Discharge Needs of Allogeneic Transplantation Recipients

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Hematopoietic cell transplantation (HCT) recipients are one of the most complex patient populations to teach at the time of discharge. The purpose of this article is to discuss the qualitative themes that emerged at the time of discharge for 141 transplantation recipients who were enrolled in an advanced practice nurse (APN) intervention study. The APN intervention consisted of six teaching sessions, and the qualitative data for this article involved the first session at the time of discharge. Content analysis was conducted on the patient-initiated narrative content and structured into three groups: content scheduled to be covered at Session 1, content scheduled to be covered at a later session, and content that was not part of the scripted intervention. All topics were organized into the quality-of-life framework (physical, psychological, social, and spiritual or survivorship). Most of the patient-initiated topics, which were not part of the scripted intervention, were psychosocial in nature. Nurses need to be aware of the complex teaching needs that encompass not only physical issues but also psychosocial issues at discharge. That teaching awareness needs to be coupled with flexibility, competence, and comfort with challenging psychosocial issues.

The National Marrow Donor Program (NMDP), 2012 reported that about 25,000 allogeneic hematopoietic cell transplantations (HCTs) (e.g., bone marrow, peripheral blood stem cell, cord blood) are performed annually worldwide. This fast-growing specialty is considered a standard of care for many hematologic cancers. HCT recipients are perhaps the most complex population among patients with cancer because of the number of complications, increased mortality, long trajectory of rehabilitation, immune function complexity, and patient and procedure intensity. The first weeks and months after transplantation may be filled with unexpected readmissions and setbacks from factors such as graft-versus-host disease, infection, relapse, and gastrointestinal complications (Cooke, Gemmill, Kravits, & Grant, 2009).

When HCT recipients approach the time of discharge, distress may actually increase (McQuellon et al., 1998). The informational needs for the patient and caregiver can be overwhelming as they both struggle to learn about infections, infection precautions, eating again, rehabilitation needs, and signs and symptoms to immediately report to the healthcare team. Although patients look forward to leaving the hospital, the care remains very complex and informational needs are high at the time of discharge. Readmission rates of 51% have been reported with the HCT population, but adequate educational preparation at the time of discharge may have the potential to affect the number of readmissions and subsequent readmissions' length of stay (Grant, Cooke, Bhatia, & Forman, 2005). Transplantation units are trying various models of care delivery to lower costs and improve outcomes (Schmit-Pokorny, Franco, Frappier, & Vyhlidal, 2003).

Hospital stays have become shorter, diseases have become more chronic, technology has advanced, and hospitalized patients are more acutely ill with chronic conditions and complex needs (Foust, 2007). Interest has grown in refining discharge teaching for acute patients to decrease unscheduled readmissions and preventable complications. However, that interest to decrease admissions coupled with the shortened length of stay because of economic factors heightens the importance of adequate discharge teaching (Jacobs, 2000). Research has shown that patients' knowledge and information at discharge can be minimal and, in many informational areas of need, patients felt they were not given essential specifics (Holloway, 1996). HCT recipients remain one of the most fragile populations to prepare for discharge and present a challenge for the nurse to be information ready. The purpose...
of this article is to discuss the qualitative themes that emerged from spontaneous concerns that patients had during a structured teaching intervention study.

The study tested an advanced practice nurse (APN) intervention that focused on teaching the HCT recipient after discharge. Because the intervention was tailored, the APN addressed all concerns that the patients had, whether or not they were scheduled teaching topics. However, all spontaneous concerns were recorded to assess for qualitative data themes. The data were collected at the time of discharge for 141 allogeneic transplantation recipients. The overall goal of the larger study was to test a two-group intervention study (control versus intervention) designed to compare quality of life, functional status, caregiver issues, mortality, and treatment complications between the two groups of allogeneic transplantation recipients. The qualitative data arranged and presented in this article are from the spontaneous content initiated by patients at the time of the discharge teaching.

Methods

The data in this study are part of an institutional review board-approved larger mixed-methods study (Cooke, Gemmill, & Grant, 2008). Consent-ed intervention participants had six sessions with an APN. The first session, at the time of discharge, is the focus of this article. During that session, concerns about discharge were collected from participants in a nurse charting form called a debriefing form. The APN covered the manualized content in the intervention, and because the intervention was tailored, also addressed all additional questions from patients. The sessions ranged from 45–60 minutes long, allowing for covered content and any additional concerns that patients might have had.

