



Patients' experiences of discharge processes



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ABSTRACT

Background. Sound admission and discharge processes are essential for quality health care delivery and are one area of nursing practice that requires constant review, evaluation and development. Very little research has been done in regard to patient experiences of discharge planning in the field of pre-admission clinics, and admission through an accident and emergency department. The study presented in this report is the second phase of a project , 'Improving patient discharge processes through a practice development framework'.

Aims and objective. The overall aim of this phase of the study was to explore patients' experiences of the discharge process and to elicit their perceptions and needs in relation to discharge planning. Within the context of practice development which is focussed on a process of improvement towards effective patient centred care, gathering the service user's experiences (ie the patient) is a key component.

Methods. In-depth interviews were undertaken with 21 patients who had been admitted to hospital; 8 via a pre-admission clinic, 10 who had come into hospital as an emergency admission and 3 patients who had been routine booked admission. All participants were interviewed one to three weeks following their discharge from hospital. Thematic analysis was undertaken off the interview transcripts.

Findings. Four key themes; being prepared, medication misunderstanding, preparing for home and being a patient, were identified that reflect the central focus of patients' experience of discharge processes. The discharge from hospital is clearly influenced by the type of admission. The pre-admission clinic offered a pivotal point of contact in preparing individuals for their impending surgery and subsequent discharge. Participants whom had come through the accident and emergency department appeared to be less informed, partially attributed in this study to a lack of communication.

Conclusions. Discharge entails getting the balance right to ensure that the structure, process and outcomes lend themselves to a framework of caring, from admission either through a pre-admission clinic, a booked admission or an emergency admission. From the experiences of the participants in this study, it would appear that the pre-admission clinic offers an excellent avenue for preparing for an effective discharge.

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1. INTRODUCTION

Sound admission and discharge processes are essential for quality health care delivery and are one of the important areas of practice that requires constant review, evaluation and development to keep abreast with the constantly changing demands of health care delivery. Discharging patients from hospital is a key aspect of the nurse's role in the acute care settings and despite numerous studies undertaken in this area, it remains problematic. A multi-professional approach to discharge planning should commence as soon after admission as possible.

2. LITERATURE REVIEW

Discharge planning provides structure, planning, information and communication to patients and all members of the health care team with foresight of the patients expected recovery (Rorden & Taft, 1990; Anderson & Helms, 1994). In this way, planning for a return home or to another health care facility can be easily anticipated and prepared for by both parties. The foundation of the discharge planning process therefore rests upon the admission. Predictions for expected length of stay, planned place on discharge can be proposed and both health care professionals and patients alike can work together to achieve an end goal of independence from the facility (Rorden & Taft, 1990).

The issues of discharge planning surrounding the interdisciplinary relationships and ineffective process implementations are evidential in the literature (Anderson & Helms, 1994; Lowenstein & Hoff, 1994; Armitage & Kavanagh, 1998; Bull & Roberts, 2001; Driscoll, 2000; Cleary, Horsfall & Hunt, 2003; Maramba, Richards & Larrabee, 2004; Watts & Gardner, 2005). Issues in the initial implementation of the discharge process such as poor assessment and poor documentation often result in a rushed discharge and a negative hospital experience for the patient (Jewell, 1993; Cleary et al., 2003; Maramba et al., 2004).

The 'admission' component is considered the fundamental aspect of the concept of discharge planning (Maramba et al., 2004). Here, a concise overview of the patient is performed to explore possible avenues of care, which may be required in anticipation of the patients' discharge (Rorden & Taft, 1990; Maramba et al, 2004). The function of the discharge planning process therefore depends upon an accurate and well-performed admission. Despite this perceived status it holds, the admission component has been repetitively downplayed and devalued as an activity of lesser importance by nursing staff (Lowenstein & Hoff, 1994; Armitage & Kavanagh, 1996; Driscoll, 2000; Atwal, 2002; Watts & Gardner, 2005). Time constraints and patients with more immediate health care demands are placed with higher priority than the implementation of the discharge plan, even though this is required to be performed on an ongoing basis (Rorden & Taft, 1990; Armitage & Kavanagh, 1998; Watts & Gardner, 2005).

