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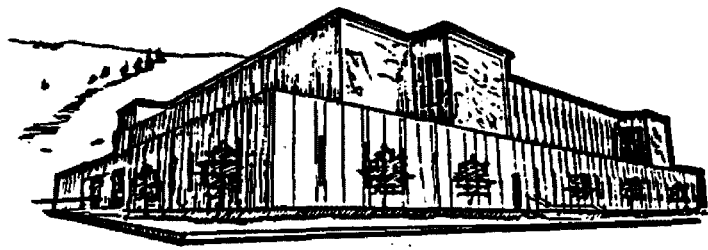
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ALTERNATIVE CARE STRATEGIES FOR ST. PATRICK HOSPITAL'S 4 NORTH

By

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B.A., University of Montana, 1987

Presented in partial fulfillment of the requirements
for the degree of
Master of Public Administration
1991

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TABLE OF CONTENTS

Chapter		
I.	INTRODUCTION.....	1
	Statement of the Problem.....	1
	A Cooperative Care Strategy	
	St. Patrick's 4 North.....	3
	Patient Care Models (Figure 1.1).....	5
	Two Models of Patient Care Delivery.....	6
II.	PROFILES OF CARE DELIVERY	
	AT ST. PATRICK HOSPITAL.....	14
	Profile of St. Patrick Hospital.....	14
	Profile of 4 North.....	16
	Summary.....	23
III.	PROFILES OF ALTERNATIVE CARE	
	IN HEALTH CARE INSTITUTIONS.....	25
	Introduction.....	25
	New York University	
	Cooperative Care Center.....	26
	The Planetree Model Hospital Unit.....	31
	Aspects of Cooperative Care	
	In Other Institutions.....	36
	Summary.....	37
IV.	RECOMMENDATIONS FOR ALTERNATIVE	
	CARE CONCEPTS ON 4 NORTH.....	40
	Obstacles and Objections	
	to Alternative Care.....	40
	Recommendations for Alternative	
	Care on 4 North.....	44
	Summary.....	47
	
	APPENDIX A.....	49
	BIBLIOGRAPHY.....	54

CHAPTER I

Statement of the Problem

Health care providers and their patients are becoming increasingly aware of the ineffectiveness of the traditional model of patient care. In the traditional model responsibility for patient recovery rests primarily with the hospital staff. Doctors, however, cannot ensure the recovery of their patients simply by prescribing appropriate medications and treatments¹. Nor can nurses ensure the recovery of their patients by providing care during the time these patients are in the hospital. As a result, health care providers and consumers alike are searching for new alternatives to the traditional model that will improve long term outcomes.

Another factor fueling the search for alternative health care delivery systems is the rapid increase in the percentage of patients admitted with chronic illnesses coupled with the shortened average lengths of stay per hospital visit resulting from efforts to reduce costs². As a result, these patients are becoming increasingly responsible for carrying out their own health care regimens after hospitalization.

Health care providers are thus confronted with a dilemma. Hospitalized patients are often too sick to learn

about their home care regimens prior to discharge, and outpatients have too little contact with providers to learn how to provide their own care³. In response to this dilemma, a number of strategies aimed at increasing patient involvement in care delivery have been initiated in health care settings. The primary objective of these programs is to integrate the patients and their families into the health care process.

One of the self-management concepts that has received considerable attention is the cooperative care concept⁴. The goals of cooperative care are (a) to reduce the cost of an episode of hospitalization by removing the less acute patient from the more intense area of the acute-care facility by using the patient and family as resources, (b) decrease the rate of rehospitalization by having both the patient and his or her care partner participate in a structured health education and training program relating directly to the patient's illness, (c) free up the traditional part of the acute-care facility to devote its resources to the care of the more intensively ill patient⁵, and (d) to create a homelike hospital environment that facilitates better health care outcomes for health care consumers and health care providers⁶.

The concept of cooperative care, was first developed at New York University Cooperative Care Center⁷. The NYU Center, opened in 1979, has been one of the most intensely

studied cooperative care units. Claims of improved patient outcomes coupled with reduced care delivery costs have motivated health care providers throughout the United States to take a closer look at the cooperative care approaches to health care delivery.

A Cooperative Care Strategy
St. Patrick Hospital's 4 North

The Montana Consortium for Excellence in Patient Care submitted a grant proposal entitled, Strengthening Hospital Nursing -- A Program to Improve Patient Care to the Robert Wood Johnson Foundation and Pew Charitable Trusts. On November 1, 1990, the consortium was awarded one of twenty grants. The Montana Consortium is comprised of Saint Vincent Hospital and Health Center in Billings, Columbus Hospital in Great Falls, and St. Patrick Hospital in Missoula.

The objective of the grant is to explore alternative health care delivery systems that promote efficiency while enhancing the quality of outcomes. At St. Patrick Hospital, the integration and implementation of the grant at the unit level is being coordinated by an interdisciplinary planning board. One of the proposals from the Interdisciplinary Planning Board calls for the investigation of models that involve patients and family in care delivery.

St. Patrick hospital's administrative team requested the author to investigate whether or not the basic concepts of cooperative care are adaptable to the hospital's cardiovascular unit, 4 North. This paper describes the characteristics of cooperative care, analyzes their applicability to 4 North, and offers recommendations regarding possible changes in patient care delivery.

FIGURE 1.1

PATIENT CARE MODELS

VARIABLES	Models	
	TRADITIONAL	COOPERATIVE CARE
1. Physical Environment	Sterile. Utilitarian, environment is designed to accommodate the functional needs of doctors and nurses.	Homelike. Changes in physical environment are targeted at facilitating patient education/patient involvement.
2. Authority Relationships	Doctors dictate treatments. Nurses carry out prescribed regimens. Patients have minimal authority in decisions that affect them.	Patients are partners in decisions that affect them. Support systems exist to assist doctors and nurses in establishing their new roles as facilitators of care.
3. Patient Education	Minimal. Provided as patient nears discharge.	Extensive information provided regarding nature of illness, treatment procedures, and patient responsibilities. Education begins prior to admission and continues after discharge.
4. Patient/Family Involvement In Care	Health care staff assumes responsibility for care. Patient/family are involved in care only after discharge.	Increased patient responsibility for care outcomes. Family members (care partners) are involved throughout the care process.

Two Models of Patient Care Delivery

Figure 1.1 provides a graphic summary of the differences between the traditional and cooperative care models. These differences are related to four basic variables: physical environment, authority relationships, patient education, and patient/family involvement in care.

