CHAPTER 2

REVIEW OF LITERATURE

This chapter assesses the contribution of the research literature on discharge planning in current practice on unit transition or hospital discharge. The scope of the literature in this study included care for cardiovascular client, discharge planning, action research and participatory action research, and the institutional context that was the situational background.

Care for cardiovascular patient

Cardiovascular patients who are treated in hospitals today tend to be more critically ill than in the past, and the severity of illness has increased among patients who are treated in their own home. Although cardiovascular care is usually envisioned as technologically sophisticated, an increasing number of agencies and a diversity of providers are delivering an array of service to address the needs of patients and their families.

The purpose of care for these patients is to provide a comprehensive approach for those exhibiting one or more of the cardiovascular conditions and complications (Pillion, 1991), based on their needs which will change over time. The patient and family's needs will vary according to the phases of illness from the time of first admission to discharge and return to work. Most cardiovascular patients have experienced a critical condition and need to be cared for in CCU. They are usually transferred to an intermediate care unit when their condition is less severe. After that

they will be discharged from the hospital and may still need home care. Eventually, they will need self-care at home.

Caring for patients in CCU

Patients are admitted to a CCU for rapid management of life-threatening cardiovascular problems, surveillance for and early management of cardiac dysrhythmias, and initial rehabilitation. Currently, the CCU often provides advanced care for patients with pacemaker insertion, and closed observation of patients for whom it is important to monitor parameters. Hemodynamic monitoring needed include arterial blood pressure, central venous pressure, pulmonary artery and pulmonary wedge pressure, and care for patients with intra-aortic balloon counterpulsation therapy.

Most CCU patients always experience many stressors besides physiological instability and increased dependence because of which they are at high risk for complication and death. Some obvious stressors related to the critical environment include the loss of privacy, artificial lighting all the time, constant noise from monitoring and life support machines, lack of meaningful stimuli, and physical pain or discomfort resulting from serious illness. Other factors leading to patient responses are psychological problems, such as fear and anxiety, sleep pattern disturbance, powerlessness, depression and ICU psychosis (Urban, 1993).

Daily care of patients in CCU, once potential problems have been assessed, can be based on the data obtained. Important components in daily care of the patient include relief of anxiety and pain, monitoring of blood gas levels and fluids,

decreasing the myocardial workload, continuation of dietary recommendations, and prevention of or early detection of complications. Limiting a patient's myocardial work continues to be an important component of daily patient care. Activities should be gradually increased according to the plan of rehabilitation and the patient's stage of recovery. Patients are now being mobilized earlier than in previous years, since prolonged bed rest may not prevent but actually promote development of complications following myocardial infarction. The patients must, however, be assisted in all activities, especially during the acute phase of the illness.

At the time of admission, it is important to collect baseline data for initiating management and for comparison at later stages. The procedures include immediate monitoring of cardiac rate and rhythm in order to detect abnormal cardiac rhythms, which may be life-threatening (Pillion, 1991). A brief explanation of the purpose of each procedure should be given to the patients at that time. As the patient becomes stabilized, nurse can discuss with the patient and family more thoroughly about the monitoring equipment need.

Relief of pain and anxiety is the most important management for patients with severe cardiac pain. The effect of pain and anxiety may result in an increased myocardial oxygen demand by an already compromised heart. Therefore, it is vital that both pain and anxiety be promptly alleviated. Analgesics and nitrates for relief pain should be administered as needed. Decrease in myocardial oxygen consumption is the goal of limit patient's activity. This is accomplished generally through absolute bed rest and assistance with activities of daily living first, then encouraging the patient to gradually exercise as possible. Cardiac rehabilitation program will be followed when patients have less severity and complications (Guzetta & Dossey, 1992).

A coronary care nurse must demonstrate caring behaviors, make skilled clinical judgements, act on behalf of others, and perform team working and be innovative. Collaboration and coordination with other health care providers are key elements of practice (AACN, 1996). Nurses should demonstrate skills in caring for the patient, while incorporating the value and preferences of patient and families (AACN, 1996). These nurses must be aware of current and emerging trends when caring for critically ill patients. They are challenged to provide care for individuals who have severe and complex needs. As care has become more complex, ethical issues need to be concerned. Termination of life support and quality of life are just a few issues that nurses must address in everyday practice. Cost for coronary care services account for a large portion of an institution's budget. Therefore, the nurses are challenged to provide comprehensive services while reducing costs and length of stay.

Caring for cardiovascular patient in intermediate care unit and home care

Patients experiencing minimum or no complications are generally transferred to an intermediate care unit by the third day following a myocardial infarction (Andreoli, Zipes, Wallace, Kinney, & Fowkes, 1991). Adequate preparations are important to minimize any emotional or physiologic reactions that may accompany transfer. Because the CCU is viewed by some patients as a safe atmosphere, they may be unwilling to leave (Riegel, 1996). Whatever the reaction may be, it is important that the health care personnel in the CCU provide explanations of the regimens to be followed that can be reinforced by the staffs in the intermediate care unit. Since the actual transfer may be planned or sudden, the patient should be

informed about the elements of transfer before the anticipated time of transfer. The patients should be aware that the staff members at the intermediate care unit would be given transfer reports concerning their illness, progress, and potential problems.

Pillion (1991) suggested 4 criteria for the successful patient transition from CCU. These are: 1) having the intermediate care area prepared with all the equipment needed by the patient; 2) monitoring cardiac activity by telemetry to provide rapid detection of potential dysrhythmic problems; 3) providing a proposed guideline of educational activities for the patient to participate in during hospitalization; and 4) providing the patient and family with information on routines appropriate to efficient operation of the unit, such as visiting policies, educational opportunities, activity routines, and the utilizing specialized equipments.

An area that is designed to allow closely supervised convalescence for patients who have been transferred from the CCU has been described using several terms, including step-down unit, liberized cardiac unit, and intermediate care unit. Regardless of the name selected, this unit has these multiple purposes (Andreoli, Zipes, Wallace, Kinney, & Fowkes, 1991). This area provides more intense observation and care than a routine medical unit but less than that provided in a CCU. Care in this area would be the continuing care following CCU.

Home care, the next level of care, is now an area of health care interest for cardiovascular care. As a consequence of recent trends in the health care system, more and more care is being provided for cardiovascular patients in their own homes (Glick, 1991). The characteristic of home care is an array of services brought to people in their own homes for the purpose of restoring health or managing illness. The focus of home care is on the family, patient education, home environment and

resources, multidisciplinary health care team, and the patient's optimum level of health. (Keating & Kelman, 1988 cited in Glick, 1991).

