IMPROVING DISCHARGE READINESS IN ELDERLY PATIENTS AND FAMILIES

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This paper is dedicated in memory of

Edna Collins
1960 - 2000

friend and colleague

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CHAPTER 1

Study Background

"Hello Mrs. C., I understand from some of the team that you are going home tomorrow so I want to ask you how you think you are going to manage with your day to day activities?" Mrs. C. responds, "My daughter is working tomorrow. I'm not well enough to go home tomorrow. How will I manage?"

The Problem/Opportunity

Unfortunately, the above scenario is typical in the world of acute care hospitals. There are times when a health care team feels a patient is ready to be discharged from hospital and the patient and/or family members disagree. Recent demands on acute care beds have led to shorter length of stays and patients going home earlier than ever before. Given nursing and allied health professional shortages, increasing workloads and the increasing acuity of patients in hospitals, communication and collaborative discharge planning between health care disciplines is increasingly challenging and easily fragmented. Many of the elderly patients seen in St. Paul's Hospital have multiple medical problems and the majority have some form of dementia (Martini, J. personal communication, April 10, 2000). These patients come from a range of socio-economic backgrounds; a person may live alone in a downtown cockroach-infested hotel with no family supports or in a self-owned four-bedroom house with a son and daughter-in-law. These considerations, along with patients' functional abilities are just some of the factors that influence their care and their discharge planning.

Complicating these factors is the fact that each stakeholder in the discharge planning process comes with his or her own perspective, thoughts and assumptions, about the process, including when someone is 'ready' for discharge. Team members may be influenced by their own discipline-specific background, as well as number of years of experience and the roles they play on the team. Patients and families may be unfamiliar with how the hospital system works, the responsibilities of each team member in the care process and may have differing views on readiness for discharge.

Although discharge planning begins at the time of a patient's admission to hospital it is not always a smooth and comfortable process for the patient and their families or the health care professionals involved. The process has its difficulties. People must persevere, be creative and committed to quality health care to address these difficulties. Insufficient discharge planning may result in a poor transition to the community for the patient and frustration for all involved. Effective discharge planning requires information sharing and joint planning within the interdisciplinary team, between the team and the patient and family, and between the team and community service organizations. Bringing all stakeholders together and understanding each other's perspectives is paramount to being able to improve the discharge planning process and ensuring the patient is, indeed, ready for discharge.

The Geriatric Assessment and Treatment Program (GATP) of St. Paul's Hospital supports this project as many of the patients they see throughout the hospital require a high degree of discharge planning. Understanding what it means to these elderly patients and families to be ready for discharge can help the interdisciplinary teams better identify and address patient needs early thus avoiding potential conflicts and anxieties around patient's feeling they are being discharged prematurely. This project provides an opportunity to explore the perceptions of elderly patients, their families and staff around what it means to be ready for discharge from acute care, and opens the door to finding ways to address the needs of the elderly who do not feel they are ready to go home at the time of discharge.

The Significance of the Problem

A patient or family member's statement that they are not ready for discharge may be a sign of an insufficient planning and communication of the plan. When a discharge is not sufficiently planned, there are many potential costs. These may range from the financial expense of extra emergency home services or patients returning imminently to emergency rooms, to the emotional and physical costs the patient and caregivers endure. There are questions as to whether the hospital and/or team are providing sufficient care. Frustration can occur between team members, community partners, the patient and family and frustration sometimes shifts to blaming. There are times when patients may simply refuse to leave hospital or families refuse to take the patient home.

Given the high percentage of elderly patients with Alzheimer's disease or other related dementia in acute care, improving planning around discharge is paramount. Cognitive impairment in the elderly is clearly recognized in the literature as a predictor of a "difficult" discharge. It is imperative for health care professionals to work collaboratively to make discharges successful for elderly patients and their families/caregivers. This means that patients receive the services and care they need to maintain their well being, but without (whenever possible) compromising their autonomy and own desires. For their caregivers, it means being recognized for the role they carry out and supported for what they give to the patient. It also means providing medical and emotional support for patients and families through the gradual physical and functional decline dementia and illness brings, as well as planning ahead for future needs. These are issues around quality of life and cannot be overlooked. They are of prime concern to the GATP team.

Potential Causes of the Problem/Opportunity

Many changes have taken place in our health care system in the last few years. There is a cry from the hospital and community health care sectors for more financial resources. Community services are spread thin and yet elderly patients are being discharged sooner and more ill from the bed-crunched hospitals. Patients are not always able to receive the amount of service they truly require to manage at home. Community health care workers struggle with whether discharge home for some elderly patients are appropriate whilst at the same time the hospital's utilization management team is demanding justification for keeping a sub-acute patient in hospital. It is not surprising then that some elderly patients may not feel, physically, emotionally, or functionally well enough to be discharged from hospital to live in the community. Health care teams need to continue asking how they can better ready patients for discharge given these environmental and system constraints.

Interdisciplinary team members vary from ward to ward in their willingness to take responsibility for the discharge planning process. Historically, this responsibility has been seen as belonging to the social workers or the nurses. Nursing shortages and the increased number of casual nursing staff in hospitals have impacted the nurses' ability to participate in the process. A casual or float nurse may only provide care for one day out of a patient's week stay depending on staffing. Interdisciplinary team members also vary in their ability and readiness to give input into discharge planning. Individual team members may not always be willing to assume accountability for ensuring all team discharge responsibilities are carried out in a timely manner. The degree to which the interdisciplinary team is integrated in their approach to care becomes an issue in improving discharge planning and patient and family readiness.

The team's relationship with the patient and family, and the degree to which their input into the discharge process is valued is another problematic area influencing discharge planning. Many of the frail elderly will decide to return to a tenuous living situation despite the recommendations of the team. The team is faced with the realities of what "client-centered" truly means. Supporting the patient's autonomy, facilitating patient-family differences over the decision and linking with the community for adequate support services can be difficult. There are often ethical considerations around living at risk that the patient may not understand due to cognitive impairment. Dealing with these ethical concerns, while attempting to be client-centered clashes with the realities of the present health care system, is difficult and must involve all stakeholders in the discharge planning process.

The Organization

The St. Paul's Hospital Site of the Providence Health Care Group, Vancouver, British Columbia, is an actue care hospital providing quartenary, tertiary and secondary services to Vancouver's urban core population. The hospital has 448 acute care beds and provides extensive teaching and research programs for interdisciplinary teams. The Geriatric Assessment and treatment program (GATP) is located at the St. Paul's site and provides comprehensive acute care services to senior citizens with multiple medical and functional problems. There are four parts to this interdisciplinary program: (a) a consult service, (b) an 11-bed unit, (c) an outpatient clinic, and (d) a home visit service. Patients are able to move from one service to another depending on their needs. This configuration is unique to the GATP as no other geriatric program within the Vancouver/Richmond Health Board (V/RHB) offers such comprehensive services. The GATP is one of several geriatric services offered across the Providence Health Care Sites. As the organization continues to be re-organized into programs, the geriatric services are collaborating to decide on a configuration of services that will meet the needs of seniors in all catchment areas.

At the municipal level, in July of 1998, the V/RHB in British Columbia completed a two-year study of acute and rehabilitative services within their jurisdiction. The review proposed a model that links hospital-based services with expanded community services creating a more integrated health care system in the region. One of the key areas targeted was the development of a regional system of support for older persons. To initiate this undertaking a steering committee was formed and produced the 'Review of Hospital-based Geriatric Services' (V/RHB, 2000 March). This document looked at building a regional model of care for seniors using the strengths of existing services. All aspects of care were examined including service integration and discharge planning. Discharge planning for the elderly in the region was identified as crucial. The report states that "Early and comprehensive discharge planning is critical in promoting successful and lasting discharge..." (Vancouver/Richmond Health Board, p.13).

The aforementioned report supports the GATP's vested interest in reviewing the clinical and research based evidence in discharge planning of the frail elderly. The GATP is committed to working with patients, families and community partners to improve patient discharges. Consistent with the mission and values of Providence Health Care, the GATP mission states, "By supporting and collaborating with patients, families, friends and community health care provides, the GATP is committed to the concept of a hospital without walls, thereby easing the transition of the older adult through the health care system." (Appendix A)

The GATP has developed several formal venues for sharing concerns brought forward by any of their stakeholders (see Appendix B). The Local Advisory Committee (LAC) is composed of community representatives from local seniors groups, governmental agencies and representatives of Providence Health Care. Working in a collaborative manner, the LAC aims to identify gaps in health-related services and to improve and promote the well being of seniors in the St. Paul's catchment area. A second venue is Joint Community Rounds. Here community health workers and members of the GATP are able to discuss patients and create joint care plans that bridge the gap between hospital and community. Lastly, members of the GATP attend patient and family conferences, a forum for information sharing and shared decision-making. The GATP needs to continue to operate with an integrated, interdisciplinary approach to ease the transition of frail elderly patients from hospital to home. As the recent V/RHB report emphasizes, "Effective discharge planning can only be successful with adequate community supports and a strong primary care system that is integrated with acute care and other health services for the elderly" (Vancouver/Richmond Health Board, 2000).

Research Questions

The goals of this research are two-fold. The first goal is to increase professional knowledge around the meaning of 'readiness for discharge' in elderly patients and families. Only by increasing our understanding of the elderly patient's experience can health care professionals improve upon the provision of client-centred discharge planning. The second goal is to provide the GATP with recommendations for improving the discharge planning process for the elderly patient population at St. Paul's Hospital. The main question that arises from these goals is, "What can the GATP do to improve elderly patient and family readiness for discharge?" Related sub-questions include:

1. What do elderly patients and families believe is needed for them to feel ready for discharge?
2. What is the health care team's perception of discharge readiness?
3. What is it that the health care teams do, regarding discharge planning, that is working for patients and families? What do the health care teams need to improve upon?

CHAPTER 2

Literature Review

Review of Organizational Documents

Providence Health Care's Mission, Vision and Values statement reflects the organizations commitment to meeting the needs of the people and communities they serve through care, teaching and research endeavours. These include "physical, emotional, social and spiritual" needs of people and the healing and wellness of communities (see Appendix C). There is also a strong emphasis on the institution as a 'learning organization' seen in statements such as: "by passionately pursuing and sharing learning"; "by seeking answers to questions not yet asked; and "we achieve excellence through learning and continuous improvement". In harmony with the above corporate statement, the GATP goal statements assist the team in delivering care and service to elderly patients. Of particular relevance to this study's focus on perspectives around discharge readiness are two goal statements: (a) "to facilitate discharge planning of inpatients through the consult service," and (b) "to provide guidance and education to family physicians, hospital staff and families regarding the management of physical, functional and mental health problems." (Geriatric Assessment and Treatment Program, 1992).

A British Columbia Provincial requirement (Providence Health Care, 2000 June, p. 1) is that all patients entering an acute care facility must be designated as either in an acute phase of treatment or in an alternative level of care (ALC) phase. The patients in the latter phase are generally those who would be discharged immediately if certain services were available to them or if barriers could be removed.

These patients may be "convalescing, experiencing social or economic barriers to discharge, waiting for homemaking or home care services or awaiting placement in another facility" (Providence Health Care, June 2000, p. 1). While the government uses this information to guide funding decisions, it is also useful to the hospital for directing utilization and resource management activities including advocating for improved hospital and community resources.

In preparing for the1995, hospital accreditation process revealed several challenges in the discharge planning process including issues surrounding abrupt unplanned discharges, communication concerns among team members, the involvement of the patient and family in discharge plans and the availability to see the discharge plan in progress. As a result, an interdisciplinary committee was formed and created a new Interdisciplinary Discharge Planning Documentation Form. This form is used for all patients admitted to hospital and by all disciplines involved in patient care. The form was initially piloted on two units and then implemented throughout St. Paul's hospital in-patient units. Although it is a permanent part of the record, it is used with a varying amount of consistency (Purton, K, personal communication, January 8, 2001).

A more recent document affecting discharges from St. Paul's Hospital is Code Triage (July, 2000). This is in draft stage and is being piloted at present. It is one of several initiatives aimed at addressing gridlock situations in the St. Paul's Emergency Room. When the Emergency room is filled to capacity and patients are in danger of waiting longer than designated safe times for assessment a Code Triage can be called. In sequential order, designated inpatient units will look for available beds and may discharge stable patients to free beds up for more acute emergency room patients.

As of February 2001, an interdisciplinary team has completed the final draft on a Providence Health Care policy for patients who refuse treatment and patients who refuse discharge. This policy is an effort to standardize the approach of the health care teams to these patients and to ensure patients are educated about the consequences of refusing treatment and/or discharge. The policy ensures that the care team addresses the patients needs for an appropriate care plan and work to resolve issue relating to the patients refusal including a review of treatment options and barriers to discharge (see Appendix D).

In 2000, Providence Health Care completed an in-patient customer satisfaction survey. A fifty-three percent response rate was achieved. While the survey addressed many areas of care and service, the section entitled "Returning Home" addressed discharge planning and its results are relevant to this study. Participants were asked six questions about their readiness for discharge, their preparation for discharge, and about follow-up care planned in the hospital. Participants replied 'yes', 'to some extent', 'no', or 'does not apply'. Twenty-one percent of patients felt they were sent home from hospital before they were ready and 37% felt that staff could have done more to prepare them to manage at home. Questions that related to discharge planning were ranked as the third, fourth and fifth of the ten top opportunities for improvement in the organization. Of the patients surveyed 44% of them were seniors (over 60 years). (Providence Health Care, 2000 November).

Review of Supporting Literature

Discharge Planning

Covey (1989) states one must "begin with the end in mind" (p. 96). This phrase holds true for the admission of any patient to hospital. Most medical and paramedical students have been told during their education that "discharge planning begins on the day of admission to hospital". In fact, much of the literature suggests that for planned admissions, discharge planning needs to begin even before the patient enters hospital. Simply expressed, discharge planning is "an ongoing process that facilitates the discharge of the patient to the appropriate level of care. It involves a multidisciplinary assessment of patient/family needs and coordination of care, services and referrals (McGinley et al. 1996).

Planning for discharge is an integral element of caring for seniors in hospital. It is an inherently complex process requiring a wide range of clinical and organizational skills, which aim to facilitate a person's transition from hospital to post-hospital destination. Systems analysis has been used to break the discharge planning process down into identifiable steps. The process may look like this (Wertheimer & Kleinman, 1990):

1. Identify the patient's medical and functional needs.
2. Develop a comprehensive and continuous care plan.
3. Provide support and quality of life.
4. Evaluate the success of the discharge plan.

The discharge process is guided by both an organization's over-arching principles as well as the values of the individuals involved. Optimally, patient autonomy and patient and family preferences need to be recognized and respected (Pothoff & Kane, 1997). However, with apparent never-ending decreases in financial and human resources, discharge planning often becomes the art of "balancing the efficient use of resources by providing the right kind of care at the right time" (Styborn, 1995, p. 273). Thus the process holds significance for both the patient and family and for the health care system. For the elderly patient, discharge from hospital may represent a critical juncture in his or her life (Pothoff & Kane, 1997). Decisions made during the process can influence how and where that individual lives out the rest of his/her life. For example, a patient may either be returning home with homemaking help or making the significant transition from a home of 40 years to a nursing home. For the family, well-planned discharges can lessen their care-giving responsibilities (Naylor et al, 1994). Most of the significance for the health care system for good discharge planning is the potential to decrease a patient's overall length of stay and prevent unnecessary rehospitalization, both of which reduce health care costs (McGinley et al, 1996).

