# CERTIFICATE

I, Xanthe Taylor-Riley, hereby certify that this Treatise, title " Early Discharge: What are the effects of programmes targeted at elderly orthopaedic patients?", being lodged herewith for examination is my original work, unless otherwise acknowledged.

I certify that it has not been submitted, in part or whole, for a higher degree in any other university and/or institution.

I understand that if I am awarded the degree of master of Community Health , due in part for my treatise titled "Early discharge: What are the effects of programmes targeted at elderly orthopaedic patients?", being lodged herewith for examination, the treatise will be lodged with the college library and will be available immediately for use. I agree that the Head of the School of Community Health and College Library may supply a photocopy or microfilm of the Treatise to an individual for research or study or for the use of other libraries.

Signed Xanthe Taylor-Riley Date 22nd April 1997

# "EARLY DISCHARGE: WHAT ARE THE EFFECTS OF PROGRAMMES TARGETED AT ELDERLY ORTHOPAEDIC PATIENTS?"

by

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# "EARLY DISCHARGE: WHAT ARE THE EFFECTS OF PROGRAMMES TARGETED AT ELDERLY ORTHOPAEDIC PATIENTS?"


## ABSTRACT

Early discharge from hospital is rapidly becoming acceptable hospital policy with increasing financial pressures that confront health services. Formalised programmes of early discharge have been developed in the United States, the United Kingdom and also Australia to support patients leaving hospital early, mainly in the areas of orthopaedics and maternity.

The reviewed literature demonstrates an overall trend to deinstitutionalise health services and identifies the general effect of early discharge on the health service, carers and patients. Elderly patients following orthopaedic trauma are more likely to be dependent on others for their care than general patients. The aim of this study was to identify experiences and perceptions of elderly orthopaedic patients who participated in a programme of early discharge.

The study involved semi-structured, in-depth interviews with a sample of six men and women who had been orthopaedic patients at the Hornsby Ku-ring-gai Hospital. Broad areas for discussion included expectations of the programme, experiences following discharge including any difficulties or problems encountered, use of formal services reported capacity to attend activities of daily living and the main areas of satisfaction and dissatisfaction. The findings revealed that patients preferred early discharge with support from both the rehabilitation discharge team and family to staying in hospital until fully recovered.

Whilst experiences of this small sample cannot be generalised to

the larger population, they provide insight to individual perceptions that can be used as the basis for further study

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## INTRODUCTION

At one time patients remained in hospital after an illness or operation until they had fully recovered but now with increasing financial pressures patients are being discharged into the community far more quickly.(Finnegan 1995)

Earlier discharge appears to be a global trend that is being quickly adopted by hospitals within Australia, which as Court (1994 p44) highlights, means increased focus on community health that ultimately changes the way in which acute units structure and provide services.

Government reforms within Australia contributed to the growth of early discharge programmes as a method of cost containment and returned patients to their homes "quicker but sicker". The health system benefits from discharging patients at a quicker rate by reducing both length of stay and waiting lists and also by reducing financial costs of prolonged hospital care that can be undertaken in the community.

Some of the costs involved seem to affect both carer and patient as they leave the structured protective environment of the hospital. Currently the patient that participates in an early discharge programme is not "sick" and can therefore receive functional care in their own home such as maternity and orthopaedic patients.

It is claimed that one of the benefits of early discharge is improved patient health and well-being (Court 1994), but there is little literature that examines how the patient perceives their early discharge from hospital back into the community. The aim of this study is to examine the experiences and

perceptions of patients who participated in a programme of early discharge. The data collected will establish grounded theory from individual experience through the client's interpretation of the process of early discharge, that will be useful for health professionals designing programmes of early discharge.

The group of patients discussed in this paper are elderly orthopaedic patients who have significant needs that require consideration when planning a programme of early discharge.

## LITERATURE REVIEW

### Overall trend to deinstitutionalise health services

There has been a world-wide trend to deinstitutionalise health services as a result of spiralling health care costs that have forced governments to seek ways of reducing expenditure. Hunter (1992) characterises the situation by remarking that in many countries rationing of health care has become a significant issue on many policy agendas as the demand for health care outstrips supply. Patients are not staying in hospital as long as they used to, they are being discharged home at a faster rate (Shegda & McCorkle 1990). There is now also greater emphasis on non-inpatient care that leaves hospitals to deal more with acutely ill patients (Wahlqvist, Boyce, Howard, Wright & Allen 1993).

Patients being discharged "quicker and sicker" (McKenzie 1993 p.1) into the community is not the new phenomenon it may seem. It was formerly known as deinstitutionalisation and referred to the transfer of care of the developmentally disabled and chronically mentally ill from institution to community. Increased demands were placed on community services, which brought about changes in societal expectations regarding community care.(McKenzie 1993)

Changes within the National Health System in the United Kingdom such as the Patient's Charter have encouraged provision of care in the community. Elliot (1995) describes programmes such as "hospital in the home" that have been introduced with the aim to provide a service based within the primary health care team where patients can make informed choices and feel in control of their package of care.

Maples (1985) describes diagnostic related groups that were introduced in the United States to account for the patients length of stay whereby the patient is classified according to diagnosis and expected to remain in hospital for a specified amount of time. This has increased pressure to discharge the patient into a supportive environment. In 1989 Stuart Hamilton, Secretary of the Commonwealth Department of Community Services and Health for Australia delivered a speech to the First National Conference on Hospital Casemix and Diagnostic Related Groups that highlighted the need for greater accountability within the hospital system to identify where the health dollar is being spent. He suggested that D.R.G's be adopted as a method to account for patients' stay in hospital (Hamilton 1989)

Early discharge programmes were designed in an effort to reduce length of stay. The United States and Britain embraced early discharge programmes as a method of containing costs in the efficient transfer of care from hospital to home (Taylor, Goodman & Luesley 1993). The United States health care system has been the pioneer and Australia is now beginning to trial early discharge, beginning with two target groups of orthopaedic and maternity patients.

The length of hospital stay in Australia has been gradually falling since the early 1970s and is projected to fall by another 31% within the next decade (Gibbard 1991). A number of cost containment policies assisted in the reduction of the average length of stay in hospital. McKenzie (1993) identifies several of these policies that lead to the formation of early discharge programmes. In 1979 the Hospital Rationalisation Policy was introduced, that required closure of aftercare hospitals and subsequent reduction in funding for hospitals and community health services. Area Health Services were introduced in 1986, in an attempt to solve health service delivery problems by

correcting the imbalance between institutions and community services. The 1989 Resource Allocation Formula was an attempt to measure and predict the health needs for NSW to guide re-allocation of resources according to need. In the same year Medicare Incentive funding was made available to overcome the difficulties associated with the early discharge of patients. This funding however, was not directed to community services but to the hospitals to develop outreach programmes. These programmes in some instances, cut across existing home nursing infrastructure and services (McKenzie 1993).

As a part of the National Health Strategy (1991) funding for hospitals was determined by their level of output and case-mix that led to increased focus on mechanisms to increase productivity.

In a NSW acute health care seminar, the Acting Executive Director of the policy division in the NSW Health Department suggested a 40% reduction in the length of hospital stay. To accomplish this safely, he proposed the development of best practice guide-lines that would be made available and gradually adopted There would need to be a move from funding specific programmes to funding that could address all early discharges. He also suggested that early discharge be a consumer choice. (Keith 1993).

**Early discharge programmes - Overseas and within Australia**

As the forerunners in early discharge programmes, health professionals in the United States are beginning to learn from the experience and question the effectiveness of the programmes. Problems have arisen in respect to patients' recovery following discharge. In a 1990 poll, more than half the patients reported a deterioration in their condition after discharge and the question of liability arose if the patient were harmed as a result of early discharge (Pilette 1990).

In Britain, Taylor, Goodman & Luesly (1993) stress the importance of adequate home support for patients leaving hospital early as they found early discharge to be beneficial to patients physical well-being. Homes were not overcrowded as were the hospital wards and patients received adequate support from partners and families.

Within Australia, one group of patients to trial early discharge programmes were maternity patients as they were considered medically fit, and did not necessarily require twenty four hour hospital care after the birth of a child. It was conceivable that there could be successful continuity of care with domiciliary midwifery support (Kenny, King, Cameron & Shiell 1993). The second target group was orthopaedic patients, but as a group they were more dependent and required greater community support when discharged early. (Fawcett & Roche n.d).

A thorough exploration of early discharge programmes requires clarification of the issues involved. Health Areas favour early discharge because it means a decrease in waiting lists, the length of hospital stay is reduced, as are the number of patients waiting for nursing home beds or community care (Hogarth 1995). It was considered more appropriate to discharge patients into their own environment with adequate community support than to have them in hospital at risk of gaining further infection and blocking beds (McKenzie 1993). Both the hospital system and patients could benefit from early discharge because the patients could regain control over their environment and the hospital would be able to reduce waiting lists in addition to containing costs.

**Costs and benefits to the system - health services**

The early discharge of more dependent patients has been fuelled by many pressures. Finnegan (1995) explains that technological change, measures to promote cost containment and consumer opinion have helped to change the face of hospital discharge policies. Consumers have been pushing for a shorter length of stay in hospital especially in areas of palliative care and maternity where the patient generally would rather be cared for at home. Hunter (1993) proposes that consumerism, or consulting the public has become fashionable in many countries.

Early discharge programmes are now expanding throughout hospitals in an effort to formalise existing early discharge of patients; these are mainly in the areas of neonatal care, orthopaedics, obstetric and geriatric care (Eager 1991).

The main force behind early discharge however is that of economic rationalisation, as it is claimed that early discharge of patients will reduce hospital waiting lists, hospital expenditure and resources. Hospitals also attract extra monies on the basis of performance based funding if they can promote a shorter length of stay and so improve output (National Health Strategy 1991).

