

ORIGINAL ARTICLE

Development of Discharge Planning Instruments Based on Patient Family-Centered Care in the COVID-19 Inpatient Room, Universitas Airlangga Hospital, Surabaya

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ABSTRACT

Introduction: The current era of the COVID-19 pandemic requires innovation in the provision of discharge planning by involving family members through the media safely and effectively. This study aimed to develop a discharge planning instrument based on patient family-centered care. **Method:** Research design Research and Development. The sampling technique used purposive sampling with a total sample of 110 medical record documents, 23 focus group discussion participants, and 2 experts (expert consultation). Data were collected through observation sheets, focus group discussions, and expert consultations. Data analysis using descriptive analysis, and validity test using I-CVI. **Results:** Development of a patient family centered care-based discharge planning instrument at the beginning of the patient's admission (admission), namely sorting and adding assessment items to the level of knowledge of the disease, information and education needs, values, and beliefs, cultural background as well as physical and psychological. During treatment, namely arranging and sorting discharge planning items, providing information and education according to the assessment results using a media approach and the method according to the COVID-19 pandemic protocol. Towards home that is adding items; readiness or environmental conditions (environment), referral plans (Outpatient referral), and continued treatment while at home (Medication). **Conclusion:** The developed instrument tested is valid. As a result of this development, the new instrument can be tested and applied, and researched in the next stage on the outcomes of patient family-centered care.

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emotional and psychological condition. The current pandemic era requires that innovative approaches involving family members in inpatient care can lead to long-term progress, not a regress from the previous standard of family-centered care (6,5).

INTRODUCTION

The first COVID-19 pandemic was reported in December 2019 in Wuhan City, China. The incidence rate continues to increase followed not only in China but also in other countries in the World (1). The main mitigation step for the spread of COVID-19 is to maintain physical and social distance (2,3). The impact of physical and social distance restrictions in hospitals is that patients become the center of decision-making, limited family involvement in services, decreased psychological and emotional support, and difficulty in providing continuous and transitional services (4,5). This condition places the patient at the center of decision-making starting from treatment plans, therapy, information, and education as well as preparation for discharge, and can indirectly affect the patient's

Some of the obstacles to service or care during the COVID-19 pandemic are the provision of education and information for patients and families about treatment plans, patient discharge plans, and ongoing and transitional services (Discharge planning) cannot be carried out properly (7). Patient Family-centered care emphasizes the support that families (or even other people who act like family) can provide to patients, especially when the patient is in a situation where it is not possible to make decisions, such as when in intensive care or isolation (8). The results of interviews with 6 persons in charge of the COVID-19 inpatient room, non-critical care at a teaching hospital in Surabaya, regarding the involvement of families of COVID-19 patients regarding the implementation of DP, showed that 3 units (50%) were sufficient and 2 units were lacking (33.33%),

while the use of media in the implementation of DP shows that direct visits are 3 units (50%), Telephone is 2 units (33.33%), and via WhatsApp is 1 unit (16.6%). In community service regarding Virtual Family Visits in the COVID-19 ward at the same hospital, it was shown that out of 18 participants, 9 participants (50%) stated that they were very satisfied with the implementation of Virtual Visits, 8 participants (45%) were quite satisfied and 1 participant (5%) not satisfied.

Several factors that can influence patient-family-centered care are organizational, patient, and hospital factors. These factors will affect the dimensions or process of implementing the PFCC, namely the provision of information and education, emotional and physical support, ongoing and transitional services, and family involvement in care (9,10). Family involvement in hospital services can be seen from the initial admission, during treatment and before the patient goes home, this process is called discharge planning (DP).

Communication and information that previously could be provided directly face to face, must be developed through a safe approach and media and comply with health protocol rules. Ease of access to services and communication as well as family involvement in care will affect mental and physical status as well as patient and family satisfaction with the services provided (6,8,9,11,12), improve clinical outcomes, and be able to reduce costs treatment (9,13-16). Based on the theory of patient family-centered care, patient satisfaction with services is the result of fulfilling the dimensions of patient family-centered care itself, including the involvement of family and relatives in care, easy access to information sharing, education, and services as well as participation and collaboration of patients, families, and staff health (10). Discharge planning by involving patients and families before the pandemic may be carried out well, but during the COVID-19 pandemic, innovation with a safe and effective approach is needed. The aim of this study is to develop a discharge planning instrument based on patient family-centered care, this is expected to be a solution to the problems described previously.