Despite the knowledge of the importance of transitions from hospital to community for the elderly, there is much literature to support that these transitions are often anything but well planned and supported. As Werheimer and Kleiman (1990) state, "Unfortunately many discharge planning models do not include both the identification of needs as well as the development of a comprehensive continuous care plan" (p. 837).

The results of poorly orchestrated discharges are significant. Insufficient planning can result in a patient's readmission to hospital, lack of patient 'compliance to medication and other therapy programs, medical complications and emotional distress for family and caregivers (Hansen, Bull, & Gross, 1998).

Bull and Kane (1996) published a qualitative study titled "Gaps in Discharge Planning". They viewed the discharge planning process and transition of the patient to the community as a dynamic process. The results of their study identified several systems constraints that impeded discharge planning as seen by hospital staff, patients and families--poor communication, insufficient planning time, attitudes towards the elderly, premature discharge of patients and decreased access to resources. All these constraints potentially affect the continuity of health care for the patient. As patients' length of stay in hospitals gets shorter there is a subsequent increasing need to teach patients and their caregivers about medical interventions, and care arrangements (Potthoff & Kane, 1997).

Families are seen as having a key role in discharge planning and yet they often have limited participation in the process (Anthony & Hudson-Barr, 1998). Family members frequently feel they have received insufficient information about the patient's condition and discharge plans and have many unanswered questions. Communication improves when patients have someone to advocate for them. Moreover, patients expect they will be provided information without asking yet 25% of professionals feel it is the elderly patients/families responsibility to ask (Bull & Kane, 1996). For discharge planning to be successful it must be client-centered as planning ongoing care treatment is not a passive modality but rather requires the active involvement of the patient and family (Congdon, 1994).

The elderly patient's ability to participate in discharge plans is dependent on their medical and cognitive condition, family supports, their locus of control while in the patient role, and the attitudes of health care staff (Abramson & Donnelly, 1993). Clemens (1995) found that staff and family generally saw patients as having minimal input on discharge decisions, either due to their medical condition or their desire to have family decide on plans. This lack of patient participation was further heightened when language barriers were present and staff seemed reluctant to make use of hospital interpreters.

Within the discharge planning process, disagreement often arises. Abramson and Donnelly (1993) state that this occurs in at least one-third of all planned discharges and most disagreements are between the family and health care professionals. With shortened length of patient stays and elderly people being sent home sooner in their recovery process than ever before, both patients and families have less time to adjust to the impact of illnesses and are not always able to outline clearly what they can and cannot undertake as far as caregiving (Cummings, 1999). They are pressured to make decisions in a short period of time and without necessarily having absorbed the implications of the situation. This has been cited as a major factor in the development of disagreements (Abramson & Donnelly, 1993).

Family members are often the major provider of care services after discharge and yet Proctor, Morrow-Howell, & Kaplan (1996) found that hospital staff are not explicit in their expectations of the care family members will provide. This is a concern when there are changes in the patient's functional status because prior care and service arrangements may no longer be appropriate. This can impact on family and informal caregivers' previous patterns of interaction with the patient. For example, role changes occur as children start caring for parents. Family members will tend to rely on previous patterns of coping and problem solving. Elderly patients may become rigid in their habits and unable to adapt easily to changes in routines or in new ways of relating to others.

Another critical observation in the literature is the fact that families may often have more influence over discharge planning than patients, even when the patient is capable of making their own decisions (Coulton, Dunkle, Goode, & MacKintosh, 1982). This can also be a source of conflict. Staff is challenged in their efforts to be client-centered and allow patients to remain autonomous in their decision making even when their choices seem unwise or risky to family members. Patient autonomy is central to decision-making and for someone to be declared incompetent to make decisions around their own person requires careful and objective assessment by a designated hospital doctor. Team members are faced with balancing patient autonomy with the principle of beneficence; the principle requiring health care professional to "do no harm" and to promote the health and welfare of the patient in their decision-making around patient care (Cummings & Cockerham, 1997). This is one type of conflict that is seen by staff as an ethical dilemma significantly complicating discharge planning (Abramson & Donnelly, 1993).

In fact, discharge planning can present patient, family and staff with several kinds of ethical dilemmas. For example, choosing between two unsatisfactory options, weighing the cost and benefits of certain courses of action, balancing patients needs without compromising a caregiver's well-being and balancing patients' needs with organizational pressures such as appropriate bed utilization or limited community resources (Abramson & Donnelly, 1993; Cummings, 1999; Cummings & Cockerham, 1997). Thus ethical concerns cross from the micro-level of patients day to day care to the macro-level of administrative agendas. Dealing with these ethical dilemmas poses inherent difficulties. For example, a social worker may address the problem from a family systems perspective only to come in conflict with the medical model of practice, which sees the patient as the central focus. A family systems perspective promotes the view that staff assists patients and families in readjusting roles and expectations in light of patients' illnesses (Cummings & Cockerham).

Essential to dealing with many of the difficulties around discharge planning is acknowledging and understanding the different stakeholders' perspectives. Some studies have started to clarify what is important in discharge planning and what constitutes a 'successful' or a 'failed' discharge for the patients, families, and staff involved. Bull (1994) studied these perceptions and found that at the root of effective discharge planning for both staff and patients was effective communication. Bull defines effective communication as "asking questions, getting answers and questioning inconsistencies" (p. 47). All staff, patients and families attributed "not asking questions" to low quality discharge planning. Of the elderly patients interviewed in her study, approximately 50% stated that they asked questions. Others felt that staff should provide certain amounts of information without being asked. Seventy-five percent of staff saw it as their responsibility to seek out the necessary information and ask questions. Professionals tended to ask questions about the patients ability to carry out activities of daily living, social supports, the physical environment where the patient lived and preferences for follow-up care. Alternatively, patients' questions focused on medications, level of allowed activity and whether they could return home. One issue raised surrounding effective communication was the inconsistencies between answers to the same questions. Both staff and patients stated that they often received different responses to questions asked of different people (Bull). This is reflective of differing perspectives as well as a lack of communication. Patient and spouse may differ on their perception of whether the patient is able to make a meal independently. Likewise, a doctor and a physiotherapist may have different ideas the physical abilities of a patient. This can be attributed, in part, to team members identifying concerns from their own discipline-specific perspective as opposed to a systems perspective (McGinley et al, 1996). Inconsistencies in answers results in additional time being needed to sort out patients needs or the problems that surface for patients and families once home from the hospital (Bull).

Clemens (1995) found that perspectives on the discharge planning process also varied in terms of who had the most influence on the decision making process surrounding the plan. Families felt that professionals had more influence on the decisions made whereas the professionals felt that families were the ones to exert a high degree of influence within the same process. These differences in perceptions extended into the amount of information given to caregivers and the number of choices given. Families felt they received little or no information and were given few or no choices within the process whereas staff felt that a high level of information had been provided and an adequate number of choices offered.

Team member characteristics such as education, amount of work experience and life experience, and understanding of the discharge process are also contributors to inconsistencies in communication (Bull, 1994). This not only impacts interactions between staff and patients or families but also effects interdisciplinary collaboration which is another aspect of effective communication. Developing open communication, and problem-solving and conflict resolution skills are seen as essential aspects to developing a team process for discharge planning (Hansen et al, 1998; McGinley et al, 1996). In addition, the literature emphasizes the need to extend the team process into the community. Communication gaps exist between health care providers in the hospital and those in outside agencies (Bull & Kane, 1996).

The contextual variable of time impacts all the above mentioned planning, communicating, educating and decision-making done by stakeholders. Patients and families express dissatisfaction with care when suddenly confronted with impending discharges and a lack of time to ask questions or learn care routines. Health care professionals often do not have enough lead time to arrange adequate discharge plans and this is complicated further when attempts to coordinate care are hampered by systems boundaries (Bull, 1994; Bull & Kane, 1996). Increasing use of primary care and continuing care services combined with budget constraints and a growing elderly population makes time a variable of growing influence on discharge planning. The well-known saying, 'Time is of the essence' is a truism in today's world of discharge planning.

The failure of a discharge plan is often seen in the form of a patient's readmission to hospital. It is usually for the same or related health problem as the original admission and occurs within 1 to 3 months of discharge (Schwarz, 2000). As well as the primary diagnosis of the patient, two other factors related to hospital readmission include insufficient caregiver support and an unsuitable home environment. Rosswurm and Lanham (1998) identified the home care needs of 507 elderly hospitalized patients using an adapted version the Discharge Planning Questionnaire. They concluded that a patient's functional ability was a better predictor of rehospitalization than severity of illness. Over 57% of their patients required help with one self-care task and an even larger group were dependent on others for some form of instrumental activity of daily living such as cooking or cleaning. While many of these patients stated they had someone at home to assist them, this person was often an elderly spouse whose own abilities might have been be limited.

Patients also struggled with pain and limited activity tolerance within the first thirty days of discharge. Rosswurm and Lanham (1998) stress the importance of preventing the deterioration of elderly patients' functional abilities and mobility while in hospital. Shortened lengths of stay mean elderly patients are discharged in more vulnerable and dependent states, requiring more post-hospital care. Hospital staff must properly assess a patient's function and discharge environment as well as the abilities of families and spouses to provide care. When discharge planning occurs very quickly, then families tend to overestimate their capacity for caregiving (Proctor et al, 1996).

Compounding the success or failure of a discharge plan is the elderly patients compliance with the plan. A Canadian study by Leduc et al. (1998), found that only

22% of discharged elderly patients used all the services prescribed for them in hospital and on average, only 56.9% of all prescribed services were used. The patient's intention to accept services offered was influenced by their perception of the benefits of the service and the ease of access to transportation. However, compliance was increased when hospital staff made appointments for patients prior to discharge and arranged both transportation and someone to accompany the patient. Leduc et al. advise that health care providers need to not only help plan discharges but be involved in the implementation of those plans and work collaboratively with community service organizations.

Proctor et al (1996) state, "the responsibility of hospital personnel should extend beyond the hospital walls into the community" (p. 39). The link to the community is integral for discharge plans to be implemented and for discrepancies between providers of care to be minimized. Discrepancies may include: (a) the hospital and community agency disagreeing on the amount or type of care a patient needs, (b) the care expected from the community agency is beyond the range of the job expectation, (c) the amount of help thought necessary is beyond what the patient is willing or able to pay and, (d) the care is not provided. These discrepancies are important given that from the patients' and families' perspective, the discharge plan does not end at the time they leave the hospital but extends into the community (Bull, 1994). Thus patient satisfaction with the discharge plan includes the outcome of the plan. Elderly patients see successful outcomes as having access to resources, their ability to function in their environment and continuity of care. By contrast, health care staff sees patient satisfaction as the willingness for the patient and family to accept the plan. Staff measures the quality of discharge planning in terms of readmission, length of stay and patient satisfaction. Patient and staff satisfaction levels are measurable outcomes of quality care. Their perspectives and experiences on the discharge planning process need to be sought, understood and incorporated into an improvement process (Bull).

Potential Solutions in Discharge Planning

Solving the articulated discharge planning woes requires both long-term and short-term remedies. While short-term solutions are the most tangible to clinicians, long-term strategies to revamp the health care system may be more effective in alleviating the problems. Indeed much of the literature has focused on models of health care delivery in which discharge planning is one aspect. The Vancouver/Richmond Health Board (V/RHB) Review of Acute and Rehabilitation Services (ROARS) report (1998) and subsequent response by the Providence Health Care (1998) is one regional proposal to improve health care, including that of seniors. There is general consensus in British Columbia that hospital-based and community-based services need to be more fully integrated to adequately meet the needs of seniors (British Columbia Ministry of Health, 1999).

While strategic long-term planning is essential, discharge planning solutions that address the needs of present seniors should not go unexplored. Those that are found effective need to be implemented. Tennier's study (1997) at the Montreal General Hospital suggested that part of the solution requires a shift in team members attitudes. In response to the survey, staff stated they needed "to get out of the mode of departmentalizing responsibilities for discharge planning and instead focus on a collaborative interdisciplinary approach" (p. 46). Staff in this study also emphasized the need to plan for discharges earlier in a patient's stay rather than waiting for a physician to indicate that the patient was ready to go home. This required improved communication with patients and families. Their strategy was to hold family meetings for 'high-risk' patients within 24 - 48 hours of admisiion to acute care to discuss the course of care in hospital and plans for discharge.

Another strategy that is well substantiated in the literature is the use of a case manager to facilitate patient discharges. Several models of case management exist and the literature generally supports the fact that case management can assist in both comprehensive discharge planning and the management of service delivery across settings (Bull & Kane, 1996; Phillips-Harris, 1998). A case manager can become a 'point' person to coordinate patient care, enhance communication, and advocate for the needs of the elderly patient. They facilitate the implementation of the interdisciplinary team's discharge plan.

The literature points to various methods and tools that can be utilized to increase the amount of education given to patients, families and other informal caregivers. Education is needed about discharge plans as well as disease and health. Reiley et al. (1996) discussed the need in their hospital to provide standardized teaching materials to improve preparation of patients for discharge and develop a patient and family learning center. Another group (Feigin, Cohen, & Gilad, 1998) took the approach of implementing single group sessions in discharge planning. They found that this enabled social workers to decrease patient anxiety, increase family members capability to organize and manage their situation. This in turn assisted the interdisciplinary team in its planning. Education needs to include supplying patients and caregivers with information about community resources and providing opportunity to train informal care givers in the care tasks they are required to undertake (Proctor et al, 1996). Discharge planning information and education needs to be given in a written form to patients and families, not just verbally (Clemens, 1995).

Enhancing communication beyond the hospital walls is another identified solution. Creating "seamless links" between hospital and community services is the aim of an integrated services approach, of which communication is an integral component. In 1994, Kelowna General Hospital and the British Columbia Continuing Care Division initiated a project entitled "Realigning discharge planning to the community using computer technology". This system provided both agencies with access to patient databases and discharge-relevant information in a timesaving manner.

Timely and accurate communication with community services is integral for the implementation of the plans set out in hospital. Community services need to be involved in the actual discharge planning so discrepancies over patient care needs do not arise and so requests for services are within the mandate and expectations of the various agencies (Proctor et al, 1996). As well, community services need opportunity to give hospital staff feedback about the efficacy of the discharge plan. This is an initial step in finding out how patients are managing post-discharge and whether plans were adequate. Research has also pointed to the usefulness of telephone follow-ups by hospital staff approximately one-week post-discharge (Bowman, Howden &

Thompson, 1994; Proctor et al, 1996). This is suggested as a means of monitoring progress, providing opportunity for patients' questions to be answered, identifying unmet functional needs and being able to institute services.

