
OLDER PATIENT PARTICIPATION IN MULTI-DISCIPLINARY
DECISION-MAKING: DISCHARGE PLANNING IN SCOTLAND
AND BRITISH COLUMBIA, CANADA.

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ABSTRACT

An increasing proportion of older people today are returning to their own homes following discharge from hospital. The aim of community care policies in both Britain and Canada has been to provide these older people with the services necessary to continue living independently in the community. The maintenance of this independence relies upon effective discharge planning. Discharge planning is a multi-disciplinary decision-making process involving negotiation between a variety of hospital-based health and social care practitioners, the patient and his or her carers, and community service agencies. The older patient's involvement in this process serves as the focus of this research.

The aim of this comparative study is to determine what role older patients play in discharge planning, to what extent they are permitted to be involved and to what extent they wish to be involved. The research setting for this qualitative study was two geriatric assessment and rehabilitation units, one in Scotland, the other in British Columbia, Canada. Older patients and health and social care practitioners were interviewed in each unit. Following release from hospital, these older patients were also interviewed in their own homes. Findings from these interviews, combined with observation and documentary analysis, demonstrate how each ward attempted to facilitate patient input in planning and what patients' and professionals' views of participation were. Findings also reveal a relationship between patient participation and discharge outcomes in each country, and suggest ways in which greater patient involvement can be introduced into the discharge planning process in order to attain continuity of care between the hospital and the home.

In accordance with Regulations 3.4.7 of the University of Edinburgh, I declare that this thesis was composed by myself, and that I performed the research described herein.

Linda Bauld

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CHAPTER 1

INTRODUCTION

The organisation of health and social services in advanced welfare states is in a period of transition. Socio-demographic change, globalisation, economic recession, technological advancement and new social movements have all contributed to changes in the planning, organisation and provision of services in many countries. Although the combined impact and pace of these changes has differed between countries, common social policy responses can be identified (Walker, 1993). Comparative research in social policy seeks to address the reasons for converging patterns of policy and their effects on service users in different countries. This study compares two similar health care systems, in Scotland and British Columbia, and examines the implications of changing health policy for older people leaving hospital. The shift from hospital to home involves a decision-making process—discharge planning—which serves as the focus of this study. The process of discharge planning highlights many of the main changes occurring in the organisation of health and social care in both the U.K and Canada. Resource constraint, conflicts between hospital and community based agencies, and issues regarding the rights of the users of services all influence the discharge planning process and discharge outcomes. Two recent policy changes in both Scotland and British Columbia have affected the way discharge planning is conducted, and could change the role of the older patient in the process. These policy shifts, the reasons for their adoption, and their implications for discharge planning, constitute the background to this study.

COMMON CONDITIONS

Two similar shifts in health policy have occurred in both Canada and the United Kingdom in the 1990s. The first is the change in emphasis from acute to community-based care in both countries. Although this change began well before the 1990s, it is in this decade that legislation and funding arrangements to implement community care have been made. The second policy shift has occurred in conjunction with the first, and in many ways is essential to the development and maintenance of community based care. This involves a new emphasis on patient participation, or patient involvement, in decisions regarding health.

Which common explanatory factors can be identified to explain these policy developments? Demographic shifts, fiscal austerity and common patterns of social change are the main causal factors.

DEMOGRAPHIC CHANGE

There has been a progressive ageing of the population in Canada and the U.K over the last century. Medical advances and a rising standard of living have caused death rates to fall and life expectancy to rise. This increase is forecast to continue into the next century. In Scotland the number of people aged sixty-five and over is expected to rise from 13.7% to 14.6% of the population by the year 2011 (Scottish Office, 1997). Over the same period, the current figure of 13% in British Columbia is expected to rise to 14.4% (Gutman et al, 1995). The most significant increase however has been in the number of people aged 85 and over. The number of 'oldest old' (Krach et al, 1996) in Scotland grew by 55% between 1980 and 1993. Although this number will continue to rise, the growth will be at a slower rate; a further growth of 11% between 1991 and 2011 (Scottish Office, 1997). The proportion of people aged 85 and older in British Columbia has also grown, and will continue to grow into the next century. Between 1991 and 2011, the number of people aged 85 and over is due to rise by 53% (see Appendix 1).

This rise in the number of older people has combined with falling birth rates in western industrialised countries to produce a rise in the 'dependency ratio', the ratio of people aged sixty-five and over to those of working age (Grant, 1991). Largely because of this rise, ageing has been constructed as a 'problem', particularly by those on the ideological right (Walker, 1991, Phillipson, 1996). The argument is that if there are more people of retirement age and proportionally fewer young people

contributing to the economy, then the increase in the number of older people is a 'burden' that modern society, with all its economic problems, can ill afford. Although there is now a substantial body of evidence disputing the 'burden of old age' thesis (Bornat et al, 1985, Denton et al, 1986, McDaniel, 1986, Hills, 1993, Warnes, 1996), it has nonetheless contributed to social policy reform in both Britain and Canada over the past decade. Evidence of this can be found in reform of the pension system, such as Britain's 1995 *Pensions Act* which will raise the female retirement age from sixty to sixty-five, or in reforms to Canada's Old Age Security benefits, which since 1989 have ceased to be universal and are now clawed back from income over a certain threshold (Shellenberg, 1996). But the impact of the 'burden of ageing' argument is perhaps most evident in policy relating to health and personal social services.

Older people are more likely to occupy a hospital bed, more likely to remain in hospital for a longer period and more likely to use primary care services in both Britain and Canada. In Britain, it is estimated that 40% of the National Health Service budget goes to care for those aged sixty five and older, who make up only 14% of the population (Scotsman, 1997). Amongst older people, it is those aged 85 and older who are the heaviest users of health and social care services. For instance, one study in British Columbia estimated that those aged 85 and older were four times as likely to be occupying a hospital bed and likely to have an average length of stay eight times higher than those aged 15 – 64 (Gutman et al, 1995).

FISCAL AUSTERITY

The high cost of an acute care bed is the problem. Any alternative type of care is cheaper in terms of public expenditure. Since the 1970's, Britain and Canada have been seeking ways to contain health care costs, while retaining the comprehensive, universal aspects of their services. In the past, one method of containing acute care costs incurred by older patients was to move them to long stay wards within hospitals. However, even these hospital-based options were costly to maintain. In 1986, the Audit Commission estimated that £295 per week was the cost of an NHS geriatric hospital bed. Daily domiciliary care in the community could be provided for £138 per week (Audit Commission, 1986). Long stay beds have also increasingly been rejected as a form of institutionalisation which restricts individual autonomy and may hinder rehabilitation. Community-based care, on the other hand, is promoted as a type of care which preserves independence and allows the older

person to live where they prefer, which, for the vast majority of older people, is in their own home. The result has been that in both British Columbia and Scotland, long stay wards and extended care hospitals have been closed, and community care promoted as the cheaper, more 'humane' alternative. Whether community care is cheaper in practice is dubious. Several recent British studies have highlighted the complexities of costing community care (Greene, 1993, Lewis, 1995, SWSI, 1996b, Vickridge, 1995) while others have pointed out the 'hidden' costs of unpaid labour by informal carers in the home (Qureshi, 1996, Twigg and Atkin, 1994). There is little doubt however, that the potential savings involved in shifting the care of older people from hospitals to the home were a powerful motivating factor in the introduction of community care policies in both British Columbia and Scotland.

SOCIAL CHANGE

The same ideological shift responsible for the rejection of institutional types of care has also affected expectations about the appropriate role of the patient within the health care system. As analysis of the concept of patient participation in this thesis will demonstrate, health policy in both Britain and Canada has been affected by the patient and consumer rights movements. These movements have their roots in the civil liberties debates of the 1960s and 70s and have resulted in the formation of interest groups within the voluntary and informal sector who have lobbied government for the rights of the individual within state provided services. Alan Walker describes this phenomenon within the social services (Walker, 1993, pg.135):

....more and more users of the social services have been complaining about their bureaucratic organisation, complexity, and lack of responsiveness to felt needs. Some groups of users - such as people with disabilities - have formed self advocacy movements to press their case for greater influence over their own lives and the services they use.

In health care, the patients' rights movement has been built around the philosophy that patients have a right to control their bodies and minds, but lack the authority to exercise these rights (Mizrahi, 1992). These groups have demanded change in health services which addresses the imbalance of power between medical practitioners and patients. In both Britain and Canada, these demands have influenced the policy process, and resulted in government directed initiatives designed to provide patients with some guarantee or assurance that their rights will be protected within the current system. However, this emphasis on patients' rights has also been connected with the prevention of access to or limiting of medical treatment,

consistent with policies of fiscal restraint. 'Choice' has been introduced as a key element in 'protecting' the rights of patients to receive the kind of services they prefer. Assumptions have been made however, that this choice usually consists of non-acute, therapeutic or community-based services. All of these services are promoted as lower-cost options, but may be neither universally available nor of uniform standard. Policies designed to offer greater autonomy or decision-making power to patients and users of health and social care services do not necessarily guarantee access to better quality services or a higher standard of care.

THE POLICY RESPONSE

In both British Columbia and Scotland, recent reforms have addressed both community care and patients' rights. Both programmes have the same basic aim, to shift the balance of care for older people from the hospital to the community, while advocating a more active role in decisions regarding their health.

COMMUNITY CARE

In British Columbia, the policy shift from acute to community care services has been given the informal name, 'closer to home'. This recent round of reforms was the product of a province-wide consultation process which began in 1990. During that year, the provincial government asked Mr. Justice Peter Seaton to chair a Royal Commission on health care. The mandate of the Commission was to evaluate the current state of the system in British Columbia, and report on directions for the future (Weller, 1995). The resulting document, *Closer to Home: Report of the British Columbia Royal Commission on Health Care and Costs*, was published at the end of 1991 and was to serve as the basis for a series of reforms, and a major restructuring, of the delivery of health services in the province. With regard to the care of older people, the Royal Commission accepted the recommendations of an earlier document: *Towards a Better Age*, a report written by the government-formed B.C. Task Force on Issues of Concern to Seniors. As one of its guiding principles, the Task Force stated that (Province of British Columbia, 1990, pg.9):

To the greatest degree possible, provincial government actions should....favour community based services for seniors. Local initiatives to develop and administer programs or to implement measures that meet

the particular needs of seniors living in these communities should be encouraged and supported.