In summary, most cardiovascular patients have experienced severe conditions and need intensive care in CCU. The purpose of care is to provide a comprehensive approach to planning and implementing the care and encourage patient and family to participate thorough the process of care based on the patient's individual needs from admission to discharge. Such an approach is important because patients are likely to be moved from one hospital area to another as their condition improves or changes. Additionally, the trend of critical care now has changed from bedside care to patient-side care (Urden, Stacy, & Lough, 2002). This trend will encourage health care providers to develop strategies to ensure continuing care.

Discharge planning

Theoretical framework of discharge planning

The evolution of the idea of discharge planning has developed in health care organization and is one of the nurses' role in planning for continuing care, particularly the nurse's responsibilities and involvement in quality of care issues. The idea of discharge planning began in 1969, it in which nurse recognized the importance of better communication between institutional and community services.

The American Nurses' Association (1975 cited in Glick, 1991) defined discharge planning as a part of the continuing of care process. It was designed to prepare the patient or client for the next phase of care and to assist them in making

any necessary arrangements for that phase of care either care by family members or care by an organization health care provider.

The terms "discharge planning" "after care" and "referral" are common terms used in health care setting. These terms are used interchangeably in order to prepare for the patients' discharge to home. In order to make this concept fit the real practice, health care personnel proposed the ideas of continuing care, transitional care, or proposed the phrase "discharge planning starts on admission". However, health care personnel seem to be familiar with the term discharge planning.

Many authors defined discharge planning as process such as the referral process of different responsibilities from nurses or social worker to patient, family or other health care providers (Clausen, 1984), and the process of promoting patient continuing care from one level of care to the next. This process included potential development of the patient to improve and it includes mental or spiritual support, patient and family education, resource provision for continuing care and provides for transferring to home care, or from one setting to another (Amitage, 1995).

Discharge planning also defined as the collaborative process among a multidisciplinary team for continuing care which includes assessment of continuing care needs during home care and the process of patient and family plan together for practice during post hospitalized (McKeehan, 1981).

Rorden and Taft, (1990) defined discharge planning as the process that occurs within a patient care setting and that anticipates changes in patient care needs, and continuing care as the goal and planned outcome of this process. They also suggested that discharge planning should be implemented throughout the phases of care, acute phase, transitional phase, and continuing care phase. It is important that planning for

discharge should start early in the patient's care and not waits until assessment data seems to be complete.

There was an idea from another discipline. In 1972, the amendment to the Social Security Act made discharge planning services a specific requirement: skilled nursing facilities must maintain centralized, coordinated programs to ensure that each patient has a planned program of continuing care which meets his post-discharge needs (Rorden & Taft, 1990, p. 12).

There is a large research and practice literature in the general field of discharge planning with a broad spectrum of topics being included under this umbrella ranging from issues such as continuity of care, after care, post hospital care, home health care, long-term care, and respite care to management issues such as quality assurance, financial, ethical and legal issues. This literature spans multiple disciplines and specialty areas including nursing, medicine, social work, hospital administration, public health, and health policy.

A variety of definitions of discharge planning can be found in the literature but most have the same basic principles. Shine (1993) proposes a comprehensive definition that embodies the elements contained in most other authors' statements.

> *"Discharge planning can be defined as the process of activities that involve the patient and a team of individuals from various disciplines working together to facilitate the transition of that patient from one environment to another. It includes a systematic process of assessing the assets and limitations of the patient during hospitalization, planning for continuity in his health care upon discharge from the hospital, and coordinating needed individual, family, hospital, and community resources to implement the discharge plan"(pp. 5-6).*

Rorden and Taft, (1990) emphasized the dynamic, interactive, patient-centered aspects of discharge planning. The process begins with early assessment of

anticipated patient care needs, concern for the patient's total well-being and involving patient, family and care-givers in dynamic, interactive communication, placing a priority on collaboration and coordination among all health care professionals, making mutually agreed upon decisions about the most economic and appropriate options for continuing care, and being based on thorough, up-to-date knowledge of available resources.

Within the concept of discharge planning, considering a long period of the continuum of illness of individuals, this must embrace the concept of the continuum of care or care will become fragmented. As for the concept of transition and change, all transitions necessitate some degree of change. A change, whether viewed as positive or negative, generates stress for the patient, family, and staff. Thus, discharge planning protocol should be developed for these transitions with the goals of minimized stress and good patient care. From various studies, the transitional care model has also been used to describe the discharge planning protocol and the continuum of care was described as the goal of discharge planning. There are some essential points that would cause a gap in knowledge. One of the most important points that might lead to misunderstanding or term confusion among care providers is the key elements of discharge planning that leaded to the variety of its utilization.

In conclusion, discharge planning is the process of care designed for patients and families to anticipate the changes in care. In discharge planning process, interdisciplinary collaboration of care providers, effective communication, mutually agreed upon decisions about the most appropriate sources of care are included.

The major elements of discharge planning process

From the previous studies (Anthony & Hudson-Barr, 1998; Lowenstein & Hoff, 1994 ; Naylor, et al; Rhoads, Dean, Cason, & Blaylock, 1992), the successful discharge planning should be done with the interdisciplinary health care that includes the major elements of discharge planning as following; 1) the discharge planning team 2) communication 3) collaboration and coordination between patients and health care providers 4) comprehensive approach. The details will be elaborate in subsequence section.

1. The discharge planning team

Discharge planning as a multidisciplinary function, necessitates input from multiple care providers, including physicians, social workers, dietitians, home care providers, and nurses. Membership of team vary from setting to setting, but in high performance team, the nurse is a pivotal in identifying and evaluating patient and family preparedness. Basically, discharge planning team members should include the following group of people.

Patient and family

The most essential members of the discharge team are the patient and the family. Particularly for discharge to home, all decisions regarding care should be made in conjunction with the patient and family, and care should be directed by the patient or, when that is impossible, by the patient's family.

Discharge coordinator/discharge planner

One team member should be designated as a coordinator who serves as a liaison among the multiple disciplines involved. Because of the special expertise required in coronary issues and care in alternate settings, including the home, the coordinator is most often a cardiovascular nurse, or hospital discharge planner. The coordinator is the most appropriate person to define explicitly the roles and responsibilities of each member of the home care team, including the patient and family.

Clinical staff nurse or cardiovascular nurse specialist

The patient's primary nurse plays an essential role in teaching basic nursing care skills to the patient and family, ensuring that other members of the discharge planning team are aware of the unique needs of the individual and develop nursing care plans with the alternate setting of home health agency personnel. Depending on the facility, the continuing care nurse may assume the role of discharge coordinator and work closely with social services to ensure that all aspects of the discharge process progress smoothly. The nurse's role in discharge planning practice that suggested from Naylor and McCauley's studies (Naylor & McCauley, 1999) was the clinical nurse specialist.