MATERIALS AND METHODS

Study design

The design in this study is a descriptive study with a Research and Development (R & D) approach. Research and Development (R & D) is a method systematically to find, plan, create and check the accuracy of a product that has been made (17,18). The research stages of R and D in this study are 1) Evaluating the discharge planning instrument; 2) Developing discharge planning instruments based on patient-family centered care; 3) Test the validity of the development of the Discharge planning instrument based on patient-family centered care in the COVID-19 Inpatient Room at the Universitas Airlangga Hospital, Surabaya.

Population

The research population is medical record documents, in the form of patient discharge planning sheets, integrated patient and family education forms as well as patient discharge instruction sheets for COVID-19 patients, who have been treated at IRNA COVID-19 Universitas Airlangga Hospital from April to June 2021 a total of 477 Medical records (MR).

Sample size, and sampling method

The sample of this study was taken that met the inclusion criteria 1) Medical records of probable patients and Confirmed COVID-19, 2) Medical records of patients treated in the COVID-19 inpatient room, 3) Medical records of adult patients (aged > 18 years). The exclusion criteria in this study were 1) Medical records of patients treated in HCU or ICU, 2) Medical records of patients who had no companion or family, and 3) Medical records of terminal patients (unconscious patients). The sampling technique of this research used the purposive sampling method with a total sample of 110 medical records.

Instruments

The instruments in this research are; 1) Evaluation sheet for the completeness and suitability of the Discharge planning instrument, 2) Focus group discussion (FGD) guidelines, FGD 1 with families of COVID-19 survivors, FGD 2 with nurses and doctors IRNA COVID-19, and FGD 3 with nursing managerial ranks, continued with discussions with 2 experts, namely 1 senior nurse as well as the head of the nursing service section and 1 pulmonary specialist as well as the secretary of the COVID-19 task force at UNAIR Hospital, 3) Assessment sheets or validity tests for developing Discharge planning instruments based on patient family-centered care in Inpatient Installations Airlangga University Hospital COVID-19 with I-CVI. Items on the instrument were assessed by; 1 = not relevant, 2 = somewhat relevant, 3 = moderately relevant, 4 = very relevant. CVI is calculated as the number of experts who gave a good rating of 3 or 4 (ordinal scale dichotomized to be relevant = 1) and a score of 1 or 2 (irrelevant = 0), divided by the total number of experts. The instrument validity test was carried out using the Content Validity Index (CVI). Instrument development is said to be valid if the CVI value is not lower than 0.78 or S-CVI/Ave 0.90 (90%) or higher (19).

Procedures

First, the researcher submitted a permit application to the Academic Department of the Faculty of Nursing Universitas Airlangga, Surabaya. After obtaining permission, the implementation process begins with submitting a data collection permit application to the director of Universitas Airlangga Hospital. Before data collection, All respondents received written information about the aims and procedures of the study, as well as an option to withdraw at any time. The researcher

assured the respondents that their personal information would be kept confidential. Before the study started, each participant had given informed consent, If the respondents agreed, they were asked to sign a signature (17).