The push for early discharge has been supported by the misconception that it is cheaper to care for patients at home when they no longer require acute care (Fawcett & Roche n.d.). There seems little literature to investigate the invisible cost of caring for the patient at home, including medication costs, heating, special food, transport, and lost opportunity costs such as the loss of income because the carer has to sacrifice employment for unpaid caring.

Within hospitals where the greatest support for early discharge of patients exists, there were problems mainly as a result of poor communication that led to confusion about eligibility criteria for the programme. In the St George early discharge programme, hospital management was concerned that fewer patients than expected were being admitted on to the programme and surgeons were confused as some of their patients they had recommended for the service had not been accepted (Colbourne 1993). Staff tension arose at St George that encouraged the fragmentation of care. There was a distinct feeling of "them and us" between the nurses of the wards and the early discharge team. Stern (1991 p.7) describes early discharge programmes as being the "icing on the cake" for health care providers who are already stretched to their limits of staff and resources. By this the author implies that health care providers did not want to be concerned with the extra work involved in arranging the early discharge of patients.

Many of the initial programmes had to be redefined because they proved to be too expensive (Colbourne 1993). A reorganisation of staff was needed as salaries claimed a significant part of the funding.

Early discharge programmes, by discharging dependent people into the community, significantly impact community services, where increased pressure is placed on services already in demand. McKenzie (1993) points out that many problems exist with access to H.A.C.C. funding and services and the availability of the services vary from area to area. There appears to be a shortfall in funding in relation to demand. H.A.C.C. provides funding to services such as Sydney Home Nursing Service for elderly clients and the young disabled, but it does not cater for the increased number of more acutely ill patients leaving hospital who require more intensive nursing.

Community services such as home care and meals-on-wheels cannot cope with the current demand on their services. There needs to be a major redirection of funding from the hospital into the community if this current trend of early discharge is to continue and place increased pressures on the community services. Frequently many centres of the Sydney Home Nursing Service have waiting lists to cope with the increasing number of patients in the community who require nursing services.

Early discharge programmes generally care for patients in their own home for a specified amount of time in their own home, after which the programme is terminated and patients referred to other agencies if they require further care (Colbourne 1993) (Cameron 1995). If these patients can not be accepted by the aforementioned agencies then they must pay for private services, some of which they may not be able to afford or go without.

**Costs and benefits to the carer**

Some families were reported to be happy to have their relative home early and saw the home situation as adaptable, able to meet the needs of the person returning early from hospital (Bull 1992). But on the whole, early discharge placed an increased burden of care on to the person at home, the carer.

Carers often venture into an area in which they have very little experience. Tierney, Worth, Closs, King & Macmillan (1994) found that the factors most likely to frustrate carers were fears about coping, or refusal to offer support, transport problems and inadequate community resources.

Draper (1992) in a discussion on the carer's ability to cope, notes that hospitals often assume that if a patient were being cared for prior to admission there should be no problem in sending the patient home early to be cared for

again. What they neglect to take into account is the fact that the carer may not be able to care for a relative who is still recovering. King & Macmillan (1994) suggest that there is a tendency to assume that relatives or carers are willing to give increased support after patient discharge, but many are too old or frail. It is important to gain a realistic picture of the patients social network before discharge.

The effects of population shifts are significant. As childbearing age increases, the period when looking after young children often coincides with caring for elderly parents (Draper 1992).With dependent relatives who require a great deal of care and time a carer may be required to give up work and so needs recognition for the lost opportunity cost of caring, as the carer is restricted to the home by their responsibilities and cannot benefit from occupational or leisure opportunities. Clay (1985) points out that it is generally women who will be expected to act as unpaid and untrained carers.

Organisations exist to assist the carer such as the Carers Association of N.S.W.which acts as a support network, but as Draper (1992) highlights, the practical help that is needed is not often available. H.A.C.C. services are not often available when there is a female carer, as it is presumed that a female carer can cope with the demands of her new role.

Early discharge places stress on the whole family as the patients are returning home more acutely ill. The carer is highly likely to experience feelings of loss and grief that will reduce the ability to cope (National Association for Loss and Grief n.d.). They may feel anxious about their relative leaving the safe environment of the hospital when they have not totally recovered and this anxiety can be transformed into anger when they are given the burden of responsibility. They may experience a loss of control or even

social withdrawal . Carers are subject to increased stress and pressures that inevitably take a toll on their physical or psychological health (Bull 1992).

Some early discharge programmes rely on a carer being at home to care for the patient (Taylor, Goodman & Luesly 1993) and this is not always possible. There needs to be some official recognition for the work of the carer to enhance the success of early discharge programmes.

Although there was quite intensive support and back-up for the first four weeks from the early discharge programmes such as that at Hornsby Ku-ring-gai Hospital with a nurse to visit every day for four weeks and the rehabilitation discharge team organised home care and gardeners to attend the household chores (Hughes 1995), the bulk of the caring always fell to the resident carer as support was only available for certain periods during the day. Caring for someone for twenty four hours a day can be extremely demanding especially when there is little relief and there has been no period of training. (Tierny Worth, Closs, King, & Macmillan 1994)

**Cost and benefits to the patient**

Some patients enjoyed the benefit of a shorter stay in hospital because they preferred to be at home with their family and friends in a familiar environment where they quickly regain control of their environment and so their independence. Sadler (1990) found that early discharge was psychologically beneficial for patients because it made them think that staff were trying to make their discharge from hospital as smooth as possible.

Stern (1991) notes that well designed early discharge programmes provide not only support, but also safety for the patient when they return home. The patient's physical status improved with a shorter stay in hospital

because there was less chance of any set-back caused by hospital borne infection and also there was reduced availability for unnecessary tests (Wadsworth 1995).

It appears that patients who are discharged early generally fare better both physically and psychologically than longer stay patients. This is dependent, however on the patients' desire to go home early and adequate support at home, because if the patient feels unsupported full recovery could take longer than expected (Wong, Wong, Nolde & Yabsley 1990).

The patient leaving hospital only a few days following surgery will undergo a range of emotions and physical challenges. The stress and emotional distress that can occur during the transition can result in anxiety, insecurity, frustration, depression, apprehension, ambivalence and loneliness (Schumacher & Meleis 1994). Health professionals therefore, have to be aware of these psychological effects when planning for discharge from hospital. Shegda & McCorkle (1990) advise that the way in which continuing care is carried out will have a direct effect on the physical and mental health of the patient. Waters and Booth (1991 p.32) describe early discharge programmes as "a stage in the patient's care that is situated towards the end of one continuum which has a period of preparation and from which there are consequences".

Bull (1992) suggests that patients' anxieties and concerns range from apprehension about learning new skills to managing treatment that is likely to disrupt family activities. Patients face physical as well as psychological challenges when they return home: for example, the main problems for the early discharged patient after a total hip replacement are physical limitations such as the inability to dress independently, putting on shoes and socks, sitting,

walking and household chores (Wong et al 1990) Some patients do not see the benefit in being discharged from hospital early, as the recovery period following a total hip replacement is often arduous and restrictive. Rayfield (1995) maintains that this physical manifestation often has a psychological effect causing reduced self esteem and a gradual loss in confidence that may lead to depression. Patient's emotional as well as physical health has to be considered therefore when contemplating suitability for programmes of early discharge as mental attitude may influence the ability to cope independently at home.

The threat of becoming a burden or dependant on another is often a concern, as patients may envisage difficulties in the provision of special meals, modifying the environment or more significantly the change of established roles that can place increased pressure on a relationship. Egan, Warren, Hessel & Gilewhich (1992), describe studies that showed that a substantial number of patients were more dependent at home than they were in hospital.

When patients leave the hospital they are leaving an extremely structured and supportive environment, in which they have been totally dependent on professional care. They are now faced with the prospect of leaving this safe environment and so will want to be assured of adequate support in the community. Wong et al (1990) advocates that early discharge programmes be supplemented by a well organised programme of care. This should involve a variety of organisations working cohesively to ensure the patients' continued recovery. There must be adequate community services to be able to cope with the increased demand, and so adequate funding.

Cost containment directly influences patient care and so for the patient to benefit from rationalisation forced upon them, there needs to be effective care planning. Shegda & McCorkle (1990) found that the continuing care process

was effective in meeting identified patient needs if there was active patient and family participation. The level of planning that occurs before and during a transition influences the success of the transition. Effective planning is achieved by a comprehensive identification of the problems issues and needs as well as identification of key people to provide support. (Schumacher & Meleis 1994 p 123). A patient's recovery will be affected by the level of family involvement and support. Johnson, Morton, & Knox (1992, cited in Schumacher & Meleis, 1994) found that when there was inadequate support or poor communication with professional staff, clients experiencing a process of transition experienced feelings of powerlessness, confusion, frustration and conflict.

Much of the literature indicates however that patients are not involved when planning their discharge. Bowman, Howden, Allen, Webster & Thompson (1994) &Tierney et al (1994) suggest that the discharge plan could be enhanced by involving both patients and their carers in the planning process. Haddock (1994) & Bull (1994) found that the majority of their patients stated that the ability to perform daily activities such as cooking, cleaning and bathing were important issues for health professionals to consider.

McWilliam, Belle Brown, Carmichael & Lehman et al (1994) indicate that being involved in one's own care improves relationships and feelings about self that in turn plays a significant role in determining success or failure to independently manage care at home. Rehabilitation at home is functional and relevant to the patient who will understand and be more likely to co-operate with treatment (Meeds & Pryor 1990).

Avis, Bond & Arthur (1995) found that when patients were satisfied with their care they were more likely to follow planned care and so it follows that if patients are included in their discharge planning, well informed of their

condition and treatment they demonstrate better coping mechanisms and are more likely to comply with any treatment.

**Specific issues in discharge planning for elderly patients**

This transition from hospital to home can have profound effects on the elderly patient. Waters (1987) suggests the transition from hospital to home could be a devastating shock because patients are leaving an environment of total care that can create an insidious dependence. Patients don't need to think about when to eat or drink as everything is done for them, they begin to feel comfortable having developed a sense of belonging. The sick role legitimates social withdrawal from obligations, where one can become too sick to exercise or to take any responsibility (Rayfield 1995).

