

TEACHING CONTINUITY OF CARE THROUGH POST-HOSPITAL VISITS BY THE STUDENT NURSE

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Le programme de nursing de l'université d'Ottawa comporte, dans le cadre du cours de base en médecine-chirurgie, des visites de rappel à domicile une fois que les patients sont rentrés chez eux. Le projet-pilote de deux ans qui a précédé le programme actuel est exposé dans le présent article. L'objectif central de l'expérience est d'assurer que les soins dispensés à l'hôpital se continuent à la maison. Les malades visés par ce programme appartiennent à une catégorie bien définie: ce sont les patients à qui on donne leur congé sans pouvoir les recommander aux soins d'un service infirmier de la localité, bien souvent parce qu'il n'en existe pas. Nous croyons que ces visites contribueront de façon positive à la formation de l'étudiant en nursing et que, bien entendu, elles seront également tout à l'avantage du client.

Nursing students at the University of Ottawa make post hospital visits as part of their basic medical-surgical course. The two year pilot project that preceeded the present program is presented in this paper. The central objective of this experience is to provide continuity of care from the hospital setting to the home. The patient population is specific, those discharged independent of referral to an existing community health service. It is our hope that the visits will provide a valuable learning experience for the nursing student and at the same time be beneficial for the patient.

Nurse educators and practitioners have studied our commitment to continuity of care for several years. It has become a well-established fact that we must do something about providing continuity of care for the patient.

In reviewing the research that has been published on continuity of care one important fact dominates the results: commitment to continuity of care reaches into all areas of health practise and involves every member of the health team. A definition of continuity of care was clearly established by the nursing service division of the World Health Organization as "the continued responsibility for, care of, and interest in, the person as an individual once he or she has come to our notice" (United Nations 1965). The committee that was formed to establish this definition further states, "It is felt that

the over-all health of the patient should be considered as well as the prevention of recurrence of disease."

Our project dealt with just one aspect of nursing's commitment to continuity of care, the discharged patient, and more specifically, with the discharged patient who was not using established community nursing services such as Victorian Order of Nurses, Home Care Plan or other community nursing services.

As far back as 1958, a study was instituted by the National League for Nursing at Teachers College, Columbia University, to compare the difference in continuity of care for the discharged patient who went home independent of referral to a community agent and those who were referred for follow-through care (Smith 1962). The well-documented findings of this study show that nurses participated in discussion of follow-up care with referred patients while few nurses gave instructions to the non-referred patients. This finding was documented again in a study done twelve years later in England that will be discussed next. Much of the data gathered by Louise Smith's study relating to continuity of care for the referred patient has been successfully implemented.

The Dan Mason Nursing Research Committee of Great Britain carried out a study to discover what patients themselves see as their home care needs (Skeet, 1970). Some important patient needs were established; a summary follows. Life is often grim for both the patient and the family after discharge. Communication is one of the greatest needs, as patients lack information about their illness and treatment and hospital staffs lack information about the patient's home condition. There is also a lack of discharge planning. The study established that for post-hospital care to be continuous, it must be planned before discharge. This was seldom done. The study presented several criteria identified by patients to help them meet their needs after discharge. Among these are: two-way communication between hospital authorities and patients, allowing information to pass to the patients and the staff; advance notice of discharge to allow for adequate arrangements; and written discharge instructions on patients' activity, diet, prostheses, and effects of drugs and treatments.

Several studies on continuity of care have been carried out in Canada in recent years. One of particular interest to nursing education is the Comprehensive Health Care Project initiated by Dalhousie University. In 1969 nursing students were included in the study (Elahi and MacDougall, 1972). The purpose of the study was to provide the student with a learning experience in the health care of a family in the community, as a member of a multi-disciplinary team.

The results relating to the student nurses' participation in the team were significant. The study showed that the role of the nursing student in the community setting is not well-defined and patients failed to call the nurse for direction or information when they had a health problem. The nurse was called first in only 1.8% of the cases studied, but the study also established that when the nurse was called the patient found her helpful. It is clear from the findings of this study that nursing must establish a clear-cut role as health educator to the patient in hospital before returning to the community.

In a report by Louise Smith, published for a workshop on the role of the nurse in continuity of patient care, clear directives are given to the nurse (Straub and Parker, 1966). She states that the hospital nurse has a distinctive opportunity and an important responsibility in giving conscious consideration to what the patients may need on discharge and follow-up care. In this study, she found that nurses fail to talk with one-half or more of the non-referral patients about their follow-up care. These findings support data from her study previously presented, and emphasize her directives to nursing to establish a teaching role with the patient in hospital to prepare for discharge and follow the patient into the community to provide continuity of care.

THE PROJECT AND SURVEY RESULTS

On the basis of findings of available research, the nursing faculty of the University of Ottawa planned a program to get the nursing student actively involved in continuity of care. By visiting non-referred discharged patients in their homes, it was predicted that the experience would have significant effects on their future nursing practise in hospital.

The students involved were in the second year of a four year university nursing program. The experience was part of the basic medical-surgical nursing course that comprises the entire second year of the program. Two visits were made by each student, one in the first semester, one in the second semester, to a different patient each time. In the first visit the student's skills of assessment were emphasized and a structured guide was followed. The focus was on common problems of the discharged patient as established by Lynne Deakers (1972) in her project on continuity of family-centered nursing. In the second visit, the student was asked to use the nursing process to develop an effective teaching plan.