Data collection is a process of approaching the subject and the process of collecting the characteristics of the subject needed in a study (17). This research starts on November 2, 2021, until December 31, 2021, at the COVID-19 Inpatient Installation, Universitas Airlangga Hospital, Surabaya. The following are several stages of implementation in this research, namely: 1) Completing administrative procedures, 2) Conducting ethical tests, 3) Conducting research; (1) Evaluation of the discharge planning instrument based on the PFCC standard in the COVID-19 Inpatient Installation, through a study of 110 Discharge planning documents, (2) The process of preparing the discharge planning instrument based on patient family-centered care at the COVID-19 Inpatient Installation, Universitas Airlangga Hospital through; Focus Group Discussion (FGD) 1 with families of COVID-19 survivors, the average age of participants was between 26-50 years (85.71%), most of them were female (71.43%), almost all of the latest education is undergraduate education (42.86%) and the employment status is almost entirely private (85.71%), online on December 5, 2021, duration for 60 minutes; FGD 2 with nurses and doctors IRNA COVID-19, consisting of 8 senior nurses and 1 pulmonary specialist (COVID-19 task force), more than half of them (55.56%) gender of the participants were women, most of them (88.89%) the age of the participants is 25-50 years, most (77.78%) have undergraduate education, most (66.67%) their employment status is honorary (PTT) and most (66.67%) have 3-5 years of the service year, online on December 29, 2021, duration for 90 minutes; and FGD 3 with nursing managerial ranks in the nursing committee room on 03 January 2022, duration for 60 minutes, most (75%) of the sex of the participants were female, all (100%) of the participants were 25-40 years old, most of them (75%) had master's degrees, most (87.50%) of their employment status are civil servants and most (75%) have a tenure of >10 years. Discussion with 2 experts, namely 1 senior nurse as well as the head of the nursing service section and 1 pulmonary specialist as well as the secretary of the COVID-19 task force at UNAIR Hospital, (3) Testing the validity of the development of the discharge planning instrument based on patient family-centered care at the COVID-19 Inpatient Installation of the Universitas Airlangga Hospital with I-CVI, (4) Produced a new Discharge planning instrument.

Data analysis

Descriptive analysis is used to determine the frequency distribution of each sub-variable category, namely data from the evaluation of the completeness and suitability of the discharge planning instrument. The results of the evaluation of the discharge planning

instrument were raised as a strategic issue related to the process of preparing the development of the discharge planning instrument. The strategic issues resulting from the evaluation were used as material for focus group discussions (FGD). Audiovisual recordings and field notes containing opinions and clarification of FGD results were copied and analyzed according to the results found. The results of the analysis were consulted with experts, then a design for the development of a new discharge planning instrument was drawn up(17). The developed instrument was tested for validity using I-CVI. The results of the instrument validity test with the I-CVI test obtained a value of 1.00, which means the instrument is valid(19).

Ethical considerations

This research protocol has been approved by the ethics committee of Universitas Airlangga Hospital number 3603/UN3.9.1/PT/2021, and a letter of ethics approval has been issued number: 195/KEP/2021.

Instrument Development

Universitas Airlangga Hospital has developed and used a discharge planning instrument since 2011, that is, since the beginning of its operation, it has not been integrated and is only focused on when the patient is leaving the hospital (discharge). Then the instrument was revised or developed during the 2015 hospital accreditation (KARS). The instruments used were in the form of columns and items that needed to be conveyed to patients and families. The discharge planning instrument currently has 3 parts with different sheets, namely acceptance of new patients, integrated education, and discharge instructions, but this instrument has not been developed according to the needs of the COVID-19 pandemic era, where discharge planning must pay attention to health protocols during the COVID-19 pandemic era. This study aims to develop a discharge planning instrument based on patient family-centered care, and the results of the instrument validity test with the I-CVI test are 1.00, which means it is valid (19).

Procedures in the development stages

1) Evaluation of instrument completeness

The evaluation sheet was prepared by including the concept of discharge planning based on patient family-centered care (PFCC), to assess the completeness of filling out the instrument, and the suitability of the instrument with the dimensions of the PFCC; (1) Dimensions of respect for dignity (Dignity and Respect), (2) Dimensions of information, education and emotional support (Sharing Information, emotional and social support), (3) Dimensions of shared, ongoing and transitional care (Collaboration, participation, and transition). The completeness of the discharge planning instrument is assessed by; the filled one is given a score = 1, and the unfilled document is given a score = 0, Then it is presented in the form of a percentage; complete

= 76-100%, quite complete = 51-75%, incomplete 50%. The suitability of the instrument was assessed by combining the old discharge planning instrument with the instrument based on the theory of patient family-centered care. Appropriate items are given the description "appropriate" and items that do not match are given the description "not appropriate".

2) Preparation of instrument development

The results of the evaluation of the discharge planning instrument were raised as a strategic issue related to the process of preparing the development of the discharge planning instrument. The strategic issues resulting from the evaluation were used as material for focus group discussions (FGD). Audiovisual recordings and field notes containing opinions and clarification of FGD results were copied and analyzed according to the results found. The results of the analysis were consulted with experts, then a design for the development of a new discharge planning instrument was drawn up.