Bull (1992) defines the major barriers to coping as a lack of awareness of available resources, an inadequate network of informal supports and significant gaps in community services to address specific needs. A review of H.A.C.C. services (Australian Hospital 1995) showed many inequalities in the service and eligibility criteria in relation to quality and availability depending on where people live. With an increasing elderly population and subsequent increase in chronic illness and functional disability, an injection of increased funding into the community is needed to help keep these patients at home.

The effect on the patient, and also the carer, is a matter for concern, as it can be a daunting prospect to leave the secure environment of a hospital. Some patients are content to go home early, but these are generally younger and less dependent. King & Macmillan (1994), found that in their study on discharge planning for elderly patients around half of the patients lived alone. Many elderly patients discharged from hospital face problems of isolation

because of a breakdown in family structure and geographical isolation from potential carers, that increases reliance on community services. These patients consequently require more frequent visits from community nurses, physiotherapists, home care attendants and meals-on-wheels, all of whom already have heavy workloads. Some patients, however are fortunate enough to have family at home to care for them but this also means an extra emotional and physical burden for the carer.

Much of the difficulty encountered in supervising the mobilisation and return to function of these elderly fracture patients seems to stem from their fear and lack of confidence (Meeds & Pryor 1990). Loss of physical function equates with loss of independence. Waters (1987) found that independence in activities of daily living had decreased after hospitalisation.Waters & Booth (1991) suggest that elderly people are
more likely to require help with both personal and household tasks after hospitalisation than before it.

To ensure healthy healing there needs to adequate nutritional intake. When patients are in a hospital environment their nutritional intake is relatively controlled, but when they return home it becomes their responsibility. Holmes (1994) sees that nutritional status in the elderly population may be influenced by many factors such as health, chronic disorders, immobility and psychosocial and socio-economic issues.

Patients with other medical conditions are often more dependent at home than they were in hospital (Egan et al 1992) and may not give therapists an accurate indication of capabilities post discharge.

Waters & Booth (1993) identify that informal carers give a far greater

proportion of care and support to the elderly population than the formal services, whose input although essential and valuable is still minimal by comparison. Account must be taken of home and social circumstances to determine the potential effects of discharge home, as some patients may not have access to family support.

Some elderly patients when discharged from hospital go into a state of decline as they leave the supportive environment. Some patients just do not want to go home, for various social and psychological reasons they tend to find the hospital environment more welcoming than the community. (Ahulu 1995).

**Early discharge programmes in N.S.W.**

There are three orthopaedic early discharge programmes within the Sydney metropolitan area at St George, Prince-of-Wales and Hornsby Ku-ring-gai Hospitals.

The early discharge programme at St George Hospital was criticised as being "a total luxury" (King 1993 p.2 ), because it did not prove to be cost effective. The salaries for four physiotherapists, an occupational therapist three or four nurses and only a saving of four hospital beds through the early discharge of patients, was seen as excessive when the same financial commitment could fund twelve beds for incoming patients. The Prince-of-Wales Hospital programme also developed financial problems as a result of the transfer of patient care from the orthopaedic to the geriatric department. The geriatric department initiated the programme and the elderly were quickly disowned by the orthopaedic department, making it hard to sustain any gain when the geriatric department eventually withdrew (Caplan 1993). The Royal North Shore Hospital also began a programme of orthopaedic early discharge,

the Hospital Extension Service. This failed, however, as a result of poor communication between the doctors and key figures within the community. The doctors were also apprehensive with regard to litigation (Lawson 1995). Consequently the programme did not get further than the discussion stage.

**The Hornsby Ku-ring-gai programme**

The Hornsby Ku-ring-gai programme is a programme of early discharge designed for elderly patients over the age of sixty five years. The early discharge team there has been working with elderly orthopaedic patients for the last six years and is starting to involve other areas of patient care. It is now known as the Rehabilitation Discharge Team because of the negative connotation associated with early discharge.

The aims of the programme are to provide an extension of rehabilitation for orthopaedic patients in their own home for a period of up to four weeks after discharge from hospital, to provide on-going nursing care, physiotherapy and occupational therapy, to reduce hospital stay by providing rehabilitation in the home environment, and finally, to prevent hospital admission of patients who have minor orthopaedic problems and who are not seriously ill enough for admission but still require some assistance at home. There are several eligibility criteria. Patients must be 50 years of age or older, they must have an orthopaedic problem, must be able to toilet themselves, get in or out of bed independently, and be independent in activities of daily living prior to hospital admission; they must live within the Hornsby Ku-ring-gai local government areas and cannot be residents of hostels or nursing homes. The team, consisting of four part time registered nurses, two part time physiotherapists and two part time occupational therapists, admits the patient into the programme for a total period of four weeks and then either discharges the patient or refers on to other community services such as Sydney Nursing

Service, Community Options or Home Care (Hughes 1995).

**Summary of key issues**

To summarise, it can be seen that there are global trends to deinstitutionalise health services that have been guided by increasing health care costs. In the United Kingdom, the Patient's Charter was developed that encouraged provision of care in the community and in the United States diagnostic related groups emerged to account for the patients length of stay. Early discharge programmes, whereby patients left hospital early with a programme of support, became a means to decrease length of stay and to conserve the cost of in-patient care.

The United States led the field in adopting these programmes of post acute care but problems began to arise with the threat to patients' health and also issues of liability. The experience in the United Kingdom is on a more positive note with patients actually benefiting from earlier discharge with adequate family support. Within Australia, early discharge programmes began with maternity and orthopaedic patients as they were seen as groups of patients who were not actually "sick" and could recover at home.

The system or rather the health service benefits from early discharge of patients as waiting lists are shorter because the patients length of stay has been reduced and extra funding is available on the basis of increased output.

The literature identifies a mixed reaction to the effect of early discharge on carers. Some were pleased to have their relative home earlier but on the whole early discharge placed an increased burden of care on to the carer and the family. There was little appreciation from the system for the work of the carer involved in caring for someone at home who would otherwise be

looked after in hospital.

Orthopaedic early discharge programmes within N.S.W. began at St George, Prince of Wales and Hornsby Ku-ring-gai Hospitals with mixed results. The patient leaving hospital early appears to be more dependent and for some this can present a range of both physical and emotional challenges

In planning the discharge home for elderly patients, specific issues that require consideration were the breakdown in family structure resulting in increased reliance on community services, fear and lack of confidence, increased dependence on other family members and poorer physical health.

This study involves participants who participated in early discharge from the Hornsby and Ku-ring-gai hospital where a programme was set up for elderly orthopaedic patients to provide an extension of rehabilitation in their own homes.

**Rationale for Investigation**

As there seems to be little literature that identifies how elderly orthopaedic participants view their early discharge experience, the aim of this study was to identify the experiences and perceptions of elderly patients who participated in a programme of early discharge. With government policies that encourage health professionals to devise means to contain costs, it is important to establish whether or not programmes of early discharge are meeting the needs of this particular group who are often more dependent on others for their care.

Broad topics areas for discussion include expectations of the programme, experiences following discharge including any difficulties or problems encountered, use of formal services, reported capacity to attend activities of daily living and the main area of satisfaction and dissatisfaction.

## METHODOLOGY

The principal aim of this study was to explore experiences and perceptions of elderly orthopaedic patients who have participated in a programme of early discharge. When planning and evaluating health services it is imperative that patients' views are taken into account as an essential source of data about how the service functions.(Avis, Bond, & Arthur 1995 p316).

### Rationale for method of data collection

Qualitative data collection was considered most appropriate in this study as the researcher was trying to identify individuals' expectations and experiences of their early discharge from hospital.

By conducting semi-structured, in-depth interviews it was possible to gain participants' interpretations of the situation. Grounded theory (Glaser and Strauss 1967) was used to identify individual perceptions and experiences without imposing the researchers understanding on the subjects. Semi-structured in-depth interviewing allowed for expression of informants' interpretations (Minichiello, Aroni, Timewell & Alexander 1995 p73) and allowed for immediate follow up questions for clarification and omissions.

### Reliability and Validity

In an attempt to enhance validity of the interviews, probing questions were used to verify informants' accounts and telephone contact was made two weeks after the initial interview to check the consistency of what the informants said about their experiences of early discharge over a period of time.

Reliability of this study can be tested by using the same documented framework for future investigation to examine whether or not the same findings are obtained. Using the analytic inductive method as described by

Minichiello et al (1995 p.249) the data collected were transcribed and then analysed after each interview to identify salient themes or categories, memos written to identify relationships between the themes and also to structure the next interview .

**Recruitment**

Gaining access to the informants involved approaching the co-ordinator of the programme who directed the researcher to the doctor ultimately responsible for the rehabilitation discharge team. The researcher first contacted the co-ordinator to learn about the early discharge process at the Hornsby and Ku-ring-gai and from this initial contact the researcher proposed interviewing six participants to discover their individual experiences. This proposal was put to Dr Cameron who sanctioned the interviews subject to approval by the Hornsby and Ku-ring-gai hospital ethics committee. Once approval was given the researcher discussed with the co-ordinator criteria with which to select participants for the study.

Using the co-ordinator as an intermediary solves the problem of coercion by the researcher but at the same time could create bias because the intermediary may have reasons for selecting certain participants. A good relationship was established between the researcher and the co-ordinator however that allowed the researcher to identify and for the co-ordinator to accept the selection criteria.

It was interesting to note that during the process of selection it became evident that informants were willing to participate until they were asked to sign the consent form prior to leaving hospital. Three potential informants had agreed to participate verbally and when it came time to sign the consent form they withdrew from the study.

**The Sample**

The sample was purposefully selected by the co-ordinator for rehabilitation services in conjunction with the researcher. The sample strategy was one of stratified purposeful sampling as certain criteria determined the characteristics of the sample that allowed for comparison of the data (Paton 1980 p174).