Sample

The sample of 282 patients who participated in the larger study consisted of adult allogeneic transplantation recipients at a single site collected over a five-year period. The qualitative sample consisted of 141 patients who were enrolled in the intervention arm of the study.

Procedures

The intervention study consisted of six individual sessions with the patient. Family caregivers were encouraged and welcomed to attend any session. Content for each session was based on an extensive literature review on topics for allogeneic transplantation recipients and organized according to the quality-of-life model, which consists of physical, psychological, social, and spiritual and survivorship domains (see Figure 1). The first three sessions consisted of topics that dealt with the physical domain, whereas the last three sessions covered the psychological, social, and spiritual and survivorship domains, respectively. Session 1 was completed during the time of acute inpatient hospitalization before discharge, which was usually between day 25 and 35 post-transplantation, and included topics in the physical domain that were considered high priority because of the shifting of care from hospital staff to the patient and family caregiver at home (see Figure 2).

Analysis

Content analysis was conducted on the narrative comments provided by the nurse in the debriefing form, completed by the APN at the end of the first teaching session. The study team read and examined data to identify units of analysis, which were defined in paragraphs, sentences, verb phrases, or single words that conveyed a single meaning or concept (Miles & Huberman, 1994). The content was organized into three structured groups: topics covered during Session 1, topics that were scheduled to be covered in subsequent sessions, and topics that were not scheduled to be covered at all during the teaching sessions. All investigators participated in content analysis, with coding completed by at least two investigators. Discordant coding was reviewed by the team for final consensus.

Results

The average age of participants was 49 years (see Table 1). The majority of patients was Caucasian, had acute leukemia, received matched unrelated allogeneic transplantation, and

**FIGURE 1. Model of Quality of Life in HCT Recipients**

Note. Based on information from City of Hope Pain and Palliative Care Resource Center, 2012; Ferrell et al., 1992a, 1992b; Grant et al., 1992; King et al., 1995; Schmidt et al., 1993; Whedon & Ferrell, 1994.
underwent reduced-intensity transplantation. Reduced transplantation have many concerns at the time of discharge. Content that patients initiated at discharge included possible orders in clinic to prepare patient’s expectations (e.g., IV fluids, procedures) and outpatient clinic routines. Family relocation was not uncommon. The travel away from social support networks seemed to contribute to isolation and family upheaval. Financial concerns were common at the time of discharge, as patients faced significant copays for outpatient medications and often found that the cost was more than they expected. Cultural issues also were a concern for some patients, particularly those who had language and dietary issues. In addition, it was not unusual for the patient to retell the story of the diagnosis and trajectory to transplantation at the first visit with the APN. Often, those patients felt the need to share the challenges along the journey in an effort to “be known” by the APN.

Discussion

Transplantation recipients have many concerns at the time of discharge. Content that patients initiated at discharge included all domains of quality of life: physical, psychological, social, and spiritual and survivorship. In regard to physical issues, the topics initiated by the patients tended to be covered at subsequent

Patients initiated topics that were slated to be covered in subsequent sessions, including diet details, physical symptoms, emotional and psychosocial issues, family role change, sexual issues, caregiver strain, and resources for financial needs. Because the intervention was tailored, all topics included in the content were discussed, but the APN-led intervention also addressed spontaneous, patient-initiated topics, including diabetes and blood sugar control, comorbid illnesses, homesickness, worry about pets, caregiver issues (e.g., defining who the caregiver was), childcare and coping issues with children, family disruptions, marital conflicts, family relocation, financial concerns, cultural issues, and retelling the story of the diagnosis and journey. Several patients had developed steroid-induced diabetes because of the treatment for graft-versus-host-disease, and although followed by the endocrinology service and taught by a diabetes educator before discharge, they asked several questions about their diabetes management and long-term outcomes. Patients who received reduced-intensity transplantations often were older than the ablative transplantation recipients, and it was not unusual for them to have other comorbid illnesses and concerns. One patient had developed hearing loss from the antibiotic treatment of septicemia and needed hearing aids at discharge. Many of the patients expressed homesickness. The transplantations were performed at a tertiary National Cancer Institute–designated cancer center, so it was not usual for the patients to travel long distances from their homes. They often had to stay in on-campus outpatient housing or local hotels and expressed the desire to return to their own communities. Many patients expressed concerns about their pets, such as who would care for them, how the pets would adjust without them, when they could have contact with the pets again, and the level of contact they were allowed to have in the postdischarge period. Another issue was caregiver support. Although it was a mandated requirement that patients have caregivers after transplantation, some did not have full-time caregivers available to them. Some caregivers had to work to maintain the insurance, or care for children. Some patients also had to arrange rotating caregivers during the weeks post-transplantation. In addition, when caregivers fell ill, patients had to problem-solve how to continue caregiver coverage during a vulnerable time. A number of patients had children under the age of 12. One mother had an infant, and the APN discussed how bonding with the infant could occur while balancing her infection precautions (e.g., being restricted from diaper changing).