The central aim of the *Closer to Home* commission report supported this statement. The first of four key guidelines for health reform was that (Province of British Columbia, 1991, pg.3):

Care provided in the home, or on an out-patient basis, is preferable to institutional care....Medically necessary services must be provided in, or as near to, the patient's place of residence as is consistent with quality and cost effective health care.

In Scotland, a similar shift from hospital to community care culminated in the *National Health and Community Care Act* of 1990. The Act was based on the White paper *Caring for People*. Both had been pre-dated by a 1986 Audit Commission report which highlighted the government's failure since the 1960s to adequately expand the provision of community health and social services while reducing the use of institutional care for older people and people with disabilities. Due in part to this lack of progress, the government appointed Sir Roy Griffiths to review the existing community care arrangements. In 1988 his report *Community Care: An Agenda for Action* was released. The majority—although by no means all—of his recommendations were incorporated in the 1990 legislation. He argued (Griffiths, 1988, pg. 5) that the central aim of community care was:

...to enable an individual to remain in his own home wherever possible, rather than being cared for in a hospital or residential care home.

The *NHS and Community Care Act* was to define the aim of community care as (Scottish Office, 1992, pg.2)

The provision of services and support for people who are affected by problems of ageing, dementia, mental illness, mental handicap, physical or sensory disability, progressive illness, or problems arising from the misuse of drugs or alcohol, to enable them to live as independently as possible in their own homes, or in domestic settings in the community.

The *Closer to Home* reforms, which also involved a fundamental reorganisation of the structure of the Ministry of Health and local health councils, were implemented between 1992 and 1996. The *NHS and Community Care Act* received royal assent in June of 1990 and was fully implemented by April 1993. The significance of these dates is two-fold. Firstly, they indicate that both British Columbia and Britain chose to implement reforms with comparable objectives within a similar space of time. Secondly, the implementation of the reforms was underway in both research

settings at the time of fieldwork for this study. These reforms were having a significant impact on the organisation of health and social care services at the time the research was conducted, an impact that the researcher observed during the data collection period.

PATIENTS RIGHTS

Although neither British Columbia nor Britain have enacted legislation designed to offer the legal protection to individuals which is a component of 'The Patient's Bill of Rights' now in force in most of the American States (Mizrahi, 1992), reform relating to the rights of patients has been introduced in the 1990s. In British Columbia, the basis for this reform is the *Health Care Consent and Care Facility Admission Act*, 1993. This Act was designed primarily to address the needs of patients who were assessed as unable to give informed consent to health care. The Act sets out a framework to formally acknowledge the role of informal carers and others in making legally binding decisions regarding the health of an adult who is incapable of making the decision for him/herself. However, the starting point of the Act is a framework for decision-making which acknowledges the right of all mentally capable adults to be fully involved in any decisions regarding their own health. The Bill leading to the Act states (Province of British Columbia, 1993, s.4, d):

Every adult who is capable of giving or refusing consent to health care has *the right to*: be involved to the greatest degree possible in all case planning and decision-making. (italics in original)

In Britain, the *Patients' Charter* was introduced in 1992. This document sets out a series of guarantees for minimum standards, which institutions and agencies within the NHS should uphold. While modifications and additions can be made to the Charter to suit each individual organisation, the core components of the Charter apply across the country. Several of these components detail how patients should be involved in decisions regarding their own health. One section relates directly to discharge planning, and is thus particularly relevant to this study. The Charter states (quoted in Tierney et al, 1993, pg.184):

Before you are discharged from hospital a decision should be made about any continuing health or social care needs you may have. Your hospital will agree arrangements for meeting these needs with agencies such as community nursing services and local authority service departments before you are discharged. You, and with your agreement, your carers, will be consulted and informed at all stages.

Both the *Closer to Home* reforms and the *NHS and Community Care Act* also include statements relating to the rights of service users to be involved in decision-making, particularly with reference to the assessment of need for community care services. *Closer to Home* states (pg. 32):

Strategies for change [include] increasing the power of the patient and the informal caregiver to participate in decisions about the type of home support provided and who will provide it .

Similarly, *Caring for People* states (pg. 19):

Assessments should take account of the wishes of the individual and his or her carer...and where possible, should include their active participation. Efforts should be made to offer flexible services which enable individuals and carers to make choices.

With the exception of the basic rights outlined in the *B.C Health Care Consent Act*, none of the above policy statements are legally binding. They are policy aims and guidelines, whose content is open to interpretation by organisations and individuals. Emphasis on the rights of the patient may amount to no more than good intentions on the part of policy makers in both countries. These reforms may make little impact on the power dynamic between health care provider and patient in either research setting. It is thus with caution that such policy statements are used to introduce this research. What they do provide is another basis for comparison. Along with the community care reforms, they represent a similar policy shift undertaken at a similar time in both countries. Their incorporation does represent a change in values within health care, one that is also occurring in other parts of the world. The question remains: Will this shift change the experience of the patient in hospital?

DISCHARGE PLANNING

This study aims to examine how policy is reflected in practice within the health care system. One of the best methods of evaluating the impact of policy changes is by examining the experiences of the *users* of services. In this study, the users involved were older people in British Columbia and Scotland. These older people were leaving hospital after a stay of several weeks to return to their own homes. This transition from hospital to the community occurred through the *discharge planning* process. Reforms relating to community care and the promotion of patients' rights

are directly relevant to the discharge planning process. The shift from acute to community care, combined with other pressures on health care resources, has meant that hospitals are under increasing pressure to discharge patients, including older patients, quickly. Institutional options such as long-stay care are in shorter supply, and a growing proportion of these patients are being discharged directly to their own homes, where a high level of care is required to prevent readmission to hospital. Readmission defeats the aims of community care which are to allow people to remain in their own homes, and to reduce health care costs. Thus, effective discharge planning is essential to the successful implementation of community care.

Discharge planning is especially important for older patients, whose multiple and interacting health and social care needs can necessitate a complex package of services following release from hospital. Planning is thus a process of negotiation between the patient and his/her carers, hospital staff and community agencies. It is a *multi-disciplinary* decision-making process due to the variety of health and social care practitioners involved. This study was conducted in two geriatric assessment and rehabilitation wards. In each ward, a group of practitioners including medical staff, nurses, social workers and therapy staff cared for each patient. These professionals were responsible for discharge planning.

The extent to which these professionals and the organisational structure of the hospital allow the patient's view to be included in discharge planning is important. The patient has a unique perspective on his/her needs and circumstances that must be included in the planning process in order for appropriate services to be put in place. Consideration of these views, combined with allowing the patient to choose between available services also has implications for the older person's eventual adherence and compliance with the discharge plan, as this research will demonstrate. The role of the patient in the discharge planning process serves as the central focus of this study.

This thesis begins by addressing the concepts of discharge planning and patient participation, and the corresponding literature. Other concepts relevant to the study, such as theories of teamwork and the professions are also examined in Chapter 2. Chapter 3 explains the research methods used in this study, and examines some of the reasons for undertaking comparative research, as well as some of the methodological complexities of a comparative study. The framework for this comparison is outlined in Chapter 4. This chapter identifies the structural

differences in the organisation of health and social care between British Columbia and Scotland, both within the hospital and in the wider community. Chapter 5 introduces the twenty patients who agreed to participate in this study. These individuals were interviewed on two occasions while in hospital and once following their return home. Their views—which are also included in later chapters—are examined in Chapter 5 with reference to a series of themes identified in interviews in both study settings. These views relate to each older person's perspective on issues such as social support, decision-making and independence.

Discharge planning consists of a series of stages, which are described in Chapters 6 to 9 of this thesis. Four stages of discharge planning are commonly identified: assessment, planning, implementation and follow-up (Ratliff and Thomas, 1981, Mamon et al, 1992, King and Macmillan, 1994). **Assessment** is the first stage, and is described in Chapter 6. In a geriatric assessment and rehabilitation unit, assessment consists of an evaluation of the patient's health and social care needs, conducted by each member of the multi-disciplinary team. The second stage (outlined in Chapter 7) is **planning**, or the development of the discharge plan. This involves team decision-making regarding the types and availability of services suitable to fit each patient's needs. Chapter 8 describes the third stage of the process—**implementation**—which is the provision of planned services. Implementation includes arrangements made for leaving the hospital as well as the commencement of homecare services. The last stage in the discharge planning process is **follow-up**. This stage, described in Chapter 9, is an evaluation of the discharge plan which can either be carried out directly by hospital staff or through referrals to community-based practitioners. The views and opinions of the older patient can be incorporated in all stages of the planning process. As findings from this study will demonstrate, the extent to which they were included depended on a range of factors in each research setting. Chapter 10 presents a summary of these findings, and reflects on their implications for research and practice in both British Columbia and Scotland.

CHAPTER 2

THE LITERATURE

Patient participation was the key concept used in this study. This chapter will attempt to define its meaning and examine its relevance to hospital discharge planning. The theoretical literature on participation will be presented, along with findings from empirical studies that have examined patient participation in a variety of health care settings. Relevant findings from the discharge planning literature, particularly those studies dealing with older patients, will also be discussed. Finally, theories related to teamwork and multi-disciplinary decision-making will be touched upon, as the relationship between the hospital team, the patient and the wider health and social care community had important implications for patient participation in both wards studied.

THE CONCEPT OF PATIENT PARTICIPATION

There is no clear consensus regarding what constitutes patient participation. While it has been widely used and heralded as a positive development, it remains an elusive concept. The term has been used by writers in various senses without their meaning being made clear (Greenfield et al, 1985, Clayton, 1988, Cahill, 1996). As an ambiguous concept, it merits examination first through its component parts. Brownlea (1987) has offered a broad definition of participation:

Participation means getting involved or being allowed to become involved in a decision-making process or the delivery of a service or the evaluation of a service, or even simply to become one of a number of people consulted on an issue or matter.

