

Aspects of discharge planning nursing essay

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FOR MR SMITH'S SEVERE COPD This assignment looks at the communication strategies to support and empower the patient living with COPD, a Long Term Condition (LTC) and their Significant Others when Planning their Discharge from Hospital. This is based on Mr Smith's scenario, a 78 years old man who suffers from advanced chronic obstructive airways disease. It will open with the definition of the keywords of the assignment. It will examine the characteristics of COPD at end of stage in the first section, because this is what Mr Smith suffers from and will therefore determine the discharge package of care to be used for him. The second section will look at the discharge plan and the team to be involved in the discharge process and their role. Finally it will look at the importance of communication when planning discharge and the communication strategies to be utilised for Mr Smith. As a matter of fact, Mr Smith suffers from COPD, which describes the airflow obstruction due to chronic bronchitis, emphysema, or both. It is called chronic because it is persistent, and pulmonary because it affects lungs. Bronchitis is about the inflammation of the airways of the lung, while emphysema is damage to the smaller airways and air sacs (alveoli) of the lungs. According to NICE, " Exacerbations of chronic obstructive pulmonary disease (COPD) are a sustained worsening of the patient's symptoms from his or her usual stable state, which is beyond normal day-to-day variations and is acute in onset", with symptoms such as worsening breathlessness, cough, increased sputum production and change in sputum colour (NICE, 2010). He is now classed as having end of stage COPD. Even though there is no accepted definition for end of stage COPD (Siafakas, 2006), the term end of stage gives the idea of the last phase in the course of

a progressive disease. NICE (2010) classifies COPD into four stages, Mild COPD (stage 1), Moderate COPD (stage 2), Severe COPD (stage 3) and Very severe COPD (stage 4). According to Leader (2012), "end stage COPD refers to being in the final stages of the disease; Stage IV, or Very Severe COPD." According to Global Initiative for Chronic Obstructive Lung Disease (2010), very severe COPD would have the following symptoms: "Chronic cough with a lot of mucus, Severe shortness of breath, Weight loss, Blue skin color, especially in the lips, fingers, and toes (called cyanosis), Fluid buildup in the legs and feet (called edema), Life-threatening COPD flare-ups and Lung function FEV1 of less than 30%, or of less than 50% along with chronic respiratory failure (a condition caused by carbon dioxide that stays in the lungs)" The discharge planning will start with an assessment through spirometry tests of Mr Smith's condition looking into his complete medical history. The care providers should find out how much air Mr Smith's lungs can blow in and out. It is known that Mr Smith was previously admitted to the hospital for exacerbations. This means that a serious assessment of his respiration system should be done; with a look at the level of dyspnea. The discharge is based on his request, which means that he should be involved in the process. The condition of Mr Smith's daily activity can be thought to be difficult, because his medical history shows that his condition worsened and his house had to be amended to accommodate his needs, and that he now lives in his front room downstairs and has access to the toilet down stairs as well his kitchen/dining area. This means that Mr Smith's coping skills are very limited. Mr Smith should also be assessed for cardio vascular and other chest diseases and psychological effects caused by COPD. Mr Smith

therefore appears to have functional problems as his exertion is very limited which affects his activity of daily living. So his discharge planning should include assessment of functional abilities to determine his ability to be independent in the future and the possibility of exercising. This assessment will help to determine whether he needs treatment for pulmonary rehabilitation and how strong and flexible he can be. This helps to assign the right job to physiotherapists. Several interventions have to be done in order to reduce " risk factors (influenza vaccine); short-acting bronchodilator as needed; long-acting bronchodilator(s); cardiopulmonary rehabilitation; inhaled glucocorticoids if repeated exacerbation; long-term oxygen therapy (if criteria met); consider surgical options such as LVRS and lung transplantation" (NICE, 2010). Donna and Goodridge (2006) has also described a number of symptom burden for end of stage COPD patients: dyspnea, defined as " a subjective experience of breathing discomfort that consists of qualitative distinct sensations that vary in intensity"; burden of fatigue and sleep disturbances, which has impact on functional limitations of daily activities such as self care, household chores, and leisure activities. (Elkington et al 2005); feeling of social isolation and loneliness, depression and anxiety, (Lacasse, 2001), panic, fear, and frustration. Tranmer et al (2004) goes a step further to add feelings of worry, sadness, nervousness, irritability, and concentration difficulty. Finally the needs of the patient's family should be taken into consideration, because they are the people to stay with the patient at home, and are therefore " the patient's advocates, companions, personal caregivers, and surrogate decision-makers" (Selecky, 2005) Given the services to be involved in Mr Smith's discharge planning, one

can correctly identify the process as a complex discharge planning as it involves multidisciplinary care planning and ongoing care. Actually, this discharge plan calls for a multidisciplinary team of professionals such as nurses, respiratory nurses, physiotherapists, occupational therapists and generic health workers as suggested in NICE (2007) in order to meet the needs of patients in different domains. Even though the patient remains under the care of the hospital consultants while making the GP aware of the home care, this team of professionals will work with referrals coming from secondary care in order to care for the patient at home. A respiratory nurse specialist will set and implement the care in order to improve Mr Smith's respiration. This will help to reduce any anxiety and fear. The in-reach nurse will educate, support and advise the different parties mainly patients, his relatives and staff and assess the various devices to be used as well as organise the followup and other referrals to competent departments and services (spirometry, chest checkup ...). Physiotherapists will help with exacerbation at home to clear secretions and provide chest physiotherapy at home as well as advise the patient on breathing pattern and exercises that might help. However a proper training is required for nurses, because there appears to be a limitation in their knowledge and the way to deal with end of stage COPD patients. (Disler and Jones, 2010)The palliative care for Mr Smith should be based on the above symptoms associated with advanced COPD. Oxygen therapy will be needed, because COPD patients usually become hypoxaemia with the progression of the diseases. This is not a curative treatment, but it helps relieve the symptoms of breathlessness. However it has been observed that caution should be taken for the