Rorden and Taft (1990) highlight the importance of planning discharge to meet both short term and long term needs of the patient; however, further studies suggest that patients are often being discharged with unmet needs (Jewell, 1993, Salter, 2002; Driscoll, 2000; Bowles, Naylor & Foust, 2002). These needs include physical, psychological, social, and emotional, aspects to patient care, as the patient moves through the health care system; and the stress and anxiety that may be anticipated or experienced with the reestablishment of the patient in the community (Rorden and Taft, 1990).

Patients' needs for discharge have been described as: information on medication, expected recovery time, activity level, care of wounds/dressings, how to manage pain, who to contact if problems arise, social support, and many more (Jewell, 1993; Salter, 2002; Driscoll, 2000; Bowles, et al., 2002). In failing to address these needs prior to discharge, it contraindicates the very essence of implementing a discharge plan and negates an essential component of caring.

Patients viewed discharge with anticipation (period) filled with “uncertainty and hope,” Fielden, Scott & Horne (2003, p 433). Although there is an eagerness to return home, there is a fear of how they will be able to cope once they are at home, given their altered health status (Armitage & Kavanagh, 1998). Bull (2000) states that patients and caregivers often feel better prepared for care post hospitalization with a planned and participatory involvement in discharge planning process.

Effective discharge planning processes are essential for meeting the ongoing care needs of patients post-discharge. Timely discharge planning enables patients to engage fully as partners in decision-making and have greater control over on-going care decisions.

3. RESEARCH AIMS

The study presented in this report is the second phase of a project, 'Improving patient discharge processes through a practice development framework': This overall project seeks to develop through a culture of critical inquiry an improvement in discharge planning processes so that it reflects the needs of patients and is evidence based.

Practice development is: “ a continuous process of improvement towards increased effectiveness in patient centred care. This is brought about by enabling health care teams to develop their knowledge and skills to transform the culture and context of care. It is enabled and supported by facilitators committed to a systematic, rigorous continuous processes of emancipatory change that reflect the perspectives of service users and providers” Garbett & McCormack (2002, 88).

In this context the patient is a ‘service user’ and hence, in line with the underpinning philosophy of practice development gathering patients' experiences of the discharge process is a key component of the overall project. The second phase of the project aimed to:

- Elicit patient’s perceptions and needs in relation to discharge planning;

- Improve the discharge process of patients in an acute care sector.

4. RESEARCH DESIGN

This qualitative study was premised in the framework of practice development and utilised in-depth interviewing (Minichiello et al.,1995).

4.1 Sample

The study sought to voluntarily recruit 20 adult in-patients (age 20 plus) with a minimum hospitalisation stay of three days who had come through either a surgical pre-admission clinic or who had been admitted via the accident and emergency department. Patients with medically diagnosed dementia or of non- English speaking background were excluded.

Twenty one participants were interviewed, eight who had been through the pre-admission clinic, ten who had come into hospital as an emergency admission and three participants who had been routine booked elective surgical admissions.

Ethical approval was obtained from the Standing Committee for Ethics on Research with Humans, Monash University and the Medical Advisory Board of the health agency.

4.2 Data Collection

In-depth one-to-one interviews were conducted with the participants, aimed at eliciting their experiences of hospital discharge, over a ten month period. The patient interviews were undertaken in the patient's home one to three weeks following their discharge from hospital. These open-ended interviews comprised of several broad questions aimed at focusing the participants' thoughts on their recent experience in hospital, for example, Tell me a little about what your hospital experience was like? and When you were informed you could go home how did you feel? The interviews

lasted approximately 30 -40 minutes and were audio-taped and then transcribed.

Demographic data was collected to provide contextual perspectives of the participants.

4.3. Analysis

Twenty one audio-taped interviews were undertaken by the primary researcher. Ten interviews were with patients who had been admitted via the participating hospital's accident and emergency department, eight with patients who had been admitted via a pre-admission clinic for elective joint replacement surgery, and three patients who had been routine booked admissions to the hospital. The emergency admissions were for a diverse range of health problems from chest pain, bowel obstruction, asthma, torn Achilles tendon, acute viral infections.

Demographics: The age range of the participants varied from early forties to eighty five, with an average age of 65 years old. Eleven of the participants were male and eight of these were retired gentlemen and one unemployed having recently step down from being a service station proprietor. Of the ten female participants two were school teachers with dependent children, one who was a widow; working in the retail industry the remainder indicated they were housewives, mothers and grandmothers. Table 1 provides a more detailed summary of the demographics.

