taste.

Source; amended from: [www.medicare.gov/Pubs/pdf/11376.pdf](http://www.medicare.gov/Pubs/pdf/11376.pdf)

## Talking with your Spouse/Partner

- Talk openly and honestly with your spouse or partner. It is also helpful to listen to your partner's thoughts and feelings
- Don't assume you know what your partner is thinking or feeling or what your partner will say next. Ask questions if something is unclear
- If you become angry or upset, finding a calming routine can be more helpful than forcing yourself to continue
- Take turns talking, and don't interrupt each other
- Don't expect to resolve difficult topics in one conversation. Agree to continue talking about the subject at another time
- Choose times to talk when you are both free from distractions and not rushed
- Continue talking about topics you usually discuss. You don't always have to talk about cancer
- Talk honestly about your feelings, both positive and negative. Hiding feelings may create distance between partners and prevents them from supporting and comforting each other

## Talking to your children

- It is important to talk openly with your children about the diagnosis and treatment while answering their questions as much as possible
- Children feel that something is wrong, and by avoiding the topic can lead them to believe that the situation is worse than it is, which can create feelings of confusion and fear
- Reassure your children that cancer is not contagious
- Let your children know that it is okay for them to have many different feelings and that you have many of the same feelings, too
- Speak about a realistic but hopeful assessment of the situation, and focus on the steps to treat the cancer
- Try to keep your children's daily routines as consistent as possible...
- Prepare your children for possible physical changes, such as hair or weight loss, before they happen

## ACTION ITEMS

## NOTES

### For the caregiver

- Ask for written discharge instructions (that you can read and understand) and a summary of your current health status. Bring this information and your completed "My drug list" to your follow-up appointments.
- Use "My appointments" to write down any appointments and tests you'll need in the next several weeks.
- Do you have any questions about the items on this checklist or on the discharge instructions? Write them down, and discuss them with your provider. Can you give the patient the help he or she needs?
- What tasks do you need help with?
- Do you need any education or training?
- Talk to your nurse about getting the help you need before discharge.
- Write down a name and phone number of a person you can call if you have questions.
- Get your medications and any special diet instructions early, so you won't have to make extra trips after discharge.

Source; amended from: [www.medicare.gov/Pubs/pdf/11376.pdf](http://www.medicare.gov/Pubs/pdf/11376.pdf)

## MY MEDICATION LIST

Drug name	What it does	Dose	How to take it	When to take it	Notes
Valtrex	Anti-Viral	500 mg	twice daily	with or after meals	take note of red spots on skin. Call your doctor immediately
Nexium	Proton Pump Inhibitor	40 mg	once daily	on an empty stomach	take your pill when you wake up for better absorption
Voriconazole	Anti-fungal	200 mg	every 12 hours	before a meal	take your pill when you wake up for better absorption
Magne B6	Magnesium Supplement	2 tabs	3 times daily	after or during meals	take note of numbness of hand & feet. Call your doctor
Neupogen	White Blood Cells Stimulator	300 mcg	every 12 hours	one injection morning & evening	injection sites to be changed frequently

## MY APPOINTMENTS

Appointments and tests	Date	Phone number
Blood tests (CBC, Chem9, LDH)	On Mondays and Fridays	+961 350 000 ext. 5232
PET Scan	After 3rd cycle (Thursday May 12, 2016)	+961 350 000 ext. 7770
First outpatient appointment	1 week after first cycle	+961 350 000 ext. 6287

## MORE INFORMATION

**Your treating physician is** \_\_\_\_\_

**You can contact your Doctor on** \_\_\_\_\_

*Remember you can contact Bassile In - Patient Unit on +961 1 350 000 ext. 6282 (24 hour availability)*

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