The stress of transplantation was challenging for some families, particularly those who exhibited behaviors of coping that were not helpful. For example, one caregiver began drinking alcohol while caring for her daughter, the patient. The intervention nurse enlisted the support of a social worker to set boundaries and help the caregiver cope with the experience in healthy ways. Some marital conflicts occurred during the time of discharge. One patient was served divorce papers during her post-transplantation. In addition, when caregivers fell ill, patients had to problem-solve how to continue caregiver coverage during a vulnerable time. A number of patients had children under the age of 12. One mother had an infant, and the APN discussed how bonding with the infant could occur while balancing her infection precautions (e.g., being restricted from diaper changing).

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- Mouth integrity protects against infection
- Reasons for mouth sores
- Strategies to help with mouth healing
- Skin integrity protects against infection
- Care of skin (e.g., soap, water temperature, moisturizer, use of sunscreen, sun protection)
- Mastery of care for venous access device
- Protection strategies
- Review the importance of adequate hydration.
- Review common strategies for hydration.
- Develop a strategy for hydration.

Outpatient clinic routines
- Review schedule for clinic visit.
- Possible orders in clinic to prepare patient’s expectations (e.g., IV fluids, procedures)

Signs and symptoms to report
- Review list of symptoms to report.
- Review who, when, and how to call to report a symptom.

Dehydration prevention
- Review the importance of adequate hydration.
- Review common strategies for hydration.
- Develop a strategy for hydration.

Medication review
- Discuss each medication’s role in the transplantation process.
- Populate an Excel® spreadsheet with the patient for administration of each medication.

Discharge review
- Discussion of teaching topics and relevant literature

Oral hygiene
- Mouth integrity protects against infection
- Reasons for mouth sores
- Strategies to help with mouth healing

Skin management
- Skin integrity protects against infection
- Care of skin (e.g., soap, water temperature, moisturizer, use of sunscreen, sun protection)

Venous access device care
- Mastery of care for venous access device
- Protection strategies

Outpatient clinic routines
- Review schedule for clinic visit.
- Possible orders in clinic to prepare patient’s expectations (e.g., IV fluids, procedures)

Signs and symptoms to report
- Review list of symptoms to report.
- Review who, when, and how to call to report a symptom.

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sessions and dealt with symptoms and diet, which was consistent with the literature. Compared to patients undergoing chemotherapy, the capacity for oral intake is less favorable in transplantation recipients (Mank, van der Lelie, de Vos, & Kersten, 2011). In addition, appetite loss, diarrhea, fatigue, and sleep disturbances have been reported in the literature at the time of discharge and within 100 days post-transplantation (Hacker & Ferrans, 2003). The physical issues that patients initiated focused on two main topics, hyperglycemia and comorbidity. Patients with hyperglycemia and steroid-induced diabetes needed more teaching content, which was interesting because they did spend time with a diabetes educator. Perhaps the patients needed more reinforcement or had additional anxiety regarding their blood sugar at home. The rate of acute graft-versus-host disease among transplantation recipients ranges from 12%–36% (Couriel et al., 2004). Graft-versus-host disease often is managed with the use of steroids in the acute phase, and steroids are known to be a risk factor in the development of hyperglycemia and diabetes in transplantation recipients (Baker et al., 2007; Fainman, Bilotti, Mangan, & Rogers, 2008). Tight blood sugar control is essential for better outcomes for transplantation recipients, and content on glucose monitoring and insulin injections needs to be routinely assessed before discharge (Voltarelli et al., 2007). Patients who are older also are more likely to have comorbid illnesses (Sorror et al., 2005, 2007). Managing comorbid illnesses was an unexpected topic for the APN nurse; however, the issue of comorbidity with transplantation recipients is becoming more and more common with older adult patients (Sorror et al., 2007). An approach to comorbid disease management is to collaborate with primary care providers. However, transplantations are typically done at tertiary transplantation centers and the primary care providers are in the community. That is certainly a breach in communication that needs to be improved in patients with comorbid issues. Transplantation nurses need to incorporate comorbid illnesses and adequate symptom management in the teaching content to provide more comprehensive instructions.