The differences in the physical environments of the two models are considerable. The traditional environment is utilitarian and sterile and is designed to accommodate the functional needs of health care providers. By contrast, cooperative care units are designed to provide a homelike environment. The cooperative care model proposes that a homelike environment is therapeutic to a patient's convalescence⁸. Specific design features are devised to promote healing, learning, and patient participation⁹. For example, the Planetree Model Hospital Project, located at Pacific Presbyterian Medical Center in San Francisco, has been experimenting with creating an improved care environment since 1978. The standard nurse's station has been removed. The unit has been redesigned to include a lounge where patients, families, and friends can relax, share a meal, or watch a movie. The unit also includes a kitchenette where patients and their families can prepare meals¹⁰.

Authority relationships are another significant variable in the comparison of traditional and cooperative

care models. Traditionally, doctors have dictated treatments and nurses have carried out prescribed regimens. The traditional health care system breeds and reinforces dependency on medical professionals¹¹. Communication networks between doctors, nurses, patients, and families have been weak and often non-existent.

Cooperative care concepts promote a new set of relationships in which patients are provided opportunities to participate in the decisions that affect them. Patients are offered the opportunity to learn about their illness and to take responsibility for their health. In the Planetree unit, patients are involved in various decisions about their hospital stay such as their sleeping schedules. Patients are also encouraged to make entries on their charts that reflect how they feel about their treatment, or other general observations¹².

Changes in the patient/health care provider relationship have facilitated changes in management structures at the unit level¹³. For example, at Newark's Beth Israel Medical Center, nurses are being compensated for reduced control over the care process by gaining increased control over their work environment. For example, nurses make their own staffing decisions. There are no traditional supervisors¹⁴.

The utilization of primary nursing as the means of delivering cooperative care provides the necessary impetus

to create an environment which promotes autonomy of nursing practice and patient participation¹⁵. At Beth Israel, the focus is on decentralized decision making to facilitate greater participation from the staff. There is one nurse manager\team leader on each shift. This manager reports directly to the Director of Nursing. The staff nurses are responsible for making all nursing decisions that directly affect their patients. Nurse managers function as colleagues with other nurses in the unit and facilitate collaboration and teamwork among the nursing staff.

A third variable is the kind and amount of patient education facilitated by hospitals and health care providers. The recent trend toward shortened average lengths of stay, combined with the increased percentage of hospital patients admitted with chronic illnesses, has magnified the need for health care providers to improve patient education. Patient education has been minimal in traditional settings. Typically, patient learning has occurred as patients near discharge. In the traditional model, patients may receive some instruction concerning post-hospital administration of medications and treatments; but typically, opportunities for hands on practice of skills that will be utilized during out-patient recovery are overlooked.

Improving health care education to affect long term improvements in patient health is one of the fundamental

objectives of the cooperative care model. It rests on the assumptions that patients wish to be active participants in their care, that they have the capacity to learn, and that their return to health is largely in their own hands. Health care providers adopting a cooperative care approach to health education offer a continuum of care that facilitates learning before, during, and after hospitalization¹⁶.

In addition to practice of self-medication, cooperative care concepts promote learning that affects long term patient health outcomes. In a traditional setting, a patient that requires changes in dietary habits is handed a proscribed diet at discharge. By contrast, patients requiring dietary changes in cooperative care settings are provided with learning opportunities throughout their hospitalization period. For example, Rochester Medical Hospital developed a Nutrition Education and Dining Cafeteria (NED) to better serve its patients. Patients are taught about the special requirements of their diet by a dietician. Patients are then provided with the opportunity to practice making appropriate dietary decisions by ordering meals from cafeteria menu.

Also, Cooperative care concepts advocate the use of peer support, volunteer, and self-help programs to further patient education. For example, the Friendly Visitor program at St. Luke's Hospital in Fargo, North Dakota

matches thirty categories of visitors who have successfully coped with some type of illness with patients that are going through similar experiences¹⁷.

The fourth organizational variable is patient and family involvement in care. In the traditional model, patients delegate their responsibility for the healing process to the hospital staff. In the traditional setting, patient and family involvement in care typically does not begin until after the patient has been discharged.

Cooperative care shifts some of the responsibility for care outcomes to the patients and their families. While some cost reductions may be obtained in this way, the primary motive for this transfer of responsibility is related to the belief that involving patients and their families in care delivery and decision making will decrease the stress of hospitalization and prepare patients more effectively for the post-hospital recuperative period¹⁸.

One method utilized to enhance patient involvement is the use of a contract¹⁹. During the admission assessment, patients inform the nurse of their reason for hospitalization and what they hope to accomplish during hospitalization. The contract may be verbal or written. This contract helps to clarify patient, family and nurse responsibilities during treatment.

With these four variables of cooperative care in mind, Chapter II provides a description of current care delivery

practices on St. Patrick Hospital's 4 North. In Chapter III, a more in depth analysis of cooperative care in hospital-based settings is provided. Chapter IV describes obstacles and objections to alternative care implementation. Chapter IV concludes with recommendations for possible adaptations of cooperative care concepts in the 4 North setting.

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CHAPTER II

Profiles of Care Delivery at St. Patrick Hospital

The purpose of this chapter is to describe current health care delivery practices on St. Patrick Hospital's 4 North in relation to the organizational variables identified in Chapter I. Hospitals, and units within hospitals, apply traditional and cooperative care concepts to varying degrees within the continuum of care delivery methods. It is useful, therefore, to establish a context for analysis by describing current practices.

Profile of St. Patrick Hospital

St. Patrick Hospital is a 213 bed hospital, which is relatively large for a rural area. The hospital provides secondary and tertiary services for all hospitals in Western Montana, Northern Idaho, and even as far as Great Falls. St. Patrick Hospital provides tertiary care only for some services. For example, the hospital provides what is considered tertiary care in valve replacement surgery for the heart, but does not provide heart transplants. Patients must go to Spokane, Seattle, or somewhere else, for heart transplants. Among regional hospitals, St. Patrick specializes in cardiac care. St. Patrick is also the only

regional provider of in-patient mental health services, addiction treatment services, renal dialysis, and radiation therapy.

The region St. Patrick serves with each of these services is different. For example, in radiation oncology the zone of treatment reaches from Kalispell to Butte. St. Patrick serves a much larger area for valve surgery, open heart surgery and arterial bypass surgery. The area of service spans as far North as Libby, as far south as Salmon, Idaho and across to Dillon, Montana, and Sheridan Wyoming.

Open heart surgery at St. Patrick Hospital was established in 1975. Prior to that time open heart surgery was only performed in Spokane. Improved technology combined with population growth in the Northwest have enabled other hospitals to adopt open heart surgery capabilities.

St. Patrick Hospital is certified by the government as a regional provider of cardiac surgery. Hospitals participating in the Robert Wood Johnson grant are charged with the responsibility of sharing ideas and methods that contribute to better care outcomes. Cooperating with referring hospitals through the cardiac network facilitates the betterment of health care delivery for patients all across the Northwest region. Other hospitals with similar environments are learning from this grant and developing their own programs that make the delivery of care more efficient and of higher quality.