The term patient literally means 'the one who suffers' (McEwen et al, 1983) although its modern definition is that of a user or recipient of health services. Patient

participation thus implies the involvement of an individual in health services. This involvement can take the form of decision-making about one's own health, decision-making as part of a group about the planning or provision of services, or simply taking part in activities or actions that form a component of health services. McEwen and his colleagues (1983, pg.1) choose the first interpretation. They define patient participation as:

...the process whereby a person can function on his or her own behalf in the maintenance and promotion of health, the prevention of disease, the detection, treatment and care of illness and the restoration of health, or where recovery is not possible, adaptation to continuing disability. This may occur both independently of, or within, the existing system of care.

In this study, the term 'patient participation' is taken to mean participation in *decision-making* regarding each patient's own health¹. While interpretations like the one above relating to selfcare, and others relating to involvement in hospital activities will be mentioned by the older people and professionals interviewed for this study, all other references to patient participation should be interpreted as referring to involvement in decision-making.

THE DEVELOPMENT OF PATIENT PARTICIPATION

The current popularity of patient participation as a concept is evidenced by the number of writers choosing to examine it in studies relating to the health and social services (Steele et al, 1987, Ashworth et al, 1992, Brearley, 1990, Cahill, 1996). These writers also chart its development from the traditional model of patient behaviour and relate the decline of this traditional model to wider societal changes. Knowledge of this process of development assists us in understanding the reasons for the current promotion of participation, and also permits us to understand why the concept has limited relevance in relation to some types of patients and some forms of decision-making.

¹ The term 'health' should be interpreted broadly throughout this thesis. There are two definitions, both cited in McEwen et. al (1983, pg.36), which are appropriate to the interpretation used. The standard World Health Organisation definition is: "A state of complete physical, mental and social well being". Parsons (1972) also offers the following definition: "the state of optimum capacity of an individual for the effective performance of valued tasks."

THE SICK ROLE

The traditional model of patient behaviour is that of the "sick role", a concept developed by Parsons in his 1952 text, *The Social System*. This role became a central concept in medical sociology and shaped modern interpretations of patient/health professional interaction. Parsons argued that illness was a state of existence that exempted individuals from responsibility for their own state of health and the performance of normal social tasks, particularly working and earning a living. In return for this exemption the sick person was expected to want to get well and thus comply with medical advice. This role implied that the individual was expected to accept that illness implied passivity and dependency, with no other recourse than to place his/her return to 'normal' functioning in the hands of a benevolent professional, most commonly the doctor. Freidson (1970) explains that Parsons's sick role involved not only a prescription for passive patient behaviour, but also a description of how the doctor should act. The physician was supposed to:

...avoid emotional involvement with the patient or his plight, to restrict his activities to those in which he is professionally competent, to treat every patient the same way irrespective of sex, race, socio-economic status and so on.

Hence application of the sick role to the medical encounter required not only a patient who was willing to defer to clinical authority in order to get well, but also necessitated a practitioner who fitted the image of the competent but emotionally distant professional.

Naturally controversy concerning the applicability of this paradigm began almost immediately after Parsons's publication. Most notable among its early critics were Friedson (1961, 1970) and Kassenbaum and Baumann (1965). However, the sick role did reflect the status of medical authority in society in the immediate post-war period. It was realistic that all patients be regarded as recipients vs. participants in medical care due to the fact that, as Steele et al (1987) have argued: 'in the first half of this century...doctors enjoyed unparalleled dominance: medical authority was seldom questioned and patient acquiescence assumed.' This dominance had been caused by advances in medical science beginning with discoveries like anaesthesia and X-rays to the ascendancy of surgery and rapid expansion of the acute care sector. Power relations between doctors and patients were characterised by a growing "information gap" (Brody, 1980) of scientific knowledge and an expanding social division as medical education and medical earnings grew in comparison to other occupations. Yet, today, the sick role is being replaced throughout the medical

and social science literature by alternative models of doctor/patient interaction. What factors contributed to its decline?

Writers such as Haug and Lavin (1981), McEwen et al (1983) Steele et al (1987) and Cahill (1996) all provide similar explanations for the decline of Parsons's model of patient behaviour. One explanatory factor was the growth in access to education which occurred in western countries in the post-war period. This led to the adoption of an existentialist philosophy rooted in personal ethics that emphasised the importance of self-determination. This ethical stance led to a mistrust of established authority and doubts about the merits of rapidly expanding technology. The civil rights, ecological and second-wave feminist movements were all products of these new social beliefs. Within health care, this ethical shift had two important consequences. Firstly, it changed the way that the public viewed the traditional professions (law, the clergy and medicine). The emphasis shifted away from the importance of an individual bound first and foremost by group loyalty to the duties of the profession towards professional ethics that required a more holistic and individualistic approach.

Secondly, this ethical shift affected the rise of consumer activism, which infiltrated many sectors of society, including that of health and social care. Consumerism is about negotiation and bargaining, rather than authority acceptance. As Haug and Lavin (1981) attest: "In the consumer model, the seller has no particular authority; if anything, legitimated power rests in the buyer, who can make the decision to buy or not to buy, as he or she sees fit." Consumerism in health meant that the patient had the right to choose the medical services he/she wished to use, with the assumption (embraced to a greater or lesser degree by government policies of the 1980s and '90s) that these services existed in a more open marketplace than that previously occupied by state monopoly. Consumerism also buoyed the self-help movement, which implied that the patient should venture to treat illness him or herself, based on knowledge no longer monopolised by the professions but rather available through experience, education or the media.

Consumerist ideals however have been seized upon by governments concerned with identifying new resources and ideas. A reduction in the growth of public spending for health care in both Canada and Britain has prompted investigation into the cost-effectiveness of existing systems. Many describe the current emphasis on participation in health, self care and family care as a political search for cheaper alternatives (McEwen et al, 1983, Richardson, 1983, Chadwick and Russel, 1989).

The fact that this search has extended to all groups of patients and their families, irrespective of appropriateness, would suggest that patient participation is indeed being used as an excuse for the state to withdraw partially from universal health care provision.

One additional challenge to the sick role has come from the health care professions themselves. There has been a growth in the allied professions such as nursing, physio and occupational therapy. In the earlier days of surgery and general practice, the doctor had a monopoly on medical knowledge. But as technology became more complex, it became impossible for physicians to be expert in all the rapidly growing treatment methods. The population was ageing, and as the incidence of chronic illness grew, the power of doctors to “cure” patients in return for their unquestioning compliance was decreased. It became clear that the locus of control previously centred in medicine had now spread to other professions specialising in different aspects of treatment. The knowledge and training of these professions had expanded with technology and they had begun to organise themselves into a coherent voice through professional associations and unions. The fact that these professions were engaged in their own battle with medical hegemony at ward and community level meant that they became the natural allies of efforts to expand patient autonomy and education (Steele et al, 1987).

ALTERNATIVE MODELS

The earliest alternatives to the sick role were proposed by Szasz and Hollender in 1956. They considered that the doctor-patient relationship was a continuum of behaviour, that changed depending on the health status of the patient. At one end of their continuum was the *activity/passivity* model. Treatment took place irrespective of the patient's contribution. Szasz and Hollender argued that this relationship was most applicable when patients were severely injured or comatose. Their second model was the *guidance/co-operation* model, which more closely resembled that of the sick role in that the patient who was suffering was willing to cooperate with medical advice in order to return to health. This model contained a power dynamic that could favour either the patient or the doctor, depending upon what they contributed to the relationship and how willing the other person was to cooperate. Szasz and Hollender's third model was called *mutual participation*. It had three preconditions. Firstly, the doctor and patient needed to have equal power. Secondly, they had to be mutually interdependent. Finally, they had to engage in

activity mutually satisfying to both, implying that the doctor helps the patient help him or herself. This final mode was essentially foreign to medicine, implying notions of partnership that were not evident in most medical encounters. Interestingly, all three models considered the health status of the patient to be an essential determinant of the amount of power he/she had.

Thomasma (1983) described four alternative models of doctor/patient interaction, called the legalistic, contractual, economic and religious model. These models applied the client/provider relationship found in other professions to that between doctors and patients. More recently, descriptions of doctor/patient interaction have been extended to examine interaction between patients and other health care professions such as nursing and social work (Jewel, 1994, Abramson, 1988, Jarret and Payne, 1995). Other writers have concentrated on the role of the patient in any health care setting, and have devised concepts relating to an 'ideal' of 'active' patient behaviour (Steele et al, 1987, Tuckett et al 1990, Brearley, 1990). Steele et al describe the characteristics of an active patient:

According to this ideal, 'activated' patients reject the passivity of sick role behaviour, and assume responsibility for their own care. They ask questions, seek explanations, state preferences, offer opinions, and expect to be heard. As a consequence, active patients are more knowledgeable about, satisfied with and committed to their treatment regimes.

This description of the active patient assumes that the users of health services are autonomous actors, capable of decision-making. The problem with any ideal model is that it can be easily undermined in the face of external influences which can affect one or more of its components. Different states or types of illness, social or economic factors can all affect the patient's ability to act autonomously. Most importantly, the active patient model assumes that health professionals will facilitate patient decision-making. As studies have shown, this is often not the case. The patient's role in decision-making is determined by a variety of factors, many of which are described in other studies that have tested the concept of participation in a variety of health care settings.

THE PATIENT PARTICIPATION LITERATURE

The patient participation literature can be divided into five main groups. Studies dealing with the *meaning and theories* of patient participation have been mentioned above. A second group is those studies that have described or evaluated the *benefits* of participation. Thirdly, participation relating to *different diagnostic groups* has been described in another series of studies. Recent research has focussed specifically on *older people* and their participation as patients. Finally, there are studies that discuss *participation in discharge planning*. These will be examined in conjunction with the discharge planning literature.