Psychological issues that were initiated by patients but scheduled for a later session were feelings of depression and anxiety. Those psychological responses are supported by Lee et al. (2005), who found that 44% of patients post-transplantation had symptoms of depression, anxiety, or post-traumatic stress disorder either at the first clinic visit after discharge or at 100 days post-transplantation. The other topics that patients wanted to discuss involved family role changes, which normally were discussed during the fourth session. Mosher, Redd, Rini, Burkhalter, and DuHamel (2009) found that 27% of patients were concerned about keeping their job, including work in the home. Other topics in the psychological domain were initiated by patients who were homesickness and concern about pets. The fact that many patients were homesick was an unexpected finding and has not been reported in the literature; however, it makes sense. These patients often are away from home for weeks at a time, away from the comfort of familiar people and possessions. The APNs suggested that patients bring in blankets, pillows, pictures, books, and other items from home to assist when discharged to hotels near the transplantation center. Another topic initiated by many transplantation recipients was pets. Although the APNs reviewed the guidelines by the Centers for Disease Control and Prevention (CDC), Infectious Disease Society of America (IDSA), and American Society of Blood and Marrow Transplantation (ASBMT), 2000) for transplantation recipients as needed, patients wanted to discuss the guidelines and how relationships with pets would be impacted. The patients missed and worried about their pets. Cohen (2002) discussed the importance that

### TABLE 1. Sample Demographics and Clinical Characteristics

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<th>Characteristic</th>
<th>( \bar{X} )</th>
<th>SD</th>
<th>Range</th>
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<tr>
<td>Age (years)</td>
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<table>
<thead>
<tr>
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<tr>
<td>Yes</td>
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<td>23</td>
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<tr>
<td>Race</td>
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</tr>
<tr>
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</tr>
<tr>
<td>Diagnosis (N = 154)*</td>
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<td></td>
</tr>
<tr>
<td>Acute leukemia</td>
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<td>51</td>
</tr>
<tr>
<td>Myelodysplastic syndrome</td>
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<td>16</td>
</tr>
<tr>
<td>Non-Hodgkin lymphoma</td>
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<td>12</td>
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<tr>
<td>Chronic leukemia</td>
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<td>10</td>
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<tr>
<td>Myelofibrosis</td>
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<td>3</td>
</tr>
<tr>
<td>Myeloproliferation disorder</td>
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</tr>
<tr>
<td>Hodgkin lymphoma</td>
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<td>3</td>
</tr>
<tr>
<td>Other</td>
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<td>2</td>
</tr>
<tr>
<td>Type of BMT (allogeneic)</td>
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<td></td>
</tr>
<tr>
<td>Matched, unrelated donor</td>
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<td>53</td>
</tr>
<tr>
<td>Related donor</td>
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<tr>
<td>Type of BMT (myelosuppression)</td>
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<td>Partial or reduced intensity</td>
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<td>55</td>
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<tr>
<td>Full intensity</td>
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<tr>
<td>Human leukocyte antigen match</td>
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<td>Match</td>
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<td>81</td>
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<tr>
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<td>5</td>
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<tr>
<td>Missing</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>

| Remission status at transplantation | | |
| Persistent disease | 72 | 51 |
| First remission | 37 | 26 |
| Second remission | 18 | 13 |
| Chronic phase | 8 | 6 |
| Accelerated phase | 2 | 1 |
| Blast crisis | 2 | 1 |
| Third remission | 2 | 1 |

N = 141, unless otherwise noted.

* Some patients had more than one diagnosis.

BMT—bone marrow transplantation

Note. Because of rounding, not all percentages total 100.
pets can have in the live of individuals. Pets provide companionship and comfort and allow people to express deep feelings with nurturing (Cohen, 2002). Transplantation nurses need to be aware of the role of pets in patients’ lives, particularly if separation from those pets is extremely difficult for the patient.