Profile of 4 North

4 North is the 33 bed cardiovascular unit at St. Patrick Hospital. Eighty percent of the patients admitted to Cardiovascular Services are treated for one of the following diseases: myocardial infarction, coronary artery disease, open heart surgery, congenitive heart failure, angina, pulmonary embolism, or aortic aneurysm repair. The remainder of services provided include pacemaker installation and telemetry rhythm monitoring.

The average length of stay (LOS) for the overall patient population on 4 North is 3-4 days. Open heart surgery patients average 7-10 days per stay. Angioplasty and angina patients are in the unit for 24-48 hours on average. Pacemaker implants generally require an LOS of less than 24 hours. The average LOS for congenitive heart failure patients varies from 3-10 days depending upon the health status of the patient.

Characteristics of Patient Care Delivery on 4 North

Environment

4 North is located in the main hospital which was constructed in 1984. Prior to 1984, the unit was housed in the Broadway Building which was constructed in 1947. A walking tour of each of these buildings provides evidence of the startling contrast between traditional and alternative architectural and interior designs.

The straight, narrow, tiled hallways of the Broadway Building are reminiscent of utilitarian military hospitals of old. The walls are painted off-white and the rooms are comparatively small. Although this portion of the hospital now houses support and administrative services, it stands as a stark reminder of what had once been the norm in health facility architecture.

The environment on 4 North in the new hospital is more homelike. An interior decorator was consulted for paint and furnishing decisions. The walls are painted soothing colors such as mauve, blue, egg shell, and beige. The hallways are carpeted. The waiting area/lounge is equipped with comfortable furniture and plants. The nurse's stations have open access to the hallways and do not contain dividers to separate patients and their families from the nurses.

4 North houses 27 private rooms (1 bed per room), and 3 semi-private rooms (2 beds per room). Each room is equipped with a television, telephone, wash basin, toilet, shower, nurse call system, and two upholstered chairs.

Authority Relationships

4 North management uses a total patient care system.

This means that all care provided to a patient is provided by either an RN or an LPN. The unit is moving toward development of a case management system of care delivery in which RNs plan twenty four hour care for patients during their entire lengths of stay. This change requires a different mix of staff. Historically staffed predominantly by RNs, 4 North management is now beginning to integrate the LPN and the health care assistant roles in care delivery. These roles have traditionally been performed by nurses aides.

Because cardiac care involves life-threatening diseases for surgical procedures, health care professionals have traditionally assumed that these patients need to have the highest level of care available at all times. By substituting lower paid workers to perform certain lower-skilled tasks, the professionalism of RNs can be upgraded. RNs can devote their skills to assessing, planning, and coordinating care delivery. As a result, the patient gets

more attention because the nurse administrator can send a lower paid person into the room more often than a higher paid RN.

4 North is very traditional with regard to authority relationships in care delivery. Doctors assume responsibility for the medically specific aspects of care. For example, doctors prescribe medications, diet restrictions, levels of activity, lab work, tests, and treatments. Nurses, on the other hand, are responsible for coordinating patient care. Nurses provide basic nursing care, such as administering medications and monitoring patient stability.

In one respect, the role of nurses on 4 North is slowly beginning to evolve away from the traditional model. As nurses make the transition to a system of case management, they are beginning to increasingly function as advocates for their patients. Doctors in the traditional model were viewed as experts and directors of all care. The case management approach to care delivery is providing opportunities for nurses to communicate information to doctors and to make more decisions.

Patient Education

The level of patient education provided on 4 North depends upon which illnesses are being treated. Because of decreasing lengths of stay and rapid patient turnover, education is generally individualized. The only exception to this rule is a bi-weekly diet class that is offered to patients with a variety of illnesses. Although patients are permitted to make meal selections from the hospital's food service menu, dietary counseling is individualized. Patients on 4 North receive individual consultation for a variety of other services, including physical therapy, occupational therapy, cardiac rehab, pastoral care, social services, and respiratory therapy.

For open heart patients, pre-operative education is provided. This information covers what patients should expect as they are being prepared for surgery, as well as discussion of post operative procedures. Patients are also given a tour of the intensive care unit by a nurse from 4 North. During the tour patients are provided with opportunities to ask questions about apparatus and procedures. During the period leading up to discharge, the staff on 4 North does approximately 90 percent of the education concerning the patient's medication and allowable activities after discharge. Physicians provide approximately 10 percent of the teaching concerning what

patients can do at home, what the patients' limits are related to their illness, and how to treat incisions. Cardiac rehabilitation nurses teach activities which enable patients to increase their levels of activity. Then the dietician sees the patient to talk about his/her diet. Additionally, if a patient has a unique need occupational therapy can be brought into the process.

Angioplasty patients receive pre-procedure information. The nursing staff talks to patients about risk factors, life style modifications, coronary artery disease, and medications. Because these patients are in the hospital for only a short term, the bulk of their education falls to physicians and nurses in the office prior to admission to the hospital. All cardiac patients are provided with education regarding their medications, the treatments they are receiving, and an explanation of what their diagnosis means. The process is generally informal and geared towards the needs of the individual patient.

One of the goals of cardiovascular rehabilitation on 4 North is to make the education process more formalized so that standard plans of care can be taught to patients with specific illnesses. The cardiac unit is unique in that they treat six or seven primary diagnoses so they can target education programs at those particular diagnoses. Standardization can then be individualized.

If patients ask questions that the nurses are unable to answer, the nurses either try to find the answer, or redirect the question to the patient's physician. It is uncommon for patients to ask for additional information beyond what is presently provided. The hospital does have a medical library on the premises which is open to the public, as well as medical personnel. However, patients and their families rarely utilize this service.

Patient/Family Involvement in Care

Patient and family involvement in the healing process is not very evident in present practices on 4 North. Generally, there is still a very strong sense that the nursing staff is primarily responsible for care of the patient. However, nurses are beginning to accept increased involvement of family members in the care process if family members express an interest.

Typically, willingness to be involved in self care varies with age and personal characteristics. In the elderly population there seems to be a great resistance to wanting to do some of their own care. With the younger population, the level of involvement depends upon the person. As a rule, younger patients tend to be more critical than elderly patients of how care is delivered. Elderly patients have generally learned to assume a passive

role in health care delivery through a lifetime of exposure to traditional care models.

If the patient will need help administering medication, families tend to get involved in the process prior to discharge. However, family members must indicate that they would like to be involved. Inclusion of patients or their families in the administration of care is not automatic.

Summary

Traditional health care models view treatment as episodes of limited duration in response to existing medical problems. They also foster dependency of patients and their families. In order to move away from traditional models, everyone must be educated to pursue preventative health care and to view the hospital not just as an institution that treats illnesses, but also as a place that can assist in teaching patients how to take care of themselves. Preventative care can be emphasized even in acute settings where episodic care has been the norm.