Additionally, patient and family input into the process of discharge planning needs to be sought as they are the clients in the discharge plan. Patient and family perceptions of the care they receive are integral to setting standards for quality improvement processes in service-oriented entities. Values and experiences may vary from one region to another and what a patient or family member may see as crucial in the outcome of a discharge plan cannot necessarily be generalized to other regions (Bull, 1994). Further study of all participants' perceptions around discharge planning is required. Clemens (1995) encourages staff to examine what patterns of discharge planning practice are fostering these mismatched perceptions in an effort to improve the process. Only by understanding each stakeholder's perspective on discharge planning can hospitals aim for continuous quality improvement in this area. Ultimately this will improve the effective and efficient use of resources by allowing staff to offer client-centered care for their patients upon discharge and ensuring patients have a say in their care. In the current economic climate of health care, the ability to meet patient and family needs through discharge planning is necessary for optimal patient recovery (Leske & Pelczynski, 1999).

CHATPER 3

Conduct of the Research Study

Research Methods

Action research draws on the post-positivist paradigm that promotes a collective process of inquiry. The basic principle behind action research is that "those who experience a phenomenon are the most qualified to investigate it" (DePoy, Hartman & Haslett, 1999). This research aims to generate knowledge that can then inform action. It begins with the identification of a problem, dilemma or issue requiring critical reflection and action. A systematic inquiry, utilizing appropriate data collecting tools ensues and ends with planning about what is to be done with the new learning (DePoy, Hartman & Haslett; Kirby & McKenna, 1989).

This applied form of research enables practitioners in many fields to (a) work to solve practical problems and (b) work to improve their own actions or the operations of the institution in which they work. This is one of the strengths of action research. Practitioners are able to engage in research and the subsequent development and implementation of activities that help improve practice. Problems get solved simultaneously while knowledge is generated (Meyer, 2000). As with many qualitative methodologies, action research can help bridge the gap between scientific research and its implementation in everyday clinical contexts. As Green and Britten (1998) point out, "In medicine, qualitative research can investigate practitioners' and patients' attitudes, beliefs, and preferences, and the whole question of how evidence is turned into practice" (p.1230).

Another strength of action research is that research is done with and for people rather than on them (Meyer, 2000). Action research assumes that those participating in the research have knowledge and experience relevant to the problem or issue being examined. Furthermore, there is a commitment to action by the participants based on the learning acquired by the investigation (Deschler & Ewert, 1995). Thus the researcher is part of the community being examined rather than an objective observer. The researcher assumes a role of 'facilitator of change' and consults with participants on both process and evaluation. The input of participants helps to root the process and its outcomes in the realities of day-to-day practice (Meyer).

Action research is carried out using many of the data gathering methods of qualitative research (and sometimes quantitative research). The open nature of the action research process permits a flexibility to change research methods as necessary (Deshler & Ewert, 1995). Methods are selected based on their appropriateness to the question being asked, and the organization in which the study is being conducted. The methodology of the study must still be evaluated for its reliability and validity and this is done using the same criteria as other qualitative research methodologies. By utilizing some or all of the following criteria, the researcher will increase the reliability and validity of the study:

1. As in all qualitative designs, the influence of subjectivity from the researcher cannot be eliminated. Throughout the action research process, the researcher needs to utilize tools of personal reflection to stay alert to biases. Kirby & McKenna (1989), term this researcher subjectivity "conceptual baggage" and discuss the importance of recording reflections to help identify whether pre-established goals, and assumptions are influencing the research development and data analysis. They

assert that awareness of one's conceptual baggage provide opportunities to re-think the thoughts and beliefs one holds as the researcher and opens oneself up to new learning.

2. Respondent validation may also be sought as a check of credibility. The researcher has participants review the analyses and then incorporates their reactions into the study findings (Mays & Pope, 2000).

3. In action research, triangulation through varying sources of data and varying methods of data collection is seen (Carpenter & Hammell, 2000). This ensures both the comprehensiveness and the plausibility of the data.

4. A clear report of the methods used makes explicit the dynamic relationship between the process and the content of the research (Kirby & McKenna, 1989).

Meyer (2000) contends that the quality of action research should not be judged solely in terms of the implementation of a solution but rather also in the learning gained by participants as they go through the process. Meyer (2000) uses the example of an action research project addressing the care of the elderly in an emergency room. At the end of the study, it was noted that staff from two health care services had improved understanding and communication with each other, enhancing their working relationship. Because action research focuses more on creating change in practice or policy than contributing to theory development, it makes sense for there to be a focus on the by-products of the process as well as the outcomes for change.

The focus of this project, supported by the GATP, is an inquiry into understanding elderly patient and staff perspectives around discharge readiness in St. Paul's Hospital. In addition to enhancing knowledge of discharge readiness in our hospital, the study aims to find strategies to improve the quality of multidisciplinary discharge planning practices for the elderly in the hospital. The focus of this research is in sync with the principles of action research and so this was the method chosen.

Data Gathering Tools

Interviews

A semi-structured interview, a process recommended by Jongbloed (2000), was used to gather data from geriatric patients and/or their family. Each interview was structured around six basic questions. The questions were open-ended in nature, allowing for more breadth and depth of conversation (see Appendix E). These questions asked patient/family members why they were not ready to go home, about what needs to change for them to be ready to go home, about how staff could assist in this and about discharge planning. Other questions then emerged from the participants' responses and were asked as appropriate (Jongbloed).

The benefits of this interview tool included: (a) face-to-face contact with the patient and/or family, (b) opportunity for clarification of questions, (c) an ability to probe more deeply into areas as necessary, and (d) an opportunity for the patient to be listened to when articulating their concerns about the process happening to them at that time. Interviews were chosen as they provided an easier way for patients to participate given the nature of the hospital setting. Patients were already familiar with answering questions about themselves from their stay in hospital, and often do not have glasses and such with them to respond easily to other forms of data collection such as a questionnaire. The interview also allowed the researcher opportunity to reword questions and adjust language to suit the patients' needs.

Survey

A survey probing staffs' thoughts and perceptions around discharge planning was used to gather data from interdisciplinary hospital staff (see Appendix F). A survey was chosen for several reasons. First it allowed for input from a large variety of staff. This was important, as the researcher's aim was to reach a cross-section of interdisciplinary staff. Secondly, there was a desire to preserve staff anonymity in their responses to questions, because the researcher is also a colleague of the staff being surveyed. Thirdly, given the time frame and monetary considerations surrounding the research, a survey provided an expedient and efficient way to collect a larger amount of data than other methods.

A 14-question survey was constructed with input from various members of the GATP. Seven of the questions were scaled using a six-point Likert Rating Scale, using an agree/disagree format. The researcher was interested in the level of agreement/disagreement of the respondents with statements based on best practice standards (Palys, 1997). Two questions were checklists and the remaining questions were open-ended requiring a written response. The questions required staff to think about when an elderly patient would be ready for discharge, who was responsible for discharge planning, what were their own attitudes when an elderly patient refused discharge and how much input should patient and family have in deciding discharge readiness.

Chart Reviews

Chart reviews were done for all patients who had participated in an interview. The patient chart represents the medical-legal record of the patient's stay in hospital.

The information recorded by the health care team is a by-product of their clinical activity (McEvoy, 1999). The chart review process may be considered an assessment of patient care and assist in determining the similarities and differences in current patient care practices (Smith, 1996). The chart reviews provided a secondary source of data including some demographic information and length of stay.

Study Conduct

The first step in this study, once proposed, was to seek ethical approval from both the Royal Roads Ethics Committee and Providence Health-University of British Columbia Ethics Committee. This required all methods to be outlined and data gathering tools to be created. Interview questions were created but not piloted. The survey was created with input from a small number of staff on the GATP team and piloted amongst other GATP members. Feedback was incorporated prior to submissions to the ethics committees and then ethical approval was obtained from both institutions.

The first phase of data collection was the interviews. Members of interdisciplinary staff on medical and surgical wards in the hospital were approached by the researcher and alerted to the study both verbally and in writing and were asked to identify prospective subjects to the researcher. Purposive sampling was used; that is, subjects were intentionally sought because they met the criteria for inclusion into the study (Palys, 1997). The subjects were 65 years of age or older, had been deemed ready for discharge from hospital by the unit's team, but were themselves, stating that they were not ready to be discharged. These prospective subjects were initially asked if they were interested in the study by either the staff member themselves or a designate for the researcher. Only then was the researcher permitted to talk to the patient and/or family member, clarify eligibility for the study and then explain the nature of the study, the role of the patient as a participant and review the ethics consent form (see Appendix G). The researcher was not involved in the care or treatment of any of these patients. With the exception of one patient, who had attended an out patient clinic two years previously, the researcher knew none of the patients.

Six patients and one family member were interviewed using the semi-structured interview outlined above. Interviews lasted approximately 30 to 40 minutes and were taped. Each interviewee was asked if they would like to review transcripts as well as see results of the study. All declined further participation in reviewing transcripts and only one patient requested the results of the study. The interview tapes were coded and transcribed and each patient was assigned a pseudonym. All tapes and transcriptions remained secured.

After the completion of the interviews the second data-collection phase was initiated. Seventy-five surveys were hand delivered by the researcher to interdisciplinary staff throughout the medical-surgical units. Again purposive sampling was used as the researcher chose to handout the survey in attempts to seek participation from a cross section of disciplines. The researcher did not know everyone to whom she gave the survey. Each survey had a cover letter explaining the nature of the study and outlining consent. An addressed envelope was attached so surveys' could be returned through interdepartmental mail to the GATP Administrative Secretary. A one-week turn around time was given.

The transcribed interviews were then analyzed. Firstly, each patient's particular concerns were noted. These findings were later used in the chart reviews. Next the findings were compared to each other for similarities and differences across the patients' experiences. Similar concerns, topics, or experiences were compiled together and labelled. The researcher took time to reflect on the data, and sorted these labels until clear themes emerged which were also labelled. Once the themes were created, the researcher went back to the original bits of the transcripts to check for 'fit' in the themes. At this stage the analysis sought to identify links between the themes. Kirby and McKenna (1989) support this process as a method of organizing and understanding data.

Returned surveys were collected, counted and the results of each question entered into a spreadsheet. Questions with a rating scale were tabulated for the mean, median, mode and percentage of answers in each rating. The results of the checklist questions were compiled, percentages tabulated for each category and presented in pie charts. For open-ended questions, the data was analyzed, compiled into themes and then recorded. As the sample size of the surveys was small, no further statistical analysis was done, but the overall survey results and the level of agreement/disagreement seen in each question was considered in relationship to the other questions.

The chart reviews took place after the interviews had been analyzed for each patient's concerns. The patient's concerns, noted from the interview analysis were recorded and the chart reviewed for any documentation about each concern. The charts were also reviewed for any documentation around discharge planning, to identify which team member made that documentation, its' content and at what point in the patient's stay the note occurred. Basic demographic information such as the patients' ages and length of stay was collected. Where possible, the researcher also noted testing scores related to the patients' cognitive status and also any information relating to their functional abilities. The data from the reviews was tabulated and any patterns or trends noted.

CHAPTER 4

Study Findings

Interviews

Interviews with five elderly patients and one elderly patient with his daughter present were completed. Four of the patients were women and two were men. The patients were all seniors, ranging in age from 68 to 84 years old with the mean age being 78 years. Cognitively patients were able to carry out multiple step directions and follow the course of the interview appropriately. Mini-mental status exams were completed and recorded by a member of the geriatric team on five of the six patient charts during the patients' hospitalization. Of these, one patient scored 26/30; one patient scored 27/30 and three patients scored 29/30. All patients were living independently in the community; five lived in apartments and one lived in a hotel. Two patients were living with spouses. Another two patients received formal home-making help for cleaning and/or shopping prior to admission to hospital. One patient relied on family members for assistance with cleaning, shopping, and help with medication. All patients were independently mobile with or without walking aids, prior to admission.

The intent of the interviews was to probe the patients' and families' perspectives on readiness for discharge and their thoughts and concerns about going home before they felt ready. The transcriptions of the interviews were reviewed and information categorized and themed. The interview content analysis yielded the following seven themes: medical and functional concerns, social supports, perceptions, quality of life, perceptions of team members, coordination, and hospital constraints. The interview results are discussed below, using these headings.

Medical and Functional Concerns

Medical and functional concerns were at the root of every patient's reason for not feeling ready for discharge at the point that the interdisciplinary team was saying they were ready for discharge. Unresolved medical concerns, intolerable pain, lack of energy, difficulty keeping food down, lack of ability to walk, difficulty managing some aspect of self-care or daily living task, and wanting to avoid coming back to hospital because of the above list, were mentioned. Several patients felt they still had outstanding medical issues that needed to be addressed prior to discharge. For example, Mrs. A who was admitted with flash pulmonary oedema, stated: "...there are many things I need to have answered, so when the kidney doctors say "you can go home" [and] my blood pressure in the meantime was 200/100...I can't go home, I mean it's just waiting for another disaster to happen." Mrs. E, who lived alone, felt there was no resolution to her chronic inability to keep food down: "I go along for a while and then I get suddenly sick, and lay there for two or three days, and can't get up and do anything for myself...I wanted to talk to them [the doctors]...I'm sick of coming in and out, you know?" Mrs. C. related her shock at no one addressing the pain from her fractured pelvis "I was having intense pain. Walking was out of the question and [when] they suggested, or the doctor suggested, I should go home that night, and I was stunned."

Other patients worried about functional issues; how they would manage day-to-day activities with their limited physical abilities. Mrs. B. spoke about a lack of energy and a "softening up" from being in hospital, despite a period of rehabilitation: "I'm just wondering how I am going to cope with getting meals and running a home again. Not doing anything elaborate." Mr. D, recovering from complications from hip surgery, stated he "was really bowled over" when told he was ready to go home the next day. "If I went home to that hotel" he said, "and I laid in bed all night and tried to get up and use some contraption to put on a sock or whatever, I might just end up on the floor." All six patients named outstanding functional concerns. As one patient, Mr. F. perceived the problem "They [the team] had considered nothing of what my circumstances were, and were ready to have me go home into whatever environment exists."

Social Supports

The amount of social supports the patient and family had also contributed to the degree of perceived readiness for discharge. Of the six patients interviewed, three lived alone, and three were married, one of whom was the primary caregiver for her husband. Two patients had children who were actively involved in providing support and advocacy. A perceived lack of people in the home environment appeared to add to the patient's hesitancy about going home. Patients wanted to be self-sufficient. Mr. D, worried about another fall stated, "It just imposes hardship on my landlord." Mrs. E, despite having a neighbour visiting daily and Lifeline, commented: "I could lay there all night, you know, if I did have another bad attack, and nobody would notice me gone, until the next day." These patients discussed the need for team members to inquire about supports. Mrs.C noted, "they [team] could have said 'well, how can you cope when you go home? Have you got somebody there that can help you? Have you got a friend nearby who can come over and help you, shop for you, do this, do that?"

Yet at the same time, these patients were expressing a reluctance to impose on other people. Mrs. C stated " I don't like to impose on people...it's a very transient sort of population in apartments and the people are always afraid if I befriend her, she's going to come knocking on my door every night wanting..." Mr. D said he was "not opposed to people helping, but I don't think that it's good for the head" (meaning he would rather not become dependent on others). Interestingly, four of the six patients related stories about appreciating unexpected kindnesses from acquaintances while in hospital and this seemed to provide some sort of morale support. One example was Mrs. C whose landlady phoned and offered to pick her up and another tenant who brought her flowers and essentials such as toothbrush and a comb. Mrs. C commented that "so I feel there's two people right in my building that I can sort of call on if I have to..."