Table 1: Participant demographics

AGE (in years)	GENDER		TYPE OF ADMISSION		
	MALE	FEMALE	PRE-ADMISSION CLINIC	A& E ADMISSION	BOOKED ADMISSION
≤40	1	1	0	2	0
41- 50	0	3	0	2	1
51- 60	2	2	1	2	0
61-70	4	2	4	2	1
71-80	1	1	1	1	0
≥ 81	3	1	2	1	1
Total: n	11	10	8	10	3

The patient interviews were transcribed verbatim and a process of thematic analysis was used to analyse the transcripts following the steps described by Tesch (1990). To ensure anonymity pseudonyms were ascribed to the participants. Several themes emerged that reflected the patients' experiences of discharge processes. To explore if the type of admission process had any influence on the patients' discharge the analysis was undertaken separately of the three admission groups: Accident and Emergency (A&E), Preadmission Clinic (PC) or Booked Admission (BA). Coding of the themes from the three groups of admission was then undertaken and the following themes identified: being prepared, medication misunderstandings, preparing for home and being a patient. A detailed description of these themes is presented in section 5.

5 THEMES

This section examines the themes that have emerged from the analysis of the interview transcripts of the patients. The data is presented under four key headings; being prepared, medication misunderstandings, preparing for home and being a patient. These headings reflect the central focus of patients' experience of discharge processes.

5.1 Being prepared

Being prepared was a phenomenon that emerged from mainly the preadmission group, though included one booked admission participant. It centres on the notion of the patients having an awareness of hospital procedures, processes such as discharge planning and staff relations after either being educated about it prior to admission to hospital or having experienced the procedure, or something similar before. By being prepared it appeared to reduce anxiety about the impending surgery as the following quotes illustrate:

"It does give you a chance to if you found any apprehensions or anything to ask questions...but yeah well I think it is to the patients benefit...it gives them a chance to get anything of their chest if they want to," Mr Johns (PC)

Mrs Gibbs (PC) epitomises the voice of several participants:

"I think, um, well the surgeon is really only concerned with his little bits, the cut and the chop, um she [the preadmission nurse] was more interested in making sure that I was tranquil about what was happening, assuring me that I wouldn't be turfed out of hospital until I felt ready...and I'd heard all this ghastly stuff about the operation...I think the preadmission answered the human side perhaps, the emotional side of what was going to happen so that I didn't have any concerns when I went in..."

Having this knowledge prior to the hospital admission seemed to make the patients far more relaxed about their stay in hospital. If there were any adverse effects during

their stay the patients remained comfortable as they had an understanding that this may occur as a possibility during their hospitalisation. Overall this group of participants indicated a positive experience of their stay in hospital and their discharge process. This is exemplified by the following quotes:

“It was brilliant. You know and again, having done it before, I knew exactly what to do, and I knew exactly what to expect and the fact that I met some of the nurses in there that were there the first time around, just made it a ball.” Mr Roberts (PC) he goes on to continue,

“I don’t think, as far as discharge was concerned I was more than comfortable with the procedure, how they handled it, the people, yeh it was fine.”

Mr Facey, an active 86 year old noted: *It [the preadmission clinic] gave us a full round up of what was going to happen which I think is important to know what is ahead of you”.*

The benefit of pre-admission clinic on the overall sense of well-being of the patient and their hospitalisation and discharge clearly is reflected in this group’s experiences. One area that did cause some concern for a few of the participants was in relation to medications.

5.2 Medication misunderstanding

The theme of medication misunderstanding related to several issues pertaining to medications. It occurred predominantly in the A&E admitted patient group, however, there were some instances where it occurred in the preadmission clinic participants. Patients expressed uncertainty or lack of clarity in relation to any changes in their medication prior to discharge. Frequently they expressed that doctors had been in and altered the medication without telling them, or changed the medication and given the patient no indication of what the drug was for, how long they should take it and what, if any, were the adverse effects to look out for. Similarly, patients felt that the nursing staff were unaware of these changes too, so they could not rely on the nurse

to provide explanations or clarity on these issues. The duration of time they were expected to take and dosage, especially with medications such as warfarin therapy or clexane therapy, also emerged as concerns. Nursing error with checking of the drug chart, giving the appropriate dose, or omitting the dose altogether also worried patients. The following excerpts from the interview transcripts highlight these misunderstandings.

“I mean the process when the bag came out there nothing there and no one actually checked it... and how long am I suppose to take this for? ... nobody actually said at the hospital end you know possibly you might need to take these for a week, two weeks, a month, whatever...”