3) Content Validity

The assessment of the Discharge planning instrument based on Patient Family-Centered Care was carried out by 3 experts based on the items resulting from the development of the new instrument. Items on the instrument were assessed by; 1 = not relevant, 2 = somewhat relevant, 3 = moderately relevant, 4 = very relevant. CVI is calculated as the number of experts who gave a good rating of 3 or 4 (ordinal scale dichotomized to be relevant = 1) and a score of 1 or 2 (irrelevant = 0), divided by the total number of experts. The instrument validity test was carried out using the Content Validity Index (CVI). Instrument development is said to be valid if the CVI value is not lower than 0.78 or S-CVI/Ave 0.90 (90%) or higher (19).

RESULTS

Demographic Data

At the evaluation stage of the completeness of the filling and the suitability of the instrument, 110 medical record documents were evaluated. The results of the evaluation are used as a strategic issue for the FGD.

The frequency distribution in the first FGD with families of patients or COVID-19 survivors totaling 7 people (Table I), the average age of participants was between 26-50 years (85.71%), and most of them were female (71.43%), almost all of the latest education is undergraduate education (42.86%) and the employment status is almost entirely private (85.71%).

The frequency distribution in the second and third FGD (Table II). In the second FGD with 9 health personnel, consisting of 8 senior nurses and 1 pulmonary specialist (COVID-19 task force), more than half of them (55.56%) gender of the participants were women, most of them (88.89%) the age of the participants is 25-50 years,

Table I: Distribution of FGD frequency for family groups of patients or COVID-19 survivors (n = 7).

Items	Frequency	Percentage (%)
Gender		
Male	2	28.57
Female	5	71.43
Age		
20-25 Years old	1	14.29
26-50 Years old	6	85.71
>50 Years old	0	0
Education		
Elementary/junior high school	1	14.29
Senior High School	2	28.57
Diploma 3	1	14.29
Diploma 4/Bachelor	3	42.86
Profession		
Private	6	85.71
Government employees/retired	1	14.29

Table II: Frequency distribution of FGD groups of health workers (n = 9) and nursing managerial groups (n = 8)

Items	Health workers		Nursing managerial	
	n	Percentage (%)	n	Percentage (%)
Gender				
Male	4	44.44	2	25
Female	5	55.56	6	75
Age				
20-25 Years old	1	11.11	0	0
26-50 Years old	8	88.89	8	100
>50 Years old	0	0	0	0
Education				
Diploma 3	1	11.11	0	0
Diploma 4/Bachelor	7	77.78	2	25
Specialist	1	11.11	0	0
S2/Master	0	0	6	75
Employment Status				
Honorary (PTT)	6	66.67	1	12.50
Permanent Employee (PT)	0	0	0	0
Government Employees (PNS)	3	33.33	7	87.50
Years Of Service				
<1 year	0	0	0	0
1-5 years	6	66.67	0	0
>5 years	3	33.33	2	25

most (77.78%) have undergraduate education, most (66.67%) their employment status is PTT and most (66.67%) have 3-5 years of the service year. In the third FGD with 8 nurses in managerial nursing, most (75%) of the sex of the participants were female, all (100%) of the participants were 25-40 years old, and most of them (75%) had master's degrees. , most (87.50%) of their employment status are civil servants and most (75%) have a tenure of >10 years.

Instrument development process

1) Evaluation of filling completeness

Completeness of filling in Discharge Planning obtained initial entry (admission) components from 110 RM documents, most (83.33%) were complete, and a small part (16.67%) were incomplete, incomplete items were in the assessment of knowledge, culture, values, and belief. Components during treatment showed most (88.24%) were incomplete with 0 (zero) filling in psychological factors, personal hygiene, ROM exercises, and activities, a small part was complete in handwashing procedures. The component before going home (discharge) shows half of it is complete (50%) and a small portion (12.50%) is incomplete, incomplete items are found in the environment.