The researcher's intention was to interview three participants who have co-resident carers and three participants without carers to see if there was any relationship between their ability to cope at home and whether or not they have a carer, as this may have some future bearing on future selection criteria for the programme. It proved difficult however, to find informants to fit this category within the time limits of the study and so the informants interviewed consisted of four with carers and two without. Both men and women were included in the sample as the programme caters for both sexes and also people from varied ethnic backgrounds as the results of the study may benefit those from non English speaking backgrounds, especially if significant problems arise. The age of the study participants was not significant because age is not related to the outcome of the areas to be discussed and is not directly associated with their ability to cope at home. Exclusion criteria included those that were too sick or confused or those with poor English or communication skills to be able to participate in meaningful discussion.

Six patients were selected who participated in the early discharge programme run at Hornsby Ku-ring-gai Hospital. The sample size was small as it was limited by time constraints of the study and the interview process.

## The Interviews

The interviews took place in the informant's own home with their permission, at a time suitable to them. An interview guide of broad topics areas was used to guide the interview. The topics for discussion included expectations of the programme, experiences following discharge including difficulties or problems encountered, use of formal community services, reported capacity for activities of daily living and main areas of satisfaction and dissatisfaction.

Two weeks after the programme ended, the researcher contacted the participants by telephone to identify any discrepancies in their accounts and also to identify any problems they may have had

## Data Recording

A tape recorder was used with informants' consent and then the interviews were transcribed to allow the interviewer to concentrate on the interview and to provide continuity by retaining a complete record of it. Tape recording also allowed for verbatim quotes to be included in a report of the findings.

## Ethical Considerations

As the research involved patients as subjects, ethical issues may be raised because informants' thoughts feelings and behaviours were being examined. Permission to undertake the study was granted after approval by the Hornsby and Ku-ring-gai hospital ethics committee.The research proposal was submitted firstly to the Cumberland campus of Sydney University and secondly to the Hornsby and Ku-ring-gai Hospital ethics committee for their approval. Participants were approached by the co-ordinator for the rehabilitation discharge team and asked if they would participate in the study. If

they agreed each participant was given an information sheet to inform them of the nature of the study and information about the researcher.(Appendix B). They were then asked to sign a consent form prior to their discharge from hospital by the co-ordinator for the rehabilitation discharge team (Appendix C).

## THE SAMPLE PROFILE

### Characteristics of the Interview Sample

Orthopaedic patients from Hornsby hospital who had been discharged early with the support of the rehabilitation discharge team, were the focus group for the study. All participants interviewed happened to be Australian nationals and so it was not possible to identify perceptions and experiences of those who were not Australian citizens. The sample consisted of three women and two men, only two lived alone. Within the time frame of the study it proved too difficult to find three participants with resident carers and three without. Even those that lived alone had good support networks that consisted of family and friends.

### Individual profile

Mrs A.

Mrs A found herself in Hornsby Ku-ring-gai hospital after a fall at home that resulted in a fractured femur. Prior to this admission she had quite a significant orthopaedic history with a total knee replacement, a fractured neck of femur and fractured wrists, all of which had resolved by this admission. At the time of her discharge home she was mobile with a frame and the rehabilitation discharge team were providing supervision with personal care, physiotherapy and an occupational therapist was involved to assess her home situation. Mrs A lives with her extended family in a large house but is alone most of the time as the grandchildren all go to school and her daughter and son-in-law work during the day. She tries to be as independent as possible by cooking her own meals and trying to shower herself that makes her feel less dependent on her family. Community services for cleaning and meal preparation are not needed as the family take care of those responsibilities

Mrs B

Mrs B lives alone in her one storey house but has supportive family who visit regularly. She is mobile with a walking frame after having sustained a broken fibia that she has in a plaster cast. She is quite an independent lady who seizes any opportunity to do things for herself, for example, learning how to shower with a plastic bag covering the plaster having been taught by the nurse from the rehabilitation team. Initially the rehabilitation discharge team provided nursing to assist with personal hygiene as well as also physiotherapy and an occupational therapy assessment for any equipment or home modifications that might be useful. Meals-on-wheels provide Mrs B with meals currently but she intends doing the cleaning herself when she becomes stronger. Mrs B appreciated coming home early as she would have felt restricted staying in hospital any longer.

Mr C

Having elective surgery, Mr C was able to plan his admission into hospital for a total knee replacement. This made life easier for both Mr C and his wife, as his wife was unable to drive and therefore would have found shopping difficult. The rehabilitation discharge nurses assisted with personal hygiene until Mr C became independent as well as wound dressings and the physiotherapist and occupational therapist also assisted in his recovery. Mr C made frequent reference and expressed appreciation for the concern that the rehabilitation team demonstrated for their clients and he highlighted how safe they made him feel. Mr and Mrs C have a daughter who is very supportive and visits regularly to see if she can be of any assistance, but they seem to be quite self sufficient. Mr C was well informed about the kind of medication he was having and how often he was to take it. He also knew how to access local community services for cleaning and gardening, but as he had supportive family he had no need to call on them for assistance.

Mrs D

After having a shoulder repair, Mrs D went to stay with one of her daughters for a week immediately after her discharge from hospital. She did not feel a burden on her family as Mrs D had ten children, all of whom were very supportive. After spending a week at her daughter's home Mrs D returned home to the support of her neighbours and the family still visited regularly to help her with shopping and cleaning. The only support needed from the rehabilitation team was some physiotherapy to help her regain movement in her arm and elbow. Mrs D had undergone more serious operations in the past that made her feel very relaxed about this shoulder operation and she was quite eager to return home soon after the operation. The flat that she lived in was purpose built for the elderly as it was part of a retirement village and so no modifications were needed on her return home.

Mrs E

Mrs E not only had to cope with coming home early with a fractured wrist following a fall, but was concerned about her husband who was also in hospital for an operation at the same time. She normally lives with her husband in their bushland home, but when she was discharged from hospital Mrs E was alone for a week whilst her husband was recuperating. Supportive sons and daughters came to stay overnight but during the day demanding jobs meant that they could not look after their mother.

Mrs E received assistance with personal care, physiotherapy and an occupational therapy from the rehabilitation discharge team when she arrived home. She reported her main problem to be one of pain that limited her mobility, making her initially quite dependent on others. Assistance was also sought for cleaning from a private agency and both friends and family were

able to help with the provision of food and ready made meals. Being on her own for just a short period of time, Mrs E was grateful for the visits from the rehabilitation discharge team to reassure her that she was progressing normally.

Mr F

Mr F suffers with chronic back pain and was admitted to hospital with several spinal fractures. The treatment whilst in hospital focussed upon rest and pain control and when he was discharged he was mobile with the aid of a walking stick. Mr F was still experiencing slight pain two weeks after his discharge and as a result his mobility was quite limited. He lived with his wife who assisted with most things but the nurses were visiting for support and he was also having physiotherapy at home. Mr F is a stoic man who doesn't like to complain and frequently praises his wife for the assistance and attention she gives him. They were able to afford private assistance with cleaning that helped to take the strain from Mrs F.

## FINDINGS

The experiences of the patients receiving services from the rehabilitation discharge team and leaving hospital early were characterised by four emergent themes. Each theme will be presented using excerpts from both the interviews with informants and follow up telephone conversations,that represent strong instances of the themes.

*Expectations of early discharge

*Experiences of early discharge

*Main areas of satisfaction and dissatisfaction

*Reported capacity to attend activities of daily living

*Difficulties encountered

*Use of formal services

### 1. Expectations of Early Discharge

1.1 Awareness of range of support from the rehabilitation discharge team

It became apparent that although informants had the early discharge process explained to them whilst in hospital in that they would go home early and have support from the hospital for the first four weeks after discharge, not all patients had the same level of understanding about what the rehabilitation discharge team could offer. Two weeks into the programme Mr F expressed concern about who was paying for the service and he had no idea of how to arrange on-going care after the rehabilitation discharge team withdrew their services at the end of the four weeks. Two other participants, Mrs A and Mrs B however, were well informed of the range of support:

*The team will come out and they come for so long* (Mrs A )

Mrs B had considered what the programme could offer and came to the conclusion that while it would suit some with few expectations it would not

suit those who expected more:

*Well it* (the early discharge service) *might work for some but I think there's a lot that probably won't be able to cope.....some people aren't as easy to.....they expect too much*

Awareness of the programme even spread to those not directly involved, Mr C's friends had learnt about the services provided for early discharge:

*Our friends are shocked aren't they! surprised you know, that these things are available or that they look after you so well*

1.2 Anxiety associated with early discharge

Four out of six informants expressed some concern in relation to returning home earlier than expected, as they were anxious as to whether or not their family would be able to cope.

*The only feeling I had was wanting to get home but maybe, I had a thought of is it too premature* (Mr F)

Patients who participate in a programme of early discharge are coming home to an environment in which they do not have the medical support and they may feel quite vulnerable. This was highlighted by:

*I was still a bit shaky and you know when you've had a fall and hurt yourself you're terrified of falling again, you know the injury is still very painful and the thought of falling over again is terrifying so you're very careful with yourself* (Mrs D)

For Mrs E the proposition of early discharge seemed almost too much for her to cope with:

*Well yes I was very worried about coming out. Before they mentioned discharge service, I was hurt on the Sunday night and I was operated on Sunday morning and my husband went into hospital on the Monday. I was very concerned.*

Hospital staff did however consider patients individual needs as no informant left hospital feeling that they should stay in hospital longer.

*The day before I came out, the Doctor came round in the afternoon and he said he thought I could go home but then I honestly didn't feel ready. I felt ghastly and the Sister in charge came up to me and said "you don't have to go " and I said "Can I stay until tomorrow?" and she said yes. Which was just as well because my arm was swelling up.* (Mrs B)

It became evident that for some there was a preference to come home earlier rather than waiting in hospital.