THE BENEFITS OF PARTICIPATION

Very few studies have associated any negative consequences with increased participation in health care decision-making (Brearley, 1990, Cahill, 1996). McEwen et al (1983) point out that participation is "widely acknowledged as a good thing as it results in increased patient responsibility and a commitment to health and health-promoting behaviours." Writers have identified the following benefits of increased participation: it results in enhanced decision-making, or better decisions for the individual patient (Coulton et al, 1982, Abramson, 1988, Clayton, 1988); patients are more satisfied with the care received and decisions made about their health (Fry and Hassler, 1986, Steele et al, 1987, Bird et al, 1988, Brearley, 1990, Weaver et al, 1994, Proctor et al, 1996); patients have greater understanding of their own illness and therefore improved capacity for future self-care or health maintenance (McEwen et al, 1983, King, 1990, Young, 1996); patients have a greater understanding of information and therefore improved compliance (Kane, 1980, Wilson-Barnett and Osbourne, 1983, Steele et al, 1987); and patients experience an enhanced quality of life as a result of participating in decisions regarding their own health (Coulton et al, 1982, Brownlea, 1987, Clayton,1988).

One of the most recent British studies outlining the benefits of patient participation was completed in 1993 as part of the College of Health's Consumer Audit. In an article by Loughlin (1993), the Audit's findings from qualitative interviews with 50 orthopaedic patients are discussed. It was found that :

- 1 Patients respond better to treatment if they are involved and given information

2. If patients know about and understand what occurred during an operation they may heal faster.
3. If drugs are explained, the probability of compliance is higher.
4. Involving patients can positively influence the way they view the service.

A problem shared by Loughlin with many of the other studies mentioned above is that most make assumptions about the benefits of participation, with very little empirical evidence to support their claims. They assume, rather than prove, that participation is a good thing and hence must result in better health outcomes. Loughlin's study for example, uses phrases such as: "It is generally accepted that patients respond better to treatment if they are involved in their own treatment and given more information." Techniques of data collection are often based on questionnaires with little observation of the setting in which participation is supposed to take place. Generalisable conclusions about participation appear to be very difficult to reach, and require rigorous application within a research design intended to address the benefits acquired by a *specific* group of patients.

PARTICIPATION AND DIAGNOSTIC GROUPS

Which patients benefit from increased participation is one area that a small range of studies have addressed. Some have examined patient participation within the setting of the GP's surgery, between the GP and patient (Bloom, 1963, Bird et. al, 1988). Findings have suggested that access to records, improved information about their condition and increased opportunities for question-asking have improved patient satisfaction and compliance in that setting. Studies done with cancer patients (Magnusson Arenth and Mamon, 1985, Denger and Sloan, 1992) indicate that those diagnosed with a terminal illness may be more likely to want clinicians to make medical decisions for them, particularly when they are newly diagnosed. Alternatively, a study of diabetics (Graham and Schubert, 1984) indicates a high demand for information and instruction in self-care. Glenister (1994) completed a very comprehensive review of the patient participation literature on psychiatric patients. He details a wide spread acknowledgement of the necessity of treating psychiatric patients humanely, recognising their right to have a say in care decisions, but simultaneously acknowledging the ethical dilemmas therein. Issues of patient participation and care preferences have also been addressed in studies about arthritic patients (Lowrey et. al, 1983), hypertension (Harper, 1984, and Dawson, 1985), or heart disease (Rideout and Montemuro, 1986).

PARTICIPATION AND THE OLDER PATIENT

A growing number of studies have addressed participation amongst older patients. The factors affecting older patient participation are many, and several appear to be unique to this group of patients. Although studies have made shaky generalisations about generational differences, there is one series of papers by Haug and Lavin (1983, 1988) supported by Denger and Sloan (who compared cancer patients of all ages) that provides concrete empirical evidence that older people may have very different *participation preferences* from younger patients. Their evidence suggests that three main issues must be considered within the design of any study aiming to examine older patients' participation in health care decisions. These are: the fact that older people may be less likely than younger people to adopt the active patient role; that the health care professions and society in general may expect older people not to participate; and that the modern hospital environment may hinder the efforts of older patients who do wish to adopt the attributes of an active patient.

There is considerable research evidence to suggest that older patients may be less likely to ask questions, state their views or question professional opinion while they are under medical care. The 1979 Royal Commission on the National Health Service (in the UK) measured patient attitudes to the hospital service. They found that younger patients were far more critical of the organisational routine of hospitals and the attitudes of professionals than were older patients. In 1992, Denger and Sloan surveyed both younger and older cancer patients. They found that, of all socio-economic variables they applied, age was the most significant predictor of passive role preference. Haug and Lavin (1983) found that those aged 18 to 34 were three to four times more likely than those over age 65 to claim willingness to question a doctor's advice. Over half of this younger group claimed that they had actually done so in the past, compared with only a quarter of those aged eighty and over.

The age of the patient is therefore an important factor in influencing whether or not he or she acts out the sick role. Studies done within the psychology and psychiatric literature also recognise age and its cognitive implications as a factor in determining just how well an individual is able to cope with the debilitating effects of illness (Glenister, 1994). The fact that older people often have multiple and interacting conditions and may be hospitalised for an *extended period of time* (as was the case with patients in this study) can exacerbate the psychologically debilitating effects of

being a patient. This may in turn result in increased patient passivity and reduced willingness to challenge authority.

One exception in the list of older patient characteristics inhibiting participation may be related to chronic illness. Chronic conditions such as angina, arthritis, diabetes and osteoporosis are experienced by a significant proportion of older people in hospital. These patients may have been managing the symptoms of these conditions over a period of years. Knowledge of their condition may have provided the older patient with enough information to ask questions and challenge authority when receiving treatment. Although no studies were identified that deal purely with *older* patients with these conditions, observations from other studies of older patient behaviour suggest that those with chronic conditions may be very willing and able to engage in self care and participate in decisions about their own health (Brearley, 1990, Young, 1996).

Regardless of older patients' personal willingness to participate, public and professional attitudes may not afford them the opportunity to do so. In the 1993 EC study *Age and Attitudes: Main Results from a Eurobarometer Survey*, respondents in twelve EC countries were asked who was the person in the best position to decide on the most appropriate services for older people needing long term care. In the UK, 29.3% of respondents felt that it was the older person him or herself, 29.6% a relative or close friend, and 30.6% believed that a professional such as a doctor was in the best position. In Germany, the corresponding figures were 47.3%, 21.35% and 25.2%. Similarly in Denmark, 48.1% stated the older person, 24.8% a relative/friend, and only 17% a professional. Only France and Italy favoured doctor-driven rather than patient-led decision making to a greater extent than the UK. These findings may support Brownlea's (1987) assertion that participation in health is *culture specific* and that some communities are more participative than others.

Older patients may also fail to become equal partners in health care decision-making due to attitudes about autonomy. Support for the autonomy of others can serve as the moral reason why all individuals should be involved in making care choices. Older people can be perceived as possessing limited autonomy and competence, especially if they are confused. Excepting those diagnosed with dementia, practitioners and carers may have doubts about the ability of the older patient to comprehend information or make rational choices. These doubts place at risk the patient's right to information and informed consent. When the older

person's autonomy is questioned, incidents of paternalistic treatment behaviour are more likely to occur. As Gillon (1985) explains:

Extensions of paternalism are argued for by claiming that... chronologically mature individuals share the same deficiencies in knowledge, capacity to think rationally and the ability to carry out decisions that children possess. Hence in interfering with such people we are in effect doing what they would do if they were fully rational. Hence we are not really opposing their will, hence we are not really interfering with their freedom.

Justifications of paternalism in the case of elderly patients are not difficult to formulate but are contradictory to the ideals that have driven the current movement for greater patient participation and advocacy. The problem of absent or diminished autonomy is an enormous one and vigorously debated. Studies of participation must account for this dilemma within their methodology, identifying as objective a means as possible to identify those patients whose cognitive capabilities may limit their decision-making potential.

One final point concerning professional and societal attitudes to older patient participation has been raised by Chadwick and Russel (1989). It relates to the development of community care in the UK and hence could be viewed as relevant to other countries undergoing similar shifts away from the acute care sector. The authors acknowledge the pressures that fewer beds and shorter lengths of stay have placed on medical teams who plan the discharge of elderly patients. They state that these teams have to find ways to justify rapid discharge. There are many patients who are not sick enough to justify continued occupation of a bed but who a number of years ago would not have been considered quite well enough to go home. Those that state a preference for earlier discharge (as is often the case, the patient is eager to return home and expresses a wish to be released as soon as possible) are listened to and their request accommodated immediately in some cases. This action is justified with the argument that early discharge is showing respect for the autonomy of the individual by encouraging self-reliance and honouring the patient's wishes. Chadwick and Russel call autonomy a 'double-edged sword', because the pretext of patient participation is being used as an excuse for the fact that definitions of health and illness are now increasingly linked to issues of resource management.

Chadwick and Russel emphasise the importance of the decision-making process in discharge planning. A series of decisions have to be made about aftercare services when an older patient returns home after a long stay in hospital. The extent of

patient involvement in this discharge process is determined not only by the condition of the patient, but also by the decision-making structures within the hospital. Analysis of the structure and organisation of discharge planning is part of a significant body of literature, which provides an important foundation for the study at hand.

THE DISCHARGE PLANNING LITERATURE

Discharge planning is a complex process that has produced numerous studies in America, Canada and the UK for over twenty-five years. As the authors of one Scottish (Tierney and Closs, 1993) and one Canadian (Jackson, 1994) review of the discharge planning literature have pointed out however, many of the problems identified as early as 1968 (Madsen) and 1970 (Skeet) remain unresolved in the hospitals of today. This lack of progress may be partially explained by the fact that this multi-faceted process involves a negotiation between not only the patient and hospital staff, but also between professionals and a variety of health and social care agencies. These problems begin with defining precisely what constitutes discharge planning. Krommiga and Oswald (1987) define it as:

A process and service where patients' needs are identified and evaluated, and assistance is given that prepares them to move from one level of care to another.

Armitage's (1981) definition provides a holistic view of the process, within which the role of patient participation can be easily conceptualised:

The term 'discharge' is regarded not as a single event when the patient leaves home but as a stage in patient care situated towards one end of a continuum which has both a period of preparation and from which there are consequences. Discharge cannot effectively be examined in isolation from what has gone before-hand, and, if patient care is to be regarded as continuous between hospital and community, then it also cannot be separated from what follows after the event when the patient leaves hospital.