The patients receiving support from either children or spouses, relied on them to gather information from the team and coordinate equipment and community resources in readiness for discharge. As Mr. F stated, "more of this information went to my children...my children have been very much involved." Mrs. A related, "my son came from Ottawa...our boys had to ask for everything... he's [son] been checking out a place where we could get some help to come in... he did a lot of the leg work." Mrs. B relied on her husband to organize equipment for her discharge; "Mr. B has been so splendid. My husband coping with everything when he's not really well himself."

Quality of Life

Each of the elderly patients interviewed referred to an internal or intra-personal process they needed to resolve in readiness for discharge. Patients talked about adjustment, fear, and the desire for some quality of life. Mrs. B described her experience, "it was a shattering experience to me to be suddenly whipped into the hospital, because I couldn't move my legs, couldn't walk. And thinking am I going to spend the rest of my life trying to get around, in a wheelchair or something like that." When asked if the team was helping her with this experience she reflected "...everybody is doing their utmost, so it is just required of me to get myself together." Mrs. A experienced both her self and her husband being hospitalized at the same time "...all of a sudden our world just fell apart" and later she reflected on her discharge and her husband going to a nursing home, "I have tried to be strong and everything, but it's getting to be a little more than I can handle."

Patients also felt fear and worry at the prospect of going home before they were ready. Mrs. C stated "Fear, fear, I thought. How can I possibly manage? I can't even walk. How would I make it into the bathroom or the kitchen or the door? I was just shocked." Mrs. A feared another medical disaster with her high blood pressure while Mrs. E feared having a repeat admission, and Mr. D worried he would fall.

Patients also related their ability to do things for themselves when discharged with having some degree of quality of life. For Mr. D this was "being able to dress without confinements (a sock aid)". managing his incontinence and attending the church across the street. Mr. F wished to be able to 'go home and function at a certain level which will keep me happy and reasonably well." His daughter echoed this importance, commenting on her father's 'fierce' independent nature. She reported "without the ability to do anything for himself, then he is totally aware that for him personally, that negates a quality of life of any sort." As Mrs. A summed it up " well, you're half better, but not totally better, but you are taken out [of hospital]...our population is getting older and older...they are saving more people all the time, saving their lives, then when you save their lives, what are you going to do with them? Just because you save their lives, that doesn't mean they are going to have healthy lives."

Patients' Perceptions of Team Members

Patients had mixed perceptions of team members. Patients used words such as wonderful, incredibly patient, encouraging, helpful and knowledgeable to describe team members. They acknowledged team members' workload, as Mrs. C stated, "I must say, the girls here are just wonderful, they really are. Sometimes they're just run off their feet you know, but they never seem to lose their tempers. They are always very calm and very good to me. So I appreciate it." Mrs. C. stated this of her stay on an inpatient ward. Her experience of her potential discharge from emergency with a fractured pelvis, produced different thoughts: "I don't want to blame anybody because I know how busy they are, but I think it's a case of the sooner you can patch this one up and send her on her way the better you know, and if she's limping, well, that's life...a little more consideration, that's all I would say [is needed]. The basic thing anyway."

However many patients felt that team members did not hear them, or believe them. Mr. D. described his experience: saying "I just told you about getting up in the morning and having less mobility than the day before, and I got the impression that nobody was hearing me, or if they heard me, then they figure I don't know what I was talking about." Elsewhere, Mr D. stated he felt that team members thought he "wasn't right in the head" and that he "got the impression that they think I'm exaggerating". He had difficulty figuring out why team members were not believing him, "I'm not asking for the moon…I wouldn't want anyone to think I planned on being here for the winter." He summed up these interactions by stating, "it makes me feel like two cents."

Two of the three patients with families who were assisting them during their hospitalization reported perceiving team members as resentful to being asked questions. Mrs. A. stated, " When they [sons] were inquiring about things, trying to find out and organize stuff, they usually found resentment, like 'what are you doing poking around and asking all these questions for and everyday checking this and checking that out?' Well, I mean who is going to do it? Somebody has to do it?" Mr. F's daughter concurred "…there becomes a point when they are tired of our asking questions, and that we felt since the beginning." Other patients felt that they had many unanswered questions about their medical status at the time they were told they were ready for discharge as evidenced by phrases such as "I am just wondering…" "There are many things I need to have answered…" and "It hasn't been discussed…"

The elderly patients also had interesting perceptions around doctors and singled them out from the rest of the team in regards to two aspects of communication. These were, communication between themselves as patients and the doctor, and communication between different doctors. The patients seemed dissatisfied with the conversations and information they received from their doctors. Patients felt doctors visits were too brief, often occurring at times when patients were only just awake, or in hallways and did not provide answers to their questions. Patients looked to their doctors for information, for direction on what was happening to them medically and for coordination of medical aspects of care. Most patients felt that they did not find this as seen by the following quotes:

Mrs. E. "I had just fallen asleep and he [surgeon] came in and patted me on the leg and said 'oh, I'm going to go ahead and make arrangements to do surgery' and then he just took off...I haven't seen him since."

Mr D: "They have taken urine specimens and said they sent them and I never heard anything more. I had blood tests and I never heard anything more."

Mrs A: "...they [doctors] rush in and out for five minutes in the morning and they're gone...he [doctor] would ask me what was going on. He would say 'well did you see so and so and what did he say?" Well my chart is out there for heaven's sakes, he should be telling me what was going on..."

Mr. F's daughter: " [doctors said] okay we'll just cut it [pain medication] back, and they didn't prepare us for the sort of withdrawal symptoms he was having..."

The second issue was around the doctors communicating amongst themselves. Two patients felt strongly that their care and readiness for discharge was affected by poor communication between doctors. One patient, Mrs. E., who named four specialists consulting on her care finally told one doctor inquiring about plans "I can't seem to get two of them to agree on the same thing." She told her son "they're all different. They've all got different ideas of what should be done." In fact she related that nursing was asking her "when are they going to do this surgery?" Mrs A made this observation about her doctors: "I have seen doctors pull up short like this if they saw another doctor at the door or by my bed." She continues, "everybody is a specialist…and nobody wants to step on anybody's toes…instead of working together, each guy has his own little part and he is ever so afraid to impose on somebody else's territory, and where is the patient left? He's just left there, and you have to have an advocate, somebody has to take charge." Mrs. A felt strongly that this impacted her discharge, "So before they send somebody home from the hospital, the heart and the kidney guys should be talking and coordinating…because I am a whole person, not just a kidney or a heart."

Coordination of Discharge Plans

The theme of coordinating plans was woven through the text of the interviews. Several patients spoke about the lack of coordination in discharge planning and the need for a better way of coordinating both medical and functional care issues around discharge planning: "…there needs to be one coordinating things" "there are other things that need to be on a checklist, by that I mean, no human can remember everything all at one time…" Others intimated the need for better planning when relating concerns about their outstanding needs. Mr. F's daughter talked about how no one had come to see her father's home and assess its accessibility, and how no one told him of the importance of following up with his family physician. Mrs. C. mentioned that no one had tried to get her to walk at the time they wanted to discharge her, simply assuming she could. Mr. D. was offered a home support worker for his laundry, which he was able to do himself in the sink, while he was wondering how he would manage his urinary frequency. Mrs. A. and Mrs. E. were both wondering what was in place to prevent them being readmitted with the same medical problems.

Of the patients interviewed, one had experienced a family meeting and another was looking forward to one the next day. Two mentioned they had experienced family meetings during previous hospitalizations. Their attitudes to these meetings were positive and they saw the meetings as an opportunity to hear and share information with the team. Patients, who did not have a conference, seemed generally unclear on the roles of team members, such as physiotherapy, occupational therapy or social work, in regards to discharge planning. These patients tended to identify the doctor as the team member responsible for discharge planning.

Hospital Constraints

Of the six patients interviewed, three mentioned hospital constraints as part of the reason for being discharged before they felt ready. Mrs. B stated "I was thinking that you could sort of take your time to when you felt able to go and cope, but they're so short of beds here, and so they want people out. Mrs. A. said she felt guilty, "I know that there are lots of people who need a bed and I have been here since the 10th and you know, I feel guilty about that, but I can't help it." She felt that something else was needed in the health care system to accommodate patients, "It seems to me what's really needed, because I see other people who are in need of medical help and can't go home, that there should be some extension of the hospital...you're half better, but you're not totally better, but you're taken out." Mrs. A. furthers this argument by acknowledging the hospital as a source of iatrogenic infection, "I know that the longer you stay in hospital, the more likely you are to get it [infection]. She calls this a 'Catch -22' situation: "You're going to get stuck if you stay and stuck if you don't stay. Mrs. C lamented about being told there were no beds for her in emergency, "You find out I guess, when you have a little bit of a crisis, just where you stand. I thought I had been paying into this medical services plan since the day it started, and when I need it, where am I? I'm out."

Survey

A four-page survey was distributed to only one stakeholder group, the interdisciplinary team members at St. Paul's Hospital (see Appendix C). A return rate of 45% was achieved with 34 surveys completed and returned. Team members were located on medical and surgical units, the family practice unit and the geriatric unit. While the researcher distributed the survey purposively and in person to doctors, medical residents, nurses, occupational therapists, physical therapists, speech language therapists, social workers, pharmacists, dieticians and home care liaison nurses, it cannot be verified that these people in fact were the ones to complete the survey. Since the researcher had worked with most respondents no demographic information was collected in the survey to provide increased anonymity and the likelihood of honest responses. The results of the survey are reported in the next section and discussed. Conclusions drawn from the entire body of data are discussed in a later section.

The first six questions of the survey sought the level of agreement around general perceptions of readiness for discharge. The results are displayed in the following table (Table 1) with the value 1 equalling 'strongly disagree' and the value 6 equalling 'strongly agree'.

Table 1

Team members' perceptions on geriatric patient readiness for discharge

Survey Question	Range	Mean	Mode
1. Geriatric patients are ready for discharge when they are medically stable, despite their level of function.	1-5	1.67	1
2. Geriatric patients are ready for discharge when they are medically stable and able to mobilize.	1-6	2.82	4
3. It is the family's responsibility to care for a geriatric patient at home if they are medically stable.	1-6	2.23	2
4. I have usually found that when a geriatric patient or family is refusing discharge, their concerns are usually unfounded.	1-6	2.26	2
5. Geriatric patients/families who refuse discharge do not understand how the system works.	1-5	3.1	2
6. All team members are responsible for considering physical, mental, social factors when deciding if a geriatric patient is ready for discharge.	2-6	5.61	6

Questions 1, 2, and 6 sought the level of agreement about when a geriatric patient is ready for discharge. There was strong agreement (88%) that there are other factors beyond medical stability to consider for a patient to be ready for discharge. When a patient is both medically stable and ready to mobilize, 33% of respondents felt that he/she was ready for discharge. However 94% of team members also agreed that all team members needed to be involved in considering physical, mental and social factors in relation to discharge readiness in geriatric patients.

Question 4 looked at whether team members felt family members were responsible for looking after the medically stable patient at home. Again, 82% team members felt that there was more than medical stability required for family to assume care. Question 5 asked team members whether they felt that patients refusing discharge did not understand how the current day medical system works. Sixty-seven percent of team members disagreed with this statement, indicating that geriatric patients and families are seen as knowledgeable about how the health care system operates.

Question 7 was an open-ended question where team identified who they felt was responsible for documenting discharge plans. All respondents stated that 'all disciplines' involved in the patient's care are responsible for documenting discharge plans. Some respondents further stated that all disciplines included the homecare liaison nurse and that input from the patient and family needed to be included.

Question 8 was a two-part question first asking team members about whether or not the team's responsibility for the discharge plan ends when the patient leaves hospital. Eighty-two percent of team members felt that the team's responsibility for discharge planning did not end once that patient left hospital. However there was discrepancy as to which team members remain responsible for the plan post-discharge. Team members were asked to name all the disciplines they felt remained responsible for the discharge plan. Thirty one percent of respondents singled out the physician as the individual responsible for the patient. Similarly 29% of team members saw the community care team as responsible for the discharge plan. Only 33% of team members named one or more of inpatient team members such as the social worker as being responsible.

The results from question 9 showed that respondents thought that all team members involved in the patient's care are responsible in addressing patient and family concerns when they refused to be discharged home.

Questions 10 and 11 sought out the team members' reactions to a patient or family members statement that they are not ready to go home. Team members were asked to select from two lists of phrases; one that reflected their thoughts on this issue and the other that reflected their feelings. They were also given an opportunity to add to the list. The list of thoughts reflected phrases that the researcher has heard over her years of working with teams in the hospital. The results to Question 10 and 11 are represented in the pie charts (Figures 1 & 2) below:

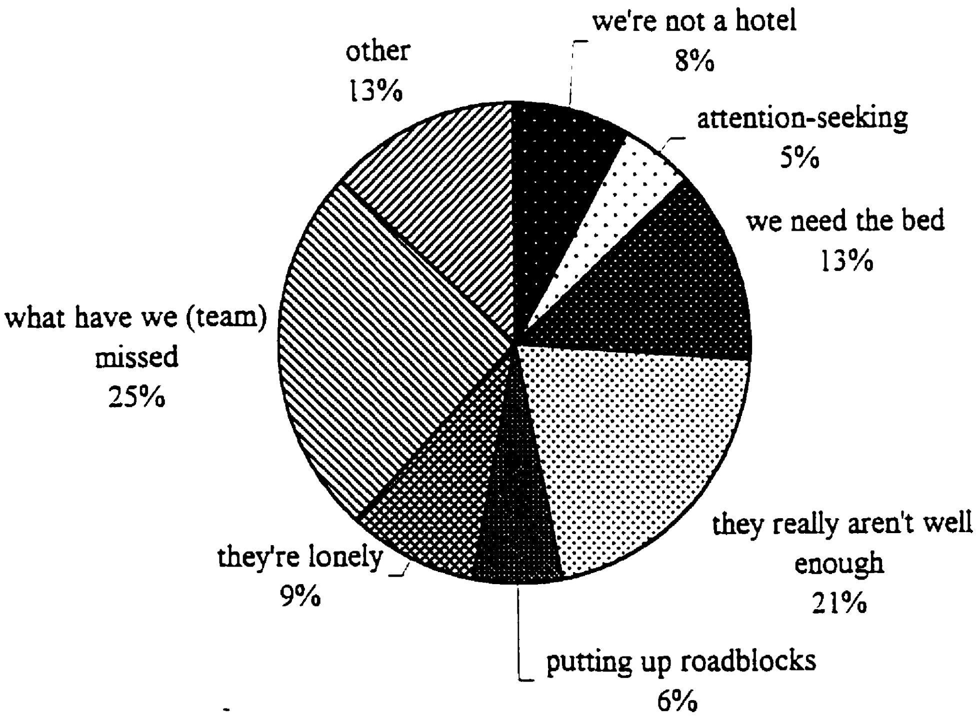

Figure 1. Team members' thoughts in response to patients stating they were not ready for discharge

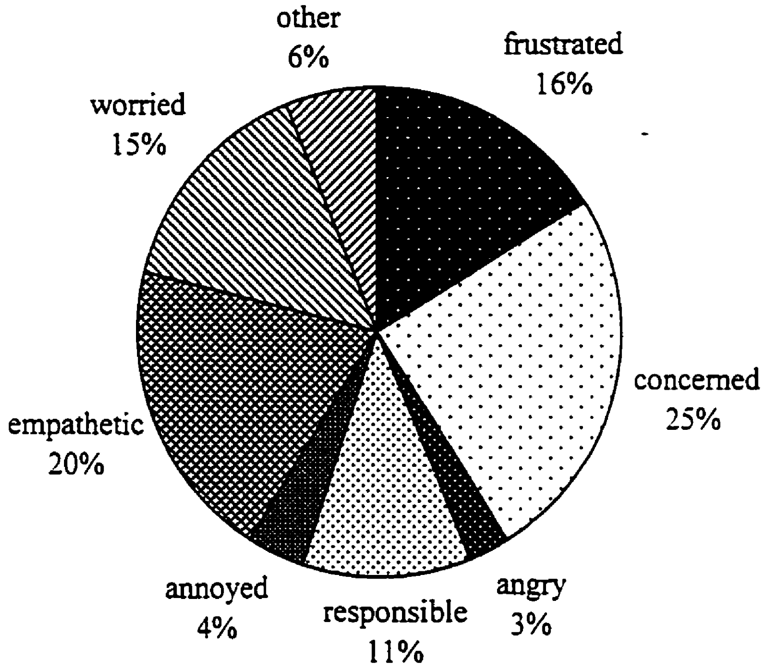

Figure 2. Team members' feelings in response to patients stating they are not reading for discharge.

