

Improving Patient Knowledge of Discharge Medications in an Oncology Setting

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Discharge medications for a patient with cancer typically are numerous and complex. During the transition between inpatient stays and ambulatory follow-up visits, patients commonly misunderstand medication instructions, placing them at risk for under- or overdosing. This column discusses the results of an evidence-based practice change project at the Seattle Cancer Care Alliance to improve adult patient knowledge and use of discharge medications. Ensuring patient receipt of written discharge medication instructions and checking in with patients after discharge may be an approach to maximize the safety of self-administered medication.

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Patients with cancer often transfer between inpatient and ambulatory care and typically experience a new set of nurses with each transfer. Once discharge instructions are given to a patient in the hospital, the ambulatory care clinicians may or may not have access to these instructions. The responsibility for ensuring patient follow-through on discharge instructions is not clear with either set of clinicians. Patients are left with the responsibility to adhere to what often is a complex medication regimen. Since the early 1990s, clinical wisdom and some evidence have promoted the implementation of comprehensive discharge planning approaches to smooth transitions from inpatient care to all other settings (Maramba, Richards, Myers, & Larrabee, 2004).

Problem Identification

In the oncology setting, patient self-administered pharmacologic agents are ubiquitous, not only for addressing cancer-related symptoms and preventing or mitigating side effects, but also for treating the malignancy. The discharge medication list for a patient with cancer often is complex and contains the oncology-specific drugs in addition to drugs for management of preexisting chronic conditions.

The medications provided and/or confirmed on discharge from inpatient services often are taken incorrectly or not taken at all. Ellenbecker, Frazier, and Verney (2004) summarized that polypharmacy, lack of knowledge or understanding, cognitive status, older age, living alone,

and cost of medications all contribute to failure to follow a discharge medication plan. In a study of 101 homecare nurses representing 1,467 patients, the researchers found that 21% of the patients were discharged from the hospital without understanding how to take their medications (Ellenbecker et al., 2004). Patients with cancer who return home with oral chemotherapy may not even fill the prescription (Streeter, Schwartzberg, Husain, & Johnsrud, 2011), may take more doses than prescribed, or may stop taking the medications when adverse effects worsen (National Health Service, 2008). Although no well-powered randomized trials have established efficacy for interventions in the oncology setting (Haynes, Ackloo, Sahota, McDonald, & Yao, 2008), provision of comprehensive written discharge medication instructions (Ramalho de Oliveira, Brummel, & Miller, 2010) and follow-up postdischarge telephone calls (Mistiaen & Poot, 2006) both have shown preliminary evidence of having a positive impact on patient adherence to medications in nononcology samples.

The Pan Alliance Nurse Practice Council (PANPC) of the Seattle Cancer Care Alliance (SCCA) planned an interinstitutional practice change project to address the complexities of discharge medication management. The purpose of the project was to improve patient understanding of discharge medication teaching with regard to knowledge of the medication name, dose, frequency, and route of administration, in addition to the purpose or action of the medication. The practice change included written medication instructions prior to discharge, and an ambulatory care nurse calling each patient 24–48 hours after discharge to review