The discharge planning literature can be divided into four different categories: those focusing on the discharge *process* within the hospital; those detailing acute care/community care *co-ordination*; those that explain the *GP's role* in the process; and those presenting the *patient's view or role as a participant* in the process. Many studies cover more than one of these categories.

THE DISCHARGE PROCESS

The discharge process has been described by Mamon et. al (1990), and indeed also by McKeehan (1985), Muenchow and Carlson (1985), and King and MacMillan (1994) as consisting of four steps: assessment, plan development, service provision and follow-up/evaluation. The process studies are concerned with the first two (and the hospital portion of the third) steps. Much of the process literature is American, arising from the fact that formal discharge planning has been required by the Joint Commission of the Accreditation of Hospitals (JCAH) since 1974. Hence in the USA it is a highly developed concept, although, as the literature shows, not necessarily more effective or efficient. Many of these studies identify organisational problems with the planning process, such as inadequate notice of discharge, badly planned transport home, lack of instructions about medication and self care and inadequate mechanisms for informing primary care staff about discharge (Madsen, 1968, Roberts, 1975, Victor and Vetter, 1988, Tierney et.al, 1993).

Other studies have examined the best organisational structure for discharge planning: team or individual. Townsend (1988), Mamon et. al (1990) and Naylor (1990) all carried out experimental studies on the best discharge planning approach to prevent readmission and unmet treatment needs. Each study found that the presence of a case manager or liaison nurse responsible for making all arrangements for the patient's return home yielded better outcomes (although it did not reduce the length of stay) than a multi-disciplinary team approach. Their evidence suggests that multi-disciplinary teamwork does not necessarily produce the best discharge decisions, despite its acceptance as the main method of discharge planning in the majority of geriatric assessment and rehabilitation wards.

HOSPITAL/COMMUNITY CO-ORDINATION IN DISCHARGE PLANNING

Effective discharge planning is dependent upon the availability of services to support the older person at home. Hospital professionals are thus dependent upon their colleagues in the community to implement the discharge plan. Studies examining the implementation and follow-up portions of the discharge process, in both Scotland and Canada, have focused on the problems of co-ordinating care between the hospital and the community (Tierney et. al, 1993, McWilliams and Sangster, 1994). In Britain, as early as 1970, Muriel Skeet identified a lack of communication between community services and the hospital staff involved in planning for aftercare. Neill and Williams (1992) identified the same phenomenon

over twenty years later, despite numerous reforms designed to facilitate co-ordination. Problems concerning the speed and accuracy of community service provision post-discharge have been found (Wilson and Wilson, 1971, Waters, 1987, Neill and Williams, 1992, Proctor et. al, 1996). Elderly patients are particularly vulnerable in the period immediately following discharge (Fethke and Smith 1991, Neill and Williams, 1992) and can lose the benefits that hospital rehabilitation has bestowed upon them if not immediately supported in the home. This is especially true for those living alone, who often return to an empty house with none of the basic necessities (Simmons, 1986, Harding and Modell, 1989, Ginn and Arber, 1991, Seale, 1996). Evidence from the literature proves that hospital/community co-operation may be one of *the key factors* in determining how well patients cope following discharge.

THE ROLE OF THE GP IN DISCHARGE PLANNING

As is the case with the patient participation literature, the role of primary care staff is not neglected by discharge planning studies. In both Britain and Canada, the GP constitutes a large portion of step four of the process - follow-up and evaluation. It is often the GP who is witness to the immediate effects of discharge and is thus well placed to make a judgement on the wisdom of the plan. Tierney and her colleagues (1993) questioned Scottish GPs and found only 93 of 311 could provide an example of a successful discharge. Because the GPs are the main source of medical support in the community, it is especially important that they be made aware of discharges and care instructions as soon as possible. Studies such as those by Lockwood and McCallum (1970) and Curran et. al (1992) have detailed the shortcomings of existing hospital/GP communication and suggested methods by which this aspect of discharge planning could be improved.

OLDER PATIENT PARTICIPATION IN DISCHARGE PLANNING

A growing number of studies have interviewed elderly patients directly in an effort to understand their perceptions of the discharge process. These studies have focused on one of three aspects of discharge planning. One group has attempted to assess how satisfied the patients and their family have been with the process of discharge, focusing on such issues as transport home, notice of discharge and information about services. A second group of studies has asked older patients to describe what their own needs were prior to discharge and assess to what extent the

discharge plan was successful in meeting them. Finally, there are two studies that have identified factors that help or hinder patient participation in discharge planning.

Skeet (1970), Armitage (1981), Gay and Pitkeathley (1981), Klop et. al (1990) Neill and Williams (1992), Tierney et al (1994), Weaver et al (1994) and Moore (1996) all describe the views of a group of older patients concerning the discharge process. Consistently, each found that the extent of consultation between staff and patients had been inadequate. Patients, and more often their carers, reported that they would have been more satisfied if they had received more information and had more consultation with ward staff.

Magnusson-Arenth and Mamon (1985) and Krommiga and Ostwald (1987) asked older patients to assess their needs following discharge from hospital. They compared these assessments with the patient's needs before they left hospital (self reported in Krommiga and Ostwald, reported by nurses in Magnusson-Arenth and Mamon) . Both studies identified needs not met by the implemented discharge plan; needs for assistance with daily tasks, aids and adaptations, counselling, therapy and a variety of unmet information needs; for nutrition, activity and medication instructions.

Both groups of studies mentioned above are important because they *evaluate discharge outcomes from the patient's perspective*. They link the issues considered important by older people with their actual experience of the process. What is missing from these studies is a link between the patient's perspective and patient participation. If the patients were involved in planning, did that make any difference to their assessment of the process? Did the presence or absence of participation improve their ability to cope at home?

There are only two studies that this researcher has identified which specifically describe older patient participation in discharge planning. Unfortunately, neither succeeds in linking participation to the older patient's experience once they have returned home. The first, by Julie Abramson (1988) evaluated the nature and extent of older patient participation through the eyes of social workers. They identified factors that encouraged or hindered the patients' ability to participate - factors such as severity of illness, dementia, depression, time factors and the extent of family involvement in discharge planning. Abramson found that the participation of patients who were cognitively and physically capable of participating was often

limited by family control over decision-making. However, Abramson did not connect the extent of participation while in hospital with how the older people coped at home.

Claudia Coulton and her colleagues (1982) also attempt to identify the factors that determine to what extent older patients were involved in discharge decision-making. Their data was drawn from medical records and semi-structured interviews with forty older patients while still in hospital. They ranked each patient as “fully involved”, “partially involved” or “minimally involved” based on nine factors. These were: level of impairment; information; perceived freedom of choice; time available; degree of hope; family power structure; commonality of family goals; physicians' opinions; and social support. They then attempted to measure the *effect of involvement*. Their results revealed that those fully or partially involved in decision-making judged their satisfaction with the care plan to be fair to excellent. The majority of those who were minimally involved (ten out of seventeen) were dissatisfied with their plan.

The weakness in Coulton et al's study was that they asked older patients to evaluate their satisfaction with discharge planning *at the time of discharge*, rather than following their return home. No studies have been identified that have conclusively linked older patient participation in discharge planning with better health outcomes, greater ability to cope or greater satisfaction once at home. This study will go some distance to fill that gap, by presenting evidence from two countries that links planning with what happens at home post-discharge. This will be achieved through the observations of the researcher and the accounts of the older patients interviewed.

COLLABORATION, CO-ORDINATION AND THE MULTI-DISCIPLINARY TEAM

The role of the older patient serves as the focus for this research. However, it is the interaction between the patient, practitioners on the ward and the wider health and social care community that actually determines what form the discharge plan will take. As a result, concepts of teamwork were important in this study, teamwork on several levels: between practitioners, the patient and carers; between professionals on the ward; and between the hospital and community. Within and between these

levels of team functioning, two questions arise which relate the concept of patient participation to that of team functioning. The first is - How does multi-disciplinary team work facilitate patient participation in discharge planning? The second is: How do problems in team functioning - at hospital or community level - affect the role of the patient in discharge planning? Both these questions will be addressed through an analysis of the data collected for each stage of the discharge planning process. To begin, it is necessary to define the terms involved and discuss some of the components of team decision-making.

Brill (cited in Lowe and Herranen, 1978) offers the following definition of a team:

A team is a group of people each of whom possess particular expertise, each of whom is responsible for making individual decisions; who together hold a common purpose; who meet together to communicate, collaborate and consolidate knowledge from which plans are made, actions determined and future decisions determined.

Brill's definition is an ideal, which should be interpreted with caution. It is however useful as it succinctly describes both the components of a team and the action its members undertake - teamwork. What distinguishes multi-disciplinary teamwork from other types of team is the *varied* and complementary expertise of the individuals involved. Multi-disciplinary teams perform tasks that cannot be effectively tackled by one individual with one type of training. As Webb and Hobdell (1980) point out, multi-disciplinary teams in health and social care have been formed with an awareness that a patient/client's needs are often interconnected and cannot be adequately addressed by the solo practitioner. Certain fields of health care, such as mental health and paediatrics, have found that increasing specialisation amongst practitioners has necessitated team work in order to avoid service fragmentation. The same has been true in geriatrics, which since its development as a distinct medical speciality, has been characterised by a team approach to care. The Royal College of Physicians has defined geriatrics as a branch of general medicine concerned with the remedial, preventative and social aspects of health and illness in older people (cited in Packwood, 1978). The interacting health and social needs of older people in hospital necessitate the involvement of other practitioners in addition to the geriatrician.

Eliot Jaques (1980, pg. 149) offers the following definition of the hospital multi-disciplinary team:

Multi-disciplinary clinical teams are small groups, always including a doctor, plus a few other professionals engaged in patient care....These

teams can be identified by the fact that the particular individuals concerned work together for relatively long periods of time; their existence as a working group is explicitly recognised. They meet regularly to discuss the cases in their care.