Physician

The American Medical Association has outlined the physician's role in the discharge planning process. The overall responsibility for the transition and care of

cardiovascular patients always rests with the primary physicians, preferably a cardiologist experienced in the management of long term cardiovascular care. When the primary physician is not a cardiovascular specialist, consultation and input should be obtained from one such a specialist. Because sending a cardiovascular patient home imposes a significant burden on the family, the physician should inform the patient and family of the burdens as well as the benefits of home care. .

Social service/hospital discharge planner

Because of many reimbursement-related issues as well as the potential need to secure space in non CCU acute care facility which include intermediate care facility and long-term care facility other than the home, a member of the social service department frequently coordinates discharge. Discharge planning in the social service perspective is a role to manage the financial aspects of discharge and placement even when a social service department member does not provide discharge coordination. Financial issues include coverage of nursing personnel and payment for alternate setting care. Identification of any health care benefits, covered by a third party, entitlement, and assistance available from community organizations, self-help groups, and from federal, state, or local agencies are important factors to consider in determining the appropriate setting of care. The economic cost and social burdens of the long-term care should be clarified for the patient and family.

The social worker can also provide an evaluation of the alternative location as well as an evaluation of community and home resources and support available for long-term care. The social worker works collaboratively with the nurse case manager in coordinating services provided by other disciplines, insuring patient is ready to

leave the hospital. The available resources identified should be compared with the resources needed for long-term cardiovascular care to allow responsible planning and decision making. Significant gaps between available and needed resources may be a serious barrier to long-term care, particularly home care.

Others disciplines also include in the team when the patient has each specific problem and need. Although the discharge planning should be practiced in the interdisciplinary way, the real practice remains the nurse who provides this role in many setting. Most of nurses perform discharge planning role using the advanced practice nurses.

Successful transition of cardiovascular patient from coronary care unit to an intermediate or long-term care environment outside the traditional hospital setting, in particular to the home, requires the collaborative efforts of a discharge team. The team identifies all patient care issues that must be resolved prior to discharge and develops a discharge plan to facilitate transfer. The team, which includes the patient and his or her family, should be comprised of key hospital and community-based personnel, many of whom will play an on-going role in the patient's care once he or she is discharged. In the recent survey of situations related to discharge planning in CCU Maharaj Nakorn Chiang Mai Hospital (Boonchuang, Pothiban, & Panya, 1999), clinical nursing practitioners agreed that discharge planning will be successful if there is an effective discharge team. Although there is not yet any standard method for coordinating the discharge of patient, a team approach as described in this section should be encouraged not only because of the complexities involved in this type of discharge but also to ensure the success of discharge.

2. Communication

Since discharge planning is an activity facilitating the transition of the patients from one setting to another (Schneider, 1992), it needs good communication. Anderson and Helms, (1994) and Bull (1994) emphasized that communication with the clients and among care providers is the important responsibility and accountability in promoting successful discharge planning. Rhoads, Dean, Cason, and Blaylock, (1992) evaluated the effectiveness of the discharge planning program. They visited cancer patients at home within 2 weeks after receiving the program, which focused on a partnership between hospital-based providers and home health care providers in order to facilitate the patient's transition from hospital to home. They found that communication among health-team members within an institution, as well as between hospital and providers at the next levels of care concerning patients' needs is fundamental to the continuity of patient care. Information about the home environment can facilitate the hospital discharge planning team's work.

Lowenstein and Hoff, (1994) explained that discharge planning as a multidisciplinary collaboration necessitates input from multiple care providers including physicians, social workers, dietitians, physiotherapists, home care providers, and nurses. Memberships of the team vary from setting to setting, but in a high-performance team, the nurses are pivotal in identifying and evaluating patient and family preparedness. Exchange of information between health care providers and nurses needs skills of communication to make it successful. The quality of communication and cooperation between professionals is determined by the amount of trust and mutual respect they are able to establish with one another (Anderson &

Helms, 1998; Lowenstein & Hoff, 1994; Waters, 1987). Moreover, Taylor (1993) suggested that discharge planning is a multidisciplinary team anticipating and planning for the needs of a client and family after discharge from a health care facility.

Pheby and Thorne, (1994) developed a module holding core data pertaining to the functional status and current resource of elderly or disabled patients. Its purpose is to assist early identification of unmet needs and facilitate a prompt transfer to community care. The module provides a shared database, which is completed or updated as necessary on admission and is then available to all appropriate users of the hospital system, avoiding duplication of data collection. A summary is proved for easy communication with other care agencies, and it is concluded that poor patient outcomes have been associated with flawed communication. Anderson and Helms, (1998) also explained that the importance of communication is that the continuity of patient care involves a series of coordinating linkages across time, settings, providers and consumers of health care.

From the application of the transitional model developed by Naylor and McCauley (1999), Bixby, McMahon, and McKenna (2000) concluded that using the model in a complex case study involving multiple medical, as well as social and emotional issues helped practitioners to identify and anticipate problems that were encountered in the home. Communication and coordination with family members and other health care providers ensured successful continuity of care and led to positive patient outcomes.

Communication is a core task in coordinating patient care. Increased and improved inter-organizational communication is needed when patients are discharged

to nursing homes or home health care agencies. Although communication between the caregiver team and client is one of the most essential parts, what often occurs is the lack of communication (Charles, Gauld, & Chambers, 1994; Congdon, 1994; Reiley, Pike, & Phillips, 1996).

3. Collaboration and coordination between patients and health care providers

Normally, the process of discharge planning results in mutually agreed upon decisions about the most appropriate options for continuing care. In this process the trust relationships that have formed with health care practitioners during acute care are most important. These practitioners allow patients the freedom to plan honestly and realistically for their continuing care. Nurses and health care providers must be sensitive to the needs of patients and families at the time of discharge and provide them the opportunity to verbalize their feelings and expectations and invite them to participate in collaborative care delivery.

Carver, (1996) developed a care delivery model focusing on shifting nursing care delivery from task-oriented care planning to outcome-oriented care management. Patients are guided through levels of care over a time continuum toward discharge according to the achievement of patient outcomes. The bedside staff nurse team leader's role is expanded to include the coordination of multidisciplinary services, collaboration with physicians for improving care delivery, increased responsibility for patient-family education and discharge planning, and increased awareness of cost containment.

Carros, (1997) studied in NICU to investigate the multidisciplinary team in action whose primary goal was discharge planning, and found that the team made decisions in a consistent style which is based upon a constructed reality. The construction of the reality involved having team members conduct assessments on patients and families.