2) Conformity evaluation

The suitability of the format of the Discharge Planning instrument used in the Covid-19 Inpatient Installation of the Universitas Airlangga Surabaya Hospital with a PFCC-based DP resulted in a small portion of the initial entry (admission) component following the standard, namely the explanation of inpatient facilities. Components during treatment were mostly inappropriate, and a few were appropriate, appropriate items contained in the description of the disease (cause, signs and symptoms, prognosis), examination results (physical and diagnostic), disease management and care, complications, development of the condition, risk factors, medication therapy (indications and side effects), diet or nutrition program, and pain management. The components before going home (discharge) were mostly inappropriate, and to a lesser extent appropriate, the appropriate items were found in health (maintaining health and preventing recurrence while at home), diet (recommendations and taboos), treatment (continued care at home).

3) Evaluate the completeness of the format

Half of the Discharge Planning instrument format complies with the PFCC standard. Some of the content standards in the Discharge Planning instrument did not match the standard, there were in the placement or order of filling, and there were several components that were not appropriate. Standard time, media, method/ means partially inappropriate contained in the media and method of administration.

4) Focus group discussion (FGD) on instrument development

Recommendations from the FGD regarding the development of patient family-centered care-based discharge planning instruments to be used in the COVID-19 Inpatient Installation at Universitas Airlangga Hospital include: 1) The form is revised according to the rules of the discharge planning process from the time the patient enters, during treatment and before going home, 2) The discharge planning form is simplified but

still meets accreditation standards, items are adjusted to new standards and eliminates duplication, 3) Methods and methods are adapted to the COVID-19 pandemic era by paying attention to health protocol rules and mitigating the spread of COVID-19, and increasing family involvement in the maintenance process, 4) The form resulting from the development is disseminated to all health workers, and 5) SPO or regulations regarding virtual DP and virtual ratification are made.

5) Expert consultation

Expert consultations were carried out to obtain inputs in the process of preparing the development of discharge planning instruments based on the results of medical record searches and FGDs. This expert consultation was carried out with two experts, namely nursing and medical practitioners from Universitas Airlangga Surabaya Hospital at different times. Expert recommendations from the results of the consultation are as follows; 1) The title section is added to the document number code column, and the filling instructions column is separated from the care provider education column. 2) Cognitive items can be added with mental disorders, each profession (caregiver) is given several blank lines for additional special education, and the header (column title) is distinguished from the column title (because the contents are different). 3) Add validation to the initial assessment column. 4) The media and methods are following the era of the COVID-19 pandemic.

6) Content Validity

The assessment of the Discharge planning instrument based on Patient Family-Centered Care was carried out by 3 experts based on the items resulting from the development of the new instrument. Items on the instrument were assessed by; 1 = not relevant, 2 = somewhat relevant, 3 = moderately relevant, 4 = very relevant. CVI is calculated as the number of experts who gave a good rating of 3 or 4 (ordinal scale dichotomized to be relevant = 1) and a score of 1 or 2 (irrelevant = 0), divided by the total number of experts. All instruments have a CVI value of 1.00. It can be concluded that the validity test of all instruments is valid (19) (Table III).

7) Final Product

The beginning of the admission, the items or components are arranged according to the discharge planning theory and the PFCC theory, in which each incoming patient is assessed and identified by the nurse or midwife and doctor in the form of; Doctors

Table III: Test results of the validity of the discharge planning instrument

No	Items	Validity test results (CVI)			Conclusion
		Expert 1	Expert 2	Expert 3	
1	Admission	1,00	1,00	1,00	Valid
2	During Treatment	1,00	1,00	1,00	Valid
3	Coming home (discharge)	1,00	1,00	1,00	Valid

conduct educational needs assessments regarding the disease and its treatment, physical and psychological assessments. The nurse or midwife conducts an initial assessment of educational needs including knowledge (level of education, language), psychosocial support, beliefs, values, and culture. Admission officers provide explanations of rights and obligations, general consent, facilities, visiting hours, and administration.