Both teams in this study met formally at least once a week in order to discuss patients, and engage in discharge planning. During these meetings, decisions were made regarding which team member would perform which task and with whom. This type of decision-making, and the actions that followed, could be described as *collaboration*, which Ovretviet (1993, pg 1) has defined as: "to labour together, to act jointly". Collaboration is distinct from co-ordination, although the two terms are often used interdependently. *Co-ordination* involves different actors or agencies acting in combined order for the production of a particular result, or common goal. While collaboration in this study occurred between members of the multi-disciplinary team and patients, co-ordination was something that occurred between the hospital team and community agencies who were responsible for implementing parts of the discharge plan. The extent to which collaboration and co-ordination take place is dependent upon a series of factors that have been raised in other research addressing the concept of teamwork in the health and social services. These factors are: the relationship between patient and practitioner; collaboration between professions in teamwork; the roles of multi-disciplinary team members; and organisational constraints.

THE PATIENT/PRACTITIONER RELATIONSHIP

The vast majority of work examining the relationship between patients and health care professionals has concentrated on doctor/patient interaction. However, other disciplines, particularly nursing (Jewel, 1994, Koch et al, 1995, Jarrett and Payne 1995) and social work (Abramson, 1988, Proctor et. al, 1996) are making a growing contribution. Many of the studies of patient participation already mentioned actually discuss the concept at the level of interaction between the individual practitioner and patient (Szasa and Hollender, 1965, Thomasma, 1983). However, any discussion of the effect of teamwork on patient decision-making must consider how membership in a team *alters* the relationship that the practitioner can have with the individual patient in his/her care.

Each practitioner in a team has experienced a different type of training from other team members. This training involves a component of socialisation which affects the way in which the role of the patient is perceived by the practitioner. For doctors, the

traditional medical model of care employs some objectification techniques in order to assist the doctor in diagnosis and curing or alleviating the patient's condition. Physician training has also been described as containing an element of paternalism, tied up with the concept of clinical responsibility. This paternalism, although often benevolent, can involve disclosing or withholding information according to the anticipated effect on the patients' well being (Mizrahi and Abramson, 1985). Both these principles - objectification and paternalism - can limit the autonomy of the patient in decision-making . In contrast, other practitioners, such as nurses and social workers, emphasise in their training patient advocacy and the importance of facilitating patient autonomy in health matters. Occupational therapists in turn have as part of their education an emphasis on assessment of the patient's social as well as functional needs (Yerxa, 1992). The different experience of each team member means that they interact with the patient in a different manner. Each wants a different type of information from the patient, and each may encourage patient input in decision-making to a lesser or greater extent. Action by one practitioner may undermine the efforts of another, if effective collaboration has not been planned. If the patient is not adequately informed about the structure of the team and the reasons why each practitioner has differing expectations, he or she may be left with an impression of teamwork that is fragmented and unclear.

Inadequate collaboration between team members can undermine the patient/practitioner relationship. If the energies of the team are spent trying to harmonise their tasks, the role of the patient may be suppressed altogether (Evers, 1982) . The patient may not feel that he or she has been given adequate time with any single practitioner. As Hannay (1980) points out, patients or clients are rarely given the choice as to whether they would rather confide their personal problems to one single professional, or have them discussed by a whole team. Jaques (1979, pg. 151) makes a similar point:

Team decisions imply responsibility of the whole group for the care of an individual patient; such an arrangement vitiates the right of the patient to a personal confidential relationship with one person in connection with his health care, and undermines the ultimate sense of responsibility of individual professions for patient care.

This idea of teamwork 'swallowing' the contribution of the individual patient will prove to be an important observation arising from the data collected for this study. If teams do not attempt to provide older patients with one key person with whom they can communicate, the patient's contribution can be lost.

THE PROFESSIONS IN TEAMWORK

Occupations are one way in which working roles are classified (Dingwall, 1980). Within occupational classification however, the debate rages as to which groups can be defined as 'professions' and which have not attained that status. Webb and Hobdell (1980, pg.98) contrast what they see as a modern definition of the professional with the traditional interpretation of Carr-Saunders, which was: "an occupation based upon specialised intellectual study and training, the purpose of which is to supply skilled services or advice to others.". The modern definition they offer for the health and social services is: "a person who by virtue of training is expected to take an overview of an individual case." In both definitions we see that the importance of specialised training is what separates professions from other occupational groups. Eliot Freidson's extensive writings on the medical profession (Freidson, 1961,1970,1972) have described how society has granted the professions autonomy in recognition of special knowledge and in expectation of a service orientation towards society. This autonomy has however several implications for teamwork.

The first concerns the relationship between the professional and the client. The gap between client or patient and professional has grown as professions have become increasingly specialised. As Hannay (1980) points out, the prestige of professionals has grown as the common areas of shared experience and knowledge between professional and client have shrunk. With growing prestige, other occupations who previously were not classified as professions have attempted to gain this status, through increasing regulation, longer periods of education and growing specialisation. Nursing and social work are now widely regarded as professions², but this is a fairly recent phenomenon. Occupations who attempt to reach professional status must as a result isolate themselves from common ground with their clients. This means that the function they previously served - bridging the professional/client gap - is diminished, to the detriment of contact with the client. The professionalisation of nursing and reluctance of higher grade nurses to engage in hands-on care is the best example of this.

² The term 'professional' and 'practitioner' will be used interchangeably in this study to describe all members of the ward multi-disciplinary teams.

Increasing specialisation amongst professionals has, however, fostered the expansion of team work, as the single specialist is unable to address all of the patient's needs. Professions in a health care setting depend on each other in order to treat a patient, as one group has expertise or access to resources that others do not. As Bion (1961, cited in Booth, 1983) has pointed out, collaboration can be viewed as one way in which individuals try to manage their dependence. This interdependence illustrates what Webb and Hobdell (1980) have described as the two goals of teamwork; to overcome the disadvantages of specialisation by improving co-ordination, and to exploit the advantages of a division of labour by facilitating specialisation. These goals reveal the contradictions inherent in professional involvement in teamwork. Professionals value their autonomy and accountability for their clients, yet must abdicate a portion of both in order to become members of the team. However, if too much of this autonomy and accountability is surrendered, responsibility for patient care becomes fragmented.

The inherent difficulty in multi-disciplinary team work is that, when no particular professional group has primacy (equality amongst team members is presented as an 'ideal' in much of the literature), leadership becomes problematic. Without effective leadership, the division of tasks becomes more difficult and rival professional groups attempt to assert their dominance. This struggle for 'turf' (Wilson, 1989) is a common problem in teamwork and results when a lack of structure for the activities of the team results in members drawing boundaries around the tasks that they consider their own. This delineation can result in disagreements about team objectives, which in turn hinders decision-making concerning patient care. The strength of a team approach lies in the varied and complementary expertise that professionals can offer to one patient. If agreement between team members is undermined by professional disputes, the patient will not benefit from the multi-disciplinary skills available.

ROLES IN MULTI-DISCIPLINARY TEAMWORK

The role individuals play in clinical teams is closely related to their respective professions. However, unlike the study of the professions (which has been primarily historical in emphasis) the study of roles has a strong theoretical base, usually referred to as role theory (Hannay, 1980). Role theory provides a useful framework for examining the ways in which individuals behave in groups. Concepts such as

role security, role overlap and role conflict can be applied to the relationships between multi-disciplinary team members.

Role security refers to the individual's sense of place in the group, a knowledge that the role they play is essential to the smooth functioning of the team. Team members must have a clear sense of what their responsibilities are with respect to patients and other team members. Inherent in this understanding is the perception that other team members have a mutual understanding of each others' roles (Carter, 1983). Role security is important in team functioning because, as Adamson (1983) has argued, only when team members are secure will they provide good patient care; the treatment of patients is always second to the survival needs of staff.

Role overlap arises from the very nature of the multi-disciplinary team, which implies a mixing of similar skills. If the responsibilities of team members are unclear, or not understood by others, role overlap can occur. Overlap often manifests itself as duplication of work - Rowbottom and Hey (1978) give the example of duplicated referrals. Role overlap can cause conflict between team members, particularly if fear of loss of status is involved. This fear can lead team members to seek and consolidate alliances with others, which can be extremely divisive and lead to further duplication of work (Lowe and Herranen, 1978). Role overlap or ambiguity is closely related to the concept of 'turf' mentioned in relation to the professions. Team members seek to expand their responsibilities in order to protect their place in the team, and in so doing, infringe on the traditional tasks of other practitioners.

Role conflict refers to dual responsibilities experienced by individual team members. Role conflict is common amongst hospital staff as they have loyalties to their profession or occupational group as well as the multi-disciplinary team (Evers, 1982). Dual loyalty can undermine team work if the goals of the professional group conflict with those of the ward team. The clearest examples of this concept at work are amongst team members not directly employed by the hospital. Social workers in Scotland or liaison nurses in Canada are two examples from the study at hand. Mizrahi and Abramson (1985) apply this dilemma to social workers, arguing that separate record keeping and patient confidentiality are common practices of 'external' team members which can undermine collaboration. Even within the hospital, disputes between medical and nursing or therapy staff concerning hospital wide procedures can cause conflict within the multi-disciplinary team.

Hannay (1980) argues that the aim of effective team work should be role congruence, which he defined as (pg. 5): "...the opposite of role conflict and means that the normative expectations of each role complement those of other roles which are reciprocal." Role congruence occurs when team members understand the responsibilities of the others in the group, as well as their own. Overall goals are also agreed between team members whose roles are congruent. Obviously team working is developmental - it changes, based on the patients being treated and the individuals and professions who make up the team. However, the single most important factor that determines how successful the team will be is the pressure placed on it by outside agencies - the hospital, the community and beyond.

ORGANISATIONAL CONSTRAINTS

The choices available to individuals and teams within large organisations are limited by a set of rules, routines and structural constraints. Organisation theory provides us with several models of organisational behaviour which present a challenge to the rational choice model of decision-making. Theorists such as Steinbruner (1974) and Katz and Kahn (1966) describe the most common constraints as cost, time and administrative feasibility. All these factors affect the workings of multi-disciplinary clinical teams, whose activities are constrained at three levels; within the hospital, between individual team members and external organisations, and between the hospital and community organisations.