Mr. Jockey, an articulate 60 year old gentleman who had been admitted through A&E commented:

“Both those drugs were prescribed by a different doctor. So I’m supposed to be taking those (medications), but I suppose it was explained to me why you’ve got them but in a sense I don’t know how long I’m supposed to take them. So there is a bit of, I suppose, a gap there in terms of do I keep on taking them until the script runs out or do I keep on taking them until I go back to see the surgeon”

Mrs. Calling, a very independent 67 year old, who was admitted to the hospital via preadmission clinic experienced uncertainty with what to do with used clexane syringes. Although she was adequately informed of her procedure and outcomes both before and during her stay in hospital and knew that you had to have ‘blood thinning medication’ she had not been informed that she would have to self-inject:

I had to give myself injections in the stomach for the blood thinning, which when they told me about that I sort of freaked a bit, but I did it and they watched me do it. I hate it, but I did it. So I had about 15 of those to do when I got home.

She expressed some frustration when referring to the disposal of her syringes as reflected in the following quote:

“The only thing that I don’t know what to do with is the syringes. I’ve got all these syringes and I don’t know what to do with them! But apart from that I can honestly say that there wasn’t anything that I had that I didn’t like. I just thought that the whole thing went well and I was happy with the surgery.”

Being uncertain of medications was a particular concern for some of the older participants as is captured in Mrs Smith’s, a sprightly 80 year old, voice:

“I think that the medication I found that rather confusing... I went into hospital not knowing I was going to be kept in... My husband brought it [the medications] in the next morning and because it wasn’t in its original packaging the hospital couldn’t or wouldn’t use what I took in but they had brought me up medication from pharmacy and I was just so confused because the tablets were a different colour, a different size, a different name and I didn’t know what was what. I was so used to getting the tablets and I knew them by feel and size as much as I knew them by name, well I didn’t know one tablet from the other ...although they were the same thing as I had been taking they were all under different names so that was really confusing.”

It would appear that admission to hospital and subsequent discharge does, for some clients impact on their routine and understanding of their medications particularly if there has been an alteration. From the analysis there was a dichotomy of experiences in relation to preparing for the discharge from hospital.

5.3 Preparing for home

Within this theme there is mix of experiences, for those whose discharge just happened compared with the experience of some participants who were left waiting around. Several participants commented on the uncertainty of when they would actually be discharged. The extracts below highlight the diversity of experiences.

I was rather surprised actually that everybody was on the ball. It all just happened. You know, I didn't have to sit around to wait for anybody, I didn't, nobody was missing. The nurses were there, they were wonderful... the administration lady came up and made sure everything was okay. Gave me documents, discharge papers and all that sort of thing. We went down to the reception area, we got booked out. Oh it was well done, Mr Roberts (PC).

As Mrs. Brinkwood, a 67 year old from the BA group recounts in relation to her discharge: *"Well they just came and gave me all my medication and put me in a wheel chair and pushed me out."*

I was quite prepared it was a bit of a mix up as to no one seemed to really know that I was going that morning. There was a nurse that checked up everything more or less at the last moment... Mr C said I would be going home on the weekend and I kept saying is it Saturday it looks like Saturday it wasn't really until that morning I got a really final answer and everything was sort of arranged, Mr Facey (PC)

For Mr Toohey (PC) who had some complications post-operatively, there was openness to when he would be discharge: *...they weren't sure when I would be well enough to go home, so you know it was sort of well maybe tomorrow, maybe the next day. There was certain indefiniteness about it...I thought I was going to go home on the Saturday but I didn't actually go until the Monday which was a bit disappointing but on the other hand it was understandable.*

Mrs Charters, an A&E patient, describes her experience of discharge as a process of waiting for the doctor:

"I had to really see Dr. before I was allowed to be discharged obviously. So I waited about 3 or 4 hours, he's coming, he's coming. He was just downstairs in the consulting suites but he had to do some paperwork. So I just waited there..."

Whilst there was some uncertainty and hesitancy surrounding the timing of the actual discharge, the majority of participants indicated they felt well prepared for their discharge home as illustrated in the following quotes.