Questioning what the team had missed along with thinking the patient is not well enough were the most frequently identified thoughts the team members reported. This parallels the highest reported feelings of concern and empathy. However, only 23% of team members reported these categories as the only thoughts or feelings experienced. By far the majority of team members (77%) ticked multiple categories suggesting that reactions are dependent on the particular situation or that conflicting thoughts and feelings may occur for any given situation.

In the 'other' category of question #10, team members reported thinking about the patient's possible needs, and the patient's/family member's expectations They also reflected on the patient's being fearful stating, "they are scared that something may go wrong at home". In question #11's 'other' category team members reported surprise and puzzlement: "why is this?" "curious as to the reasons" "surprised that we have missed what their concerns actually are."

Team members were uniform in their response to question #12 stating that their first priority when a patient/family refuses discharge is to determine why, notify the appropriate team members and take necessary steps to allay their concerns by furthering the discharge plan. The responses to question #13 fell into three main categories. Patients and families needed: (a) team members to listen, reassure and support them, (b) information and education, and (c) more community supports at home.

Answers to question #14 reflected the team members' perceptions regarding the degree of patient and family input in deciding whether the patient is ready for discharge. Sixty-eight percent of team members reported that patients and families should have a lot of input into this decision, whereas 30% felt that patient and families should have some input, and only one respondent felt that patients and families should have very little input. Team members were asked to give their reasoning behind the rating they gave in this question. Respondents who gave an ' a lot' rating saw patients and families as needing to be involved as they have the knowledge of the home environment, about prior level of function, what the needs are regarding equipment and services and also potential barriers to discharge. Team members also saw patient and family involvement as being necessary to gain agreement with the discharge plan if it is to be successful. Respondents in the 'some input' rating group, also saw patients and family as part of the team, but stated that there are limitations to the weight of this input. Some of these limitations seem to arise out of concern that patients/families' expectations are not always realistic or legitimate. As one person articulated, "Ideally everyone should stay [in hospital] until they feel 'comfortable' but this is not always realistic. Many times a patient is being too dependent and needs to be discharged. Also family members sometimes want people in hospital for different reasons - not always realistic [ones]." This latter statement was echoed by several respondents who felt that sometimes family have hidden reasons for keeping a patient in hospital such as guilt, greed or wanting to go on vacation. Another reason for limited input is the constraints of the hospital system: "...they also need to be aware of the limitations of the hospital system and what we can and can't deliver in the context of an acute care hospital." The respondent, who stated patients and families should have little input in deciding readiness reasoned that trained professionals evaluated patients and decided discharge plans and dates and that while patients and families could voice their concerns and changes could be made when valid, they need to communicate them early on in their hospital stay. Likewise, the team members were responsible for informing patients and families of how long they were expected to remain in hospital to avoid discharge being a "surprise".

Chart Reviews

All six charts were reviewed after the patients were discharged from hospital and after their interviews were transcribed, analysed and recorded. This was done so that the stories the researcher recorded would not be coloured by any information coming from the chart. The chart reviews were done to see if the team acknowledged the patient was not feeling ready for discharge and if the patients concerns were recorded and addressed. The review also looked at what point in their stay discharge planning was initiated, how well the plan was documented and what was planned for follow-up. Table 2 records some of this information:

Table 2

<u>Results of chart reviews</u>

Patient	Length of Stay (in days)	# of days into admission when team stated patient ready for discharge but patient disagreed	# of days into stay when first documentation of discharge planning appeared	Discharge plan clearly documented	Follow-up arranged
Mrs. A	34	20	20	No	Vascular surgeon
Mrs. B	34	30	30	Yes	Family doctor
Mrs. C	4	1	1	Yes	None
Mr. D	32	31	29	Yes	None
Mrs. E	28	10	9	No	None*
Mr. F	22	14	14	Yes	Renal unit, home care nursing and home care OT

*(after two admissions to emergency within one week post discharge, follow-up with geriatrics was planned.)

Charting around discharge planning was variable and, in some cases, sub-optimal. None of the charts stated that the patient was saying they were not feeling ready for discharge although it was members of the patient's care team who identified these patients for my study. Table 2 shows that the time that the patient said they were not ready for discharge is approximately the same time that the very first chart note referring to discharge appeared. However, in four of the six charts, someone had acknowledged the patient's concern or feelings about going home prior to the initiation of discharge planning. The discharge plan was clear for four of the six patients, that is, the reader could see what the plans were and how they would address functional and medical issues. Plans ranged in depth from one line "patient will go home with private home support services and follow up with surgeon" to an in depth review (3 patients) of problems identified, status on discharge and plans laid.

The charts were difficult to analyze and there seemed to be a paucity of information. One chart contained no written nursing notes, only clinical records of patient vitals such as, blood pressure and temperature. One chart had no social work notes; another chart had only two physiotherapy and occupational therapy notes despite an apparent 22-day involvement. Of the six patients, only one chart clearly stated the patient's goal and specific plans to assist that patient in reaching her goal. Mrs. B's goal was "running my apartment and look after [Mr. B]." Meal preparation was her specific goal; for her husband it was that his wife could get up from the floor if she slipped. The occupational therapist did a kitchen assessment and arranged frozen meals and the physiotherapist taught Mrs. B how to get up from the floor, recording in the chart "this was the husband's concern and he can now be reassured."

The charts contained few descriptive notes about patients' feelings and concerns. Team members appeared to document only when a patient seemed excessively anxious. Mrs. A's anxiety was addressed by one geriatrician: "grieving over her husband's condition and poor prognosis for discharge home...will ask social work to see re: grief counselling". However the issue was clearly far from resolved by the time of her discharge as seen by the dietician's note, dated the day prior to discharge, "Patient seems very depressed and concerned about going home." No follow-up plans to assist Mrs. A with this issue were documented. Mrs B's concerns were documented in the chart early in her stay by pastoral care," [Mrs. B] is worried about her husband and 'can't cope with meals' at home." The medical resident also acknowledged that she was "fearful to walk". Mr. F was described as "kind", "pleasant, cooperative" by various team members in the chart and the social worker addressed his daughter's concerns around the patient's quality of life: "he wished he could regain his ability to do things..." For Mrs. C there was acknowledgment of her concerns around managing at home the day prior to her discharge. Her concerns around being unable to walk had been documented on her first day of admission. While Mrs. C said in her interview that no one tried to walk her while she was in emergency, a discrepancy between her story and the chart record was found. During her admission to emergency, both the doctor and the nursing notes state she was walked with a walker at least twice. The notes further stated that she had been kept overnight in emergency as she did not have apartment keys and could not contact the building manager. It was only the next morning that her pain and mobility worsened to the point of needing admission to acute care. For the other two patients, Mr. D and Mrs. E, no descriptors about their feelings or their concerns were found.

The patients' reasons for not feeling ready for discharge identified from the interviews were noted and the researcher looked to see if these were resolved by the time of discharge. Results were mixed with medical concerns being resolved more often than functional concerns. Doctors' documentation showed that the medical concerns articulated by patients were stable at the time of discharge. Only one patient had a repeat admission within 30 days of discharge; Mrs. E. was readmitted with pain within 1 week of going home and then seen again within emergency where a detailed discharge plan including follow-up was finally written. The same cannot be said for the functional issues that the patients were concerned about. For Mr. D, who lived in a Salvation Army hotel, the team had consistently documented that he was continent using a urinal or toileting. Clearly though, Mr. D's concern about how to manage this at home, without the luxury of nursing to change linen and empty the urinal and the frequency (up to eight times a night) with which he had to use the urinal throughout the night was not addressed despite nursing notes documenting his frequency. There were no notes stating how far he had to go from his hotel room to the common bathroom or if he was given a urinal to use in his room. Again, no one had addressed his concern of lessening mobility in his leg or the increased pressure he felt in it when he bent forward. Mr. D. was unable to dress his lower body at the time of discharge without the use of aids. He was given a list of where these could be purchased.

Mr. F. went home accompanied by the hospital occupational therapist to address his environmental and accessibility concerns. As he was effectively discharged at this time, there were no notes recorded about this visit or the recommendations stemming from it. Interestingly, his chart did note that in the months prior to his admission, Mr. F had turned down two offers of home assessments by community care team members. Neither he nor his daughter mentioned this in their interviews only stating "the house has never been assessed." The daughter was asked specifically about home care occupational therapy but was unaware if it had ever been offered. Her specific concern of follow-up with the family physician was not mentioned and no follow-up appointment made. Mrs. B. went home on a two-day pass and was discharged at the end. No one noted in the chart how she managed at home. The only documentation was "to be discharged."

Lastly, the chart had piecemeal interdisciplinary charting on the discharge plan. Notes were scattered in various parts of the chart making it hard to put the patient's records together in a logical sequence. Some disciplines did chart in the progress notes section where the doctors write, rather than in the discipline specified sections and this increased clarity. However, unless a family meeting took place or team rounds were recorded, it was difficult to see the contributions of the interdisciplinary team to the discharge plan. There was no charting by nursing reflecting their own actions towards the formation of discharge planning for any of these patients.

Study Conclusions

The survey results show clearly that team members agrees that discharge planning is an interdisciplinary effort that requires the assessment and planning of the medical functional and social issues surrounding the elderly patient. All team members are responsible for documentation of the plan and the majority of team members think that patients and families should have a lot of input into this plan. This is in agreement with the literature and reflective of best practice. However, for five of the elderly patients and the one family member interviewed in this study, none of the above had taken place in a comprehensive manner. Only one patient had a cohesive documented discharge plan in place at the time she stated she was unready to go home. This patient, Mrs. B. had had a family meeting where the plan was constructed, had services and equipment in place and had the concerns she articulated addressed. By her own admission she stated she was not ready for discharge because "I am a coward at heart."

The chart review showed that generally discharge planning began in the middle to end of the patients stay (Mrs. C being the exception). If discharge planning begins at the time of admission to hospital, it would logically follow that documentation about discharge goals and plans would also begin at this time but this was not the case in this study. In addition, while all team members agreed that every discipline involved in the patient care should be documenting the plan, this did not occur. The lack of charting on discharge planning from the nurses, who are the primary caregivers in any patient stay, was alarming. This may be attributed, in part, to the nurses' format of charting 'by exception'. However, given that nurses write much of the literature on discharge planning and see themselves as a key stakeholder, then one would reason that their clinical interventions in regards to discharge planning need to be documented. The nurses' reasoning behind 'charting by exception' and their outlook on the chart as a tool for communication needs to be investigated in relation to their practices around discharge planning.

The first discharge note for the patients appeared at approximately the same time they patients stated they were not ready for discharge. It is difficult to know how many previous conversations happened between patients, family and team members around discharge planning prior to this time. At the time these notes appeared, team members identified to the researcher that the team felt the patient was ready to go home. Can one assume that discharge planning with the patient had occurred prior to this point? It is a question that cannot be answered given the data available. Only once the patients had stated they were not ready to be discharged did the frequency and degree of discharge planning documentation in the chart increase. Still at the time of discharge only four of the six patients had discharge plans addressing medical, functional and social problems.

The fact that patients had outstanding medical and functional issues at the time they were deemed ready to go home is a red flag that something in the acute care system is not working. Team members reported that they felt concern both about their own performance (what have we missed) and about the patient's well being (they really aren't well enough). Moreover, team members know that what the patients generally need is to have someone listen to them, to provide them with information and education and to have access to community supports. These nneeds were corroborated by the elderly patients during their interviews. The question that arises is why has this not already occurred during the patients' hospitalization? Perhaps, as health care providers, we underestimate the amount of information and discussion patients and families want or are actually giving. As Clemens (1995) found, team members felt they were giving a high degree of information, but patients and families perceived they were not given very much. The literature also discusses the inconsistencies that may occur in both the assessments team members perform and the answers patients and families' give and how these affect discharge planning (Bull, 1994, McGinley et al, 1996). Unless team members document their assessments and interactions with patients, inconsistencies might not be detected until the time of discharge arrives. Sadly, the chart reviews reflected this lack of documentation. If team members have stated they are surprised they have missed something while patients have stated they are not being heard and are not being asked, then improving communication may be integral to solving the dilemma of what it means to be ready for discharge.

One answer to the communication challenge appears to be the family meeting. A well-constructed family meeting is a time when patients, family, and all team members gather to share information, and discuss the care plan for discharge. In this study, the family meetings for Mr. F and Mrs. B resulted in clearly documented discharge plans, including plans that addressed the outstanding functional issues that the patients articulated in their interviews. For team members, the family meeting provides a forum to involve patients and their families in discharge planning as well as a forum to discuss what are realistic expectations in the acute care setting. For the patient and family members, the meeting provides an opportunity to ask questions regarding their care and prognosis, to articulate their concerns, and to seek support from team members.

The results of this study corroborate many of Tennier's (1997) findings. Barriers to effective discharge planning in their Canadian hospital included: (a) lack of clear documentation of the discharge plan, (b) a lack of communication and coordination between team members, (c) inaccessible or inadequate community resources, (d) patients and families not being adequately informed about discharge dates, (e) a failure to consistently include patients and families in the discharge planning process, and (f) a failure to start discharge planning early enough in the patient's stay.