Hospitals are bureaucratic organisations, characterised by hierarchical leadership and patterns of communication (Lowe and Herranen, 1982). As theorists such as Hayek (1960) and Carlson (1975) have argued, this bureaucracy subsumes the individual patient. Time and staffing restrictions depersonalise the service provided, and access to those in a position of power (such as Consultants) is limited (Evers, 1982). It has been argued that a publicly provided health system serves to increase the alienation experienced by the patient as he or she has power of neither voice nor exit (Vickridge, 1996, Wiles and Higgins, 1996).

The characteristics of a bureaucratic organisation that alienate the patient also affect the multi-disciplinary team. Hierarchical communication and command structures preserve the dominance of the medical profession, in contrast to the decision-making structure of the team. Teams may be attempting to establish greater equality between members in order to foster collegial decision-making. If the Consultant is considered responsible for team activities by the hospital command structures,

alternative leadership chosen by the team has limited influence and no accountability. Professional differences in general are enhanced by the hospital organisation, whose division of labour is organised between professional departments. As Abramson and Mizrahi (1993) point out, departmental and team accountability may clash, causing conflict. This may be particularly true for those professionals employed by an outside agency (such as liaison nurses), who may have to act as 'gatekeepers' to community resources required by the hospital team. Lowe and Herranen (1982, pg.6) describe these dual loyalties:

Teams also require loyalty and a commitment from their members which often supersedes that required by the institution and department. Thus, the dichotomies between the hospital organisation and the team structure require that the interface between the two be understood and evaluated in order to address those aspects which create conflict and are ultimately dysfunctional to patient care.

However, it is in dealing directly with community organisations that the multi-disciplinary team encounters its greatest challenges to effective discharge planning. Even with the presence of a liaison professional, outside agencies are facing time, cost and administrative pressures of their own which will affect the availability of services and staff which the hospital team is attempting to access on behalf of its patients. Geriatric medicine in particular is used to the challenges of inter-agency co-ordination, as Packwood (1978, pg.227) indicates:

A major difficulty experienced in geriatric departments is the feeling of being pulled in different directions by demands from the community and hospital services. Orienting the department too far to one rather than the other must significantly alter its role.

Because the border between health and social problems is blurred in the case of many geriatric patients, the hospital team faces the frequent dilemma of deciding when patients are fit to be discharged to the community. In turn, community agencies may be reluctant to provide service to older people with a high level of need who they believe have been discharged too soon. Booth (1983) has identified two general obstacles to interagency co-ordination which are supported by findings from this study. The first he refers to as 'problems of information'. This arises because "hospitals and community agencies lack the knowledge they require about each other's plans and intentions to adequately harmonise their services and activities." If hospital teams are not fully acquainted with recent changes in the classification of the needs of older people used to allocate home helps for instance, they cannot adequately predict what level of service the newly discharged patient

will receive. This lack of information means they cannot inform or reassure patients themselves.

Booth also points to the 'problem of compliance' as a barrier to interagency co-ordination. The hospital team has no power to compel community agencies to adjust their policies and priorities to complement hospital plans. For instance, the problem of a waiting list for day hospital places cannot automatically be solved by an increase in community physiotherapy visits. Although the presence of liaison professionals may alleviate problems of both information and to a lesser extent of compliance, the co-ordination essential to good discharge planning may still be difficult to realise.

Problems of interagency co-operation have, historically, been more acute in Scotland than in British Columbia. This is due to structural reasons - responsibility for the provision of health and social care has been separated between the jurisdiction of the health boards (and now Trusts) and local authorities. This separation has spawned a vast literature dealing specifically with the problems of inter-agency co-ordination and collaboration. Rowbottom and Hey (1978) as well as Booth (1983) have constructed a similar list of the divisions between hospital and community services. They describe them as: political (they are accountable to different levels of government and different departments); financial (they are dependent upon different sources of funding - largely from central government in the case of health, and from local authority revenue in the case of social care); organisational (services are provided by different organisations); professional (the Trust and the local authority are dominated by two very different professions - medicine and social work); and planning (each organisation faces different types of demands on resources and different perceptions of what is urgent).

In Canada, only the last three of Booth's divisions apply. These will be discussed in greater length in Chapter Four. These differences were highly significant in that interagency co-ordination was less of a barrier to multi-disciplinary discharge planning in Canada than in Scotland. They demonstrate how structural aspects of service provision can affect the individual patient.

CONCLUSION

This chapter has defined and discussed the concepts central to this study - patient participation, discharge planning and multi-disciplinary teamwork. In addition, relevant findings from patient participation and discharge planning research have been summarised in an attempt to indicate which issues have been neglected in the available literature. It has been argued that more research needs to be done in order to explore the relationship between the involvement of older patients in discharge planning and their self-perceived ability to cope at home. Discharge planning has been described as a process that is continuous between the hospital and the community. The extent of patient participation in hospital and the implications of multi-disciplinary decision-making must therefore be evaluated in light of the patient's experience following their return to the community. The research design chosen to accomplish this, and the reasons for undertaking a comparative study, will be addressed in the next chapter.

CHAPTER 3

METHODS

No two health systems will ever be found to be exactly the same, but the attempt should be made to examine the ways in which similarities and divergences in institutional context and structural factors explain variations in health policy, health service systems, and their effects on real health.

Wilensky et al (1987, pg. 422)

Social research is by its very nature a comparative exercise. People, behaviour, customs and organisations are constantly compared and contrasted in an effort to discover more about the processes and events that make up society. Comparative research however is a specific activity, with different aims and methodological problems from research which is conducted in one setting only (Grimshaw, 1973). These aims and the research methods chosen to achieve them will be discussed in this chapter.

THE NATURE OF COMPARATIVE RESEARCH

Social scientists have made several attempts to define the nature of comparative research. Warwick and Osherson (in Grimshaw, 1973) use the term comparative research with reference to scientific analysis which involves observations in more than one social system, or in the same social system but at different points in time. Galtung (in Etzioni and Dubow, 1970, pg.7) describes "a design whereby the same process of data-collection and data analysis is carried out within a number of spatial units." Walton (1973) argues that it can refer to broad comparisons between total societies, as well as inter-societal comparisons of subunits. He gives the examples of cities, regions, institutions, organisations, groups and social movements. Walton differentiates between three kinds of comparative research methods: comparative case studies, comparative analysis of archival data, and original comparative studies employing standardised (usually survey) methods. Although this list is by

no means exhaustive, it is useful for identifying the type of comparative research undertaken in this study. This comparison of discharge planning in Scotland and Canada can be described as a comparative case study. Two sites were chosen on the basis of their comparability, and all data collected related to the discharge planning process in each ward. The people and processes associated with each ward were examined as case studies—two detailed, in-depth studies of two separate organisations—which were then compared.

What are the arguments in favour of comparative research, and how do they relate to the study at hand? Firstly, comparative research overcomes some of the methodological limitations of a study done in a single location. It is difficult to make generalised statements about the relationships between variables if they are examined in only one setting (Sjoberg, 1970). Admittedly generalisations are difficult to make, even when the research is extended to a second case study, but the comparison does go some distance in attempting to determine whether what is being observed is system-specific or universal (Grimshaw, 1973). This particular benefit of comparative research is more applicable to human behaviour than to organisational structures. Thus in the study at hand, the researcher was able to observe important differences in attitudes and beliefs between the two groups of patients and the two groups of professionals in Scotland and British Columbia. Striking similarities were also found, both in the attitudes of older people in both countries with regard to returning to their own homes from hospital, as well as similarities in the attitudes of types of professional staff with regard to their role within the multi-disciplinary team. These observations could have been made in a single case study, but their occurrence in both research settings allowed assumptions to be made about the commonality of experience between people in different health systems.

A second benefit of comparative research stems from the experience of conducting the research in an unfamiliar environment. The removal of the researcher from his/her culture (most common in cross-national research) and into a comparable but unfamiliar research setting encourages questioning of established practices in one's own society. This is particularly the case in policy research, where policy development can be influenced by a knowledge of effective alternatives from other systems (Wilensky et al, 1987). In the study at hand, several concrete policy suggestions were raised through the analysis of findings. These suggestions stem from the fact that examples of good practice were identified in each ward studied. Examples such as the discharge checklist used in the Scottish ward and the practice

of holding family conferences in British Columbia are ideas that, in the opinion of the researcher, could be implemented to good effect in *either* system studied, or indeed within geriatric in-patient settings in locations other than Scotland and British Columbia.

Comparative research is also quasi-experimental in nature. This is uniquely beneficial as it facilitates the evaluation of practices that exist in one setting but not the other. As Grimshaw (1973) points out, experiments consist of the creation of different conditions that lead to differences in the material being studied. In comparative research, "the differences in conditions are not created but selected and viewed as causative agents" (Scheuch in Grimshaw, 1973). In the study at hand, the research did have an experimental element as the researcher was aware that the structure of discharge planning in each ward differed most significantly in one important aspect - the presence or absence of a community liaison nurse who implemented the discharge plan. The involvement of the liaison nurse in Canada was in a sense the 'experiment', whereas the Scottish ward, minus liaison nurse, served as the 'control'. The effect of this structure of discharge planning was evaluated through comparison with a research setting where an equivalent structure did not exist.

Finally, comparative research forces the researcher to pay close attention to conceptual clarity and methodological precision (Armer, 1973). This occurs because systematic procedures have to be applied to ensure that the material gathered during data collection is comparable. There is no way of ensuring perfect comparability between two research settings, but rigorous research design can assist in the process. As Walton (1973, pg.175) points out: "...standardised data collection procedures are essential to standardised case comparison." If standardisation is not achieved, then differences in the data collected may end up being artefacts of the methods used rather than valid differences between the two research settings. This emphasis on methods means that issues of phenomenal similarity and conceptual equivalence have to be addressed (Armer, 1973). These two concepts relate to finding a balance between using identical research methods in each setting and using appropriate methods. Phenomenal similarity implies the use of similar or identical indicators and techniques of data collection, while conceptual equivalence refers to the validity of methods; are they measuring the same concept in both research settings? Both issues were addressed in this study, as descriptions of sample selection and interviewing techniques will show.