*If you're laying in hospital you're thinking you're worrying about things that are outside that you have to do you know. That's always been with me, all I was worried about was paying my phone bill .* (Mrs D)

**2.Experiences of Early Discharge**

2.1 Preparation for discharge

When elderly patients return home after a period of hospitalisation the occupational therapist becomes involved in the discharge planning process to

ensure that the patient will be able to manage activities of daily living such as bathing and mobilisation. Each patient was offered appropriate modifications to their home or use of equipment that would make their lives easier. This is one of the key components in planning for early discharge as patients can potentially be more debilitated leaving hospital earlier than anticipated.

*They came out on a home visit and my son-in-law was here, he took the time off. That was on the Tuesday and then I was released on the Thursday..... Rob the occupational therapist, he came out and had a look and they were satisfied to see me home.* Mrs A)

All informants interviewed were well prepared for their early discharge as they reported how the occupational therapist visited them at home immediately after discharge or just before they went home.

*No they came down the day I got discharged to go through and check it all out. And what I like about it is they don't accept your word that you can do these things. They've got to be satisfied in their own mind that what you tell them is true.* (Mr C)

Mr F's early discharge was facilitated by clear instruction on why and how to take medication before leaving hospital.

*When I got discharged this time I was given a packet, told what to do with all the different tablets they gave me and what I had to take up there .... they gave them back to me plus all these notes telling me what to do and this is what they handed me when I left hospital.*

Mrs A experienced problems with transition of care from hospital to

rehabilitation team staff once she became involved with the rehabilitation discharge team, as the focus of care then turned to organising support at home with little attention paid to the potential difficulties encountered on the journey home:

*I was a bit nervous coming home because when I got out they brought me home in the bus and I had to climb up into the bus which I'd never walked on the step or anything before..... Then they couldn't get the bus up the side and I had to walk up* (the steep hill) *which was a bit traumatic at the time.*

2.2 Involvement in discharge planning

With the informants interviewed, there seemed little formal structure to involve patients in the assessment or identification of their needs on discharge:

*What you mean when he told me I could go, no he just come and said I'd be alright to come home on Sunday and so I said that was fine.* (Mrs D)

The process of arranging the transition of care from hospital to community was controlled by hospital staff with little input from patients, contradicting one of the principles of effective discharge planning that stipulates family and patient involvement in the entire process.

*Most of the time I was under pain killers. I think Peter was speaking to the Sister and my children and husband sort of worked it out that someone would be there every night. So it was really between the family and the hospital and the hospital mentioned the discharge service and a neighbour said she'd pick me up..... So I wasn't terribly involved .* (Mrs E)

## 3. Main areas of satisfaction and dissatisfaction

AREAS OF SATISFACTION

3.1 Increased independence

One of the positive outcomes of early discharge appeared to be that it increased informants' sense of independence. They no longer had health professionals to rely upon twenty-four hours a day to assist with tasks that they could often do for themselves.The effect of being in hospital for any length of time or becoming dependent became apparent:

*I think you can get, it's like any institution, you can get institutionalised. I think you do and I don't think that's good for anybody really* . (Mrs A)

A sense of independence was encouraged by informants' motivation to get better and a realisation that any improvement in health was ultimately their responsibility once at home:

*I moved around as much as I could because I thought perhaps that was the only way to get better. Just sitting in one place isn't going to do much for me* . (Mrs A)

Independence in a hospital environment is not often cultivated as a result of pressure placed on staff to increase productivity that results in depersonalisation of care and the tendency for care to be task orientated.Five informants felt more independent at home than they did in hospital because they felt they had more control in their own home.

*It improved it* (independence) *You keep trying, you keep endeavouring to get back to normal* . (Mrs B)

It was felt a faster recovery could be made at home:

*The progress I've made since I've come home within myself with just what I can do is ... like getting into the bathroom well there's no problem there at all .* (Mr C)

3.2 Supportive rehabilitation discharge team

All informants spoke highly of the service provided by the rehabilitation discharge team. The staff were found to be accommodating, anticipating the needs of their elderly patient returning home early to ensure a smooth transition from hospital to home.

One nurse upon hearing that the battery in Mr F's hearing aid was flat took the time immediately after his visit to get a new one. All informants felt they could contact the team at any time with any query or concern and all felt that they were being looked after exceptionally well.

*I didn't expect they'd be as good as they were! I mean they're delightful people, all of them and they just have this air of confidence and competence that makes you feel it's alright .* (Mrs E)

All informants were very complimentary about the staff of the rehabilitation discharge team. Mr C appreciated the time taken to ensure his safety:

*I'd say the service I've been receiving is absolutely phenomenal We had the girl here who came and made sure I could get on and off the bed and on and off the toilet.*

The staff would educate as well as help the informant to overcome their disability. Mrs B learnt how to cope with showering:

*I was taught how to do that without getting water in there, I've done it from the time I came home, just educated how to do it and then no problem.*

Mrs E expressed her appreciation for the attentiveness given by the occupational therapist and also the diversity of available equipment.

*They were very good. The occupational therapist brought a bathseat and a shower stool, because I was still a bit shakey .... and she offered equipment for the kitchen which I actually didn't need because I wasn't cooking and it's only a temporary thing.*

Mr C felt safe in the care of the rehabilitation discharge team:

*Well they're continually enquiring either phoning me or calling in to the house and they want to know how things are going.*

The depth of appreciation was succinctly characterised by:

*It's just they cared. It was wonderful, nothing was a problem to them and you knew they just cared .* (Mrs A)

AREAS OF DISSATISFACTION

3.3 Restricted care in hospital

Informants were introduced to the concept of early discharge whilst in hospital, where they were informed they could return home earlier than

expected with the assurance of on-going nursing and allied health support at home.

Informants generally felt well supported and felt they actually received better care at home than they did in hospital.

*Well supported yes, no doubt about that and I felt that I could be looked after at home as well as I was in hospital. I got constant attention. The team have told me I can ring them any time if I am anxious or worried about anything and mostly there's one of them here, they don't always come on the same day but they'll be here one time or another. But they've given me the confidence to the fact that I really think that if I was stuck or anything I would just have to ring and they would put me on the straight and normal .*
(Mr F)

Mrs A welcomed the idea of returning home early as she felt her hospital stay was affected by increasing financial constraints and subsequent pressure on hospital staff.

*I realise they can't get enough beds now as it is and they're always looking for beds for people and I suppose they can't keep people in until they're really better.*

Comparisons were made with previous hospital admissions when pressure on the nursing staff in particular, was not so intense:

*I've been in Hornsby hospital three or four times, I've been in the San a few times and this is the first time I've been so glad to get out..... they've cut the services to such an extent now..... I mean before if you were uncomfortable*

*they* (the nurses) *were in and out and you didn't have to ring for anyone. But now you ring and you ring and it's not their fault* . (Mrs E)

The pressure placed on hospital staff that affects quality of care is reflected in the following statement where the care given in hospital appeared regimented without regard for individual need:

*I can't say that I enjoyed my stay in hospital.... a hospital is a hospital not a rest home and as such patients have to be treated as soldiers. do as we say, not as we do!* (Mr F)

3.4 Need for reassurance

Two of the informants felt vulnerable coming home where there was limited medical cover and needed the reassurance of health professionals

*I am the kind of person that likes to know that things are going alright. you know if you look at my wound or sickness or something and say no that's fine. I can forget it and think right that's right. But I do need that reassurance..... without them* (the rehabilitation discharge team) *I would have been very anxious coming out of hospital with no-one here and having a sick husband* . (Mrs E)

**4.Reported capacity to attend activities of daily living**

4.1 Greater expectations

At times informants displayed frustration at not being fully mobile, as if not aware they had been discharged earlier than normal. They had greater expectations for their functional ability than expected for the natural recovery process.

*I don't think anybody really knows what's likely to happen or how long it's going to take, it's just I feel I've been that long that I should be at another stage but I'm not* . (Mrs A)

and

*I just wished I felt better, I expected to feel better* . (Mr F)

Mrs A seemed to associate being at home with automatically having improved functional mobility.

*My idea is I would come home on crutches or something like that. The mere fact of me coming home and having to have a walker was a smack in the eye to me because I was going to get up and be on crutches and be home.*

4.2 Nutritional intake

For four of the informants their nutritional intake was in some way affected by being in hospital and as the healing process is promoted by a healthy diet perhaps this should be more formally addressed. Mr F lost two stone in weight when in hospital and never regained his appetite. This would be of particular concern for those who lived alone and were unable to go out to buy food or unable to cook for themselves.

## 5. Difficulties encountered

5.1 Limiting factors

Four out of the six participants interviewed were well supported by family members but there were still many issues that made coping independently difficult. Leaving hospital with a physical disability was not going to be an easy process.

*I thought at the time when I came out, I thought it's not going to be easy because I wasn't walking and not putting full weight on your leg.* (Mrs A)

Informants accepted limitations placed on them by their disability and seemed resigned to the fact that they had to cope. Mrs E could not maintain her usual standard of hygiene as a result of her disability and changed her lifestyle rather than finding solutions to the problem. This could also be related to the fact however that she knew her situation and her disability were only temporary.

*And there were things like, for the first week I didn't ask the children, I just climbed into bed how I was and climbed out how I was and had a shower when someone came.*

Pain and subsequent immobility featured as limiting factors to functioning independently at home:

*Oh yes I can't do lots of things, I can't do ..... I'll have a fair wait for that one until I get enough bend into the joint but it is progressing slowly .* (Mr F)

and

*I can't bend my leg up sufficiently to, I have difficulty putting on a sock for that reason* (Mr C)

The effect of not being able to manage the little things was not fully appreciated by Mrs D's local doctor:

*Well me shoe laces and turning the taps on and off. He* (the Doctor) *said no worries but it does worry me because I'm diabetes you see, but I didn't get that until I was seventy*

5.2 Family burden

Returning home early from hospital made the majority of informants feel awkward about the extra load placed on family members. Mr F expressed particular concern for his wife:

*I felt that I would be a burden on Lois coming home early.*

Mrs E was concerned about becoming dependent on family for assistance especially when her family had other responsibilities such as their own family and demanding jobs.