The patient-initiated topics that encompassed the social aspects of their lives were the greatest in number. Interestingly, social issues at discharge is the one area that nurses are both least familiar and least interested (Atwal, 2002). The medical literature also reports social issues to be challenging at discharge (Kripalani, Jackson, Schnipper, & Coleman, 2007). The issues scheduled for discussion in later sessions centered on patient worry about caregiver strain, sexuality, disability, and work adjustment. Concerns about financial issues, work adjustment, and sexuality all are reported in the literature (Hacker & Ferrans, 2003; Mosher et al., 2009; Siegel, 2008). In addition, caregivers have increased fatigue, cognitive dysfunction, depression, sexual issues, and insomnia compared to healthy controls (Pidalà, Anasetti, & Jim, 2010). With caregivers having their own strain in addition to patients’ concerns about returning to work and roles, it is understandable that these concerns may impact patient worry about the caregiver. The additional topic about caregivers centered on the presence and availability of the caregiver. Research has shown that not having an in-hospital lay care partner is a significant independent risk factor for death (Foster et al., 2004). Although the transplantation program makes it very clear at the time of transplantation that each patient is to have a committed available caregiver for 24 hours a day for the first 100 days post-transplantation, the reality was that not all patients had this resource. The time commitment and financial hardship of a 24-hour caregiver on the family of a transplantation recipient is immense (Meenan et al., 2006). Because these patients are desperate to live and see transplantation as their only hope for survival, it became clear to the APNs that they often gave the impression of a committed caregiver when one was not always present. Therefore, flexible scheduling and clear guidelines after discharge had to be communicated with patients and working caregivers to manage potential emergencies, such as a fever spike, if the patient was alone.

Another topic was children and childcare concerns. As previously mentioned, one patient had a newborn and the APN needed to discuss bonding with the infant while balancing infection precautions and fatigue. Other patients were concerned about how their children would cope with the changes in family life. The APN made frequent referrals to child-life specialists, and also offered to meet with the children to teach age-appropriate content and answer questions to decrease children’s anxiety about their parent. Family disruptions did occur; however, challenging coping behaviors seemed to occur among families that had a history of problems, such as substance abuse. Perhaps transplantation admission assessments need to include past history of stressful events and family coping. Marital conflicts also occurred. Some patients felt they had the expected support from their spouse, but others did not feel supported enough by their spouses. For the transplantation patient, studies have indicated that social support and the presence of the caregiver improves patient mortality, as well as patient psychological and physical functioning (Foster et al., 2004; Frick et al., 2006; Grassi et al., 1996; Jacobsen et al., 2002; Jenks, Kettmann & Altmaier, 2008; Lloyd-Williams & Friedman, 2001; Rodrigue, Pearson, & Moreb, 1999; Widows, Jacobsen, Booth-Jones, & Fields, 2005). Being aware of the powerful impact the presence of a caregiver makes is key for nurses, as they support both the patient and the caregiver.