Coronary care nursing has always involved collaborative practice with other health care professionals. Today environment emphasizes collaborative practice teams for the care of patients. The goal of these teams is to provide comprehensive patient care in a cost-effective manner, while recognizing and using each other's talents and expertise. Some medical studies viewed the physician as the team leader who is responsible for all aspects of discharge planning, acting as the gatekeeper to all services. Other health professional studies view the physician as only one member of the discharge planning team, with all members providing leadership in relation to their area of expertise and patient and family needs. As most studies recommended a multidisciplinary approach, however, all literature reviewed on discharge planning was found to be discipline-specific.

With the goal to help patients learn of the existence of possibly useful resources, anticipate possible needs and identify ones that are certain, participate in realistic planning and decision-making, discharge planning coordinates caregivers so that their goals of care are mutually shared during each step of discharge planning process. This practice also aims primarily at ensuring that patients who need further care will be provided the care by preparations for supporting care at home, organizing available social support and community resources, collaborating of the

multidisciplinary team and emphasizing patients and family participation to ensure continuing care (Closs & Tieney, 1993; Rorden & Taft, 1990).

4. Comprehensive approach

The process of discharge planning is also considered to be a comprehensive approach because it has structured activity guidelines and their effects on patient outcomes are dynamic. As patient begins to enter each level of care, new needs emerge, while acute care is still ongoing, its urgency is reduced, and patients begin to turn their attention toward their future. Although the process is very complex, Slevin and Roberts, (1987) used a flow chart which provided consistency in coordinated discharge planning process and guided practitioners to practice. The chart served as a visual aid and handout in service education programs for staff nurses. Staffs have used it as a resource to guide them in making referral to the discharge planning department. The flow chart has been very successful in breaking down the multistage discharge planning process into workable and easy to accomplish stages. Nurses and other health care providers are increasingly expected to assist hospitalized patients to make the transition from the acute care to the community or convalescent setting. This transition is a complex and challenging task that requires data gathering and decision-making skills. The patient needs a professional who will collect and sort the pertinent information and assist in the formation of discharge plan.

Kee and Borchers, (1998) encouraged incorporation of a discharge planning role into everyday activities of the hospital-based clinical nurse specialist. They developed discharge intervention models for the clinical nurse specialist and

suggested that using the clinical nurse specialist in discharge planning and intervention is a practical and expeditious way to accomplish the role.

Developing discharge planning guidelines was the strategy to help keep the interdisciplinary team together. Models of multidisciplinary discharge planning are used (Pray & Hoff, 1992). These models emphasized multidisciplinary collaboration and discharge planning rounds. The discharge planning rounds were found to improve productivity, promote more effective communication among health care team members, decrease duplication of work and facilitate more efficient discharge planning, and all members agreed that the meetings stayed within the established time constraints.

In the comprehensive approach, discharge planning is based on thorough, up to date knowledge of available continuing care resources. All members of health care team have to work together in making clinical decisions. Interdisciplinary collaboration is well accepted in the situation that health care organization intend to improve the quality of today's health care.

Naylor, Brooten, Jones, Lavizzo-Mourey, Mezey, and Pauly, (1994) designed a discharge planning protocol for the elderly which was implemented by specialists to improve their outcomes after hospital discharge and to achieve cost savings. Patients and caregivers received the hospital's routine plan and comprehensive, individualized discharge planning protocol specifically for elderly patients implemented by gerontologic clinical nurse specialists. This protocol included the following unique features: 1) comprehensive initial and ongoing assessment of the discharge planning needs of elderly patients and his or her caregivers; 2) development of a discharge plan in collaboration with the patient, caregiver, physician, primary nurse, and other

members of health care teams; 3) validation of patient and caregiver education; 4) coordination of the discharge plan throughout the patient's hospitalization and through 2 weeks after discharge; 5) interdisciplinary communication regarding discharge status; and 6) ongoing evaluation of the effectiveness of the discharge plan. The findings revealed that patients in the intervention group had fewer re-admissions, fewer total days of re-hospitalization, lower re-admission charges, and lower charges for health care services after discharge.

Furthermore, Naylor and McCauley, (1999) continued the study of the effects of discharge planning and home follow-up intervention on the elderly hospitalized with common medical and surgical cardiac condition. This study suggested that comprehensive discharge planning and home care follow-up by advanced practice nurses was the most effective in preventing multiple re-admission, decreasing the number of hospital days per patient, and reducing the number of hospitalizations with prolonged lengths of stay for medical cardiac patients. The findings of this study also suggested that the high-risk elderly with significant cardiac problems got benefit from a care program that emphasizes collaborative, coordinated discharge planning and continuity of care that includes home and telephone follow-up.

This conclusion is further supported by findings from a study conducted in elderly patients with heart failure, where a nurse-directed multidisciplinary intervention that included home follow-up. The findings revealed an improved in survival from hospital discharge, fewer re-admissions, and for a subset of patients, improved the quality of life (Rich, Beckham, Wittenberg, Leven, Freedland, & Carney, 1995). These multifaceted programs are becoming increasingly important since the older adults hospitalized with heart failure are likely to be re-hospitalized for

this health problem and other reasons, have a high mortality rate, and experience significant reductions in functional status when compared with patient who do not have heart failure.

The comprehensive approach of discharge planning was guided by the studies by Naylor, et al. (1994, 1999). Transitional care model was mentioned in their studies, the comprehensive approach which is that individualized discharge planning and follow-up care should consider the patient's unique educational needs, be culturally sensitive, and support the patient's and family's efforts to deal with chronic illness. Moreover, in such model, the nurses implemented the plan of care for individualized patients in the acute care setting. The nurse-patient relationship and continuity of care begun in the acute care setting provide the patient and nurse with an increased potential for success.

Application of the comprehensive discharge planning was reported by Bixby, McMahon, and McKenna (2000). The discharge planning needs of patients must be closely assessed to determine the actual needs of the patient. Often the patients do not want to accept help or do not recognize the challenges he or she will face when they return home (Happ, Naylor, & Roe-Prior, 1997). Moreover, the comprehensive discharge planning model guided practitioners to approach each patient individually. Although the patients have the same medical diagnosis each of them has unique needs that must be addressed on an individual basis. In designing and implementing models of patient care, flexibility must be allowed to address the concerns of each individual patient to ensure the best outcomes. In doing so, nurses can provide the best practice while reducing costly re-hospitalizations.

According to the long study by the research team of working on discharge planning (Brooten & Naylor, et al, 2002), the twenty years period of their studies revealed the model of care delivery with high- risk populations. Care providers were clinical nurse specialists, the advanced practice nurses. Several implications for the education of the advanced practice nurses are being clear in their studies. The advanced practice nurses must have in-depth understanding of how care is delivered across each level of care in health care setting as well as they must possess depth of knowledge and excellent skills that are the hallmark of specialist practice. Knowledge and skills are necessary to individualize care and to anticipate and prevent problems to keep people well over the contract period and beyond.