*It's awful when you see them* (sons and daughters) *getting more and more tired, you sort of try and do actually in some ways it was good because for their sake I did more than I might have done.*

Mrs A felt that it was better at home with family who worked because it was considered more of a burden on the family being in hospital.

*Lesley has come all the way up* (to the hospital) *there in her lunch hour to get my washing and so all those sort of things for me they were really good. That's one of the reasons I wanted to get home because it was putting a drain on them..... they've had a lot of stress in their lives and I always think I wouldn't like to add to that.*

Less stress was placed on the family when the informant was at

home. Mr C expressed concern for his wife when he was in hospital:

*I think it's taken the stress off her* (the wife)*because she was staying with the daughter and they like to visit every day and they're running catching buses and trains and buses. So I think it* (the early discharge)*took a lot of stress away from the wife and daughter.*

If the informant was fortunate enough to have a large supportive family, they did not feel so much of a burden. Mrs D for example had ten children that reduced any anxiety she may have had.

*Oh the family, yes they come ... they take me shopping and they bought me a lot of food I could just put in the microwave and heat up .... so I don't have to do any cooking you see so that's fine. I haven't washed me sheets and I'll wait for them or they're coming to visit me tomorrow.*

Not only did informants' feel guilty about being a burden on their families, but families also felt guilty about not being at home all the time to look after their relative. This was reflected in the concern Mrs D's family had for her well-being when they were at work, for when no family member was present restrictions were placed upon her in an effort to ensure her safety.

*Well she* (the daughter)*was a bit apprehensive, she told me I had to be careful, she said I couldn't go out the front other than the front verandah, not to go walking outside when there's no-one here in case I had a fall or anything.*

Some felt inhibited by the strain they placed on their families:

*I don't know how he* (the husband) *feels, he never feels any reluctance of*

*anything but I feel I don't like to ask for things all the time* (Mrs E)

The repetition of tasks seemed problematic because it was felt that family members didn't mind helping once or twice but when the informant had to keep asking for things to be done they invariably felt a nuisance. This was especially noticeable in Mrs E's case as her carer was male, traditionally unused to the caring role:

*He's* (her husband) *very good in many ways. He will do anything at all and do it willingly except that he hasn't got a lot of patience for repetition.*

Mrs A coped with the worry of being a burden by sacrificing her normal routine to attempt the task independently so as not to be a burden. She climbed in and out of bed each night with all her clothes on so that she didn't have to ask for help each time to get dressed and undressed.

These examples of feeling a burden on family have uncovered the fact that individual concerns were often ignored in planning for their discharge. There was no evidence in the interviews to suggest there was any assessment for the patients psycho-social well-being when first at home. This may have alerted health professionals to any concerns about feeling a burden on family members.

The literature suggests that carers are often elderly themselves, suffer chronic illness and are unpaid for the care they provide. The costs of caring are expensive both financially and socially, remaining largely unrecognised.

In one case forced dependence on a carer however created a positive relationship between husband and wife:

*I don't like to ask for things all the time, on the other hand it's quite a new thing to see how much time we're spending together* . (Mrs E)

One informant was fortunate enough to be in a position where he could plan ahead to relieve the burden on family members when he came home:

*In anticipating this we'd done nearly all the shopping before I went into hospital, we done the mowing and the gardening and the watering for the plants and what have you, but up until a month before we'd started to accumulate our groceries and fill our freezer and fridge* . (Mr C)

5.3 Relationship with Local Medical Officer

Three informants preferred to have their care co-ordinated by their specialists and members of the rehabilitation discharge team rather than their local Doctor. They had little faith in the their local General Practitioners as they weren't actively involved with in-patient care.

*When Rodney came yesterday he was worried about my leg clicking and he told me what to do to ring up and see the local Doctor or whatever. But it's no good seeing the local Doctor I don't think at this stage, it's useless because they don't know anything about what's going on half the time* . (Mrs A)

Hospital medical staff were perceived as appropriate people to turn to when Mr C was ill because previous experience with the local Doctor left him with the impression that the care they gave was ineffectual:

*I always say to the wife, I don't think you ever get the doctor of your choice say after 6'o clock..... all these doctors do if you're ever really sick they*

*come out ,they give you a tablet if they don't they send you up to the hospital so you might as well go to the hospital in the first place. I haven't got much faith in local Doctors*

**6.Use of formal services**

6.1 Limitations to community services

Most of the informants interviewed lived with carers and so did not need community services such as meals-on-wheels or homecare. Mrs E however required some assistance with cleaning her home whilst her husband was in hospital and happened to mention this to one of the nurses from the rehabilitation discharge team who was aware of the limitations to homecare and so was able to provide an alternative.The nurse recommended someone who had worked full time for homecare to Mrs E, someone she felt that she could trust.

*So I asked Jean about homecare, she said yes she would recommend me however it usually takes about a week to come and asses you and then you know, if they decide that you need homecare then you might need to contribute ..... she said they assess your income and they might decide that you're not eligible because your income's too high or they might decide that the help they've got available, other people need it more* . (Mrs E)

The rehabilitation discharge team furnished each participant with a list of available community services:

*They gave me this community information sheet and this is dealing with, for your private cleaning, private nursing agencies, Sydney nursing home services and all these telephone numbers should we require anything at all.* (Mr C)

As all of the informants did not need any further community assistance with hygiene, meal preparation or cleaning because they had family either living with them or close by it was difficult to determine availability of community services.

## CONCLUSION

The qualitative nature of this study provides insight into participants' experiences and perceptions when participating in a programme of early discharge. Although much of the reviewed literature portrays mixed experiences of early discharge, the data collected in this study demonstrates an overiding satisfaction returning home earlier, despite both physical and emotional challenges.

### Effect of early discharge on health services

As indicated in the literature, hospitals are attempting to contain costs and one way of doing this is to discharge patients early with support from early discharge programmes. It is suggested there would be significant impact on already stretched community services with patients being discharged early, but very few services were used by the informants in the study, mainly as a result of good family support. This may not be the case however, for those without family support.

### Patient involvement in discharge process

Studies recommend that patients be involved in their discharge planning, but the interviewed informants indicated that hospital staff seemed to control the discharge process. The patients were told when they were to go home and then arrangements were made to accommodate this. Generally however, participants were content with the preparation for discharge. All needs were anticipated by the occupational therapist in the home visit where aids were supplied to make life easier during the recovery period. It was felt that participants received better care at home than they ever did in hospital, the care was more personalised, being on an individual basis.

**Early anxiety**

For some there was initial stress and anxiety with the prospect of being discharged early. Informants felt vulnerable leaving the structured environment of the hospital and were afraid of falling again while others felt frustrated because they had greater expectations for their functional ability. These concerns were relieved by the support given by the rehabilitation discharge team who were able to anticipate the needs of each participant by providing on going assistance and education.

**Effect of being discharged early**

The majority of informants interviewed lived with a spouse as it proved too difficult within the time frame of the study to find informants living alone. This is perhaps a reflection of an unspecified requirement to have a carer to be eligible to participate in early discharge. Currently one does not have to have a carer to participate. One can only speculate how varied results of a similar study may be for informants without family support. Returning home with a disability and no family support whatsoever could make life extremely difficult.

**Problems associated with early discharge**

Within our changing society the central family unit where family members could be assured of and rely on support from others within the family when they were ill, is no longer a surety. As mentioned in the literature review, women are predominantly the carers at times being responsible for both children and parents at the same time.

When elderly patients return home after a period of hospitalisation they are very much aware of the effect their disability and dependence has on the family. Four out of six informants expressed concern as to whether or not families would be able to cope with their early discharge but there was little

evidence in their accounts that portrayed any difficulty coping. Two informants felt that with respect to feeling a burden on their family, it was better to be at home as more stress was placed on families visiting the hospital each day.

**Benefits of early discharge**

Patients' independence appeared inhibited in hospital where pressure on staff and resources results in task orientated care and little time to promote independence. Informants felt they made a faster recovery at home where they were motivated to become more independent as good health was now their responsibility. All informants preferred to be at home where they could be in control and were not unnecessarily worried about pressing matters at home.

**Satisfaction with services received from early discharge team**

All informants spoke highly of the services received from the rehabilitation discharge team in that they felt safe in their care, all needs were met and they felt confident that if there were any problems they would be attended to.

Few had faith in their general practitioners and would rather seek the opinion of members of the rehabilitation discharge team or Doctors within the hospital for any problems they may have had. It was felt the local Doctor would not have been of assistance in on going care because he was not aware of events during hospital admission

## LIMITATIONS

This study is limited by the size of the study population. Participants were from a narrow section of the population, generally well supported by family and also of high socio-economic status as they all lived in an affluent area of Sydney. The results therefore cannot be generalised to the larger population but do provide a basis for further study

## RECOMMENDATIONS

Future programmes of early discharge should be supported provided the patient has adequate support at home as this study demonstrates that the patients prefer returning home to their familiar environment where they can be assured of quality care for a time that is appropriate for their recovery. With constant economic rationalisation within the health industry, there need to be positive outcomes for people for whom the health service operates.

Further research with carers and other groups of patients would provide valuable information as to the effectiveness of early discharge.

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# APPENDICES

**APPENDIX A**

# RESEARCH STUDY INTO THE EFFECTS OF EARLY DISCHARGE PROGRAMMES TARGETED AT ELDERLY ORTHOPAEDIC PATIENTS

## INTERVIEW GUIDE

EXPERIENCES OF EARLY DISCHARGE

PARTICIPANT'S EXPECTATIONS OF THE PROGRAMME

EXPERIENCES FOLLOWING DISCHARGE

- DIFFICULTIES/PROBLEMS ENCOUNTERED

USE OF FORMAL SERVICES

REPORTED CAPACITY FOR ACTIVITIES OF DAILY LIVING

MAIN AREAS OF SATISFACTION/DISSATISFACTION

## APPENDIX B

# RESEARCH STUDY TO EXAMINE PERCEPTIONS AND EXPERIENCES OF SERVICES, PROVIDED BY THE REHABILITATION DISCHARGE TEAM, AMONG ELDERLY PATENTS

## INFORMATION FOR PATIENTS

You are invited to take part in a research study to examine perceptions and experiences of services received from the rehabilitation discharge team among elderly patients. The objective is to discover participants experiences and perceptions of their discharge from Hornsby Ku-ring-gai Hospital. The study is being conducted by Dr. Cherry Russell, Senior Lecturer in the School of Community Health and Xanthe Taylor-Riley, Co-Investigator.