4 North is very traditional in some respects. Patient and family involvement in care is minimal. Patient education is largely individualized. Patients assume very little responsibility for care outcomes in the present system.

The ambiance of the physical environment of 4 North represents a progressive step towards cooperative care design. Also, the evolving role of 4 North nurses as advocates for

their patients is providing patients with opportunities to question traditional authority relationships and communication networks.

Chapter III discusses in greater detail some of the experiments taking place in other health care institutions consistent with alternative care models.

CHAPTER III

Profiles of Alternative Care in Health Care Institutions

Acute care institutions have been experimenting with cooperative care concepts for more than 25 years¹. During this time, a few institutions have established hospital-based cooperative care centers to practice alternative care delivery methods. These centers vary widely in terms of size, populations served, admission criteria, and scope of practice². To describe the implementation of alternative care concepts in hospital settings, characteristics of two of the most prominent hospital-based cooperative care centers are delineated in this chapter.

The New York University Cooperative Care Center is among the largest, oldest, and most thoroughly studied cooperative care centers. Other health care institutions have used the NYU unit as a model for designing their own cooperative care centers³. Because the NYU unit provides a comprehensive illustration of cooperative care concepts, it was selected as a primary example in this chapter.

The Planetree Model Hospital unit is more comparable in size to St. Patrick Hospital's 4 North than the NYU unit. Planetree guidelines adhere to the same primary goals as the NYU unit; to improve patient outcomes by facilitating independence and patient education. However, standards for

admission and the role of family involvement in the Planetree and NYU units are different.

New York University Cooperative Care Center

The New York University Medical Center is a 726 bed acute care facility. Six hundred and twenty two of these beds are located in the traditional wing of the hospital. Two hundred and eight beds (104 patient rooms) are located in the Cooperative Care Center wing of the hospital. The NYU Cooperative Care Center opened in 1979.

The criteria for admission to the NYU Cooperative Care Center (CCC) are (a) the patient is ambulatory, self-mobile or mobile with limited assistance; (b) the patient does not require nursing contact more frequently than every 6 hours; (c) the patient goes to the hospital's therapeutic center for treatment by appointment; and (d) the patient's nursing needs are of an episodic nature⁴. Fifty percent of the patients admitted to the CCC are transferred from the traditional wing of the NYU hospital. The other fifty percent are directly admitted to the CCC for treatment or for invasive diagnostic procedures⁵. All patients are subject to the same utilization review procedures as other acute care patients.

A significant component of NYU's CCC is the utilization of care partners in the healing process. A care partner may

be either a family member, friend, or volunteer. A care partner's responsibilities include assisting the patient with activities of daily living, participating in the learning process regarding life style changes, and being a supportive companion throughout the hospitalization. The care partner learns along with the patient about the diagnosis, the medication, and the treatment program. Together they learn to perform many of the tasks traditionally handled by hospital staff members, such as changing dressings, taking patient's temperatures, testing urine samples, or administering medications⁶.

The care partner role is different from the care giver role. The care partner and patient share responsibilities. As the patient regains physical health, the care partner gradually decreases participation. The ultimate goal is for the patient to independently assume all health care responsibilities⁷.

The physical environment of NYU's Cooperative Care Center (CCC) is designed to be more home-like than the traditional hospital model. The 104 patient rooms (floors 9-13) are private and quiet because they are removed from the unit's Therapeutic and Education Centers (14th floor), and the dining room, lounge, and recreation area (15th floor). Each room has two beds, one for the patient and one for his or her care partner. The care partner stays with the patient for twenty four hours a day during

hospitalization. The rooms have large windows to permit natural lighting. Patient rooms are carpeted and furnished with cloth upholstered chairs. The only aspects of the physical environment in patient rooms that emulate the traditional model are the grab rails and emergency signal chords in the unit's bathrooms.

No physicians, nurses, or nurse-aides are assigned to the patient-room floors. Cooperative Care patients are brought to the 14th floor by their care partners for clinical nursing, physician assignments, treatments, and for comprehensive individualized and group educational sessions⁸.

Upon admission to the CCC, patients are first seen in the Education Center, where their condition and the availability and skill level of their care partner is assessed. The Education Center has a multi-disciplinary medical team, consisting of nurse-educator, nutritionist, social worker, movement therapist, and pharmacist. A nurse-educator screens patients and care partners to determine their ability to function in the cooperative care program. After screening, the patient and care partner view a video tape which provides an orientation to cooperative care. The specific learning needs of the patient and care partner are then identified by the nurse-educator for immediate or later instruction.

All educational protocols are developed in consultation with and reviewed by the appropriate specialist on the CCC team. They are also reviewed by the unit's medical director and the Cooperative Care Committee of the hospital's Medical Board. The programs, taught by trained educators, are reviewed and updated annually⁹.

Formal education procedures at NYU's CCC are targeted at improving long-term health outcomes. Patients, care partners, and family members that will be involved in post-hospital meal preparation are encouraged to attend regularly scheduled classes on such topics as diet and coronary risk factors, low sodium diets, diabetic and weight reduction diets, stress management, and exercise.

While formal patient learning takes place in the Education Center, daily patient "care-conferences"¹⁰ are held to monitor the patient's ability to assimilate and use the information that they have been taught. These conferences are round table discussions which involve all members of the multi-disciplinary medical team. The conferences are used as one method of monitoring and evaluating the patient's ability to self-administer medications and follow proscribed regimens.

Patients and care partners are also provided with a daily schedule of appointments. Patients that miss appointments can be contacted by telephone, or paged on the hospital's public address system.

Patients have numerous opportunities to practice the skills that are taught in the education center on the CCC's 15th floor. Patients and care partners eat cafeteria style meals in the dining room. A nutritionist is on hand to assist them with special dietary needs and to reinforce nutritional education. Patients and care partners can exchange information and socialize with others in the lounge which is adjacent to the dining room.

After initial assessment has been completed in the Education Center, the patient and care partner then proceed to the Therapeutic Center, where a senior-nurse-clinician performs a more thorough assessment of the patient's physical condition. The diagnostic and therapeutic regimens ordered by the patient's physician are initiated, and further treatments are scheduled.

The Therapeutic Center has eleven examination rooms and a six-bed observation room. When emergencies arise, patients are brought to the observation room for more intensive treatment and monitoring. If necessary, patients are transferred to the traditional wing of the hospital.

The NYU center embodies all of the cooperative care concepts which are defined in the Chapter I model. A strong reliance on patient and family involvement in care, coupled with a unique physical environment, make the NYU unit an interesting forum for experiments in alternative care. However, the scope of activities at the NYU center exceeds

the alternative care needs of smaller hospitals. Therefore, smaller alternative care units have been designed to facilitate cooperative care concepts within the structural limitations and staffing requirements of smaller hospitals.

