

Enhancing the pre-admission process for a patient with breast cancer

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KEY WORDS

family, women with breast cancer, pre-admission, nurse interventions and assessments

ABSTRACT

Objective

The purpose of this paper is to detail the development and implementation of a patient focused pre-admission process, part of which is the check list identified within this paper and comprising the main point of the paper because it is based on patient and publication evidence for women with breast cancer. Women with breast cancer together with health professionals had specific input into the designed pre-admission clinic at a tertiary care hospital. A pre-admission clinic had been established some time ago however, women who attended this clinic deemed it most unsatisfactory for their needs. Results from an evaluation provided information that indicated women with breast cancer required an improved pre-admission process that was aligned to their needs and those of the Breast Cancer Multidisciplinary Team (BCMT).

Setting

A large tertiary care hospital in Sydney, New South Wales, Australia.

Subjects

Fifty (50) women of mixed cultures. Men can be diagnosed with breast cancer however, throughout this project, women were the only patients presenting for surgery.

Primary Argument

Even though remarkable progress has been made in breast cancer survival through medical treatment, women, newly diagnosed with breast cancer are frequently concerned, stressed and anxious as they attempt to come to terms with the news on their cancer diagnosis. Beside the initial medical consultation that informs them on their diagnosis, the women's first major interaction with the healthcare system commences when they attend the pre-admission clinic as a pre-admitted person. Therefore it is appropriate to examine current nursing practices during the pre-admission phase of a Tertiary Hospital so women, newly diagnosed with breast cancer are able to receive appropriate and supportive care. The goal of health professionals is to respect each patient and give voice to them by developing a specifically designed pre-admission process. It is expected any pre-admission process will utilise available evidence and include consultation with the Breast Cancer Multidisciplinary Team (BCMT). Thus the project commenced by identifying the needs of women with breast cancer in consultation with the BCMT, including nurses, physiotherapists, doctors and social workers. This evidence based approach to best practice in the pre-admission process and clinic has not been attempted previously for this cohort of patients.

Conclusion

Improving the pre-admission process of patients encourages analysis of the evidence that is appropriate for this cohort and nursing practices. In addition, it offered time to ensure applicability of the pre-admission process and clinic to the lives of the women concerned. During this project opportunities arose for reflection on the journey women follow after their diagnosis and the involvement of the BCMT. Moreover, this process encouraged examination of the most appropriate allocation and use of resources within the context of the pre-admission process and clinic, surgery, and discharge through to home follow up. This paper maps some of the adopted process, the collected data and briefly summarises resources utilised in relation to the pre-admission process.

BACKGROUND

According to the Australian Institute of Health and Welfare (2012) there were 14,560 persons diagnosed with breast cancer in 2012, with 2,940 deaths resulting from breast cancer. Those persons diagnosed early had an 89% chance of survival in a five year period compared to the general population. The risk factors for breast cancer continue to be, obesity and physical inactivity, family history and genetic susceptibility, diet, alcohol consumption, reproductive and hormonal factors, radiation and ageing (Australian Institute of Health and Welfare 2012). Therefore, the situation for women's life expectancy with early diagnosis of breast cancer has improved. However, the women's needs are substantial in view of the reality of their situation and the impact upon their lives and those of the family following diagnosis.

Following a diagnosis of breast cancer, many women experience serious psychological distress; if not addressed early in the process, can adversely affect care and outcomes (Fox et al 2013). Moreover, the perception and uncertainty about the diagnosis may be reduced at the completion of treatment (or its recurrence), creating even greater concerns about the effort to resume normal life. Family members become affected as well, mostly due to disruption within the family unit. In facing these challenges, women seek new strategies to live with the disease (Tritter and Calnan 2002), which manages short and long term psychosocial aspects of the diagnosis, and the many consequences (Eley and Rogers-Clark 2012). These include potential treatments, such as chemo-therapy and/or radiation therapy and concern about the cancers recurrence, intervention and treatment can impact on many aspects of life and living with family. An editorial by Saeki (2013), from which the question is asked – “Do we ask? Do we listen?” where this author laments on the infrequency of speaking with patients, of asking them questions about their care and wishes. Today nurses must embrace evidence that assists them to understand the array of personal meaning contexts that influence patient values and therefore patient decisions, given the situation they find themselves in and the context (Grace and Powers 2009).