Study Recommendations

Recommendations address five main areas of practice -- communication, documentation, the role of a case manager, utilization of clinical tools and follow-up that are outlined below. While these recommendations are being given to the GATP, the sponsoring group of this study, they extend in principle to all the medical and surgical units in St. Paul's Hospital that care for elderly patients.

Communication

Communication between the interdisciplinary team members and the elderly patient and family needs to be enhanced. Patients have stated clearly that they have outstanding questions and needs. Team members recognize that there are patient concerns and issues that have been missed. It is essential for the team to provide more information rather than less information to patients and families and to provide that information in a variety of formats. Patients will have a clearer idea of expectations and this will decrease the chances of 'unexpected' discharges.

Methods for improvement.

1. Bedside Chat. Conversations with patients regarding discharge planning need to start occurring earlier in the hospital stay. Patients and families need to be given a direct opportunity to clarify their expectations of discharge destination and any barriers (physical, functional, social or emotional) that they can articulate. They also need to be actively involved in goal setting and planning to enable them to be ready for discharge. These goals need to be understandable to the patient and family. This means that patients and family members understand clearly what part of the goal will be reached in hospital and what will be reached post-hospitalization.

2. White Board. A white board at each bedside would enable patients and families to write down the questions or key words as a reminder of questions they have for various team members including the doctor. In turn, the team member can provide the writer with an answer to the question either in conversation or by writing a response if it is an early morning physician visit and the patient is unlikely to remember a conversation. If privacy is a concern, then a notebook could be given to each patient.

3. Brochure. One method of initiating this discussion would be to provide written material on discharge planning that includes a checklist of items to consider. A brochure could also state all team members' roles and responsibilities in the discharge process and even give names of the various team members. Written material provides another avenue for the GATP to state their philosophy and expectations around discharge planning to their patients.

4. Video. Providing a visual and auditory material on discharge planning will assist patients and families who may learn better from this method or who have a low literacy level. A video will also provide an opportunity for team members to give education to more than one person at a time. This video could potentially be broadcasted on the in-hospital television information channel.

5. Family Meetings. Elderly patients and families need to know early in their stay that there is opportunity to have a meeting with the team. While this is the most time-consuming of the methods recommended, the study results have pointed to the efficacy of the meetings in terms of addressing patients' needs and providing detailed documented discharge plans.

6. Follow-up appointments. Follow-up is planned for many patients, usually with a specialist or with their family physician. These appointments need to be booked and given to patients and families prior to their leaving hospital. This will provide a better opportunity for compliance with discharge plans.

Documentation

The patient chart is the legal entity that records the patient's hospital journey. It is paramount that charting by team members stands up to scrutiny and legal recourse. The chart is also one of the main methods for team members to communicate with each other. Only if a team member's intervention is recorded do others know with certainty it took place. Documentation also takes time. Team members at St. Paul's have been reluctant to adopt more forms, as they tend to create one more place to record. Each discipline has their own charting standards and this needs to be reviewed. The chart reviews in this study point to substandard charting and the fragmentation of documentation by both disciplines recording in separate areas.

Methods for improvement.

1. Recommend a model of continuous charting. The GATP could recommend to Clinical Informatics that the organization move to a system where all disciplines document in the same area would allow for better integration and continuity of plans. Less time would be required by team members to review each notes from professionals in other disciplines and readers are likely to gain a clearer picture of patient progress and functional status. In addition, the GATP needs to support the hospital's vision of interdisciplinary computerized charting,

2. Standards of charting. Understanding the different disciplines charting standards and agreeing on a minimum universal standard for the GATP unit to which all members can hold each other accountable would allow for more standardized charting and more comprehensive information on the charts.

3. Discharge plans need to be recorded earlier in the patients stay. This documentation needs to include clear statements of the patients' own goals and their discharge environment. Goals must include indicators or outcome measures that can be tracked for evaluation. The patients' concerns and feelings need to be recorded, to reflect that team members have acknowledged this aspect of patient care. Follow-up plans also need to be clearly documented by the team.

Case Manager

The case manager model provides elderly patients and families with a designated person to assist in the coordination of care, discharge planning and follow-up. The case manager is in a position to communicate and coordinate with all health care disciplines and liaise with community partners.

Methods for improvement.

1. Evaluate the benefits of case management with the elderly and develop a strategic plan for continued lobbying for funding case managers if the evaluation outcomes support such action.

2. On the GATP unit, each patient is assigned a point person whose responsibility is to act in the capacity of a 'concerns' person. Their job is to facilitate the resolution of concerns that patients and families articulate around discharge plans. This will ensure that patient and family concerns get heard and do not get lost in the

system or between rotations of team members. This person can also represent the patients' concerns at interdisciplinary rounds.

Clinical Tools

Tools such as checklists, assessments and guidelines provide a way of effectively organizing patient care and ensuring that desired discharge outcomes are achieved. There are two main tools that the GATP needs to consider for different aspects of their program.

Methods for improvement.

1. Clinical Pathway. A clinical pathway would provide all team members with a standard way of addressing discharge planning. Roles and responsibilities of each team member would be outlined and the process that must be navigated articulated. A pathway provides a method for new team members and relief team members to be clear about the process of discharge planning on the unit and provide care consistent with the GATP's mission (Seppelt, M. personal communication, March 29, 2001).

2. Discharge Readiness Checklist. The creation or adoption of a discharge checklist provides patients, families and team members with a simple tool to identify needs. Patients and team members can fill out the tool together or separately. Checklists are quick and efficient, and can be easily reviewed to see what has been addressed and what remains outstanding. A checklist will provide a way of ensuring all physical, functional, social and environmental factors that contribute to a patient's readiness for discharge have been addressed.

Follow-up

Finding a method for follow-up on discharge plans will give team members feedback as to effectiveness of their planning and allow identification of areas in need of improvement. If team members do not receive feedback, there is little incentive to improve practice.

Methods for improvement.

1. Survey of Patients. A random number of recently discharged patients or family members could be mailed a simple 5 to 10 question checklist to complete and return. The checklist would ask about overall satisfaction with or implementation of discharge plans. With carefully chosen questions, this continuous feedback provides team members the opportunity to identify gaps in planning and make improvements. Results of such checklists could easily be disseminated to team members on a regular basis.

2. Survey of Community Services. Community services to which patients are frequently referred could be surveyed to ascertain the appropriateness of their referrals, the number of referred patients who are accepted and seen and the outcome of the discharge plans the team has made for their patients. This would provide the GATP with information and feedback on the level of continuity of care for their patients and enhance new and existing partnerships with these agencies.

3. Telephone Follow-up. While more time consuming, follow-up by telephone interview with patients (all or a random number) one-week post-discharge, would provide an opportunity for team members to identify outstanding concerns and answer questions relating to the patients' hospital care and discharge plans. This has

the potential to involve all disciplines ensuring feedback is received throughout the team.

The recommendations from this study address some of the gaps in the GATP's day-to-day practice of helping patients become ready for discharge. They are strategies to improve the quality and consistency of care provided to the elderly patients. The researcher acknowledges that practice on the GATP is also constrained by the structure, processes and funding of the health care system. There is a lack of diverse, accessible community-based services for the increasing elderly population. For example, there appears to be a need for community based transitional care units where elderly patients may receive convalescent care and ongoing rehabilitation prior to returning home. Although the GATP must continue to propose and lobby for increased services for their patients, these wider systems issues need to be addressed urgently by all levels of government.

CHAPTER 5

Research Implications

Organizational Implementation

Implementing any of the recommendations concerning communication, documentation, role of a case manager, clinical tools and follow-up will require the GATP interdisciplinary team members to make changes to their operations and clinical practices. The change-making process will call for both a reorganization of the GATP system as well as a review of the team members' patient care philosophy. The GATP needs to make changes that are in line with their stated mission and values and the over-arching Providence Health Care’s organizational values. Team members will be called upon to discover their level of motivation for making change and their own level of desire to improve the care they give elderly patients and families. The researcher recognizes that fiscal and manpower resources are scarce for the GATP, but urges the GATP leaders to capitalize on their team's strengths, which include their creativity, knowledge, passion and dogged persistence.

Given the apparent increasing workloads for professionals in the health care system, making change is often met with resistance. Implementing recommendations on the GATP can be achieved one step at a time and does not require a complete overhaul of the system. If the change process has meaning for the team members and patients involved it is more likely to be embraced. Thus the change process needs to involve those it is 'happening to'. The GATP team members have previously utilized the Rapid Cycle Change Process (Baker & Norton, 1994) to improve the interdisciplinary team rounds on their inpatient unit. The researcher suggests that this process be used to implement recommendations adopted from this study. The Rapid Cycle Change Process is a plan/do/study/act process that enables small groups of individuals to effect continuous quality improvement. It is ideally suited to the health care profession where change is constant, and providing excellent care is a challenge.

Last year, the GATP underwent the hospital accreditation process. Opportunites for improvement included the need to:

1. Document the patient's experience of their disease and the patient's involvement in key decision-making needs to be further encouraged.

2. Inform patients and families need to be informed about opportunities for input into care planning meetings.

3. Use effective communication tools are required to facilitate consistent goal-oriented patient care by all team members.

4. Re-examine the need for a caregiver support group.

5. Increase the use of the Discharge Planning Form.

6. Develop a form for patient/families to give feedback to the multidisciplinary staff to identify priorities for improvement in patient care.

5. Lobby for the return of case managers to the outpatient clinic and consult team.

(Providence Health Care, April 2000)

These opportunities overlap with some of the recommendations of this study. Implementing strategies for improvement will resolve some of the issues around discharge readiness that patients and team members have identified. The GATP has committed a small group of team members to creating some strategic plans to meet the desired goals. This team would be able to identify where some of this study's recommendations fit with actions to be implemented to achieve the accreditation standards.

The implementation of this study's recommendations needs to occur in all facets of the GATP: the inpatient unit; the consult team; the outpatient clinic and the home visit program. Wherever possible, the team needs to capitalize on opportunities of the program's unique configuration. For example, home visits and the outpatient clinic provide an excellent opportunity to follow-up on recent admissions. Likewise, if the consult team starts to utilize a discharge checklist, this will be seen by other team members within the organization and would create opportunity for improvement in the care of elderly patients not seen through the GATP.

Where necessary the GATP may wish to consult other resource people within Providence Health Care. These may include the Clinical Pathway Consultant, and the departments of Clinical Informatics and Organizational Development or colleagues in other geriatric programs. Such resources can assist in developing workable solutions and ensure the focus is on a viable outcome that is consistent with the standards of best practice reflected in the literature. Consulting others outside the GATP can provide the objectivity needed to ensure that approaches are interdisciplinary in focus and can also assist with identifying and meeting the educational needs of the team.

The GATP needs to weigh the implications of implementing changes to discharge planning against the implications of maintaining the status quo. Again, this requires the GATP team members to reflect on their values and the direction they are taking their program. The GATP is challenged to look at the care from the elderly patients' and families' perspectives. Ignoring the perspective of the patients has grave implications for the care the patients receive. Patients will continue to be discharge with unmet needs, and this will increase the burden on caregivers and community resources. Unless changes are made, low patient and family satisfaction with discharge planning will result and continue to be reflected in patient care surveys. The GATP team members also need to be aware that not implementing changes in at least the area of documentation leaves them vulnerable from a legal perspective. Team members have an obligation to document patient care in the health record and recognize that the record represents a legal document.

A reluctance to make improvements in discharge planning for the GATP would create questions around the GATP and hospital's accountability towards their care and service agreements. These are the goals and key indicators set for patient care and provide a framework for the improvement and delivery of services. In many respects, the care and service agreements bring to life the mission and values of the Providence Health Care Group. They are one method of ensuring that the mission and values do not simply become words on a piece of paper. If the GATP wants to adhere to its mission statement (see Appendix A) and "ease the transition of the older adult through the health care system" then it must continually improve upon its practices to ensure elderly patients are ready for discharge.

Future Research

Future research on questions arising from this study can contribute to both the medical and allied professionals' health body of knowledge and to the effectiveness and efficacy of services provided by Providence Health Care and the GATP. While there is much literature written on discharge planning, there is less research on stakeholders' perceptions around the meaning of readiness for discharge. Discharge readiness and planning strategies to improve elderly patient and family care need to be shared between health care disciplines and organizations. These strategies need to target the patient care level and the systems level. The researcher hopes this study will contribute knowledge about patient care and foster more research. Several questions for further investigation arose from this study. Answering these questions through research could lead to further opportunities for continuous quality improvement on the GATP:

1. What staff: patient ratio is needed to achieve the GATP's goals?
2. Does documentation in the patient chart really facilitate communication between team members?
3. How can teams use the time they have more effectively with patients?
4. If team members spend more time on quality improvement projects/committees what will be the implication for meeting patient care needs?
5. What competencies and skills do team members require to fulfill the GATP mission?
6. How can physicians improve their communication between each other?
7. Is 'charting by exception' an efficacious method of documentation?
8. What does 'client-centred care' really mean for Providence Health Care?
9. How does client-centred discharge planning work given the present constraints of the health care system?

CHAPTER 6

Lessons Learned

Research Lessons Learned

This was my first experience at undertaking a formal research project. It has been a learning adventure. I have appreciated the challenge of maintaining the 'big picture' of the overall goals and experiences of the project while simultaneously attending to the finer details of ethics, methodology and data analysis. The lessons I have learned follow.

1. Passion. Prior to starting this project, I had completed a proposal on another topic, which I was growing steadily unhappy about. I tossed it aside and settled on this topic and that was the moment I felt excited about doing the work. Without that enthusiasm, I do not think I would have felt satisfied about the research process.

2. Ethics. The process for ethical approval through my organization took much longer than I had anticipated and proved to be a stumbling block at getting the project started. The hospital ethics committee also required all my methods and data collection tools at the time of submission. This meant that I could not base my survey on the data I collected in my interviews or choose other methodologies such as focus groups. Unfortunately this seems to be one area where the principles of action research do not 'fit' with the hospital's ethical approval process. To continually seek approval for additional methods, or changes to survey questions would have been very time-consuming and did not fit within the time constraints of the project. Figuring out the process for each organization's ethical approval and the timeframes for approval is necessary for planning each step of the research project.

3. Finding subjects. I thought it would be easy to find subjects to interview but it was much harder than anticipated. It required me to be diligent in making daily rounds to team members asking them about potential subjects.

4. Analysis: I found it very helpful to have clear steps to follow for the analysis. I used Kirby and McKenna's book, Methods from the Margins (1989), to guide me through my analysis and ensure I did not skip any important steps in managing my data.

5. Writing. Taking a break after the initial draft was completed was helpful in providing me to some distance and clarity around what still needed to be done in the writing.

6. Recommendations. The challenge I found here was to make certain my recommendations were realistic and achievable for the organization. This was important so that my work and the participants' contributions to this project were not simply an exercise for my degree but could lead to real change.

7. Answers beget questions. More questions will arise from research than answers.

8. Note taking. Jotting down notes or journaling in some form enables the researcher to reflect on what worked, did not work or needs to be discussed later in the writing the paper. As well, it helps to develop the skills of a "reflective practitioner" and see where personal bias can affect the research process, data analysis and clinical practice.