The Planetree Model Hospital Unit

The Planetree Model Hospital unit is a 13-bed cooperative care center. Planetree is located in Pacific Presbyterian Medical Center, a 272-bed tertiary care hospital in San Francisco. The unit opened in June of 1985.

Although established on a smaller scale than the NYU Cooperative Care Center, this unit also required renovation of existing space to produce a home-like environment for patients. The renovations included construction of a kitchen, patient lounge and open nurses' station. The kitchen is equipped with a refrigerator, stove, microwave oven, sink, and storage cabinets. Adjacent to the kitchen is a small lounge decorated with artwork and comfortable furniture. The traditional nurses station, which separated patients from hospital personnel as well as their medical charts, was eliminated. Fluorescent light fixtures were replaced with track lighting to produce indirect lighting of the unit. Equipment and supplies are stored in oak-paneled cabinets and closets. The entire unit is carpeted.

The number and size of the patient rooms remained unchanged during the renovation. The unit contains three private and five small semi-private rooms. The rooms were repainted in subtle colors. The traditional white curtains were replaced with curtains in various pastel colors. Floral sheets and colored bedspreads replaced traditional linen. Bookshelves and bulletin boards were also installed in patient rooms¹¹.

In addition to the physical changes in the care delivery section of the unit, the Planetree Health Resource Center was built. The purpose was to increase access to health information. The Resource Center provides medical and health information, as well as in-depth research services to the public. The Resource Center contains a clipping file of current medical research, catalogues of referral groups and agencies, and a bookstore.

Information from the Planetree Resource Center is provided to patients during hospitalization and also after discharge. To encourage patient use of the Resource Center after discharge, patients are issued a membership card. Members receive discounts on the purchase of printed materials, and receive a quarterly newsletter containing a variety of health and medical information. Non-patient memberships to the Planetree Resource center cost \$35 annually¹². A membership is not required, however, to

check out reading materials from the library section of the Resource Center.

All patients admitted to the Planetree unit receive orientation packets containing information about the hospital and Planetree. Most packets include a description of the patient's medical condition, as well as causes, and potential treatments. Patients are also provided with written descriptions of any tests or procedures that they will be undergoing during hospitalization. If patients are taking any medication or are prescribed a new medication, they receive directions on proper usage, warnings of possible side effects, and precautions concerning administration of the medications¹³.

A major difference between the admission requirements of NYU's CCC and Planetree is that Planetree is open to all non-intensive care patients, not just those who have the ability to move around the unit. The small physical size of the unit, combined with the use of primary nursing as the means of care delivery, reduce the need for patient mobility within the unit.

With primary nursing, one nurse provides the majority of care for one patient during the hospital stay. The primary nurses function as facilitators of education and skill training. The staff includes, a .75 FTE project coordinator, 10 RNs, 2 licensed vocational nurses, 1 patient educator, 1 nutritionist, 1 health and arts coordinator, and

20 percent of one of the staff nurse's time to act as nurse coordinator of the unit¹⁴.

The patient educator and nutritionist support the primary nurse. The health educator prepares the diagnosis, treatment, and medication fact sheets, and provides materials from the Planetree Resource Center that address the patient's illness. The nutritionist counsels the patient regarding dietary expectations. The nurse's role is to explain medical jargon so that patients can read, understand, and carry out treatment regimens¹⁵.

There is no care partner designation or requirement at Planetree. This represents a major departure from philosophy of the NYU CCC unit. Communication between care givers and patients is more direct in the Planetree unit. Although family or friends of the patient are encouraged to become involved in educational activities at Planetree, the thrust of the Planetree philosophy is to promote patient self-reliance. Family and friends are permitted 24 hour visitation, and may sleep in the patient rooms or in the lounge.

A typical example of family involvement at Planetree is meal preparation in the unit's kitchen. Patients first receive nutritional counseling by the units' clinical nutritionist. Patients then select meals from the hospital's standard menu. As an option, family members can store and prepare food in the Planetree kitchen. The

nutritionist uses this opportunity to teach patients and their families new ways to prepare food that can be used when they return home. Families and friends are also invited to attend periodic stress management classes.

Patients are included as one of the team members in managing their care. They are included in meetings with physicians and nurses to discuss treatment programs. Planetree patients have access to their own medical charts and are encouraged to chart their own progress and to make entries on their medical charts¹⁶. Patients may also sign a release form which enables family members to write on their medical charts. The primary nurse assists the patient in interpreting the charts.

Another component of cooperative care in the Planetree unit is the inclusion of arts and entertainment in the healing process. Original artwork hangs in the patient rooms and hallways. Tape players and a variety of music and relaxation cassettes are provided. Movies are also available for patients and their families to view in the lounge.

Whereas the NYU unit is afforded the luxury of an expansive physical environment and a larger staff, the Planetree unit is also successful in providing alternative care within the limitations of a smaller hospital environment. Patient education is the primary focus on the

unit. Increased patient access to health related information is a primary objective of alternative care.

Aspects of Cooperative Care In Other Institutions

The demand for patient-centered education information has fueled the development of patient-centered learning materials. For example, in 1975, 57 percent of hospitals responding to a survey reported to have one or more patient education programs with written goals and objectives. By 1978, this percentage had increased to 62.4 percent. A 1987 census of hospital-based health promotion and patient education programs documented that 87 percent of responding institutions reported having inpatient education and 73 percent outpatient education services¹⁷.

The Patient Education Facilitators Group and Department of Nursing Continuing Education of Vanderbilt University have developed a program which creates patient education materials. These materials are utilized by patients and their families in the Vanderbilt University Cooperative Care Center. These materials address preoperative teaching, drug information, home care procedures, tests and examinations, and disease processes. Samples of these materials are included in Appendix A.

To enhance patient participation, nurses at Beth Israel Medical Center in Newark, use contracts. The contract is a

means by which the nurse and patient establish mutual goals¹⁸. During the admission assessment, the patient and nurse discuss the reason for hospitalization and what the patient hopes to accomplish during the hospital stay. This contract helps to clarify both nurse and patient responsibilities.

Summary

A number of hospitals are experimenting with alternative care systems. Physical environment, authority relationships, patient education, and patient/family involvement in care are among the variables that are being scrutinized. The overwhelming majority of the literature which describes alternative care practices in hospitals provides a rosy scenario for the future of alternative care practices.

In chapter IV, obstacles and objections to the implementation of cooperative care concepts in hospital settings are provided. Specific attention is given to the adaptability of these concepts to St. Patrick hospital's Cardiac Services Unit, 4 North. Chapter IV concludes with recommendations for changes in care delivery practices on 4 North.