respiratory drive not to be suppressed by a lack of control. Here one has to distinguish between long term oxygen therapy which takes around 15 hours a day and short term therapy for other patients. But in the case of Mr Smith, a long term oxygen therapy might be better. 64, 66 Given that Mr Smith has suffered from serious exacerbation, there is a need for Oxygen therapy, and a respiratory specialist should be assigned to control the use of oxygen. Since Mr Smith will be going home, and his need of oxygen is great an oxygen concentrator with a back up supply of oxygen cylinder could be a better alternative. A proper training for its use must be given to his caregivers. There would also be a need to include steroid tablets such as prednisolone in his treatment in order to reduce the extra inflammation in the airways (). This can be taken once a day for 5 to 14 days. Dyspnea can be treated with the use of opioids which improves breathlessness. (Jennings et al, 2002) A 20mg dose of oral morphine a day also would be helpful (Abernethy et al, 2003). Airway Clearance Devices can also be prescribed in case Mr Smith has problems to clear secretions and mucus. High-frequency chest wall oscillation, or a flutter valve can be used with a positive expiratory pressure of about 6–20 cm H₂O (Ambrosino et al, 1995). Mr Smith should also be considered to receive treatment for psychological effects, as these have been observed in patients with advanced COPD because of the poor quality of life. Patients suffer from anxiety and depression due to dyspnoea (Bailey 2004), and this is said to be in the proportion of up to 90 %. (Kunik et al 2005; Norwood 2006). In this case, consideration would be given to antidepressants such as benzodiazepines, paroxetine and sertraline which have proven effective for anxiety and depression (Lacasse et al 2004). As

NICE (2010) recommends, this treatment should be supplemented by spending time with the patient to explain why all this is happening and how it can be treated. This calls for the importance of good communication. A check up is also necessary to find out if Mr Smith is coughing, in which case Morphine and codeine could be prescribed. COPD patients also feel pain in the chest, which can have a musculoskeletal or pleuropulmonary origin (Leach 2005), in which case some analgesic drugs has been proposed by the WHO, can be used, mainly non opioids such as paracetamol and NSAIDs; weak opioids such as codeine (approx. 1/10th potency of oral morphine) and tramadol (approx. 1/5th potency of oral morphine); and strong opioids. At this point, Mr Smith and his family should be educated in the way medications should be taken to avoid nonadherence to the medical plan. By Adherence, one should understand an " active, voluntary, and collaborative involvement of the patient in a mutually acceptable course of behavior to produce a therapeutic result." (Delamater, 2006). This calls for a clear understanding by Mr Smith of his condition (Johnson G, et al, 2005) and fitting the medication regime to his daily routine (Ryan and Wagner, 2003). This can be done if there is good communication. Communication should be understood as a process of conveying information and thoughts between different people, using written or spoken language and body language. Several scholars have found that communication is paramount to deliver good healthcare (Buckley, 2008), because both the patient and the healthcare provider enter into an emotional relationship. (Wittenberg-Lyles et al., 2008). It has also been observed that patients have a great need of information about their condition and that inadequacy of communication in

healthcare would prevent good provision of care for people at the end of life. (Curtis et al, 2005). Actually while planning for communication, one can also include Advance Directives in the form of living will or proxy while Mr Smith is still stable in order for him to have a voice in his last wishes. The nurse has therefore to avoid to create a communication gap with the patient, or say any misunderstanding in what they are talking about. It should be kept in mind that open communication is likely to empower the patient to have more hope and so dispel any fear they have (Davidson and Simpson, 2006). Perhaps the best way to deal with the communication issues would be to use aspects of the SPIKES model developed in the United States of America, and so use strategies such as Setting, Perception, Invitation, Knowledge, Empathy, and Strategy/Summary. With such a view in mind, communication with the patient would take into consideration preference of place and provider of care as well as the share of hope and preparation for death, or in Back et al (2003)'s terms "to hope for the best and prepare for the worst". Questions related to worries, concerns for the future, hope could be discussed (Braun et al 2007). Information related to the outcomes of different treatments with survival chances should be given with honesty (Fried et al 2002) and information about the progress of the diseases needs to be included. Empathy should be among the strategies while interacting with the patient, and the nurse has to devote more time to listen to the patient. (Edwards et al, 2006). Actually nurses need more training in the field of communication for patients at end of stage as correctly mentioned by Davidson et al, 2002. To conclude, it can be said that Mr Smith's discharge plan is a complex plan with a multidisciplinary professionals involved. The

plan starts with an assessment of Mr Smith condition and moves to focus on providing education and reinforcement of the medical plan. The medical plan includes pharmacological details describing medications intended to alleviate Mr Smith's symptoms of severe COPD, as well as non-pharmacological ones related to the devices to use and control of adherence and coping skills of Mr Smith. The pharmacological part should include medication to do with COPD and the psychological effects produced. A nutritional assessment is also necessary. Among the treatment, aspects of pulmonary rehabilitation, exercising, community resources should be included. Communication should be a key issue not only between the professionals and mr Smith, but also between the professionals themselves for the good of the patient. All these aspects call for a better training for nurses, as at present literature reveals that nurses express limited confidence in their knowledge and how to deal with aptients at end of stage COPD.