9. Satisfaction. Of all the parts of the research process, I most enjoyed listening to my subjects tell their story. It was satisfying to give them an opportunity to be

heard and to express their thoughts and feelings. It also served as a reminder to me, as an occupational therapist, of the immense importance of seeking to understand my clients' experiences of illness and disability.

Program Lessons Learned

The following section consists of my reflections on mandatory and learner-chosen competencies I undertook during the research phase of this Royal Roads program.

1. Leadership. I have remained active in the operations of the GATP through my work as a case manager in the first four months of this project and by continuing with GATP committee work in the last four months as I changed roles within the organization. I have initiated discussions around the need for improved discharge planning processes with my colleagues. I need to continue to provide leadership to the GATP and the organization by assisting in the implementation of any of the recommendations they choose from this project. This leadership competency was also evaluated through a 360 feedback process by the organization, the results of which were shared with the Major Project Supervisor and Project Sponsor.

2. Apply systems thinking. This paper discusses the need to address discharge readiness and discharge planning on both the program-level and the health care systems level. As the root of the problem is founded in both the day-to-day practice of those professionals delivering care and in the overarching organizational and financial structure of health care, solutions need to address both levels. I recognize that my present circle of influence lies with the day-to-day practice of the GATP. Thus, the recommendations of this study target the GATP. As my role within

the organization changes, I need to continue to seek information about how the system works and how I can continue to work to improve patient care in all facets of the system.

3. Identify, locate and evaluate research findings. Data collection, analysis and synthesis took place as outlined in the project proposal. The only methodology change from the proposal phase was the addition of chart reviews, which was decided upon after discussion with the Project Sponsor and submitted for ethical approval. Standard methods of qualitative analysis were followed.

4. Use research methods to solve problems. Patient and family interviews, a survey of health care teams and chart reviews were the methodologies chosen for this study. These methods, common to qualitative research designs, allowed for input from varying stakeholders into the problem and enabled triangulation of the data.

5. Communicate with others through writing. This was evident in several phases of this project: the proposal, ethics submissions, letters of introduction to stakeholders, the consent form, letters to team members requesting subjects for the study, and the final written research paper.

6. Demonstrate leadership characteristics. Personal qualities of leadership and leadership strategies were demonstrated in the workplace throughout this project course as evidenced by the results of the candidate's 360 feedback conducted by the organization. These results were shared with the Major Project Supervisor and Project Sponsor as outlined in my proposal. I need to continue to view leadership as a learning curve and take advantage of both the leadership opportunities and learning opportunities that are available to me.

7. Help others learn. I have actively discussed and shared my results and recommendations with several people in St. Paul's Hospital who have expressed interest. Formal and informal discussions about this project have provided a venue for asking questions that challenge how and why patient care unfolds the way it does in the hospital. I need to take the results of my study and write a paper for publication in a relevant health care journal and share my results with the occupational therapy students I teach.

8. Create learning opportunities in the workplace. I believe that the survey questions provided an opportunity for team members to reflect on their work and their reactions towards elderly patients who stated they are not ready for discharge. In addition, I have been asked to present the results and recommendations to members of the GATP. The implementation and evaluation of any of the recommendations will provide another learning opportunity.

9. Managed own learning to achieve maximum added value. I made active use of the resources around me to increase my learning throughout this project. I sought information both through on-line resources and through the libraries at the University of BC. I discussed the project and sought input from people in various departments of the organization - utilization management, community partnership developments, organizational development, Departments of Geriatrics and Family Practice, and Social Work. I sought regular feedback from my project supervisor and sponsor to ensure that adjustments were made early in order to increase the potential value of the project to my organization. In addition I attended two relevant workshops: "Coping with Crisis: Searching for Solutions" (on discharge planning)

and “Measuring for Improvement” (2001 BC Quality Care conference). I also networked with several of my fellow classmates as a means of reflecting on the research process and learning from each other's successes and mistakes along the way.

10. Recognize ethical considerations. There were four primary ethical considerations noted in this project:

(a) the need to ensure elderly patients participating in the interviews were competent to give consent,

(b) the need for a representative of the researcher to make the initial inquiry of whether or not a patient wished to participate in the study,

(c) the need for confidentiality of patients interviews to be maintained, and

(d) the need to address confidentiality of the survey respondents as they are the researcher's colleagues.

References

Abramson, J.,& Donnellly, J. (1993). Disagreements in discharge planning: A normative phenomenon. Health & Social Work, 18(1), 57-65.

Anthony, M., & Hudson-Barr, D. (1998). Successful patient discharge: A comprehensive model of facilitators and barriers. Journal of Advanced Nursing Practice, 28(3), 48-55.

Baker, G. & Norton, P. (Nov. 3-4, 1999). Quality learning workshop. Providence Health Care: CQI Network, Vancouver, BC: Baker, G. & Norton, P.

Bowman, G. S., Howden, J., & Thompson, D.R. (1994). A telephone survey of medical patients 1 week after discharge from hospital [On-line]. Journal of Clinical Nursing, 3(6), Abstract from: Medscape: Medline: 95162364

British Columbia Ministry of Health. (1999). Community for life: Review of continuing care services in British Columbia, Victoria, BC: British Columbia Ministry of Health.

Bull, M. & Kane, R. (1996). Gaps in discharge planning. Journal of Applied Gerontology, 15(4), 486-501.

Bull, M. J. (1994). Patients' and professionals' perceptions of quality in discharge planning. Journal of Nursing Care Quality, 8(2), 47-61.

Carpenter, C. & Hammell, K. (2000). Evaluating qualitative research. In K. W. Hammell, C. Carpenter, & I. Dyck (Eds.), Using qualitative research: a practical introduction for occupational and physical therapists (pp. 107-119). Toronto, ON: Churchill Livingstone.

Carroll, B., Baldwin, A., & Wren, A. (1994). Realigning discharge planning to the community using computer technology. Kelowna, BC: Kelowna General Hospital & South Okanagan Health Unit.

Clemens, E. (1995). Multiple perceptions of discharge planning in one urban hospital. Health and Social Work, 20(4), 254-261.

Congdon, J. G. (1994). Managing the incongruities: The hospital discharge experience for elderly patients, their families and nurses. Applied Nursing Research, 7(3), 125-131.

Covey, S. (1989). The seven habits of highly effective people. Toronto: Simon & Schuster.

Coulton, C., Dunkle, R., Goode, R., MacKintosh, J. (1982). Discharge planning as a decision-making process. Health and Social Work, 7, 253-261.

Cummings, S. (1999). Adequacy of discharge plans and rehospitalization among hospitalized dementia patients. Health and Social Work, 24(4), 249-260.

Cummings, S., & Cockerham, C. (1997). Ethical dilemmas in discharge planning for patients with Alzhiemer's disease. Health Social Work, 22(2), 101-108.

DePoy, E., Hartman, A., & Haslet, D. (1999). Critical action research: A model for social work knowing. Social Work, 44(6), 560-569.

Deschler, D., & Ewert, M. (1995, May). Participatory action research: Traditions and major assumptions. The PAR Tool Box [Cornell Participatory Action Research Network]. Available: www.parnet.org/parchive/docs/deschler_95/index.cim

Feigin, R., Cohen, I., & Gilad, M. (1998). The use of single-group sessions in discharge planning [On-line]. Social Work Health Care, 26(3), Abstract from: Medscape: Medline: 98117588

Geriatric Assessment and Treatment Program. (1992). GATP goal statements, Vancouver, BC: Martini, J.

Green, J., & Britten, N. (1998). Qualitative research and evidence based medicine. British Medical Journal, 316(7139), 1230-1232.

Hansen, H., Bull, M., & Gross, C. (1998). Interdisciplinary collaboration and discharge planning for elders. Journal of Nursing Administration, 28(9), 37-46.

Jackson, M. (1994). Discharge planning: Issues and challenges for gerontological nursing: A critique of the literature. Journal of Advanced Nursing, 19, 492-502.

Jongbloed, L., (2000). Choosing the methodology to explore the research. In K.W. Hammell, C. Carpenter, & I. Dyck (Eds.), Using qualitative research: A practical introduction for occupational and physical therapists (pp. 13 - 21). Toronto, ON: Churchill Livingstone.

Kirby, S., & McKenna, K. (1989). Experience, research, social change: methods from the margins. Toronto, ON: Garamond.

Leduc, N., Tannenbaum, T., Bergman, H., Champagne, F., Clarfield, A.M., & Kogan, S. (1998). Compliance of frail elderly with health services prescribed at discharge from an acute-care geriatric ward. Medical Care, 36(6), 904-914.

Leske, J. & Pelczynski, S. (1999). Caregiver satisfaction with preparation for discharge in a decreased-length-of-stay cardiac program. The Journal of Cardiovascular Nursing, 14(1), 35-43.

McEvoy, P. (1999). Using patients' records as a source of data. Nursing Standard, 13(36), 33-37.

McGinley, S., Baus, E., Gyza, K., Johnson, K., Lipton, S., Magee, M., Moore, F., & Wojtyak, D. (1996). Multidisciplinary discharge planning: Developing a process. Nursing Management, 27(10), 57-60.

Mays, N., & Pope, C. (2000). Assessing quality in qualitative research. British Medical Journal 320(7226), 50-52.

Meyer, J. (2000). Using qualitative methods in health related action research. British Medical Journal, 320(7228), 178-181

Naylor, M., Brooten, D., Jones, R., Lavizzo-Mourey, R., Mezey, M., & Pauly, M. (1994). Comprehensive discharge planning for the hospitalized elderly: A randomized clinical trial. Annals of Internal Medicine,120(12), 999-1006.

Palys, T. (1997). Research decisions: Quantitative and qualitative perspectives. Toronto: Harcourt, Brace and Co.

Phillips-Harris, C. (1998). Case Management: High-intensity care for frail patients with complex needs [On-line]. Geriatrics, 53(2), Abstract from: Medline: unique NLM Identifier 98145280

Potthoff, S. & Kane, R. (1997). Improving discharge planning for elderly patients. Health Care Financing Review, 19(2), 47-73.

Proctor, E., Morrow-Howell, N., & Kaplan, S. (1996). Implementation of discharge plans for chronically ill elders discharged home. Health and Social Work, 21(1), 30-41.

Providence Health Care. (1998). Response to the Vancouver/Richmond Health Boards review of acute and rehabilitation services (Final Report). Vancouver, BC: Providence Health Care.

Providence Health Care. (2000, April). Profile and planning guide for comprehensive services: Geriatric medicine and family practice team (SPH). Vancouver, BC: Providence Health Care.

Providence Health Care. (2000, June). Understanding alternate level of care. Vancouver, BC: Providence Health Care.

Providence Health Care. (2000, July). Code triage (draft policy). Vancouver, BC: Providence Health Care.

Providence Health Care. (2000, November). Canadian inpatient survey at Providence Health Care. Vancouver, BC: Parkside Associates Inc.

Reiley, P., Pike, A., Phipps, M., Weiner, M., Miller, N., Stengrevics, S., Clark, L., & Wandel, J. (1996). Learning from patients: A discharge planning improvement project. Joint Community Journal of Quality Improvement, 22(5), 311-22.

Rosswurm, M., & Lanham, D. (1998). Discharge planning for elderly patients. Journal of Gerontological Nursing, 24(5), 14-21.

Smith, A.J. (1996). Chart reviews made simple. Nursing Management, 27(3), 33-34.

Schwarz, K. (2000). Predictors of early hospital readmissions of older adults who are functionally impaired. Journal of Gerontological Nursing, 26(6), 29-36.

Styborn, K. (1995). Early discharge planning for elderly patients in hospitals - an intervention study. Scandinavian Journal of Social Medicine, 23(4), 273-285.

Tennier, L. (1997). Discharge planning: An examination of the perceptions and recommendations for improved discharged planning at the Montreal General Hospital. Social Work in Health Care, 26(1), 41-60.

Vancouver/Richmond Health Board, (1998, July). Review of acute and rehabilitation services (Final Report). Vancouver, BC: Vancoouver/Richmond Health Board.

Vancouver/Richmond Health Board, (2000, March). Pulling together: A review of hospital-based geriatric services, Vancouver, BC: Vancouver/Richmond Health Board.

Wertheimer, D., & Kleinman, L. (1990). A model for interdisciplinary discharge planning in a university hospital. The Gerontologist, 30(6), 837-840.

Appendix A

Geriatric Assessment and Treatment Program's Mission Statement

St. Paul's Hospital
Geriatric Assessment & Treatment Program
Mission Statement

The Geriatric Assessment & Treatment Program (GATP) at St. Paul's Hospital assists the older adult with complex health problems to remain as independent as possible. The GATP provides comprehensive multi-disciplinary assessment and treatment, carried out by a team with specialized skills in the treatment of the older adult. In addition to clinical treatment and care, the GATP participates in education and research activities related to health care of the older adult.

The GATP adheres to the philosophy and mission statement of St. Paul's Hospital, with a focus on promoting the dignity and autonomy of all older adults. By supporting and collaborating with patients, families, friends, and community health care providers, the GATP is committed to the concept of a hospital without walls, thereby easing the transition of the older adult through the health care system.

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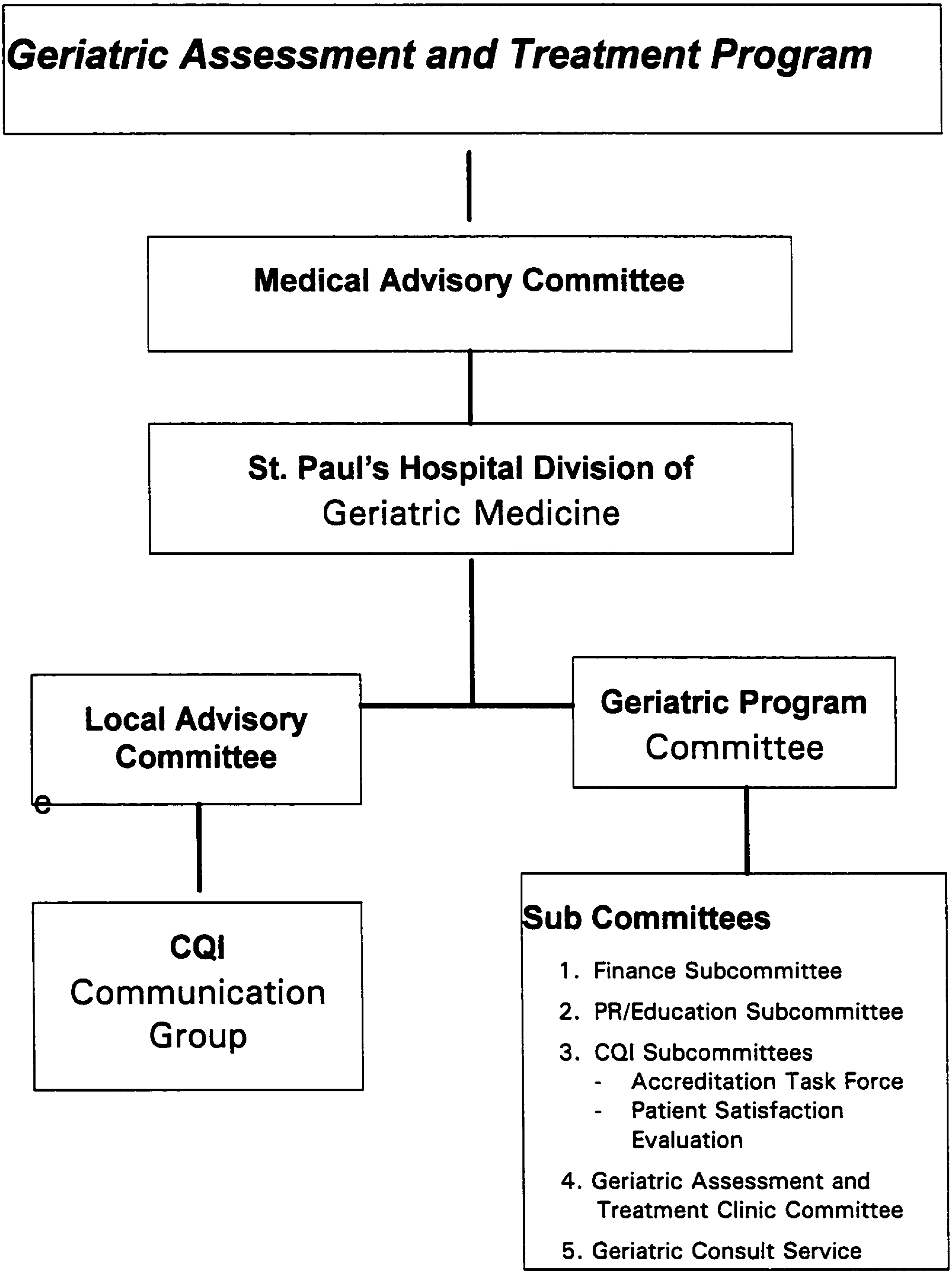
Appendix B

Geriatric Assessment and Treatment Program- Organizational Chart



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Appendix C

Providence Health Care - Mission, Vision, Values

Providence
HEALTH CARE

Mission

Providence Health Care is a Catholic health care community that respects the sacredness of all aspects of life.

