DISCHARGE AFTER COLORECTAL CANCER SURGERY 2: PLANNING

AUTHOR Claire Taylor, PhD, MSc, PGCAP, BN, RGN, is lecturer in gastrointestinal nursing, Burdett Institute of Gastrointestinal Nursing, St Mark’s Hospital, Harrow, Middlesex.

ABSTRACT Taylor, C. (2008) Discharge after colorectal cancer surgery 2: planning. Nursing Times; 104: 29, 30–31. This is a two-part unit on preparing patients for hospital discharge following surgery for colorectal cancer. Part 1 explored the rationale for different surgical procedures, and discussed common side-effects and the impact of treatment on patients. This second part addresses the various components of good discharge planning: assessment; technical care; coordination and communication; emotional support; the rehabilitation process; and family involvement (Long et al, 2002).

Hospital discharge is a significant event for patients with colorectal cancer recovering from major surgery. This is because it marks the transition from primary treatment to follow-up care and from continuous professional support to self-management.

Discharge care involves helping patients to attain a stable level of health, sufficient to enable them to leave inpatient care, while also preparing them for recovery once home. Unpublished research suggests these preparations are not always given a sufficiently high priority. Planning may begin too late, leaving patients with the feeling that their discharge has been hurried and care uncoordinated.

The process must begin pre-operatively and continue through the post-operative stay. Care needs to be organised to ensure each patient is reintroduced to key activities in a staged manner, while being provided with practical/emotional support and information.

In essence, the discharge process should support patients’ rehabilitation and leave them feeling clear about and capable of continuing the care plan.

LEARNING OBJECTIVES

1. Understand important nursing actions when preparing patients for discharge following colorectal cancer surgery.
2. Know the key professionals nurses should liaise with before discharge.

ASSESSMENT

Skilled assessment is critical in preparing patients for discharge since they may have underlying concerns or potential problems which, if unrecognised, might hinder rehabilitation. Each individual’s physical, psychological and social needs must be assessed regularly in order to ensure they are addressed as fully as possible before discharge.

Assessment tools can be helpful when assessing symptoms. These could include a visual analogue pain scale or a patient diary to gain a more objective impression of bowel function. Symptom assessment should establish the following: the nature of each symptom (the location, intensity, frequency and duration); aggravating and alleviating factors; current management; resulting responses; and patients’ perceptions of any symptom experienced.

In addition to immediate health needs, potential care needs once at home should be considered. Assessment of the home environment, level of informal support available, ability to self-care and patients’ understanding of their situation are vital. The focus should be on the extent to which patients believe they will attain independence once home and what concerns them most about this process.

TECHNICAL AND PHYSICAL CARE

Each post-operative day should be planned to maximise patients’ potential and achieve necessary functional gains.

Optimising health and minimising the incidence or effect of surgical complications requires regular monitoring and recording of patients’ physical status and then delivery of appropriate nursing care. It also involves practical measures such as maintaining comfort, ensuring rest, providing nutritional support and meeting personal hygiene needs.

COORDINATION AND COMMUNICATION

During hospital stays, nurses play an important role in referring to other agencies and delegating responsibility for aspects of the discharge process to other team members. The discharge process should be a collaborative effort involving the multidisciplinary team.

Nurses are ideally placed to coordinate different professionals’ input and share their knowledge on patients’ current condition. This must be supported by clear and comprehensive documentation. Other services may be required in the process, such as physiotherapy, occupational therapy and social services.

Patients with an ongoing need for nursing care will need referral to community nurses. Those who are symptomatic following a palliative procedure should be referred to the palliative care team. Referrals must include as much information as possible – operation notes, care plans and so on should be attached. Similarly, patients should be offered information in both oral and written form, with advice on how to manage everyday living (Suohon et al, 2005; Taylor and Norton, 1999). They should not be left to request this.

Preparing patients for what to expect after cancer treatment has also been shown to allay anxiety, enhance performance of self-care and help adaptation to treatment (Hughes et al, 2000).