In conclusion, the major elements of discharge planning process that ensure the effective discharge planning should be composed of the discharge planning team that include multiple care providers, the effective communication among health care providers, also between health care providers and the patient and family, and the collaboration and coordination. Also the comprehensive approach in care with the care providers who be prepared for this function are included.

The existing issue related to discharge planning practice

Although discharge planning has been developed for several years, one of the common problems existing in the health care setting that leads to the aspects of discharge practice is lack of practitioners' mutual understanding of the discharge planning concept. Since this care process needs interdisciplinary practice, professional relationship and communication among health care team are necessary.

Problems associated with the quality of communication and interdisciplinary working among care settings practitioners were recognized as being considerable barriers to the smooth and safe discharge of patients (Armitage, 1991). Armitage and Kavanagh, (1996) also reported the problems found in many health care settings, such as lack of continuity of care and inadequate or inefficient communication between personnel. These practical problems can result in reduced quality of care and may lead to re-admission as a result of inadequate information. More generally, it was also recognized that the process of discharge planning suffered from problems with inter-agency collaboration and communication between health and social care agencies.

Variation of discharge planning practice

There are various methods of discharge planning practice in different settings. In order to practice discharge planning in organization, Rorden and Taft, (1990) suggested the possible method for organizing discharge planning team. Professional involvement in discharge planning activities may be formally organized into a unit devoted solely to the discharge planning or discharge planning may be provided informally. The criteria for identifying patients especially those who need discharge planning services may be contained in a formal document referred to routinely in-patient assessment procedures. Of the many organizational possibilities for discharge planning services, four general categories are described.

1. Separated discharge planning unit

The separated unit occupies an office of its own and a unique place in the organizational hierarchy. The unit may be responsible directly to administration or to the nursing department. Referrals to the unit for services are made by physicians or nurses and are based on established criteria such as age, diagnosis, and the presence of certain social and financial risk factors. Because the professional appointed to the separate unit has a clear discharge planning functions and an identity with the unit, cooperation and communication between them is facilitated.

2. Decentralized discharge planning unit

This category is like the separated unit one in that it has an office in the structure but its personnel is deployed to specific patient care units. The person assigned to a unit acts as the initiator of discharge planning services and the general consultant to staff concerning discharge planning issues.

3. A coordinated discharge planning alliance

In this structure, a coordinator or liaison officer is appointed, usually a nurse, to receive referrals and contact whatever other professionals are needed to meet a particular patient's discharge planning needs. The members of this loosely constructed team may differ for each patient. The coordinator, in effect, functions in a general practice role by putting nursing colleagues and patients in touch with the required specialists.

In a small hospital or skilled nursing facility, this pattern of discharge planning services works effectively. Sometimes the director of nursing takes responsibility for this role on a part-time basis. The success of the professional alliance depends on the interpersonal and communication skills of the coordinator.

4. An information professional alliance

This pattern of discharge planning services has been operated in most institutions. It has been conducted in parallel with the formal alliance of professionals. When an informal approach is used, the nurse in this structure usually functions as the coordinator, although the services may be initiated by any caregiver who identifies that needs exist.

In this service, there are significant problems that practitioners should be aware of. One is the inconsistency of the nurse who chooses to take a coordinator role. This will affect the quality of services. Another problem is that informal systems are very vulnerable to institutional priorities. The nurse may get support from the supervisor and a hospital administrator to help patients with discharge planning, or the nurse may be discouraged from taking roles other than those of direct, acute care. This notion made informal discharge planning impossible unless the nurses joined forces on the issue to get the policy changed.

Besides, the different forms of discharge planning structures should be considered. The common method used in discharge planning was the team of patient care and the collaborative work of the team. Multidisciplinary team is likely to be more successful than single in the implementation of discharge planning (Davies & Connolly, 1995).

Practical methods of discharge planning

Since the functions of health professionals and patients or their representatives in discharge planning are reciprocal, they facilitate and respond to one another. Thus, one way of understanding the importance of including patients and their family members in discharge planning team is to recognize that professional intervention is successful only when it stimulates appropriate patient and family responses. There are some reasons and practical methods for including patients and their family members in each of the three steps of the discharge planning process, assessment, building a plan, and confirming and implementing the plan.

1. Assessment

Recognizing that the patient and the family as important sources of information, anyone who has ever worked in the admission situation knows how to access the facts about what happened, especially when the patient is in critical condition or unconscious. Patients and family members will be asked a series of questions and, in response, should share information with health care providers on a wide range of topics. The nurse who is alert to nonverbal aspects of communication often learns about attitudes, values, and beliefs as well as facts by listening carefully to answers. It is important for health care providers to remember that including the patient and family as partners in gathering information and assessing needs is the first step towards making them full members of the continuing care team.

Assessment may begin during the earliest hours following admission and continue for some times after the discharge of an individual. It may begin as part of a

screening process to identify vulnerable individuals and level of community care assessment required by their family (Godfrey & Moore, 1996). The process of assessment may involve interdisciplinary work. King and Macmillan (1994) suggested the admission of discharge planning assessment need to be accurate, thorough and complete and include a synopsis of the patient's social circumstance.

2. Building a plan

In planning for continuing care, it is the patient's right and responsibility to make decisions about continuing health care. It is his or her right to be informed about factors that contribute to those decisions and to use the resource available. Hence, educating, counseling, and supporting are the major functions of health care professionals as patient and family members learn what they need to know to continue care and sort through alternatives. If patients have already formed trusting relationships with caregivers and feel that they have retained a measure of personal power in spite of physical dependence, they will be able to participate in this phase of discharge planning with confidence. In particular, it is very important for the nurse to give clear messages about the balance of power in planning continuing care and to offer the patient and family the benefit of their knowledge and experience and help them reach the best possible decisions.

The plan should include most of actual clinical problems and anticipated problem when discharge, care strategies, patient and family involvement, identification of other care providers and community resource, and the expected date to be discharged (Closs & Tieney, 1993; Powell, et al, 1994).

Better understanding of themselves and of family dynamics helps nurses do the plan. Awareness of the state of threat or crisis in which decisions are being made also help nurses encourage families to develop backup plans and make contact with community sources of help and information so that plans can be modified as needs emerge.

3. Confirming and implementing the plan

Since discharge planning from acute care must be performed in early phase, there often is only a limited time for educating / learning and final coordination that must be done in this interval. Although it takes more time for the nurse to organize the plan, patient education should include at least one other person significant to the patient. This is to improve the chance that knowledge will be retained or a skill will be learned by at least one of the participants.

Guidance for patient and family members has been given for making data gathering more effective and handling some problems of decision making of discharge planning. The patient and family members can be actively participated in each step of planning continuing care are the activities and functions of health professionals. So one party is ineffective without the other.