If you agree to participate in this study the researcher will conduct interviews that will last approximately one hour and will be tape recorded with your permission. The interview will take place in your own home approximately two weeks after your discharge from hospital at a time that is convenient for you. When you have completed the programme the researcher will contact you by telephone to see if you have any difficulties after the programme has finished. The phone call will last approximately fifteen minutes.

All aspects of the study will be strictly confidential and only the investigators named above will have access to information on participants. A report of the study may be submitted for publication, but individual participants will not be identifiable in such a report.

While we intend that this research study furthers health professionals' knowledge and may improve the discharge of patients in the future. It may not be of direct benefit to you.

Participation in this study is entirely voluntary: you are in no way obliged to participate and - if you do participate - you can withdraw at any time. What ever your decision, please be assured that it will not affect your medical treatment or your relationship with medical staff. Of the people treating you, only those named above and the co-ordinator of the programme will be aware of your participation or non-participation. The researcher does not envisage any risks associated with participating in the study but if you feel at all distressed or fatigued by the interview the researcher will terminate the interview. If you wish to terminate the interview you only need to inform the researcher at the time.

When you have read this information, Xanthe Taylor-Riley will discuss it with you further and answer any questions you may have. If you would like to know more at any stage, please feel free to contact Dr. Cherry Russell on 646 6129 or Xanthe Taylor-Riley

on 9904 0115. This information sheet is for you to keep.

This study has been approved by the Ethics Committee of the Hornsby Ku-ring-gai Hospital and Community Health Services and Ryde Hospital & Community Health Services. Any person with concerns or complaints about the conduct of a research study can contact the Secretary of the Ethics Review Committee on 477 9436.

**APPENDIX C**

HORNSBY KU-RING-GAI HOSPITAL & COMMUNITY HEALTH SERVICES
and
RYDE HOSPITAL & COMMUNITY HEALTH SERVICES

CONSENT FORM TO PARTICIPATE IN A RESEARCH PROJECT

I,.....of.....
.....Postcode.....

have been invited to participate in a research project entitled:
A research study to examine perceptions and experiences of services received from the Rehabilitation Discharge Team among elderly orthopaedic patients.

In relation to this project I have been informed of the following points:

1) Approval has been given by the Ethics Committee of the Hornsby Ku-ring-gai Hospital and Community Health Services and Ryde Hospital & Community Health Services.

2) The aim of the study is to discover the experiences and perceptions of patients who have received services from the rehabilitation discharge team at Hornsby Ku-ring-gai hospital.

3) The results of the study will enhance health professionals' knowledge and could improve the discharge of patients in the future, but may not be of direct benefit to me.

4) Participation in the study will involve firstly agreeing to participate whilst on the ward. I will then meet the researcher in my own home where she will obtain my written consent and arrange for a mutually acceptable time to return and conduct the interview. The interview may be taped with my consent and will last up to one hour. Two weeks later the researcher will ring me to see if there are any difficulties that I might still have. The telephone conversation will last approximately fifteen minutes.

5) It is unlikely that there are any adverse effects or risks involved in participating in the study.

SIGNATURE.....WITNESS.....
(of patient / volunteer) (Please print name)
DATE.....SIGNATURE.....
(Witness)

6) My involvement in this project may be terminated if any of the following circumstances develop:
a) I become distressed during the interview
b) I become fatigued during the interview

7) If I at any time begin to feel any pain from my hospital treatment or tiredness that would interfere with the interview, I can inform the researcher and the interview will be stopped.

8) I can contact the researcher Xanthe Taylor-Riley on 9904 0115 at any time in case of some unforeseen circumstance arising that causes me distress while involved in the study.

10) The results of any tests or information regarding my medical history will not be published so as to reveal my identity.

11) The data that is collected from this study will not be published so as to reveal my identity.

12) I can choose to terminate the interview or withdraw from the study at any time and this will not affect any medical treatment or future health care.

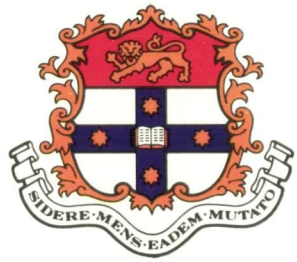
After considering all these points I accept the invitation to participate in this project.

I also state that I have / have not participated in any other research project in the past three months.

If I have, the details are as follows.....
.....

SIGNATURE.....WITNESS.....
(of patient/ volunteer) (Please print name)
DATE.....SIGNATURE.....
(Witness)

The University of Sydney




# Graduation Ceremony

The Great Hall
Thursday 1 May 1997 at 11.30 am
The Chancellor, Emeritus Professor Dame Leonie Kramer, AC DBE, presiding

The Great Hall, including two statues representing the young people of the University. The statues high in their niches, were commissioned by Lloyd Rees and sculpted by Tom Bass. They were unveiled in November 1984.

## Order of proceedings

Organ recital

by

the Acting University Organist, Amy Johansen

The academic procession enters the Great Hall

the assembly standing

Processional : Processional in D - David Johnson

The proceedings are opened by

the Chancellor, Emeritus Professor Dame Leonie Kramer, AC DBE

Graduation Ceremony

The Chancellor welcomes the graduates and visitors

The occasional address is delivered by

Mr Chris Puplick
President, Anti-Discrimination Board of New South Wales

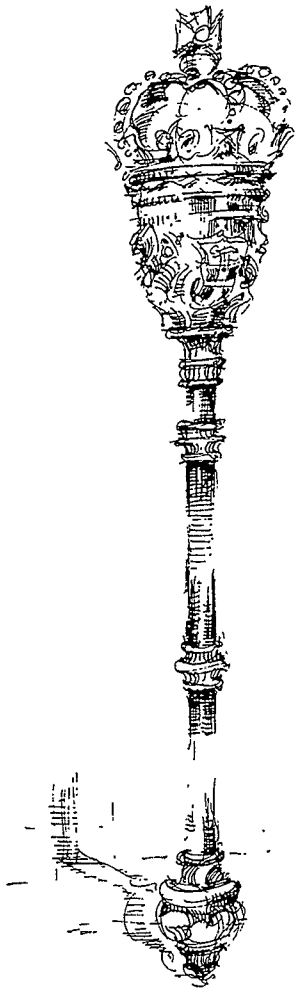
The academic procession retires, the assembly standing

Recessional : Prelude in D Major (BWV 532) - J S Bach

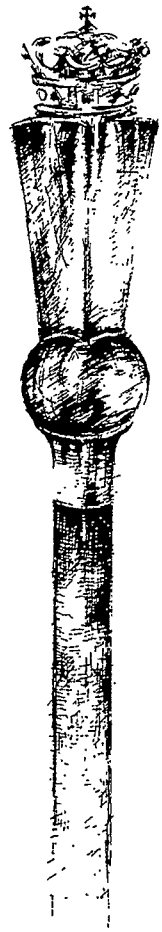
Carillon recital

by

Honorary Carillonist, Dr Reginald Walker



*The Mace, symbol of the authority of the Senate, is wrought silver with a shaft of polished hardwood. Emblazoned in gold on the head are the Royal Coat of Arms, the Arms of the Colony of New South Wales, and those of the University, with decorative motifs employing the rose, the thistle and shamrock filling the intervening spaces.*
*The surmounting feature is a Royal Crown, below which is the motto* DOCTRINA PARET VIRTUTEM.
*The Mace was acquired in the name and on behalf of Queen Victoria through the Governor of New South Wales, Sir Charles Fitz Roy, in 1854.*
*On official occasions it is carried in procession before the Chancellor by the Esquire Bedell.*



*The Lady Hailsham Staff, presented to the University in February 1982 by the Sir Robert Menzies Oration Committee, is a memorial to Lady Hailsham, who died tragically in a horse riding accident in Sydney two days before her husband, Lord Hailsham of St Marylebone, delivered the Inaugural Oration in the Great Hall of the University in May 1978.*
*The staff was designed by Mr D Connolly MP and crafted by V. Hemmingsen of Adelaide and P. Noakes of Sydney. It is surmounted by a Viscountess' coronet (a mark of Lady Hailsham's rank) on top of a thistle of silver and a ball of Connemara marble. All metals used are of gold and silver. The coronet is studded with sapphires from Sri Lanka, where Lady Hailsham spent part of her childhood.*
*The Connemara marble was donated by Lord Mayo and is from the county in Ireland whence Lady Hailsham's family originated. The thistle symbolises the association with Sir Robert Menzies. The staff is made of Tasmanian blackwood with tip and joins in silver.*
*It is carried in procession by the Yeoman Bedell.*

## Degrees and Diplomas

*Candidates will be admitted to degrees and awarded diplomas by the Chancellor, Emeritus Professor Dame Leonie Kramer, AC DBE*

## Faculty of Health Sciences

*presented by the Acting Dean of the Faculty of Health Sciences, Associate Professor Elaine Cornell*

DEGREE OF MASTER OF COMMUNITY HEALTH

Catherine Anne Butler

Rogayah Irene Shahariman

Xanthe Claire Taylor-Riley

DEGREE OF MASTER OF GERONTOLOGY

Paul Stanmore

Pui Lin Tang

DEGREE OF MASTER OF HEALTH SCIENCE (GERONTOLOGY)