Well they were very careful to make sure that I could cope. They were very patient like they weren't rushing me at all so they were good. I knew when I was going and the family could make arrangements to pick me up from hospital, Mrs Black (A& E)

They asked me relevant questions to home and if I needed, if I felt I needed care in the home which I don't at this time because my husband does all the chores around the home, Mrs Smith (A&E)

And as Mrs O'Sullivan (A&E) comments, *Well I knew that I was going to have 'hospital in the home' visiting me. So I did feel quite comfortable about that. If I was coming home to dress the wound on my own that would have been different I think.*

Several participants voiced they would have liked more support following discharge and this has been categorised as a sub-theme 'follow up'.

5.3.1 Follow up

There was a sense that patients, particularly those who had come through the Accident and Emergency department or were a booked admission, were expecting some support post their hospitalisation stay. Participants recommended it as a means of providing continuity of care whilst others were unclear on whether they were entitled to it, or what the 'hospital-in-the-home' was all about. For those patients who received follow up care they were very pleased with their experience of it as the extracts below illustrate:

Mrs Gowrie, a 55 year old from an A&E admission commented:

" Yes and look I found her [the respiratory care nurse]excellent, easy to talk to, very easy to ask questions, which is when you're not 100% you need people that are patient, you don't need people that look like oh you're stupid, do you know what I

mean? And I really appreciated the phone call, the follow up when she rang after I'd been home a couple of days. No excellent, she was wonderful."

Several participants would have liked more information regarding management and support of their health issues:

"A home visit like this [referring to the researcher's visit] would have been great about a week ago. Actually a follow up home visit, even within I think the first week would be, or even a phone call. And perhaps on the phone call would have been in fact if someone had phoned 4 or 5 days and that way when I was really unwell I probably would have well I would have said this is how I'm feeling and had I said no I'm feeling fine still everything is great, they'd go good and hang up." Ms Peters, a booked admission

The provision of information sheets on discharge that deal with frequently raised questions and concerns was identified by the participants as one aspect that could be improved upon and might enhance some of the communication issues that emerged for the participants in 'being a patient'.

5.4 Being a Patient

This theme centres on the experience of being a patient and is grounded in the notion that nurses, doctors and other allied health care professionals are very busy and only have a limited amount of time for you as a patient. The patients voiced a passive role where they just did what they were told; did not question anything especially when discussing their care or plan of care with doctors. There was a sense of a loss of independence and lack of communication. Many of the patients stated there was a lot of waiting for the doctor especially in relation to the actual decision to be discharged. There was a sense of frustration that accompanied this.

This assumed 'passive' role by the patients was evident across the three types of admission groups and created for some participants a sense of powerlessness; they

felt they had no control over their care: of not knowing or being informed of the outcomes, events where they felt they were being rushed, which is illustrated in the following quotes.

"...the doctors now I know they are busy and they have big days and all that sort of thing, but they don't really tell you much, they don't spend time with you, they just sort of breeze in, so long as you look comfortable to them I think they are happy, but they don't say anything, you know, there was no communication with the doctors"

Mrs Smith (A&E).

I think I've got a bit of an issues with specialists in that they don't tell you what is going on... they always seem to be in a hurry, they don't have time to talk to you and they give you the bare facts and nothing else, then they're off they are gone, Mr John (A& E).

One patient shared her story of waiting for 3-4 hours to see her doctor: *So I just waited there, because I really wanted to ask him some questions before I left because I was a little bit in the dark about what was going to happen to me next ...And by the time the surgeon came to speak to me, to answer my questions, he said 'I've really got to go' like he didn't have any time for me,* Mrs Charters (A&E)

Mrs. Gowrie, who was admitted to hospital via accident and emergency in discussing whether she felt well enough to be discharged home commented:

".. I suppose because they (nursing staff) said well you should be right to go home, I felt well I must be. You know, they know better than me, that's how I was feeling. I should be better."

An admission to hospital can be especially concerning for patients who are primary carers of a dependant relative, friend or spouse, have young children or who own their own business. In being a patient, the personal, social aspects of patients' lives continue on outside the hospital. It would appear that frequently with admissions

from A&E a patients' social situation is overlooked on admission in lieu of the more important immediate health care concerns. Quite often however, it seemed that this trend continues throughout the patients' stay in hospital and on to their discharge and is highlighted by the following examples.