During the treatment (inpatient), the arrangement and elimination of duplication of items, the addition of a method column or the method of providing education in the form of; video call, zoom cloud, add media in the form of powerpoint (PPT). In the education column and providing information by each health workers, there are already introductory items (patients and families with the unit in charge, with nurses, with other health workers), nurses explain procedures and times for washing hands, prevention of fall risk, personal hygiene, mobilization, lifestyle modification, psychosocial support, pain management. Doctors provide education and information in the form of; Medical diagnosis, causes, signs, and symptoms, prognosis, treatment/procedure, development of the condition, symptom management, risk factors, physical examination, and diagnostics. The pharmacist explained the therapy given, the rules for use, indications, side effects, and drug interactions. Nutritionists explain special diet programs according to doctor's orders, dietary restrictions & recommendations. Physiotherapists explain and teach about physical rehabilitation, and ROM exercises and each health worker is given an empty 2-line slot for the possibility of adding other interventions.

On the way home (discharge) several items were added according to the METHOD terminology, accompanied by a checklist of easy and simple instructions. The nurse explains about follow-up care (Treatment), maintaining health, preventing recurrence (Health), environmental support (Environment), and referral plan (Outpatient referral). Pharmacists explain Medication (Medication), and nutritionists explain the rules of eating (Diet). The discharge instructions (doctor's) are in the form or the sheet itself, namely the medical resume, this is related to the hospital administration (claims and referrals) in duplicate. In the end, the patient's notes are added and ratified by the related PPA and the patient or family.

DISCUSSION

Several factors that can affect patient-family-based services are organizational, patient, and hospital factors. These factors will affect the dimensions or process of implementing the PFCC, namely the provision of information and education, emotional and physical support, ongoing and transitional services, and family involvement in care (9,10). Family involvement in hospital services can be seen from the initial admission, during treatment and before the patient goes home, this

process is called discharge planning (DP).

The results of the evaluation of the completeness of filling out the DP were obtained, most of the initial admission (admissions) were complete, when they were treated they showed most of them were incomplete and before leaving the hospital (discharge) half of them were complete. Completeness is influenced by differences in assessment items (terminology), lack of knowledge of PPA in filling out, and there is no effective and safe media and method of filling in the pandemic era. The results of the evaluation of the suitability of the instrument obtained standard titles, contents (early admission, during treatment, before going home), validation, time, media, methods/methods, almost half of which were following the PFCC-based DP. The instrument used today uses the National Hospital Accreditation Standard (SNARS) which is one of the sources of reference in determining the preparation of the DP. The instruments developed included early admission, during treatment, and before discharge.

The DP process, according to (13), begins with the initial identification and assessment of patients who need assistance with discharge planning. Assessment and identification of patient and family needs will facilitate the fulfillment of specific needs, in addition to identifying the needs of the client, such as problems that may arise when the client returns home so that problems that arise are immediately anticipated (20). Discharge planning focuses on the needs of patients and families comprehensively, covering aspects of physical assessment, psychosocial, functional status, health education, and counseling needs (21). Assessment and identification of needs are carried out by respecting and paying attention to the dignity of patients and families, according to Ellis Carol, Joy Hurst, (2016) one of the dimensions of the PFCC is dignity and respect, health care providers listen and respect the perspectives and choices of patients and families, the composition of patients and families, knowledge, values, beliefs, and religious and cultural backgrounds. Early entry (admission) on the old instrument did not describe the process of identifying and assessing the needs of patients and families, the assessment was carried out during treatment and did not include several aspects that needed to be studied as described by Ellis Carol, Joy Hurst, (2016). This difference in terminology causes the results of the evaluation of completeness and suitability to obtain incomplete results. The development of a new instrument, the initial entry (admission) of Dignity and Respect, is to sequence the DP process according to the PFCC standard, by adding knowledge assessment of disease, values, beliefs, and cultural background, physical and psychological initial assessment (22). The initial process of entering the new instrument is following the terminology or theory and is easy to fill out.

During treatment, the old instruments showed

overlapping fillings, this was shown in the assessment of information and education needs contained in this process (in the integrated patient and family education sheet), even though in the process of service and theoretical concepts, DP was started immediately upon admission with assessment and identification of patient and family needs regarding treatment and discharge plans. In addition, during treatment, there was duplication of filling with new patient acceptance sheets, namely on handwashing procedure items and 5 handwashing times. After assessing and identifying information and education needs, the next DP process is interdisciplinary collaboration to plan and implement care, namely providing information and education, counseling, and home care skills. Planning requires collaboration with other health teams, discussions with families, and the provision of health education according to the results of the assessment (23). Zwicker & Picariello (2003) in Darliana, (2012:37) explained that the strategy to ensure continuity of patient care is known as the 4 C's, namely Communication, Coordination, Collaboration, and Continual Reassessment.