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Chapter IV

Recommendations for Alternative Care Concepts on 4 North

In Chapter IV, the obstacles and objections to alternative care are described. Recommendations for changes in care delivery practices on 4 North are then provided. Recommendations for further study of the feasibility of implementing cooperative care concepts on 4 North are included.

Obstacles and Objections to Alternative Care

Hospital-based alternative care programs hold great promise for improving health outcomes for patients, increasing patient and staff satisfaction, assuring quality of care, and increasing patient compliance with medical advice¹. While care givers and consumers support these objectives, few institutions have adopted alternative care approaches. One reason hospitals are slow to assimilate alternative care procedures is that few formal evaluations of experiments in alternative care have been completed.

Dr. Diane Martin, a professor in the Department of Health Services at the University of Washington, Seattle, recently completed a three year study of the Planetree Model Hospital Project at Pacific Presbyterian Medical Center, San

Francisco. The study compares the health status, satisfaction, utilization, and cost for Planetree patients with patients in traditional medical-surgical units of Pacific Presbyterian Medical Center. Physician and nurse satisfaction with alternative care practices is also evaluated.

Unfortunately, the results of Dr. Martin's study are not due to be published until mid-year 1992. However, Dr. Martin writes that preliminary results indicate improved patient satisfaction with the care delivered on the Planetree unit as compared with patient satisfaction with care delivery in the traditional medical-surgical units of the hospital².

The preliminary results from Dr. Martin's study also indicate some of the potential problems that were encountered while initiating the Planetree project. For example, the actual remodeling and renovation costs far exceeded the original estimates (\$175,000 instead of \$120,000). Additionally, Planetree was the first unit in the hospital to adopt primary nursing, a self-medication program, and patient education materials. Therefore, the unit staff was perceived as being a favored elite and the changes met with resistance from other hospital personnel. It was also difficult to create new unit procedures and guidelines that fit within existing hospital policies.

Finally, nurses in the Planetree unit experienced

initial discontent. Their anticipation had fostered unrealistic expectations for a smooth transition from a traditional model of care delivery to a more cooperative/teaching model. The increased amount of interactions with physicians, patients, and their families was initially overwhelming³.

One of the more controversial issues at Planetree is whether or not patients should have open access to their medical charts. Planetree patients are encouraged to read their own charts and to ask questions about what they read. Some doctors view medical charts not as tools for patient education, but rather as permanent records which function as a means of communication between care providers⁴. These physicians contend that patients with limited knowledge of medical terminology may misinterpret the information on the chart.

Other doctors view the open chart policy as a way to improve patient understanding of the medical process. Nurses tend to favor open charts because this policy reduces the need for nurses to censor information. Nurses can use the information the doctor has written on the charts when they talk with the patients.

Barbara E. Giloth, Manager of Patient Education for the Division of Ambulatory Care and Health Promotion of the American Hospital Association, defines environmental, organizational, and program planning barriers that reduce

the effectiveness of patient education programs by preventing or decreasing the patient's active contribution⁵. First, the sense of loss of control, lack of privacy, and isolation that patients experience during hospitalization reduces the patient's desire to pursue an active role in their care. Second, the recent trend towards decreased lengths of stay per hospital visit reduces the time care providers have to educate their patients. Third, the task-oriented nature of care delivery enables care givers to deliver care with minimal interactions. Fourth, physicians have been trained to treat patients rather than to teach them. Additionally, while nursing programs have included teaching skills in their curriculums, nursing students have not been well prepared to integrate teaching into demanding work schedules which emphasize physical care.

Similarly, A.E. Bedell charges that hospitals focus on cognitive rather than behavioral interventions⁶. More important than developing a medical understanding of their diseases, patients need to understand their illnesses as problems of living. Critical strategies, including skills training, family involvement, and the development of opportunities to practice skills in realistic situations, must be maximized.

Recommendations for Alternative Care on 4 North

The types of changes that will assist in the development of a cooperative approach to care delivery are (a) changes in the physical environment to increase patient education/patient involvement, (b) development of strategies which assist in creating a healthy organization, (c) making information giving and patient involvement in decision making an integral part of the care process, (d) increasing patient and family involvement in care delivery, and (e) helping patients adapt regimens to their own lifestyles¹.

As mentioned in chapter II, the physical environment on 4 North is much more homelike than the traditional Broadway building. The greatest environmental factor which limits patients and care providers is the inaccessibility of educational materials on the unit. The hospital library is located in the Broadway building, which necessitates two elevator rides and a hike through a winding corridor.

One possible method to improve availability of information is to include pamphlet racks in the units' lounge. Also, resource files including patient education materials for the primary diagnosis of the unit could be made available to patients upon admission. Samples of patient education materials used at the Vanderbilt University Cooperative Care Center are included in Appendix A for reference.

Although inclusion of a kitchenette on 4 North would

undoubtedly increase opportunities for patient dietary education, the physical limitations of the present structure are prohibitive. Instead, learning opportunities which currently consist of hospital-based dietary classes and inpatient menu selections should be extended beyond the walls of the hospital. An example of a community-based dietary education program is the Minnesota Heart Health Program⁸. In this program, restaurant and store owners work in conjunction with hospital personnel to identify low fat, low sodium meal options which support good nutrition. Store shelves and menus are then labeled, perhaps with a picture of a heart, for easy user identification.

One of the most impressive characteristics of the alternative care providers reviewed for this study is the value each places on inputs from all the people involved in care delivery. Transition from the traditional, authoritarian model of care delivery to a more cooperative model requires changes in organizational strategies. Rather than imposing changes in a top-down management style, physicians, nurses and patients must be included in the planning process.

Another strategy to enhance organizational health is the use of staff support systems. For example, the Planetree unit developed support groups to deal with the issue of staff stress. With all of the transitions that are necessary in adaptation of a more cooperative approach to care delivery, meaningful communication networks must be established.

Information giving and patient involvement in decision making are also significant components of the care delivery process. Because average lengths of stay for patients have decreased in recent years, the importance of hospital-based education has increased. Therefore, the teaching opportunities that occur during hospitalization must be utilized.

Integration of the patient into the care delivery dialogue is essential to develop a cooperative system. One way to involve the patient in dialogue is evidenced in care practices at Planetree. Patients are permitted to make small decisions concerning sleeping patterns and personal clothing. Although these decisions are minor, they function to establish the foundation for a more active role for the patients.

Increasing patient and family responsibility for care outcomes can reduce the stress of hospitalization, and prepare people more effectively for the post hospitalization period. One way to facilitate patient and family responsibility is the use of patient contracts. For example, at Newark's Beth Israel Hospital a primary nurse first discusses with each patient his or her needs related to nursing care. The nurse then develops a contract that specifies what care the patient will provide and what care the nurse will provide. This process individualizes the care delivery process, establishes lines of communication, and offers a foundation for

renegotiation as the patient's condition changes⁹.