Family relocation was another issue that came up in discussion. Families had to leave support systems and stay close to the medical center, and that isolation was challenging for patients who missed family members, children, their homes, friends, and communities. In a study by Pidalà et al. (2010), partners of transplantation recipients reported significantly less social support and spiritual well-being, as well as more loneliness, when compared to the transplantation survivors or a control group. The financial impact of transplantation can be devastating, and the APN nurses uncovered complicated factors involved with insurance coverage and financial responsibilities post-transplantation. Although the content of the sessions included preparation of disability paperwork and financial resources, insurance issues were not included. Often, patients make a desperate, rushed judgment to proceed to transplantation because of the urgency of the hematologic malignancy and financial concerns may not be in the forefront of their minds; however, the time of discharge may be the first awakening of copays for expensive medications and hotel bills for outpatient stays. Financial impact after transplantation is a topic of high interest and the National Marrow Organization is researching this issue (Murphy et al., 2010; NMDP, 2008). Many recent studies have shown that patients’ financial concerns affect their quality of life (Hacker & Ferrans, 2003). Perhaps clear financial review is needed with both patients and families before admission to cover expected and possible unexpected events to ensure more financial stability. The last topic of social concerns was cultural issues. The site of transplantation also often felt the need to retell the story of their patient-initiated topics that encompassed the social aspects of their lives were the greatest in number. Interestingly, social issues at discharge is the one area that nurses are both least familiar and least interested (Atwal, 2002). The medical literature also reports social issues to be challenging at discharge (Kripalani, Jackson, Schnipper, & Coleman, 2007). The issues scheduled for discussion in later sessions centered on patient worry about caregiver strain, sexuality, disability, and work adjustment. Concerns about financial issues, work adjustment, and sexuality all are reported in the literature (Hacker & Ferrans, 2003; Mosher et al., 2009; Siegel, 2008). In addition, caregivers have increased fatigue, cognitive dysfunction, depression, sexual issues, and insomnia compared to healthy controls (Pidalà, Anasetti, & Jim, 2010). With caregivers having their own strain in addition to patients’ concerns about returning to work and roles, it is understandable that these concerns may impact patient worry about the caregiver. The additional topic about caregivers centered on the presence and availability of the caregiver. Research has shown that not having an in-hospital lay care partner is a significant independent risk factor for death (Foster et al., 2004). Although the transplantation program makes it very clear at the time of transplantation that each patient is to have a committed available caregiver for 24 hours a day for the first 100 days post-transplantation, the reality was that not all patients had this resource. The time commitment and financial hardship of a 24-hour caregiver on the family of a transplantation recipient is immense (Meenan et al., 2006). Because these patients are desperate to live and see transplantation as their only hope for survival, it became clear to the APNs that they often gave the impression of a committed caregiver when one was not always present. Therefore, flexible scheduling and clear guidelines after discharge had to be communicated with patients and working caregivers to manage potential emergencies, such as a fever spike, if the patient was alone.

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The last domain includes spiritual, existential, and survivorship issues. Session 5 in the structured content included benefit-finding exercises (i.e., the ability to find benefit in challenging circumstances) and spirituality. However, patients at discharge also often felt the need to retell the story of their diagnosis and journey before the teaching session began. Leak, Mayer, and Smith’s (2011) integrative review on survivors found that having cancer may prompt patients to revisit their outlook in life and to find purpose and meaning (Leak et al., 2011). Often, these patients need to sift through the experiences to make sense. Referral to social work or psychology may be essential to support the patients’ search for meaning as they progress through this challenging experience after transplantation.
Implications for Practice

- Patient and caregiver understanding of physical, psychological, social, and spiritual discharge requirements post-transplantation are enhanced through timely and tailored instruction.
- Discharge preparation begins with coordination and collaboration among healthcare providers to address post-transplantation social concerns and management of comorbid conditions.
- Predischarge instruction is challenging and requires a commitment to identifying relevant informational needs, competence, and comfort in adapting to patient- and caregiver-initiated questions.

Implications for Nursing

“Hospital discharge is a critical point in the continuum of care that affects patients’ outcomes” (Foust, 2007, p. 72). This article reviewed topics that patients initiated at discharge that were scheduled for later educational sessions or not included in the standardized educational materials. When considering adult learning principles, the motivation to learn is best when patients are convinced of the need for knowing the information (Russell, 2006). Discharge is a prime time for motivation. Transplantation recipients have incredible informational needs, and literature from other populations indicate that patients feel they lack information (Jacobs, 2000). Transplantation recipients also may need more preparation and information than other populations. One suggestion for preparation is to improve pretransplantation admission education to address post-transplantation needs. In regard to teaching information during admission, one study compared nursing practice variations among HCT units (Bevans et al., 2009; Bevans, Mitchell, & Marden, 2008). Most education was done by the bedside nurse, with common topics surrounding infection prevention and precautions and nutritional restriction (Bevans et al., 2008, 2009). Some potential sources for additional physical information are recommended guidelines (CDC, IDSA, & ASBMT, 2000; Majhail et al., 2012). However, beyond the physical needs, nurses need to be aware of all areas of quality of life, including psychological, social, and spiritual and survivorship domains. The current study’s results show that psychosocial issues were the most prevalent for transplantation recipients. In addition to expansion of content to include psychosocial material, transplantation nurses need to be prepared in the art of teaching. Excellent educational assessment skills assist with what to teach in the moment, competence with a sound knowledge base provides the ability to teach complicated content, flexibility is needed to adapt to the complexity of changing content to the needs of the patients, and comfort with challenging content is needed to cope with topics that are tough on a personal level.

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