Studies about the nurse-doctor contribution suggest that women, in particular are more satisfied with nursing care (Corner 2002). Nurses tend to demonstrate this through good communication – which has long been recognised for achieving immediate goals and contributing to the patient's wellbeing and recovery (Major and Holmes 2008). Pearce (1941 n p.2) stated, “...a nurse with the gift of making her patients feel at home and free from fear, inspires confidence and provides an atmosphere of peace, serenity and security which is so important an adjunct to the relaxation of mind and body necessary for recovery from disease”

Patients and families are not expecting a diagnosis of breast cancer as illness is not present in the same way as other disease processes, for example heart disease, diabetes or stroke. Shock and concern becomes an inherent part of the journey, particularly when the diagnosis of cancer involves ...chronic illness and the potential to produce pain, and disabling of physical activity (Tritter and Calnan 2002). This includes fear of the unknown, which must be confronted on a daily basis. As a consequence of these concerns, a patient focused, pre-admission process in a tertiary level hospital with expert nurses must involve the family. Nurses understand both patient and family by meeting the women in the pre-admission clinic, and then following each one (Bergman et al 2013) towards a state of wellness. In fact, Ke et al (2012) and Eley and Rogers-Clark (2012) acknowledge the importance of funding programs in a centralised system of teaching hospitals due to the availability of specialists services in most Australian cities. This saves money and contributes to whole of family care. Expert nurses also save time because they can focus on the central issue(s), they understand patient concerns and are able to inform patients and families in a more holistic way – thereby integrating psychosocial, physical and welfare needs (Cioffi 2012). In addition, communication skills tend to prevent critical human errors (Fryer 2012) that can be fatal.

Despite a woman's age or the family support available, a diagnosis of cancer of the breast affects each person in different ways: women are unable to acknowledge how it can be handled in their busy life. Most individuals express concern about their future, feeling anxious about family needs, the general lack of knowledge about breast cancer and the pre and post-operative interventions most are required to participate in for recovery (Boehmke 2004). Newspapers and television historically have mostly told stories on the bad outcomes of women with breast cancer. Given this diagnosis, women need support from BCMT of which the relevant breast care nurse is one experienced member (Eley and Rogers-Clark 2012; Cahill et al 2010; Cruickshank et al 2007). As previously stated, concerns experienced by these women with breast cancer require effective communication that is comprehensive, not difficult to understand or manage, an environment that is safe and free from errors (Fryer 2012), timely yet exhibiting empathy and understanding (Morse et al 1992). In fact the pre-admission process for newly diagnosed women with breast cancer is the cornerstone for all future interactions, interventions and processes within the continuum of care, both within hospital and home care. It should reflect a pathway of evidence based practice where nurses recognise human responses to health situations in order to provide individualised, holistic care (Grace and Powers 2009). Given the introduction of short stay surgical interventions, women with breast cancer do not remain in hospital for a lengthy time period. Individuals and their family members must learn to cope at home, managing drains, wounds and complex issues related to the diagnosis and subsequent therapies. Thus surgery for breast cancer can no longer be in isolation to family members; collaborative partnerships have to develop between patients, families, hospitals and community nursing members (Martin et al 2013).

Aim of the Project

The primary purpose of the project was to implement a pre-admission process based on the needs of women with breast cancer, in conjunction with the BCMT and incorporate relevant evidence and research findings within a tertiary hospital environment. A secondary aim sought to improve the immediate level of support to the women concerned. Moreover, the development and implementation of patient focused changes required leadership to create and share an organisational vision for staff motivation, supportive collaboration and improved practice (Walker et al 2011). Family members of the women concerned who had previously not been recognised had to be included, and a process facilitated that sought to improve support for children thus decreased the mothers concern following diagnosis. For this project, the continuum of care is defined as commencing with the pre-admission program and continuing through surgery, clinical ward and home care follow up. For this project, the primary focus was on the pre-admission process.