According to the literature review of discharge planning practice (Anthony & Hudson-Barr, 1998; Zander, 1997), there was confusion in the vocabulary of discharge. There were some gaps of knowledge about the methods of practice, the assessment tool, and outcome measured. Moreover, one of the interesting facts gained during review of literature and practiced in real situation is that an appropriate discharge planning required a period of preparation, adequate notice of practice to

appropriate parties, discussion of after care arrangement with users and/or care providers. Lastly, a comprehensive and effective system of information collection and dissemination between the care setting and other setting/hospital or home and co-ordination by a skill or knowledgeable nurses is needed.

Discharge planning and quality of care

Quality of care is one of the important concepts in the heath care delivery system which has been studied for a decade. Quality is one of four basic concepts underlying the health care system. These concepts include cost containment, equity, access and quality (Hodges, Icenhoure, & Tate, 1994). Different people view the concept of quality in different ways. It is defined as a degree of excellence and an essential character (Buralnick, 1980 cited in Hodges, Icenhoure, & Tate, 1994). As applied to quality of care, several definitions are found. DeGeynt (1970 cited in Hodges, Icenhoure, & Tate, 1994) defined quality of care as the degree of conformity with present standards and is focused on patient care as opposed to medical or health care. Consumer satisfaction as an inherent component of quality of health care is viewed by McMillan (1987 cited in Hodges, Icenhoure, & Tate, 1994).

Among various models of quality of care, the most well known one was described by Donabedian (1988). According to Donabedian (1988), quality of care is the management by a physician or any other health care practitioners of a clearly definable episode of illness for any given patient. It remains the framework for most research. Donabedian's framework of quality of care can be considered in three ways: structure which emphasizes having the right things, process which is concerned with

doing things right, and outcome which is having the right things happen. As a result of the changing environment of health care, patients spend less time in hospital and often return homes while still in need of nursing care, so providing care with the concept of continuation of care and a discharge planning process are needed to ensure the quality of care. The quality of discharge planning as a component of hospital nursing care has received increased emphasis as professional nurses attempt to bridge the gap between the care received while bring in hospital and the care need at home (Hodges, Icenhoure, & Tate, 1994). Moreover, in 1995, the American Nurses Association (ANA) published Nursing Care Report Card for Acute Care, in this report, discharge planning is one of nursing quality indicators (Burke, 1998). So it is essential to create and implement comprehensive discharge planning for patients in the critical care unit and it is also the patients' right to expect discharge planning as part of their care and also the patients' responsibility.

The trend of health care in contemporary situations is a shift toward primary care (Disch, 1996). However, many patients do still require an intensive care with its sophisticated technology and experienced practitioners. The challenges for the intensive care team are to ensure that clinical outcomes are clearly defined, measured, and attained; that resources are used judiciously; and that accountability and continuity across settings is achieved.

Action research and participatory action research

Action research methodology has been reported as having the potential to be useful in areas such as development of innovation, improving health care

development of the practice knowledge and understanding, and involvement in users and staff. A numbers of authors have defined action research in a variety of ways (Greenwood, 1984; Hart & Bond, 1995; Heron, 1996; Kemmis & McTaggart, 1988; McNiff, Lomax & Whitehead, 1996; Reason, 1994; Stringer, 1996; Titchen & Binnie; 1994; Whyte, 1991). Waterman, Tillen, Dickson and Koning (2001) described their systematic review of action research as following:

> *..action research is a period of inquiry that describes, interprets and explains social situations while executing a change intervention aimed at improvement. It is problem focused, context specific and future oriented. Action research is a group activity with an explicit critical value basis and is founded on partnership between action researchers and participants, all of whom are involved in change process. The participatory process is educative and empowering, involving a dynamic approach in which problem identification, planning, action and evaluation are interlinked. Knowledge may be advanced through reflection and research, and qualitative and quantitative research methods may be employed to collect data. Different types of knowledge may be produced by action research, including practical and prepositional. Theory may be generated and refined, and its general application explored through the cycles of the action research process (p.11).*

Concurrently, existing with the moments of PAR is the principle of people participation which sets apart PAR from traditional research methods and other modes of action research. Other modes of action research such as the technical or practical modes do not embrace all of these principles. These principles are participation and collaboration, empowerment, knowledge and social change. The theoretical concept basis of action research in the development of discharge planning protocol in this study base on the critical social theory and experiential learning theory.

Critical social theory

The philosophy underpinning this research project is critical social theory. Based on this theory, nursing practice of discharge planning should be developed in response to perceived need at practitioner level rather than by managers or academics who have little current clinical experience and who are not in touch with the needs of patients and care providers. This perspective guides practitioners to develop the discharge planning practice from a realistic clinical situation and using critical reflection as a method of development.

The goal of using the critical social theory method is to liberate people by providing an understanding of taken-for-granted ideologies that serve to oppress certain groups. Habermas' theory (Habermas, 1972) is the key instrument for generating ideas for change in the conceptualization of the process of discharge planning. Critical social theory can advance nurse's understanding of the social organization of everyday practice situations and whether and how they might be reorganized. It is offered as a view of theory that emancipates practitioners from the positivist domination of thought through their own understanding and actions (Carr & Kemmis, 1986). Within the critical paradigm, there are multiple perspectives that differ in certain dimensions but which share the same things as a goal, which contribute to emancipation, empowerment, and change.

Empowerment is the significant method adhering to the development of nursing knowledge from a critical paradigm, in essence, the empowerment is a process by which people come into their own sense of power, a self-emancipation. It means that as people learn to perceive social and political contradictions, they become

able to take action against oppressive structures in their lives. People can be encouraged to reflexively examine the everyday realities of their lives.

From the philosophical perspective and the nature of clinical practice, participatory action research is considered to be the research methodology within this paradigm to develop a practice protocol. Problems and solutions will be identified by the nurse themselves (Hart & Bond, 1995; Holter & Schwartz-Barcott, 1993; Kemmis & McTaggart, 1988). Participatory action research involves a combination of three activities: research, education, and action (Hall, 1993, cited in Small, 1995). While there is a change of the health care environment and a shift in emphasis to health care quality, it is necessary for nurses to take the responsibility of improving teamwork, developing nursing professional roles, and developing health care partnerships. In participatory action research, the researcher takes a facilitator role, while all participants in the project are the co-researchers.

According to Grundy (1982), the study conducted in the nature of participatory action research has as its philosophical base critical science. The research problems concerned with the situation are based on value clarification. Essentially, PAR is a research process in which the research process has changed from a process of an expert "researching on" to a joint process of "researching with". From this perspective, there is no a researcher or team of researchers and research subjects in the PAR report, but there are co-researchers and co-subjects. To the reader, it may not be different from any other paradigm. However, this report still presents it in the familiar paradigm.