“ When I came out [from the anaesthetic] and he said you'll have to stay overnight and so yeah, then I thought okay, my partner's in a situation where she's vulnerable because of her epilepsy, is she going to manage okay without me if something happens? And something can happen at any time of the day or night. So then it impacts on me, I'm in hospital, there's not much that I can do,” Mr Stevens, a 62 year old (A& E). He continues this area of social overlooking, when referring to his discharge: *“They said you can go home now if you like. And so I rang and she wasn't home and so I didn't want to go home because I had no way of getting in.”*

Mr Taylor in his eighties (BA) who was also a primary carer commented: *“.... my wife's got maybe two we know that she's had one fracture vertebrae, stress fractured vertebrae. And so it makes it pretty hard. I wouldn't have come home; I'd have gone to rehab.... It was just the little things in this particular case that the wife had to do and did do. Even an hour or so a day for someone to come in and do the little tasks or the tasks that in her case she shouldn't be doing,”*

Considering the patient's social circumstances in preparing for discharge would seem to be a critical area that perhaps requires a more prominent focus amongst the allied health team.

5.5 Summary

The experience of admission and discharge into hospital is clearly by influenced by the type of admission. From the data analysis pre-admission clinics offer a pivotal point of contact in preparing individuals for their impending surgical admission and subsequent discharge. Participants whom were admitted to hospital via the accident

and emergency department appear to be less informed, partially attributed, in this study to a lack of communication. The issue of medications was a concern for the majority of participants and did not pertain to a particular admission group.

Considering the patients' social situation is an area it would appear that requires to be accentuated within the discharge process. The next section discusses these findings in light of the current literature.

6. DISCUSSION

Introduction:

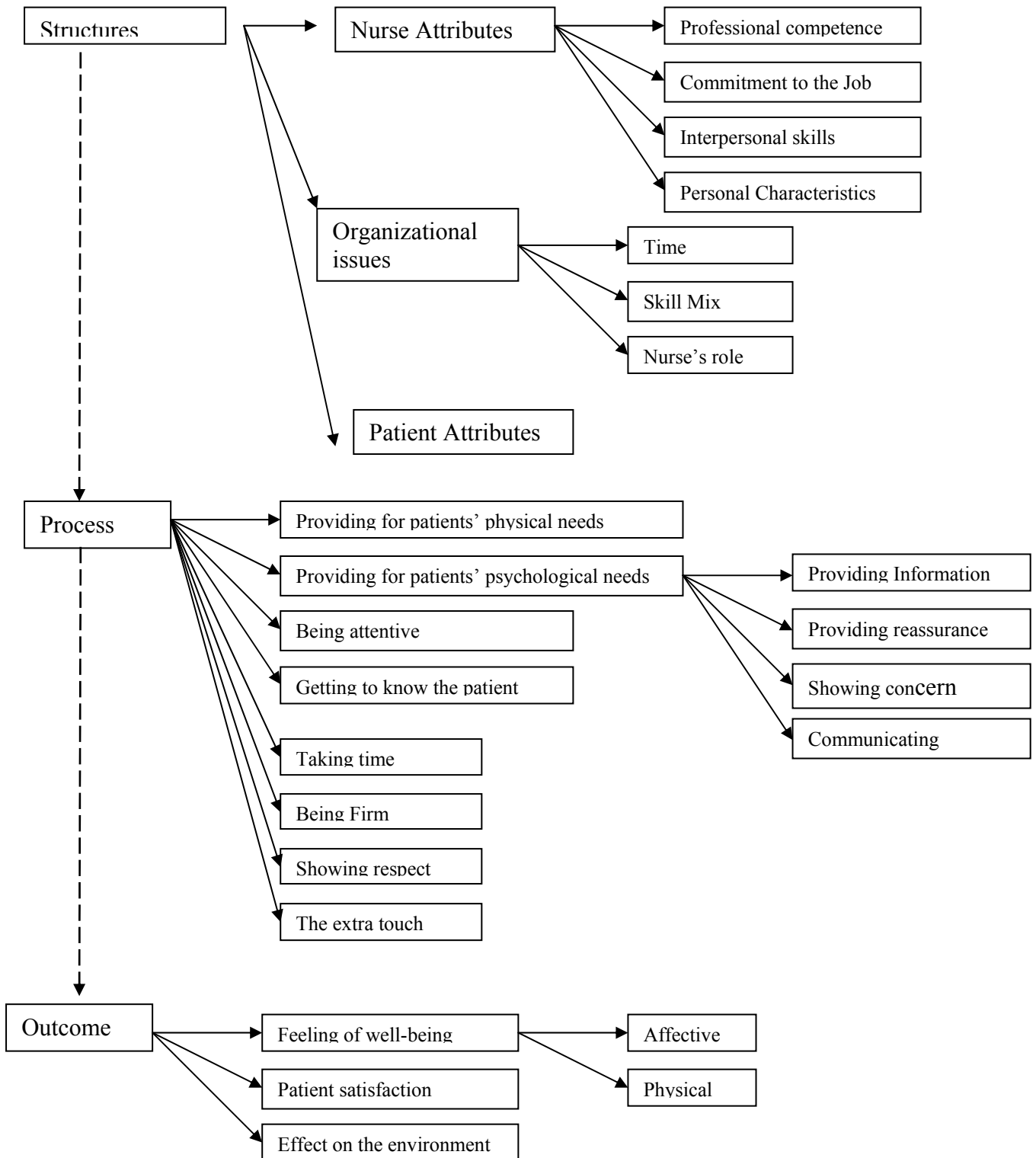
Evaluating the effectiveness of hospital discharge planning is widely considered a fundamental aspect of discharge planning (DHS, 2000) though there are limited methods to do this with. McCance (2003) offers a conceptual framework for caring in practice that is person-centred and quality focussed (see Figure 1) premised in Donabedian's structure, process and outcome. In discussing the experience of discharge processes as perceived by this particular group of patients following their admission to hospital through a pre-admission clinic or as an emergency, McCance's framework provides an thoughtful window to reflect on these experiences.