Methods

Before this program was implemented, there was a considerable waste of resources, staff rarely consulted with each other, errors occurred, some patient education was disseminated to the women but not enough to meet their needs, nor those of the family, and more importantly, family members were excluded, there were duplications in paperwork and diagnostic testing – each contributing to a very expensive process. There was little policy about the introduction of evidence based practice, an issue of great importance to improved patient care (Jeffs et al 2013). The idea of partnership between family, the patient and hospital staff had not been nurtured, thus many family members complained of feeling ignored, even though the primary patient had sought inclusion of family. Morris and Thomas (2002) and Bell and Wright (2011) asserted that the family should not be ignored during the pre-admission process. A collaborative effort should involve patients, partners in particular, and the respective members from the BCMT. In a focus group held prior to the commencement of this project, women with breast cancer and family members had expressed the lack of personalised attention experienced in the pre-admission process.

The BCMT agreed to use evidence from research findings described by Osborne and Gardner (2010 p.46),

who advocate use of the best practice evidence, in conjunction with clinical experience, and knowledge of each patient: in this way, these issues were included through all phases of the project, commencing with the pre-admission phase. This was combined with concepts from Family Systems Nursing (Bell and Wright 2011) who found that nursing practices are partnerships between the nurse and the patient and/or family members. Its implementation is the theoretical family assessment and intervention issues offered within a therapeutic conversation.

Despite the fact the initial project was funded by an external agency, the requirements of the hospital executive and BCMT had to be met in a timely and cost effective way so the long term goal of sustaining this program could be accomplished. The hospital executive viewed this project as an innovative example of nursing practice to assist new patients with their journey on the cancer care continuum. The rationale behind future improvements aimed to enable the patient to find support early in their hospital experience, thereby preventing any adverse experiences. It is asserted that if nurses are to develop patient focused care for patients and their families, it is essential to identify individual needs early and harmonise these with what is required and expected by BCMT members. This will likely lead to satisfaction with the governance of various interventions, including environment that fosters patient centred care, reflective nursing practices, increased flexibility amongst staff and enhanced co-operation amongst all members of the BCMT. The goal is to improve clinical practice outcomes for each patient, without incurring additional costs.

The project details on the program together with the focus group questions were submitted to the Human Ethics Committee and received consent without any changes. A convenience sample of 50 women, previously diagnosed with breast cancer and their family members were asked to volunteer and consent to participate in the development of the pre-admission process. From this group two focus groups (twenty five participants in each group) were facilitated by an external person to remove bias.

Data collection

The foundation data collected from the initial focus group is not reported here other than to infer the women were most unsatisfied with the pre-admission process for their admission into hospital. The aim for the data collection process was to keep it simple and use only several main questions. The number of women participants and family was n=50. The main questions posed to these women participants were:

Q.1. If you were designing a pre-admission process for women with breast cancer what would you include?

Q.2. As a family member what would you like to see included on a purpose designed pre-admission program?

The data collected was recorded by an external person and transcribed by the project co-ordinator. Two external experts analysed and categorised the results into a list of items suitable for the development of a check list on pre-admission process. An example checklist was developed and used by ten randomly selected women participants to refine and design a meaningful list appropriate for women with breast cancer being admitted through a tertiary hospital.

Data results and analysis

A randomly selected group of ten women participants (not previously used) and their family members checked and verified the analysed data and ordered the itemisation of priority elements, that is, some items needed to come before other items. From this information, the project co-ordinator categorised the list into four sections within the proposed pre-admission checklist:-

a) Personal Section – this section contained each of the elements necessary for hospital records;

b) Patient Education – this contained information that was essential in adequately preparing the patient for medical diagnostic tests, surgery and post-operative care to improve the outcome;

c) Pre-admission work-up – usually was carried out by the anaesthetists, and

d) Follow up – carried out by the breast care nurse and included organising referrals, continuing patient education, advocating for patients at BCMT meetings, ensuring there were no complications.

This tentative list was circulated to the members of the BCMT who were asked to mark items they wished to either retain or discard on the final checklist. Members of the BCMT stipulated the checklist had to be accessible, flexible, adaptive to individual needs, and user-friendly for experienced registered nurses with varying skills to use it as a template to trigger items to address with each patient. In addition, the BCMT wanted the pre-admission information to become an integral part of related paper work for each patient, including all suitable development into computerised documentation. This would enable portability and continuity of information from one health professional to another, whilst at the same time, prevent duplication or loss of details, volunteered by patients and their family. It also fostered holistic family care. The main results from the focus group data analysis is reflected in the checklist below.