Communication and information that previously could be provided directly face to face, must be developed through a safe approach and media and comply with health protocol rules. Ease of access to services and communication as well as family involvement in care will affect mental and physical status as well as patient and family satisfaction with the services provided (6,8,9,11,12), improve clinical outcomes, and can reduce treatment costs (9, 13-16). Based on the theory of patient family-centered care, patient satisfaction with services is the result of fulfilling the dimensions of patient family-centered care itself, including the involvement of family and relatives in care, easy access to information sharing, education, and services as well as participation and collaboration of patients, families, and staff health (10,22). Development of DP during treatment; Sharing Information, Emotional and social support, namely organizing and sorting items or discharge planning processes, namely providing information and education according to the results of the assessment of patient and family needs for follow-up care with a media approach and following the COVID-19 pandemic health protocol (2,3,6,1112). In the new instrument developed, media and methods in the process of providing information and education as well as family involvement in care are given an online method item, this allows all PPAs to interact with patients and families safely and effectively to plan care and discharge together.

On the way home, on the DP instrument, there are differences in terminology, the old instrument uses a treatment, health, diet approach, this does not yet include readiness or environmental conditions (environment), referral plans (Outpatient referral), and continued treatment while at home (Medication). The newly developed DP already uses the METHOD

approach, namely Medication, Environment, Treatment, Health, Outpatient referral, and Diet. The new approach has involved almost all PPA, while doctors are still separated from the new form due to several considerations, namely the importance of claims, referrals, and discharge instructions with sheets made in duplicate 3. The principle of continuous care is the existence of multidisciplinary collaboration, effective communication, coordination, and continuous (continuous). Effective communication between health workers, patients, and families will enable the realization of effective care and achieve patient health and family satisfaction. Communication can be done in writing and the results of the documentation are an assessment of patient care needs in the form of a summary of the patient in the hospital (medical resume). Verbal communication is carried out regarding the health status of patients, families, other professionals, and health services for referrals, providing health education to prevent recurrence and complications while at home, and survival programs (20,23).

The findings of this study are that this instrument was developed according to the PFCC theory from the beginning (Dignity and Respect), namely ordering the DP process according to the PFCC theory and adding assessment items for knowledge, values, and beliefs, cultural background, initial physical and psychological assessments. During treatment (Sharing Information, Emotional and social support), namely sequencing the PFCC-based DP process by providing information and education, psychosocial support, and skills to prepare for continuous care through media and (online) approach according to health protocol rules. Coming home (collaboration, participation, and transition) by adding medication, environment, and outpatient referral items so that it becomes a METHOD approach (medication, environment, treatment, health, outpatient referral, diet). The title of the instrument has been adjusted and has been simplified from the previous standard. Filling in the form of checklists and short entries related to legality.

The researcher concludes that the instrument validity test with the I-CVI test obtained a value of 1.00, which means the instrument is valid. The new instrument as a result of development is expected to be tested and researched in the next stage of the output of patient family-centered care in the form of; increasing patient and family satisfaction, patient and family involvement in care, improving health (physical, mental), reducing the length of stay (well-being), and creating a culture of therapy (adherence to therapy), and this instrument can be applied to the provision of care or services.

CONCLUSION

The instrument becomes simpler, which is to become 1 MR document number by using a checklist and a little filling. The new instruments resulting from the

development of PFCC-based DPs are the beginning of the patient's admission (admission), namely sorting and adding assessment items to the level of knowledge of the disease, information and education needs, values, and beliefs, cultural background as well as physical and psychological. During treatment, namely arranging and sorting discharge planning items, providing information and education according to the assessment results using a media approach and the method according to the COVID-19 pandemic protocol. Towards home that is adding items; readiness or environmental conditions (environment), referral plans (Outpatient referral), and continued treatment while at home (Medication). The new instrument as a result of this development can be tested and applied and researched in the next stage towards increasing patient and family satisfaction, patient and family involvement in care, improving health (physical, mental), reducing the length of stay (welfare), and creating a therapeutic culture (adherence to health care). therapy).

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