6.1 Pre-admission clinics

From the analysis the pre-admission clinic in this acute care hospital clearly offers a necessary platform for the patient to gain a sense of being cared for and prepared for their admission to hospital. It would appear that the clinic addressed most of the patients' needs as previously identified in the literature with regards to expected recovery time, activity level, care of wounds/dressings, how to manage pain, who to contact if problems arise (Salter, 2002; Bowles et al, 2002). Whilst there were a few concerns raised in relation to the self administration of anticoagulant injections, this is possibly a component that may require some review in the material presented at the pre-admission clinic so that all clients are well informed.

In the context of McCance's (2003) caring framework the pre-admission clinic provides the structure through the pre-admission nurse's attributes of professional competence, commitment to the job, interpersonal skills which are evident in the patients' recounts of their experiences. The provision of information, the reassurance, the communication that this type of clinic provides for clients is clearly articulated in the patient interviews and hence in the process of caring, is providing for patients'

FIGURE 1 – A conceptual framework for caring in practice, McCance (2003, 107)



physical and psychological needs as articulated so adeptly by the voice of Mrs Gibbs (see 5.1, p.7). The outcomes of a pre-admission clinic reverberate for this group of patients a sense of well-being and patient satisfaction that reflects on the whole a positive experience of their admission and discharge process. This is in contrast to those who came through the Accident and Emergency department where there were a few concerning issues that adversely influenced the patients' perceptions of their discharge, in relation to medications and communication.

6.2 Knowing my medications

Information on medication has been identified as one of the needs patients require for an effective discharge (Salter, 2002; Bowles et al, 2002). For participants in this study the uncertainty of how long they should continue with some of their medications following discharge is disconcerting. However it is difficult to pinpoint where within a caring framework the exact aspect that contributed to this lack of patient knowledge. It could be associated with an organizational issue in terms of both time and nurse's role. Mc Cance (2003) notes that factors that impact on time, include nurses' workloads and the perception that nurses are very busy and often patients do not want 'to bother' the nurse. From the interviews within this study, participants frequently made reference to the business of the nurses. This impacts on the process of caring where patients' nurses do not take the time to get to know their patients and are perceived as rushing in and doing their task before moving onto the next person (McCance, 2003). While the majority of participants voiced their satisfaction with their experience of discharge, there was an element of dissatisfaction (outcome) in relation to medications.

Providing information and reassurance are crucial elements of caring and are essential when patients' medications are changed. Irrespective whether the change in medication is an actual new drug or the dispensing of a generic brand that the patient is unfamiliar with, the patient needs to be informed in an appropriate manner.

Whose role it is to ensure that a patient and or their carer on discharge is cognizant of the prescribed medications it would seem still appears to cause some uncertainty in the particular care setting that this study was undertaken in. Nurses have a pivotal role in discharge planning and medication information is one component that needs to be covered (DHS, 2000). The channels of communication amongst the healthcare team are paramount in discharge planning and as the findings of this study highlight when not place can affect the structure, process and outcome for the patient.