The students were given two days of clinical experience each semester to complete their assignment. In this time, they were expected to select a patient, preferably one they had cared for in hos-

TABLE I
PATIENTS' VIEW OF THEIR PREPARATION
FOR DISCHARGE FROM HOSPITAL. N = 50

Area of preparation	Patients say they were prepared for discharge in this area			
	By doctor		By nurse	
	No.	%	N.	%
Activity	38	76	16	32
Hygiene	19	38	12	24
Drugs	25	50	11	22
Treatments	30	60	10	20
Follow-up	39	78	6	12

pital, and prepare for their visit. The students soon found that to make an effective visit and provide continuity of care they must be well prepared for the visit. Many hours were spent researching patho-physiology, current therapies, drugs and nursing interventions. There was a high level of apprehension, especially for the initial visit, as this was the first time they would leave the security of the hospital setting to further their nursing care plan independently. Individual pre-visit conferences were given to each student to assess that she was adequately prepared. The visit was made and a post conference was held with all the students sharing their experience. The post-conference proved to be most interesting and rewarding. Sharing their successes and inadequacies was profitable for all. It was an opportunity to tell about problems encountered such as getting lost, problems with dogs, and talkative patients, and a time to share the joy of helping the patient in the accomplishment of a new, challenging task.

A survey was taken on the 50 visits made in the fall semester of 1974. Each patient was asked "Were you prepared in hospital for your discharge by your nurse or by your doctor in the following areas?" The problem areas identified in Lynne Deaker's project (1972) were investigated. Results are shown in Table 1.

The results of this survey were very significant to the nursing student. In the 50 cases studied, the nursing student had cared for the patient in hospital in 34 instances or 68% of the patients studied. The fact that the patient lacked preparation to manage the identified problem areas and that the nurses did less teaching than the physicians in all areas, was a revealing experience. The survey supported

previous research studies and clearly established to the student, the need to prepare her hospital patient for discharge.

TYPES OF LEARNING ACCOMPLISHED

It was our objective as a faculty, to make the students aware of the need for continuity of care and to identify teaching needs in hospital before the patient returns home. As a learning experience, results of the project were most encouraging. In evaluating the experience, the nursing students indicated that this main objective was met and that their learning was significantly influenced to make them more aware of the need for teaching and preparation after seeing the patient in the home setting. In one student's words, following a visit to a patient with acute narrow angle glaucoma, "The questions that the patient asks during a home visit makes us discover some of the learning needs that could have been met in the hospital setting" (Pitre, 1974).

Not only was the main objective met, but several other areas of learning were influenced by this experience. This student further states that the experience gave her a total picture of the patient. This comment was made repeatedly by the students evaluating their experience. They felt that by seeing the patients in the home setting they were able to see them more clearly as individuals with individual, family and community needs.

It was interesting to note the other aspects of learning that were affected by the experience and commented on in their evaluations. Some of the positive comments are summarized below.

- with each home visit I improved my interviewing skills
- I have much more confidence in dealing with people
- it gave a break from the everyday nursing in hospital and got you more involved in the community
- we see the functions of the public health and social service people in the community
- I'm glad I spent so much time preparing for the visit because I really had to know my work in order to be able to teach her what she had to know.

We felt our objective was met by the positive response of the students and the effect it had on their learning. We were more than confident that through the program of post-hospital visits the nursing student would improve her efforts in preparing the patient for discharge. We also felt that by following the non-referral patient to the home setting, the student could extend her care established in hospital and become actively involved in the continuity of care.

The project was a rewarding experience to the faculty and to the nursing students. Based on the results of this pilot project, post-hospital visits have been integrated into the basic medical-surgical program. It is our hope that the patients also benefit from this program.

REFERENCES

- Deakers, Lynne Power. "Continuity of Family-Centered Nursing Care Between the Hospital and the Home." *Nursing Clinics of North America* 7 (March 1972) : 83-93.
- Elahi, V. K. and MacDougall, M. G., ed. *The Comprehensive Health Care Project: A Preliminary Study*. Halifax: Dalhousie University, Department of Preventive Medicine, 1972.
- Pitre, Francine. "Evaluation of post-hospital visit." Paper prepared for course 2210, University of Ottawa, March 1974.
- Skeet, Muriel, ed. *A Study of the Home Care Needs of Recently Discharged Hospital Patients*. London (England): Dan Mason Nursing Research Committee of the Florence Nightingale Memorial Committee, July 1970.
- Smith, Louise C. *Factors Influencing Continuity of Care*. A study sponsored by the National League for Nursing, Inc. New York: Columbia University Teachers College, 1962.
- Straub, K. M. and Parker, K. S., ed. *Continuity of Nursing Service in Continuity of Patient Care: the Role of the Nurse*. Washington, D.C.: The Catholic University of America Press, 1966.
- United Nations. World Health Organization. Pan American Health Organization. *Report of Seminar on Nursing Service: Planning for Continuity of Nursing Care*. Reports on Nursing series no. 5. Washington, D.C., June 1965.