Inspired by the healing ministry of Jesus Christ, our staff, physicians and volunteers are dedicated to service and to the support of one another.

In this environment of service, support and respect, we meet the physical, emotional, social and spiritual needs of those served through compassionate care, teaching and research.

Vision

Together, we shall create a healthy community of inspiration and solace:

- by enriching the lives of those we serve and those who serve with us;
- by contributing to our community's capacity for healing and wellness;
- by passionately pursuing and sharing learning;
- by seeking answers to questions not yet asked; and
- by consistently exceeding expectations.

Values

Spirituality

We nurture the God-given creativity, love and compassion that dwells within us all.

Integrity

We build our relationships on honesty, justice and fairness.

Stewardship

We share accountability for the well-being of our community.

Trust

We behave in ways that generate trust and build confidence.

E*xcellence*

We achieve excellence through learning and continuous improvement.

R*espect*

We respect the diversity, dignity and interdependence of all persons.

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Appendix D

Providence Health Care Patient Refusal of Treatment and Discharge - Draft Policy

?– CORPORATE PUBLICATIONS
Approved Date: ?
Revised Date: __________

POLICY

1. PHC adheres to the policy 4.12.13 of the Ministry of Health and the Ministry Responsible for Seniors wherein:
   - An inpatient who no longer requires acute care and who refuses:
     - The Continuing Care Assessment
     - To be wait listed for a Residential Care Facility or
     - A suitable Resident Care Placement or other options for community placement;

   must be charged the full cost of hospital care as of the date of refusal.
2. PHC follows the same policy in the event that patient refuses treatment in appropriate care that is available outside the acute care setting.

PRINCIPALS

1. All care teams are responsible to offer each patient an appropriate care plan.
2. All care team members are responsible to support patients for effective and appropriate discharge.
3. Care teams endeavor to ensure that hospital & community resources are utilized effectively.
4. Care teams and their members working to resolve issues relating to a patient's refusal for treatment and/or discharge are supported by their program leaders and by the Senior Leadership Team.
5. Patients are notified upon admission of PHC and the MOH's policies relating to refusal of treatment and/or discharge.

GUIDELINES

Patient Refusal of Treatment

As a part of hospital orientation, patients are notified upon admission of PHC and the MOH's policies relating to refusal of treatment and/or discharge. In the event that a patient refuses treatment:

1. Treatment options are outlined and documented along with clarification as to why the patient is refusing treatment.
2. Issues or concerns about the patient's competency are managed according to PHC CONSENT POLICY(CPF0500).
3. All treatment, discharge options, clinical consequences of refusal and discussions with the patient are documented in the health record.
4. The Patient is reminded of PHC policy and guidelines relating to refusal of

treatment and discharge.
5. If patient continues to refuse treatment and /or discharge, the Finance Department is notified to implement policy.

Patient Refusal of Discharge

As a apart of hospital orientation, patients and families are notified upon admission of PHC and the MOH's policies relating to refusal of treatment and/or discharge. In the event that the patient is no longer receiving or requiring interventions provided in the acute care setting and is refusing discharge:

1. Barriers to discharge are identified by patient, family or team members.
2. Barriers to discharge and discharge options are addressed with the patient and documented in the health record.
3. If the patient continues to refuse discharge, the patient is reminded of the PHC policy and guidelines related to refusing discharge.
4. If patient continues to refuse discharge, the Finance Department is notified to implement policy.

Patient Refusal of Wait list or Discharge to Long Term Care Facility or Designated Alternate

As a apart of hospital orientation, patients and families are notified upon admission of PHC and the MOH's policies relating to refusal of treatment and/or discharge as well as the first available bed policy. In the event that the patient is designated ALC and is waiting placement to a residential facility and is refusing wait list or discharge to a designated long term care facility:

1. Issue and/or barriers to the wait list or first bed available policies are identified by patient or care team members.
2. Barriers and options are addressed with the patient and documented in the health record.
3. If still refusing placement, the patient is reminded of the PHC and MOH policies and guidelines relating to refusing wait list or discharge to a long term care facility.
4. If patient continues to refuse treatment, the Finance Department is notified to implement policy.

DEFINITIONS

Care Team-is an interdisciplinary team, focusing on a defined patient population in a specific geographic area. Role of the care team:

- care planning/implementation/evaluation
- interdisciplinary communication

- accountable for decisions affecting the care of their patient population
- implementing improvements for care
- accountable for efficient use of allocated resources(i.e. equipment and supplies)
- focus on practices

Discharge Planning-a coordinated plan by the care team with collaboration with the patient/family to assist the discharge process. The team assists in the early identification and assessment of the patient's needs and implements timely discharge plans.

Potential Barriers to Discharge

- Patient/Family unable to care at home
- Patient/Family refusing to take person home
- Patient/Family refusing facility care offered
- Unidentified expected discharge date
- Family not include in discharge planning process
- Support in community not available
- Patient and family not aware of hospital policies
- Discharge plan not documented
- Lack of resources

Continuing Care-provides a variety of in-home support services, residential care services, and special support services to assist people whose ability to function dependently is affected by health related problems

Residential Care-a variety of levels and types of care for clients who can no longer live at home due to health conditions or social conditions which make independent living unsafe or impractical. Residential care is only considered when home support services are determined to be inappropriate to meet individual needs.

Alternate Level of Care(ALC)-a patient who is finished with the acute phase of his/her treatment. The patient may be convalescing, experiencing social or economic barriers to discharge, waiting for homemaking or home care services, or awaiting placement in another facility. If these services were available or certain barriers removed, the patient would be discharged immediately.

REFERENCES

Ministry of Health And the Ministry Responsible for Seniors Policy Manual, July, 1999.

Consent Policy -Corporate Policy Manual May, 2000, Policy CPF0500.

Understanding ALC -PHC, 2000, Public Folders.

Discharge Planning Policy, Social Work, Policy 12070D.

Appendix E

Interview Questions

Interview questions for elderly patients and family

Listed below are sample questions. These questions will not necessarily be asked in this order or phrased in the way presented here.

1. Tell me why you feel you are not ready to go home?
2. Why do you think the team is saying you/your family member is ready for discharge?
3. (to patients) What needs to be different for you to feel ready for discharge?

   (to family) What needs to be different for you to feel your family member is ready for discharge/for you to be ready for them to be discharged?
4. What does staff need to know to help a patient be ready for discharge?
5. How could staff have improved the discharge planning process for you?
6. How could staff have helped you/your family member to be more ready for discharge?

Appendix F

Letter of Introduction and Survey

Letter of Introduction

Dear Colleagues:

This survey is part of a research project sponsored by the Geriatric Assessment and Treatment Program answering the question, "*What qualitative differences does case management make to the discharge planning of the frail elderly seen by the Geriatric Consult Service?*" The project is being conducted by Jennifer Selman as partial fulfillment of the requirements for the degree of Masters of Arts in Leadership and training, Royal Roads University.

This project is a qualitative study exploring the role of case management in the discharge planning of the elderly on the Geriatric Consult Service. This project creates an opportunity for participants to contribute to the development of the case manager role and a clearer understanding of the needs of the frail elderly in discharge planning from St. Paul's Hospital.

Please contact the researcher at any time if you have further questions concerning any matters related to this research:

Jen Selman
Geriatric Assessment and treatment Program
Tel: work (604) 682-2344 local 63455
Fax: work (604) 806-8390
email: jen.selman@royalroads.ca

Survey

Frail elderly patients in your service area have received case management services through the Geriatric Consult Service and some of these patients have volunteered to be participants in this project. I invite you to take part in this survey (see attached) and provide feedback on the role of case management in discharge planning.

- **Completion and submission of this survey will be taken as consent to your participation in this project.**
- **All surveys are confidential. You are not required to put your name on the survey.**
- **All survey data will be kept in a secure place, inaccessible to the public. Surveys will be destroyed at the end of the study.**
- **The results of the survey will be made available through the Geriatric Offices. A general notice to each unit will be made.**

This study has been designed to comply with the ethical guidelines for research regulated by the Royal Roads University and St. Paul's Hospital, University of British Columbia. If you have any questions related to the ethical procedures governing this research, you ma contact the Director of Research at Royal Roads University, Dr. Mary Bernard (250) 391-2511.

Thank-you for your participation,
Jen Selman

Survey Questions - Staff

<u>Please note:</u> geriatric patient = patients over 65 years

⇒ answered by circling the most appropriate number

Rate your level of agreement with the following statements:

1. **Geriatric patients are ready for discharge when the doctor says they are medically stable despite their level of function.**

Strongly Disagree **Strongly Agree**

1 2 3 4 5 6

2. **Geriatric patients are ready for discharge if they are medically stable and able to mobilize.**

Strongly Disagree **Strongly Agree**

1 2 3 4 5 6

3. **It is the family's responsibility to care for a geriatric patient at home if they are medically stable.**

Strongly Disagree **Strongly Agree**

1 2 3 4 5 6

4. **I have found that when a geriatric patient or family is refusing discharge, their concern is usually unfounded.**

Strongly Disagree **Strongly Agree**

1 2 3 4 5 6

5. **Geriatric patients/families who refuse discharge do not understand how the system works.**

Strongly Disagree **Strongly Agree**

1 2 3 4 5 6

6. **All team members are responsible for considering physical, mental, and social factors when deciding if a geriatric patient is ready for discharge.**

Strongly Disagree **Strongly Agree**

1 2 3 4 5 6

Please answer the following questions:

7. **Which disciplines are responsible for documenting discharge plans in the geriatric patient's chart?**

8. **Does the team's responsibility for discharge planning end when the geriatric patient leaves the hospital? Circle answer.**

Yes **No**

If no, name the disciplines on the team remains responsible?

9. Whose responsibility is it to address the concerns that geriatric patient/ family members express when refusing discharge?

____

____

____

10. Which of the following phrases most often comes to mind for you when a geriatric patient/ family members state they are not ready to go home? Please check off all the answers that apply to you.

☐ "we're not a hotel"
☐ "attention-seeking"
☐ "we need the bed"
☐ "they really aren't well enough"
☐ "putting up roadblocks"
☐ "they're lonely"
☐ "what have we (team) missed?"
☐ other (fill in)____________________________________

11. What do you feel when a geriatric patient and/or family members state(s) they are not ready to go home? Please check off all the answers that apply to you.

☐ Frustrated
☐ Concerned
☐ Angry
☐ Responsible
☐ Annoyed
☐ Empathetic
☐ Worried
☐ Other (fill in)____

12. What is your first priority when a patient/family refuses discharge?

13. What do you think the patient/family refusing discharge needs?

14. (a) How much input should the patient/family have in deciding if the patient is ready for discharge?

Very little **Somewhat** **A lot**

1 2 3 4 5 6

(b) Briefly describe the reason for your rating in 15(a)

THANK YOU for taking the time to complete this survey.

Appendix G

Participant Consent Form

PARTICIPANT CONSENT FORM

What factors contribute to elderly patients perceptions that they are not ready for discharge?

This is a major research project sponsored by the Geriatric Assessment and Treatment Program and conducted by Jennifer Selman as partial fulfillment of the requirements of a Degree of Masters of Arts in Leadership and Training, Royal Roads University

This project is a qualitative study exploring the perceptions of patients and families around readiness for discharge from hospital. This research project will create an opportunity for all to contribute to the improvement of patient-centered care and a clearer understanding of the needs of the frail elderly in discharge planning from St. Paul's Hospital.

Please read this consent form carefully and sign it if you give your consent to participate in the study, which will follow the method described below:

- You will be involved in a one hour interview recorded by audiotape.
- You have the right to terminate the interview at any time.
- You have the right to request that the tape recorder be turned off at any time during the interview.
- All interview data and conversations will be kept entirely confidential by the research

team. You will be identified through the research notes and transcripts with a pseudonym. All identifying characteristics linking you to the data will be removed from the final report.

- All data will be kept in a secure place, inaccessible to the public. All notes, tapes, transcripts and documents containing your real name will be destroyed at the conclusion of the study.
- You will be offered the opportunity to review and verify the transcript created from the tape recording of your focus group. You will also have opportunity to review and verify the final report before its publication.
- No deception will be used at any time in this study, and the researcher will endeavor to ensure that no harm of any kind will come to you as a result of your participation in this study. There will be no monetary compensation to you for participating in this study. However, a summary of the study results will be made available to you at the end if you wish.
- Your signature indicates that you understand to your satisfaction the nature of your participation in this research study, and that you agree to participate. In no way does this waive your legal rights at any time in this study.

______________________________ ______________

Participant Date

______________________________ ______________

Researcher Date

Please feel free to contact the researcher at any time if you have further questions concerning matters related to this research.

Jen Selman
Geriatric Assessment and Treatment Program
Tel: work: 604-682-2344 local 63455
Fax: work: 604-806-8390
e.mail: jen.selman@royalroads.ca

This study has been designed to comply with the ethical guidelines for research regulated by the RoyalRoads University, and St. Paul's Hospital, University of British Columbia. . If you have any questions related to the ethical procedures governing this research, you may contact the Director of Research at Royal Roads. Dr. Mary Bernard, at (250) 391-2511

A copy of this consent form has been given to you to keep for your records and reference.