Family involvement presently provides critical emotional support for the patient. One way to increase the level of family involvement in care is to teach family members and volunteers the skills needed to assist in caring for the patient. Individualized opportunities to teach occur during daily care procedures. However, few hospital-based classes include formal training and practice of skills that facilitate family involvement in care. More instruction which includes hands-on opportunities for patients and families to practice skills is needed.

Summary

As the acuity levels of hospital patients continue to increase, combined with growing issues of health resource constraints, it is paramount that health care providers utilize all resources in the most efficient and effective manner. Patients and family members are valuable resources which have traditionally been under-utilized in health care delivery. Care providers are now in a position to facilitate more active roles for their patients and family members.

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APPENDIX A

Samples of Patient Education Materials

Vanderbilt University Hospital



INTRODUCTION/PURPOSE:

Gastrostomy feedings are a way to feed an infant by means of a soft rubber tube which is surgically placed directly in the stomach through the abdominal wall. Depending on your infant's condition, the gastrostomy tube may be a permanent or temporary means of feeding. The doctor may allow feedings by mouth to be started slowly while the tube feedings are reduced. If the doctor decides the gastrostomy tube is no longer needed, he will easily remove it in the office, and the opening in the stomach will gradually heal.

SUPPLIES:

(FEEDING)

Catheter-tip syringe
Formula

(DRESSING CHANGE)

Tape
Gauze with slit
Regular nipple
Cleaning supplies

PROCEDURE:

(FEEDING)

- Measure the amount of formula to be given and warm it to at least room temperature.
- Place infant in sitting position in your arms, or on the right side with head and chest slightly elevated.
- Unclamp the gastrostomy tube and put the syringe barrel tip in the end of the tube.
- Use this step if doctor wants to continue checking for residual (undigested formula): Lower the barrel to check for undigested formula and to allow any trapped air (burps) to escape.
- Pour the formula into the syringe barrel.
- A gentle push with the syringe plunger may be necessary to start the flow of formula, but then remove the plunger to allow the formula to flow in by gravity.
- Move the syringe so the height will give a slow, regular flow of formula. The tube feeding should take about the same amount of time as feeding by mouth would. Encourage your infant to suck on a pacifier during the tube feeding so that the infant will relate sucking to feeding.
- After finishing the feeding, clamp off the tube or leave the syringe barrel in the tube. Keep the syringe elevated. Keep your infant sitting up or on right side with head elevated for one hour after feeding.

PROCEDURE:

(DRESSING CHANGE)

The dressing should be changed every other day unless it becomes soiled; if it does, it should be changed at least daily.

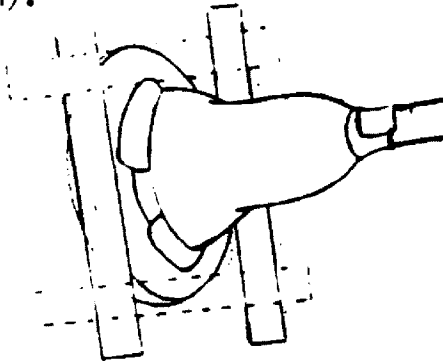
- The nipple should be changed when it looks soiled.
- Remove the old dressing carefully.

-OVER-



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- Clean the area around the tube with mild soap and water. Pat dry (Hydrogen peroxide may be used if the doctor has recommended this.)
- Apply the gauze with the slit fitting around the tube.
- Cut tape to hold the gauze under the nipple. A half-circle may be cut in the middle of the tape so the tape will lie flat (see diagram).



- Alternate placement of tape (tape up and down one time, then side to side the next, etc.) with each change to reduce skin irritation.
- When changing the nipple, a hole should be cut in the top of the nipple and then a slit along one side to fit around the tube.

CARE AND MAINTENANCE OF SUPPLIES AND TUBE:

- Clean the syringe after use with hot soapy water, rinse well, and allow to dry.
- Keep skin around the tube clean and dry to prevent skin breakdown and infection.
- Avoid extra pulling on the tube as it can cause the opening to widen and stomach contents to leak out. Also, the tube may pull out.
- During a follow-up visit for your infant, you may be taught how to put the gastrostomy tube back in if it accidentally comes out.

CALL THE PHYSICIAN/NURSE IF:

- Watch for signs of infection at the gastrostomy tube site (redness, swelling, drainage) that continues even with good skin care.
- Call the doctor if your infant begins to leak stomach contents from around the opening in the skin.
- If the tube accidentally comes out before you have learned to replace it (or if you have difficulty replacing it), put clean gauze over the opening and call the doctor. Or, take the infant to the emergency room within one to two hours.

DN-0006-HC-87



SINEMET

Levodopa/Carbidopa

(lee-vo-doe-pa/car-bi-doe-pa)

General Information

Levodopa and Carbidopa are medicines used together to help treat patients with Parkinson's Disease. Levodopa can be used by itself to treat Parkinson's disease. Carbidopa is given with levodopa to decrease the side effects seen when levodopa is used by itself. These medicines help to control the movement problems seen with Parkinson's disease. Levodopa and carbidopa can be used together or separately to treat certain other diseases. These medicines are sold together under the brand name Sinemet.

WHEN should I take this medicine?

Levodopa and Carbidopa are usually given three or four times daily with meals. Your doctor has determined the best way for you to take this medicine.

What SPECIAL INSTRUCTIONS should I follow while taking this medicine?

If you cannot swallow the tablet, you may crush it, and take it in a small amount of fruit juice.

This medicine can react with many other medicines-tell your doctor about any other medicines you take.

Your doctor may want to increase your dose of this medicine after you take it for a while. Be sure to keep all appointments with your doctor.

It may take as much as 2-3 months for this medicine to have its full effect. Continue to take this medicine as directed even if it does not seem to be working.

If you have been taking levodopa by itself, ask your doctor or pharmacist how to begin taking levodopa/carbidopa.

This medicine may make you drowsy or dizzy. Do not drive a car or use dangerous machinery until you know how this affects you.



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What SIDE EFFECTS can this medicine cause? What can I do about them?

Call your doctor if you notice any of the following side effects.

- | | |
|---|---------------------------|
| -dizziness | -fainting |
| -muscle spasms | -uncontrollable movements |
| -seeing or hearing things
that are not there | -heart flutters |
| -strange behavior | -confusion |

Some side effects are less serious. Call your doctor only if the following side effects continue to cause problems.

- | | |
|-------------------|---------------|
| -dry mouth | -hiccups |
| -nausea | -headache |
| -loss of appetite | -constipation |
| -tiredness | -nightmares |

This medicine can cause other side effects. Be sure to ask your doctor or pharmacist if you notice any unusual or troublesome problems.

What should I do if I FORGET to take a dose?

Take a missed dose as soon as you remember it. Take the remaining doses for the day at equally spaced times.