Margaret Ann Randall

Jean Frances Reid

DEGREE OF MASTER OF HEALTH SCIENCE EDUCATION

Wendy Anne Batchelor

Mei Kuen Chow

Francisco Cou

Elizabeth Anne Devonshire

Vickie Michelle Knight

Lara Leibbrandt

Melinda Jane Lewis

Susan Gai Pickering

Susan Deborah Taylor

Olivia Beatrice Unite

Beverley Loraine Walker

DEGREE OF MASTER OF REHABILITATION COUNSELLING

Josephine Helen Dowsett

Dianne Catherine Lane

Catriona Elizabeth Lorang

**Degree of Master of Rehabilitation Counselling (continued)**

Tomislav Muzevic

Sandra Elizabeth Schieb

DEGREE OF MASTER OF APPLIED SCIENCE (PHYSIOTHERAPY)

Bredge McCaren

DEGREE OF MASTER OF APPLIED SCIENCE (CARDIOPULMONARY PHYSIOTHERAPY)

Lyndal Jane Maxwell

Megan Caroline Louise Smith

DEGREE OF MASTER OF APPLIED SCIENCE (MANIPULATIVE PHYSIOTHERAPY)

Jennifer Brackenreg

Beverley Jill Giovanelli-Blacker

Paula Elvira Kairaitis

Pan Fun Daphne Lo

Ross Leonard Solomon

Benedict Martin Wand

Maryanne Elizabeth Ward

Michael Parry Ward

DEGREE OF MASTER OF APPLIED SCIENCE (NEUROLOGICAL PHYSIOTHERAPY)

Frances Mary Moran

Angela Margaret Stark

DEGREE OF MASTER OF APPLIED SCIENCE (PHYSIOTHERAPY)

Johnson Siu Chuen Choi

Kerry Dawn West

DEGREE OF MASTER OF APPLIED SCIENCE (SPORTS PHYSIOTHERAPY)

Ann Christine McLennan-Simon

GRADUATE DIPLOMA IN COMMUNITY HEALTH

Bobbi Anne Burgmann

John Michael Redondo

GRADUATE DIPLOMA IN GERONTOLOGY

Natalie Baker

Yu Yuk Kitty Lam

Sandra Jane Scott

GRADUATE DIPLOMA IN HEALTH SCIENCE EDUCATION

Jennifer Anne Baroutis

Claire Dobson

Monica Mary O'Malley

Jeanie Thomas

GRADUATE DIPLOMA IN REHABILITATION COUNSELLING

Emily Anton

Vecko Apostolovski

Sarah Baldock

Jeanette Boukheris

Matthew Robert Buxton

Linda May Byrnes

Clara Beatriz Catockinsky

Alvin Beng Liang Cheam

Vivian Wai Chung Lam

Nandy MacKinnon

Amanda Makepeace

Lynette O'Malley

James Pescud

Maria Carmen Tejedor Rovira

Ai-Qun Wei

Linda Kay Winterbottom

Mira Youssef

DEGREE OF BACHELOR OF APPLIED SCIENCE (PHYSIOTHERAPY)

**Pass**

William Anthony La Palombara

Joseph Michael Lawler

Kevin John Mason Laws

Ana Paula Lay

Huy Vu Le

Irene Boon Tse Lim

Elizabeth Anne Limberg

Antony Howe Sen Lo

**Pass (continued)**

Ronald Hayman Lo
Carolyn Stephanie Lockman
Megan Loraway
Kristina Natalie Love
Nicola Alison Lovejoy
Kit Man Luk
Hieu Minh Trung Ly
David Munro MacKenzie
Helen Mandoukos
Anne Margaret McClean
Ruth Jane Mueller
Lucy Anne Mulholland
Richard David Nankervis
Taleb Nasr
Michael Kalevi Neuvonen
Michael Vincent Northwood
Andrew Noyes
Mark Raymond Oberman
Vu Hoang Ong
Tobias Bruce Pettigrew
Christine Gay Potter
Adam Lawrence Prater
Armaghan Raghemi-Azar
Simon Andrew Reid
Konstantin Riadis
Merren Anne Richardson
Rachel Roberts
Mark Andrew Ross
Timothy John Schneider
Amy Noel Scott
Elizabeth Carmel Shields
Belinda Juliet Smith
Marcus Bradley Smith
Rachel Anne Smith
Sandra Denise Smith
Ryan Stanley Michael Stanton
Steve Symonds
Kelly Thurlow
Erica Dung Tho Tieu
Serena Ching Yee Tong
Adam Douglas Tysoe
Despina Vamvalellis
Jennifer Ruth von Tiedemann
Tanya Maree Walsh
Michael James Ward
Danielle Maree Wilton
Stuart Alexander Wood
Melinda Woodward
Rebecca Ann Wright
Suk Fun Josephine Yau
Ozgur Yildirim
Jennifer Young

DEGREE OF BACHELOR OF HEALTH SCIENCE (PHYSIOTHERAPY)

Huey Fei Lee
Su Eng Liaw

**THE UNIVERSITY OF SYDNEY**
**FACULTY OF HEALTH SCIENCES**

**APRIL 1997**
**PRIZE WINNERS**

*FACULTY OF HEALTH SCIENCES*

## "1996 Faculty of Health Sciences Award for Excellence in Teaching"

[*awarded to an individual member of academic staff, or a team, for innovation, development or activity in teaching leading to a significant enhancement of student learning; for a project entitled "Generic Skills and Enhanced Learning in Computer Education"*]

**MR IAN CATHERS**
(Department of Biomedical Sciences)

*SCHOOL OF PHYSIOTHERAPY*

## "The Alcusal Prize for Research"

*[awarded for the best undergraduate research project submitted within the School of Physiotherapy by a student completing an individual honour program research project]*

**CLAIRE KATHLEEN MONGER**

## "The Australian Physiotherapy Association Prize"

*[awarded to the most proficient graduand of the Bachelor of Applied Science (Physiotherapy) course]*

**CLAIRE KATHLEEN MONGER**

## "The Australian Physiotherapy Association Prize"

*[awarded for the highest standard of clinical practice in the Bachelor of Applied Science (Physiotherapy) course]*

**MICHELLE DENISE BRIEN**

## "The Cardiothoracic Prize"

*[awarded to the student exhibiting the highest proficiency in Cardiopulmonary Physiotherapy in the Bachelor of Applied Science (Physiotherapy) course]*

**KEVIN BLAY HEWSON**

**"The J. Val Simpson Memorial Prize for Manual Therapy"**
*[awarded for exhibiting the highest proficiency in manual therapy in the Bachelor of Applied Science (Physiotherapy) course]*

**CRAIG ALEXANDER**

**"The Rosemary E. Wilson Memorial Prize for Caring and Giving"**
*[awarded for having best shown an awareness of patient's total needs and real empathy with patient's physical, psychological and emotional needs in the Bachelor of Applied Science (Physiotherapy) course]*

**CATHY MARIE SESTAN**

**"The Physiotherapy Research Foundation Research Prize"**
*[awarded for the best research honours thesis in the Bachelor of Applied Science (Physiotherapy) course*

**SEAN MICHAEL ROBISON**

# The Great Hall

The Great Hall was designed by Edmund Thomas Blacket (1817-1883). In 1849 Blacket was appointed Colonial Architect of New South Wales, but in 1854 he resigned and returned to private practice to design and supervise new buildings for the University of Sydney. Although he designed many buildings during his career (including St Paul's College and St Andrew's Cathedral), the Great Hall, in the style of the Victorian Gothic revival, represents one of his most spectacular achievements. It was first used for the conferring of degrees on 18 July 1859.

The Hall measures 41 metres (135 feet) in length and 14 metres (45 feet) in breadth. The side walls are nearly 14 metres (45 feet) in height and the apex of the open timbered roof is 22 metres (70 feet) from the floor. The walls are local standstone, except that on the Oriel window in the south side there are armorial bearings carved in Caen stone. The same stone has been used for the Tudor fireplace and carved doorway into the Ante Room. The floor of the hall is of Australian marble. The frame of the roof is made of Australian hardwood faced with cedar, while all of the great beams and carvings are of cedar from the northern rivers area of New South Wales.

The Hall is clearly modelled, although on a smaller scale, on Westminster Hall, the oldest and largest part of the Palace of Westminster in London. This is one of the most important English medieval buildings still extant, having been reconstructed by Richard II between 1394 and 1399 from the building first constructed by William II in the eleventh century. Points of similarity are the ground plan and the hammerbeam roof decorated with the carved wooden figures of angels. Those to the left and right above the dais bear scrolls inscribed *Scientia inflat, Charitas aedificat* (1 Cor. 8.1) and *Timor Domini, Principium Sapientiae* (Prov. 9.10). The other ten figures carry books inscribed with symbols referring to the arts and sciences over which they preside. Grammar has a papyrus roll, dialectic has Aristotle's diagram of the three syllogistic figures, poetry has a harp, ethics has St Mary's lily, metaphysics has a symbol of the deity, arithmetic has an abacus, geometry has the forty-seventh proposition of the first book of Euclid, astronomy has a star, music has a lyre, and physics has an ancient air pump. James Johnstone Barnet (1827-1904), Clerk of Works to the University in 1859, and later Colonial Architect of New South Wales, is credited with the design and painting of the roof decorations.

The stained glass windows consist of the Royal window in the northern wall (containing a fine portrait of the young Queen Victoria), and the Oxford and Cambridge windows of the west and east respectively, portraying the founders of the colleges of those universities. The side windows contain portraits of people famous in English literature, history and science.

Below the Oxford window is the eighteenth century Gobelin tapestry representing Joseph and his brethren. The tapestry was a gift to the University by Sir Charles Nicholson, Bt (1808-1903), a former Chancellor.

A pipe organ, built by Forster and Andrews of Hull, was installed in the Great Hall during 1881-1882. It was replaced in 1971-72 by the present organ which was designed by Rudolf von Beckerath of Hamburg and constructed and installed jointly by von Beckerath and Mr R.W. Sharp of Sydney.