PAR methods, which have the nature of understanding of events, are understood in terms of social and economic hindrances to true equity. The purpose of

research in this sense is to uncover and understand what constrains equity and supports hegemony to free oneself of false consciousness and change practice toward more equity. Predictive and descriptive type of knowledge are produced in these methods.

The literature on the use of participatory inquiry is increasing, thereby illustrating the potential depth and breadth of these egalitarian strategies. For example, Rains and Ray (1995) illustrated the value of community participation in the development of health promotion programs in a rural community, whereas Ervin (1996) discussed similar approaches to urban planning. In the educational arena, participatory research and planning have been used to develop many interventions and system changes, such as those described by Billingsley and Houck (1988), in which the needs of students with learning disabilities in a secondary school were ascertained and addressed through a participatory action effort. For the most part, the use of participatory strategies has been applied to problem resolution for marginalized and oppressed populations (Finn, 1994), and therefore these approaches provide an excellent vehicle for social change that emerges from and are controlled by those affected by the systems that is in need of revision. However, the use of participatory strategies need not be restricted to the concerns of disempowered groups. Action research, however, must involve disenfranchised stakeholders democratically in change-oriented inquiry. A key element in participatory strategies is to ensure that the resources for the conduct of an inquiry and for the application of the knowledge to social change are available.

Thus, egalitarian collaboration among professional and clinical practitioners is essential. Methodologically, although qualitative strategies have dominated

participatory and critical inquiry, no methods are dismissed. Choice of method is purposive and collaborative and thus may include qualitative as well as quantitative techniques (DePoy & Gitlin, 1998; Finn, 1994).

Review of the literature on participatory action research across disciplines, such as public administration, business, medicine, education, anthropology, and sociology (Cole, 1993) revealed that although full participation is supported theoretically, it remains sparsely used in hospitals and in these other fields. Moreover, when participatory strategies were used, they typically were directed by researchers with consumer input elicited through interviews. Although participatory strategies were supported as most desirable (Argyris, 1989; Dugan, 1993; Whyte, Greenwood, & Lazes, 1989), only one study (Sarri, 1992) involved consumers in the research design and data analysis. More characteristic are studied such as that discussed by Simonson and Bushaw (1993), who conducted a community need assessment in which participation of lay researchers was limited and thus seriously hampered by methodological dominance by the researchers.

In participatory action research, using the process of planning, action and observation and reflection are necessary. The research team continually monitored the practitioner's progress, evaluated the results of the action, identified possible problem for improvement, and modified the plan for subsequent actions. The team will complete cycles of the plan-action-evaluation-reflection action research spiral. As shown in the figure 1

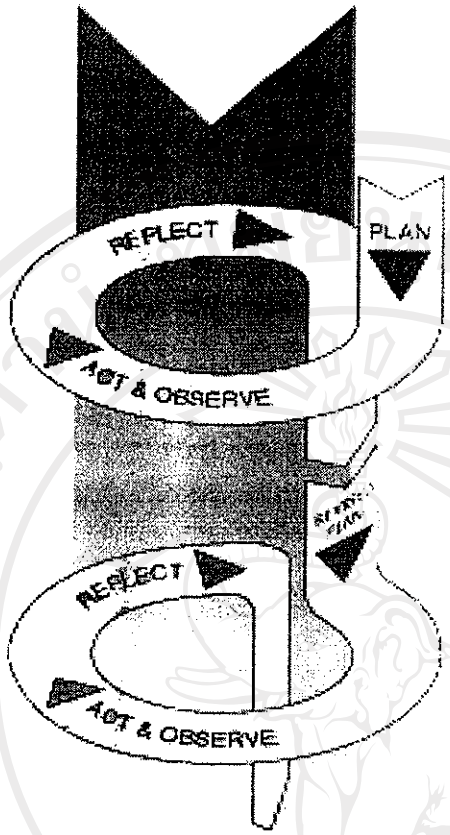

Figure 1 The spiral process of action research

Note. From 'The Action Research Planner' by S. Kemmis and R. McTaggart, 1988, p.14 Copyright 1988 by Deakin Universty press.

Among a number of the authors, key characteristics of action research have been identified. When those characteristics were scrutinized it was noted that two criteria were fundamental to action research. Firstly, the cyclical process of action research which involves some kind of action intervention. Secondly, the research partnership, in which the degree of involvement or participation of the researcher may range from cooperation, when the research participants work with outsiders to

determine priorities but responsibility remains with the outsiders to direct the process, to collective action (Waterman, Tillen, Dickson & Koning, 2001).

The purpose of action research is to both implement change and to generate theory (Elliot, 1981; McNiff; 1988, Whyte, 1991). The emphasis is on the involvement of collaboration of researcher and practitioners in diagnosing problems designing action plan and implementing these actions. The result is the solution of practical problems, change in practice, and development of new refinement of old theory (Holter & Schwartz-Barcott, 1993)

Action research may follow a sequence of problem identification to development of solution, to implementation of solution and finally to evaluation of the process. However it is more often of an iterative process that has multiple cycles. One set of observations or one sequence of the process is usually completed and documented before another cycle or sequence begins.

Action research has been chosen as an appropriate methodology for this study, since it is consistent with an intervention based approach where the focus is on action to improve a situation and the research is a conscious effort. Moreover, it is appropriated because of its problem solving and evaluating features and its similarity to the stages of the nursing process. This kind of research is also appropriate for nurses because it does not require expert researchers. The participants define the problem themselves and both researchers and practitioners participate together in the process (Hart & Bond, 1995; Kemmis & McTaggart, 1988). Furthermore, it is less structured for possible changes, empowering the participants, and is reflect on of their practice (Hart, 1995; Kemmis & McTaggart, 1988; Titchen & Binnie, 1993).

Most of action researchers use the name 'action research' and 'participatory action research' (PAR) interchangeably in their reports. But some attempt to describe PAR, that it is intense as more participative from the problem identification step (Greenwood & Levin, 1998; Rammasute, 1997; Whyte, 1991; Zuber - Skerritt, 1996).

Experiential learning and reflection

Experience learning is the concept that provided the tool for the development of nursing skills (Miles, 1987, cited in Burnard, 1995). This concept has been used in a wide variety of ways in the literature. Example of the concepts which various writers have used in the context of experiential learning include the following; learning by doing, learning from life experience, adult education, and learning through reflection.

Nurse education has changed in the last decade. There is a combination of academic learning with practical learning to ensure that everyone studying to be a nurse gets an education as well as training. Also, the notion of the reflective practitioner has become a central one.

Reflection is defined as the process of internally examining and exploring an issue of concern, triggered by an experience which creates and clarifies meaning in terms of self' and which results in a changed conceptual perspective (Boyd & Fales, 1983). Reflection is an important process in participatory research. It is explained as the central role of professional action (Schon, 1983) and it is the significant process of human learning.