Never take two doses at one time to make up for a missed dose.

What STORAGE CONDITIONS should I use for this medicine?

Keep this medicine in its bottle. Keep the bottle tightly closed and keep the bottle in a dry place away from children.

What SPECIAL PRECAUTIONS should I take while using this medicine ?

If you are a diabetic and test your urine for ketones, Sinemet may cause the results to be wrong. Do not change your insulin dose based on these tests without talking to your doctor first.

Tell your doctor about any other medicines you take.

If you need to have surgery or dental work done be sure to tell the doctor that you take Sinemet.

DEPARTMENT OF PHARMACEUTICAL SERVICES
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CARDIAC CATHETERIZATION

Cardiac catheterization is a test that looks at the structure and function of the heart. This test allows your doctor to look at the chambers and valves of your heart as well as the coronary heart arteries to see if a blockage exists.

WHERE IS THE PROCEDURE DONE? HOW LONG DOES IT TAKE?

The test is done in the Cardiac Catheterization Laboratory on the first floor of the main hospital. The test usually takes from 1 to 2 hours from the time the doctor begins. This does not include waiting time or the time needed to set up equipment. It may take longer for patients who need more studies of their heart.

WHAT PREPARATION IS REQUIRED?

The evening or night before your cardiac catheterization, the doctor who'll do the test will explain it to you. You will be asked to sign a consent form giving permission for the test to be done.

You should not eat or drink anything after midnight the night before the test but you may take sips of water to swallow your medicine. Sometimes the doctor may order a clear liquid breakfast if your test is to be done later in the day.

The area where the catheter will be placed (usually the top of your leg) will be cleaned and shaved.

If you are taking blood thinners or medicine for diabetes, check with your nurse before taking them.

WHAT SHOULD BE EXPECTED IMMEDIATELY BEFORE THE PROCEDURE?

You will be asked to put on a hospital gown and empty your bladder. Intravenous (IV) fluids will be started in a vein in your arm.

(OVER)

The nurse will give you an injection to relax you but it will not put you to sleep. You may wear dentures and glasses. You will be put on a stretcher and taken to the Cardiac Catheterization Lab.

WHAT CAN BE EXPECTED DURING THE PROCEDURE

You will be awake and lying on your back on an x-ray table during the entire test. A large movable x-ray machine will be above you. You will also see TV screens. On these screens you will be able to see the pictures that are taken of your heart during the procedure. Even though a cardiac catheterization is not considered surgery, the doctors and nurses will wear surgical gowns and masks to help keep the equipment sterile. EKG leads will be attached to your chest so your heart can be monitored during the test. Sterile drapes will be placed on your abdomen. The area over the top of your right leg (the right femoral artery) will be cleaned with a soapy solution, draped with sterile towels, and then numbed with a local anesthetic. A needle is placed in the artery and through this needle a catheter (long, thin tube) is threaded to the heart. An iodine dye is injected through the catheter. The dye may cause an intense burning sensation which lasts for about ten seconds. You may have headache, nausea, chest pain, or fluttering of the heart. These are not serious but you should tell your doctor.

After the test the doctor will remove the catheter and will hold firm pressure over the site for 15 to 20 minutes. This helps stop the bleeding from the site. A large dressing will be placed over the area and you will be taken back to your room.

WHAT SHOULD BE EXPECTED IMMEDIATELY AFTER THE PROCEDURE?

Once you are back in your room your nurse will check on you frequently, take your blood pressure, check for bleeding in your groin, and check the pulse in your foot. **You must stay in bed until your nurse tells you otherwise (usually 8-12 hours).** Your nurse will raise the head of your bed slightly but you need to remain basically flat. You will need to keep your leg straight. If you need to cough or sneeze you should place your fingers or hand over the bandage and press firmly. Be sure to report any bleeding or swelling that you see or feel in the groin area. You may eat and drink. You should try to drink at least one glass of water every hour unless your fluid intake is restricted. The nurse will take out your IV after a couple of hours.

After the films of your heart are studied, your doctor will talk with you about the results of your test.

DN-0011-TI-91

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ANGIOPLASTY

WHAT IS IT?

Angioplasty, or **Percutaneous Transluminal Coronary Angioplasty**, called **PTCA**, is a procedure used to widen tight spots in diseased blood vessels. A small tube, called a catheter, equipped with an inflatable end or balloon is passed through the narrowing or blockage and inflated. The inflation causes the blockage to be squeezed back against the walls of the blood vessel. The balloon is then deflated and removed, leaving the vessel open wider than before the procedure.

WHAT PREPARATION IS REQUIRED?

The area at the top of your leg will be shaved and cleaned to remove any bacteria on the skin. Do not eat or drink anything after midnight the night before the procedure.

WHAT SHOULD BE EXPECTED IMMEDIATELY BEFORE THE PROCEDURE?

Immediately before the procedure, a nurse will place an intravenous (IV) line in your arm to give you fluid and medicine if you need it. Before you go to the catheterization laboratory where the angioplasty will be done, you will need to urinate. You will also be asked to take out any dentures, partial plates, leave your glasses and all valuables with a family member and wear only a hospital gown. You will be given medicine to help you relax. You will not be completely asleep during the procedure, but you need to be comfortable. You will be transported to the cardiac cath lab.

WHAT SHOULD BE EXPECTED DURING THE PROCEDURE?

The procedure itself is very similar to a cardiac catheterization or arteriogram. Long thin tubes, called catheters, will be threaded through a tube in the artery of your leg and advanced up into your heart. The doctor

will find the exact place with the blockage and will thread the catheter with the deflated balloon over the blocked area. The doctor will then inflate the balloon for 60 to 90 seconds. Sometimes several inflations are required. If you feel any chest pain or discomfort during this procedure, let your doctor know right away. After the doctor is satisfied that the blockage is reduced, the balloon catheter will be removed. A small plastic tube may be left in your leg until the next day. This decreases your chance of bleeding from your leg immediately after the procedure and provides a quick way to get back into your blood vessels if you experience any complications. A large pressure dressing will be placed on your leg.

WHAT SHOULD I EXPECT IMMEDIATELY AFTER THE PROCEDURE?

Immediately after the procedure, you will be taken back to your room. Your nurse will check you frequently the first few hours to make sure you are not bleeding from the catheterization site. **If you feel anything warm or wet on your leg or if you notice blood, let your nurse know immediately.** In addition, you will need to lie with your leg straight for at least six to eight hours. If the plastic tube is left in, you need to lie still until six to eight more hours after it is removed.

After you return to your room, you may eat and drink. We encourage you to drink plenty of liquids to get rid of any x-ray dye that may have been used. Let your nurse know if you would like a lunch or dinner tray.

DN-0050-TI-91

•Vanderbilt University Medical Center

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