Each care intervention provides opportunities to offer information. For instance, while dressing a wound, patients can be informed about wound healing, the rationale for dressing selection and signs of infection. Similarly, medication should be administered with explanations about what
it is, how it works and when to take it, as this will soon be patients’ responsibility. Offering information in this way makes it meaningful, manageable and memorable.

EMOTIONAL SUPPORT
Achieving emotional stability following cancer treatment can be difficult and most patients experience waves of vulnerability, fear and frustration over subsequent months. Nurses should warn patients about this possibility.

While patients are in hospital, emotions may be bolstered by providing choice, independence and control. Supportive services should be signposted, such as telephone helplines provided by Cancerbackup and Macmillan Cancer Support, and local patient support groups.

Patients with a newly created stoma should not be discharged until the stoma therapist is happy they have achieved sufficient independence in stoma care and all necessary preparations are in place. Following discharge, GPs resume responsibility for patients’ care. In addition, liaison should take place with the colorectal clinical nurse specialist, who generally maintains close contact with all patients.

Greater support may be required by patients:
- Admitted as an emergency;
- Requiring further treatment;
- Who were in poor health previously and/or have ongoing co-morbidity;
- Who lack social support;
- From a younger or older age group.

These patients’ concerns about managing once home should be ascertained and care planned accordingly. Consideration should also be given to emotional support.

REHABILITATION PROCESS
During the first six weeks, most patients have to make compromises in their day-to-day routines, as even the most mundane activities can prove physically challenging.

They should be advised of the importance of paying attention to their body, balancing rest with enough exercise to regain strength, stamina and confidence. Vigorous physical activity, especially swimming, should be avoided until the wound has completely healed. Sexual activity can be resumed as soon as this feels possible and comfortable.

Most patients ask about what food to eat and avoid after colorectal cancer surgery. They should be informed that unless they have received specific guidance from a dietitian, they can eat what they feel like, preferably choosing easily digested foods, little and often at first. Those with loose bowel motions should limit spicy foods and stick to those with a low residue (low fibre). Many patients do temporarily lose a few kilograms in body weight and may need to eat high-calorie foods to counteract the catabolic effects of surgery.

Patients will initially feel uncertain about what they are able to do once home. Nurses can advise them that staggering necessary activities through the day and setting small goals on a daily basis will raise morale. This means that activities need to be carefully planned, paced and prioritised until they feel stronger and more able. The need for incremental increase in activity may be most relevant to older patients whose recovery can be slower and attainment of full ambulation protracted (Bailey et al, 2004).

As increasing physical capability is often a priority, patients often seek guidance on what they should be able to do, by when. Such guidance must be tailored – although parameters of what is ‘normal’ can and should be offered, there is much variation in ability. Encouraging patients to set their own realistic goals can aid this process by directing achievement towards independent action and indicating progression.

An important goal for many patients after surgery is being able to drive again. Most wait six weeks before driving, although this decision should be determined by ability to maintain full concentration, twist their upper torso easily and have the strength to press on the brake pedal hard enough to make an emergency stop at speed. Patients should also check their insurer’s requirements.

Patients should plan to have 4–6 weeks off from usual responsibilities. This advice may be cautious for those recovering from laparoscopic surgery. However, many do not appreciate the impact of fatigue until after discharge. Indeed, for the first two weeks at home, fatigue can mean they need plenty of sleep and it can prevent many patients from leaving the house.

Nevertheless, patients should experience progressive improvement in most aspects of functioning as the acute physical trauma lessens and treatment side-effects settle.

FAMILY INVOLVEMENT
Family members as well as patients should be clear about where to gain advice or further treatment should it be required after discharge. The family should be involved in the planning process, including discussions about the suitability of the home environment and considering ways in which patients may be best supported.

KEY REFERENCES


The full reference list for this unit is available in Portfolio Pages at nursingtimes.net.