6.3 The linchpin of discharge processes

As identified from the literature, issues in the initial implementation of the discharge process such as poor assessment and poor documentation frequently result in a rushed discharge and a negative hospital experience for the patient (Cleary et al., 2003; Maramba et al., 2004). Certainly for several of the participants who had been emergency admissions or a booked admission there appeared to be gaps in their preparation for discharge, which was not apparent with those participants who had come through the pre-admission clinic.

Planning a hospital discharge should involve the patient and carer and include both written and verbal information (DHS, 2000). Reed et al. (2002) in their research found that co-ordination, that is making sure that the right things happened at the right time was an important aspect of discharge and was not dependent on fiscal resources but on systems being organised and working well. To have a patient waiting around for 3-4 hours (see 5.4, p.12) to seek information from their consultant; informing a patient that they may go home when they have no way of getting into their home or to discharge an individual who is a primary carer whose partner is in a compromised health status, clearly is not a well working system. In the context of the caring framework there would appear to be organizational issues that need to be addressed; along with the process (see figure 1) of getting to know the patient and providing for the patients' psychological needs. To get to know a patient, that is,

knowing what is important to the patient and knowing about their family members, requires time (McCance, 2003). With reduced length of stay for surgical and medical patients, this time is not always available in today's nursing workforce which is frequently beset with staffing issues.

Communication it would seem is the linchpin ensuring effective processes are in place. A feature of a good discharge is when patients and carers' feel 'in charge' (Reed et al., 2002). For this to happen the patient needs to have a voice though this can be problematic in situations where the individual's health status precludes them from engaging (Fielden et al., 2003; Heine et al., 2004); or as experienced by some of the participants in this study whom assumed a passive role as a patient. This passivity was grounded in the nature of the perceived business of the healthcare professionals and as previously eluded to centres around the organizational issue, of time. However in the context of caring in this study it did not just pertain to the nurses but also as referenced numerous times by the participants in the sharing of their experiences it focussed on the time, or lack of it, given by the consultants. Time it would seem has become a precious commodity in the current health-care system and perhaps all those involved in the care of patients need to reflect on the importance of this commodity in the context of care and the impact of business on the totality and quality of the care provided.

Within the acute care sector some health agencies have introduced discharge co-ordinators and it would be interesting to examine this role in relationship to the area of communication and whether the issues identified by the participants' experience of discharge processes in this study, is still an area of concern for patients and/or their carers.

Summary

Discharge entails getting the balance right to ensure that the structure, process and outcomes lend themselves to a framework of caring, from admission either through a

pre-admission clinic, a booked admission or an emergency admission. From the experiences of the participants in this study, it would appear that the pre-admission clinic does offer an excellent avenue for preparing for an effective discharge.

6.4 Limitations

This study was an exploration of individual's perceptions and thus by its very nature cannot be generalised. Individual perceptions are influenced by past and present events and experiences and thus can be unpredictable and quite subjective. The study only investigated a group of patients admitted and discharged through one acute care facility and may not provide a representative viewpoint of patients' experiences at other healthcare facilities. To be able to offer a wider representation the study would need to be replicated across several health care facilities both within the public and private health sector. However it is important to note that the findings do offer some insights into the benefits of pre-admission clinics and the issues that impact on discharge processes as identified in this study are reflective of previous studies undertaken in the area of discharge processes.

7. RECOMMENDATIONS

The positive affirmation elucidated from the participants in relation to their experience of a pre-admission clinic does suggest that this approach to admission and discharge could be expanded to include a variety of surgical procedures. This would warrant further research to be undertaken to ascertain the effectiveness in regard to patient outcomes.

Critical to an effective patient discharge is the communication throughout the whole hospitalisation of the patient. This begins with ensuring accurate information is obtained during the admission process, is constantly reviewed and updated. Regular in-service education that incorporates case based scenarios, which focus on the importance of accurate assessment, to heighten nurses understanding of the pivotal role they play in the discharge process is recommended as one strategy for improving the discharge processes of patients. The education that is offered in undergraduate curricula in the area of patient discharge may require review to ensure that new graduates enter the workforce with a clear understanding of their role in regard to patient discharge.

In the context of care provision nurses need to ensure that each client is considered as a unique individual and as such will have their own idiosyncrasies and needs in preparing for discharge from hospital. Amongst the business of the workplace, nurses, as the findings of this study demonstrate, need to take time to get to know the patient.

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