Reflection is initiated by an awareness of uncomfortable feelings and thoughts which arise from a realization that the knowledge one was applying in a situation was

not itself sufficient to explain what was happening in that unique situation (Murphy & Atkins, 1994, cited in Burnard, 1995).

From the perspectives of reflection, experience of learning is considered to be its root. Experiential learning, the new concept in nursing education, has become an important tool for the development of nursing skills and reflection and used as it applies to the development of interpersonal skills (Burnard, 1995). The characteristics of experiential learning are that there is an emphasis on action, practitioners are encouraged to reflect on their experience, a clarifying approach is adopted by the facilitator, there is an emphasis on personal experience, and human experience is valued as a source of learning.

In everyday nursing practice, most clinical settings use the nursing process as a framework of nursing care. As an enhancement of employing discharge planning, the process of reflection may be considered as the most significant method. In order to change practice, nurses must begin by thinking about what they do and what they would like to do better. Much of the literature about reflection focuses on its educational value. In a nursing practice context, reflection will be used as a conscious active process (Boun, Keogh, & Walker, 1985; Schon, 1983).

Reflective process is considered as three stages: 1) an awareness of uncomfortable feelings and thoughts, arising from a realization of the situation in everyday practice, 2) a critical analysis of the situation, which is constructive and involves an examination of feelings and knowledge, and 3) the development of a new perspective on the situation. The outcome of reflection, therefore, is learning or perspective transformation (Mezirow, 1982) or affective and cognitive changes which may or may not lead to behavioral changes (Bond, et al., 1985).

Javis (1991) argues that reflective practice is an essential part of nursing as a professional activity and makes a point that although nursing tends to be a highly structured and ritualized activity, mentors and supervisors can help neophyte nurses develop reflective skills.

Furthermore, the identification of key stages in the processes of reflection demonstrate that self-awareness, an analysis of feelings and knowledge, and the developments of a new perspective were crucial to reflection. Atkin and Murphy, (1993) also showed that certain cognitive and affective skills are necessary to engage in reflection. These skills are identified as self-awareness, description, critical analysis, synthesis and evaluation. An understanding of the processes of reflection is important, and sufficient attention must be given to developing the skills required to engage in reflection.

Reflection can also help nurses grow both professionally and personally (Burnard, 1995). Burnard emphasized that reflection may even be described as a particular state of consciousness: consciousness or awareness of events, in the present time and as they happen, with the doer fully aware of his or her intentions as well as his or her action.

The complexity of nursing practice in terms of knowledge use and knowledge production suggests the need for nursing as a human science and practice discipline to develop a method of inquiry that involves practitioners in the inquiry. This proposed method of inquiry, therefore, involves critical examination of what is actually going on in situations of practice through systematic self-reflection, reflective discourse, and critically oriented change.

The Institutional background

The following information is drawn directly from a formal document of Maharaj Nakorn Chiang Mai Hospital from late 1998. As it was at the commencement of this study although there have been changed over time. The actual hospital policy of the Hospital Accreditation began in October 1999.

Hospital Accreditation

As mentioned earlier, the health care system in Thailand has encountered changing health care needs, especially for improving the hospital system through quality care and the hospital accreditation. Quality strategies for practice were reviewed and guidelines were developed for practice. Regarding the nursing service division, several standards of nursing practices have been developed and attempts made to implement in real situation. Thus the clinical practice guidelines for use have been tested by clinical nurses.

Quality assurance, continuous quality improvement and total quality management are being implemented, especially for the nursing service division and some departments in the hospital. The outcome of these improvements has been reported periodically.

Since October 1999, the hospital policy started to improve the system by developing a plan to guide practitioners to do the right thing for the individual patient and to improve the system of providing care for future patients. This plan has basic principles for reconsideration and mutual understanding such as leadership, quality oriented service, commitment, functional structure, staff development, reorganizing

and restructure, and expression of mission. In order to meet these, the hospital practitioners decided to use a contemporary quality improvement base on the original principle which has the basic strategies as follows: awareness of customer requirement, continuous process improvement, employee empowerment and teamwork, value-based leadership and professional standards and practice guidelines.

Nowadays, hospital accreditation is being developed and implemented by a standardization in hospital policy and reconsidering guidelines for practice. The nursing service division, the major part of patient care provider, developed strategic and action plans for nursing personnel as tools for accomplishing the goals. These plans encourage nurses in all levels to take each responsibility. These plans include the development and improvement of leadership and nursing staffs, quality services, nursing administrative system, service behaviors, effectiveness of therapeutic instruments, environment and education and research (Nursing Service Division, Maharaj Nakorn Chiang Mai Hospital, 2000).

Regarding the strategic and action plans, it demonstrated that the nursing service division intends to improve the quality of care in this setting. In the plans, quality care processes are being as written guidelines. Discharge planning is one of the quality care processes that should be developed and implemented as soon as possible in each nursing care service section.

From this policy, now there are several quality care strategies developed in each department or medical nursing service section together with other health care providers are in the process of developing the Patient Care Team. The establishment of this team has led to the interdisciplinary work that health care providers can work together for the improvement of patient care. Regarding Northern Cardiac Center

Maharaj Nakorn Chiang Mai, because there is no guideline or any practical tool for practice, care providers are developing the Complete Cardiac Care Team. The non-complicated myocardial infarction patient is the first group of cardiovascular patient which is their concern.

The major goal of the Complete Cardiac Care Team is providing comprehensive and effective care for acute myocardial infarction from admission to discharge from each setting. The team operates in four stages: 1) initial recognition and management in the emergency department, 2) hospital management, including the first 24 hours and after the first 24 hours, 3) preparation for discharge from the hospital, and 4) long-term management.

The members of this team consists of care providers from CCU, sub-CCU, Emergency Department, Non-invasive unit, Cardiac Catheterization Lab Unit, Out patient Unit, and Medical Record and Hospital Statistics Section. Although this team has only just begun, this is an interesting concept and it is a good atmosphere for caring for the client. The team sets the schedule of working as continuing plan. Initially, the outcome of their working group is that they agree with the time line of patient care in each care unit. The critical pathway for each patient is being developed.

Summary

In conclusion, discharge planning is necessary for CCU. However, from reviewing the current situation in CCU, Maharaj Nakorn Chiang Mai Hospital, it was found that discharge planning has not been well implemented. The nurses agreed

with the need for discharge planning but the initiation of discharge plan by themselves seem not be possible. Discharge planning suitable for CCU, therefore, is not available. The researcher, as a clinical instructor working in CCU, would like to investigate discharge planning process and to develop discharge planning protocol for use in CCU.