Pre-admission – Women/men with breast cancer and family

A) Personal section

Patients partners and family members are encouraged to attend	☐
Set the scene by being warm, friendly but professional interactions. Commence communication by asking the person concerned to tell her/his story	☐
Assess patient's knowledge and understanding about future surgery	☐
Identify feelings and views and if possible, develop and empower each person. Make each interaction patient focused	☐
Encourage each person to talk about previous experience with health care	☐
Encourage self-appraisal of health	☐
Identify each persons' coping ability in previous stressful events	☐
Assess for stress/anxiety (NB and OCC questionnaire) – depending on results –refer	☐
Elimination, bowels habits/continence	☐
If person concerned is having a mastectomy, discuss prosthesis and/or plastic surgery (this is a very sensitive area and may not be appropriately addressed here but later)	☐

B) Patient education

Multidisciplinary Team discussion and purpose	☐
Diet, stress, fatigue, balancing life and body image	☐
Pre-operative preparation – deep breathing, fluid intake and exercise	☐
Hygiene factors, liquid anti-bacterial soap	☐
Post-operative showering and management of drains	☐
Process and procedure of in-hospital journey	☐
Anaesthetists and anaesthetic process	☐
Pain control and management	☐
Recovery and wards	☐
Drains and sutures/staples	☐
Outline normal post-operative trajectory over 1,2,3 days	☐
Deep breathing and leg exercises	☐

Discuss ward, hierarchy of staff, language used in health care, future plans	☐
Family, support and visiting	☐
Identify high risk (young women, women with children etc and refer to appropriate resource for care)	☐
Physical exercise and activity within ward	☐
Importance of fluid intake twenty four hours prior to anaesthetic	☐

C) Medical pre-admission work up

Blood biochemistry and pathology	☐
ECG – if ordered	☐
Chest x-ray if ordered	☐
Medical assessment and admission documentation, including assessment by anaesthetist	☐

D) Follow up

Referrals –social worker, clinical psychologist, physiotherapist, cancer support	☐
Discharge planning	☐
Identify who is at home and link patient into home care or support from community nurses	☐
Visit to ward area and explain	☐
RN or breast care nurse follow up at home	☐
Telephone call and visit to person at home	☐

Evaluation of above checklist and pre-admission process

A focus group follow up was used to collect data from ten women patients who in the previous two weeks had breast surgery. Qualitative data was collected that indicated the checklist met their needs. To ensure patient confidentiality and preserve anonymous responses, patients and family members were designated a number by the clerical staff in Hospital Admissions. The members of the BCMT were also asked about their use of the pre-admission data and documentation and feedback from their patients. There was a positive response with many stating the planned and developed pre-admission checklist met each of their needs.

Conclusion

This was a timely, yet important step in the development of the first phase in a patient-focused process. It advocates for patient and family focused care and follows what Tritter and Calnan (2002) recommend, as the incorporation of experiences of patients, those that care for patients, as well as those who provide treatment and support. Cancer and the patient experience, despite having aspects in common with other chronic diseases, is distinctive (Tritter and Calnan 2002). With growing complexity associated with health care, health professionals are advised to reflect and examine their views on whether they and the service with whom they work, is meeting the needs of individual patients and families. In addition, there is a growing recognition that the carers and support family- members who frequently continue the care of patients after discharge, require information (Morris and Thomas 2002) and education. To remain contemporary, current and dynamic, health care professionals and their service organisations need to review, adapt and even modify practices to include best practice of the day for patients, families and carers. Safe practice is best practice for patients. Edozien (2013) postulates that safety for patients and families is a key aspect of healthcare delivery, and hospitals are obliged to have robust systems in place to continually monitor and improve safety of care for patients. With resource limitations, so often there is little time or money to carry out a full circle

of a patient's journey however, pressures from consumers is becoming an ever increasingly real requirement and nurses are ideally equipped to carry out this vital partnership with patients.

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