SELECTION AND ACCESS

Meaningful findings in comparative research are dependent upon the selection of appropriate research settings. The settings chosen have to be similar enough to permit effective comparison. Similar settings are sought in an effort "to control as many determinant variables as possible, in order to identify the crucial determinants more easily" (Armer, 1973, pg.57). For this reason, many comparative researchers engage in *purposive sampling*¹, both when selecting their research setting and later choosing their subjects or informants (Moser, 1958, Wallace, 1994).

The two research settings were chosen precisely because they had many similar characteristics. Health care systems in Scotland and British Columbia were selected because they were convenient and accessible to the researcher², and because their basic structure (state-run, comprehensive services financed through taxation and insurance contributions) was comparable. Health policy in both countries had developed in a similar direction, shifting the emphasis from acute to community care, and promoting patient involvement in health care decision-making. Once comparability at the level of policy and system structure was established, suitable hospitals in which to conduct the research had to be identified. The wards themselves were carefully selected over several months. In the Spring of 1994 the researcher contacted one psycho-geriatrician in Edinburgh on the advice of her supervisors. Over a two week period she was permitted to attend multi-disciplinary team meetings at the Scottish hospital in which this psycho-geriatrician worked. Through this experience and observing ward routine there, the researcher began to formulate ideas about the kind of research questions she wished to ask and what kind of setting would be appropriate. Because of the researcher's interest in patient

¹ Purposive sampling is the selection of research settings or subjects by human choice or judgement, rather than by standardised, scientific sampling techniques such as random or quota sampling (Moser, 1958). Purposive sampling in qualitative research allows developing ideas to be explored, providing a more complete understanding of the phenomena being studied (Wallace, 1994). In this study, a ward in B.C and a ward in Scotland was *purposively* selected in order to compare two systems which had adopted a similar policy approach to caring for older people and emphasising the 'rights' of individuals to be involved in decisions regarding their health. The research settings were purposively sampled in order to facilitate meaningful comparison.

² As Armer (1973, pg. 58) points out, most comparative research is carried out in locations selected largely for their convenience, available contacts or expected satisfaction. He argues that this is not unreasonable however, because often the researcher "must choose between abandoning the comparison or doing research in a society than has been chosen in part by consideration of extraneous circumstances." He argues that this is acceptable as long as this is honestly acknowledged.

involvement in discharge planning, it was decided that a geriatric assessment, rather than psycho-geriatric ward would be suitable. The Scottish psycho-geriatrician then suggested a series of wards that the researcher should visit, and provided her with the names of the geriatricians who could be contacted.

Following this first experience of the geriatric in-patient setting, the researcher travelled to British Columbia. The researcher had a well established network of contacts in the capital city, where her family live. A prior knowledge of the health care system in B.C. and a conviction that meaningful comparisons could be made with Scotland determined the choice of the Canadian research setting. While in B.C., the researcher visited two geriatric assessment units, and was permitted to attend team meetings in both. Details of the professionals who made up the team, size of the unit, average age and length of stay of the patients were all noted. When the researcher returned to Edinburgh, she negotiated access to visit four assessment wards in different parts of the city. The Scottish ward chosen was that which most closely resembled the Canadian ward selected. Although there were significant differences between the Scottish and Canadian hospital, the wards themselves, the size and professions of the multi-disciplinary team, the type of patients treated, their age and length of stay, were all very similar. On this basis, sufficient equivalence to allow meaningful comparison was attained.

Although initial access to both research settings was unproblematic, access for fieldwork that would involve interviewing patients and reviewing confidential case notes was naturally more difficult to obtain. As Bryman (1989) has suggested, organisational research (unlike research in the community) involves substantial negotiation, as organisations impose an additional layer between researchers and the people they wish to study. Both the Scottish and Canadian hospitals used generic research ethics forms to select suitable research. The Scottish version in particular was geared to quantitative studies - indeed, clinical trials - and as a result inappropriate and difficult to complete. Although access to the Scottish hospital was secured, it was delayed over a month as the relevant committee met only once in four weeks and had an unusually large number of applications to review, with the result that the researcher's submission was not considered until the subsequent meeting. An additional problem encountered with the Scottish research ethics form was the patient consent document. The research ethics committee preferred that their model was used once access was granted. This model was cumbersome as it was intended to apply to all forms of research. It was confusing to the older patients who were presented with it on the ward, and proved to be a barrier in recruiting

older people for the study. Problems of access were minimal in Canada, where the form required was adaptable and the researcher was permitted to use her own consent forms.

RESEARCH DESIGN

Access to the research settings had in part proved problematic because the researcher had chosen to adopt a qualitative research design, rather than employing the quantitative methods commonly used in studies relating to health. Qualitative methods were chosen because the focus of the study was discharge planning - which is a *process* rather than a series of separate events. Process cannot be easily measured or analysed by structured instruments. Within this study of discharge planning, the central issue to be addressed was the substance and extent of older patient participation in decision-making. Studying this participation could only be fully achieved by observing the planning process, asking staff how it was conducted, and exploring the perceptions of the older people themselves. Asking how people experience a process is a qualitative exercise; it involves exploring the details of a person's social reality. This reality cannot be adequately examined by numerically based methods, such as surveys. Qualitative research is not about asking questions and offering a choice of answers, and then generating from those answers theories about all older people engaged in a similar exercise. Qualitative research can *comment* on system-wide or national issues based on the observations of the researcher, but it is always prevented from making truly universal statements because of the specific nature of the data collected. Hakim (1987, pg.28) puts it succinctly: "If surveys offer the bird's eye view, qualitative research offers the worm's eye view."

Qualitative research methods are by nature open-ended and interpretative, which means the researcher begins the data collection process without a set of precise hypotheses to be tested (Hellreigel et al, 1986) . Instead, data collection usually begins within a framework of broad themes that the researcher wishes to explore

within the research setting.³ On this basis, six main research questions were formulated around the topics of:

How older patients were involved in discharge planning.

How health and social care staff perceived the role of the patient in decision-making.

How patients themselves saw their role.

Whether staff and patient views on the role of the patient were congruent.

What patients saw as their discharge needs.

Whether the needs of the patient were met by the implemented discharge plan.

These research questions were addressed by the findings of this study. A combination of methods enhanced the validity of the research questions in each setting.

TRIANGULATION

Any single research method has its limitations. A study of discharge planning could be conducted using only interview or survey methods, but this would limit the findings to the perspective of either professionals engaged in planning or the older people returning home. Discharge planning could also be studied by reviewing patient case notes and discharge policy documents, but this would involve relying on the contributions of the professionals who had compiled the documents, excluding the patient's particular point of view. Similarly, studying discharge planning merely by observation may reveal how the hospital organisation impacts on planning structures, and how the ward team make decisions during their meetings, but it excludes the staff's and patient's own interpretation from inclusion in the findings. Because each method has limitations (Fennell et al, 1988), multiple methods are used in an attempt to counterbalance any weaknesses. As Pawson (1996, pg.296) points out:

³ Some qualitative methods such as 'grounded theory' (Glaser, B.G and Strauss, A.I, 1967) allow themes to develop from data gathered, so that the focus of the research project can alter significantly during the collection process. This technique does not lend itself as readily to comparative research, in which boundaries around research themes are what makes meaningful comparison possible during analysis. For this reason, the researcher selected and adhered to general research questions generated before the project began.

...in actual research practice it is often sensible, indeed advantageous, to operate with a combination of diverse methods...thereby producing a more comprehensive understanding of the institution under study.

The use of multiple methods in both qualitative and quantitative research is called *triangulation* (Denzin, 1970, Hami, 1996). Each method occupies one point on the triangle, implying that linking the points produces a whole. In this way, triangulation is a validity ensuring method (Kirk and Miller, 1986). Validity concerns the degree to which a given question or method actually measures what it claims to measure (Hellriegel et al, 1986). Diversity of methods is one way to guard against asking the wrong kind of question or drawing conclusions from limited evidence. As Kirk and Miller (1986 , pg.30) argue:

When a hypothesis can survive the confrontation of a series of complementary methods of testing, it contains a degree of validity unattainable by one method alone.

Triangulation was employed in this study by the use of three qualitative methods: participant observation, semi-structured interviews, and document analysis.

PARTICIPANT OBSERVATION

As a researcher conducting a study in an unfamiliar setting, observation served as the foundation for the research. As Becker and Geer (1969) have pointed out, the issue of language becomes key when conducting research in a new setting. Although spoken language per se was not a barrier in fieldwork between Scotland and Canada, terminology and common practice within the health care setting was. Observing the ward staff at work and becoming familiar with the terms used in discharge planning was an essential pre-requisite to understanding patients' records and interviewing professionals. Participant observation allowed the meaning of both words and actions to be learnt by the researcher, through the study of their use in context.

Participant observation as a research method can be applied in a variety of ways. Indeed there is a typology or continuum of types of observation originally proposed by Gold (1969) and further developed by Spradley (1980), Bryman (1989) and others. Bryman (1989) describes three types of participant observation: *covert* - where a work role in the organisation is assumed anonymously; *full*, in which the researcher becomes a member of the organisation and their work position is known,

and *indirect*, "when the researcher is constantly in and around the organisation, but does not possess a work role in it." This latter approach was adopted by the researcher in this study. She was permitted to attend all multi-disciplinary team meetings in the wards over a five month period in each country. She also observed day to day routine on the ward - medication provision, meal time, ward rounds, and attended meetings between family members of patients and ward staff. The researcher was also permitted to attend home visits with ward therapy staff and patients. Finally and perhaps most valuable of all, the researcher was invited to have coffee and lunches with team members. This informal interaction allowed the researcher to hear staff air their views on issues not mentioned during team meetings, particularly inter-professional issues⁴. All these observations were recorded in the researcher's field notes. As well as recording what was observed in ward practice and through formal and informal interaction with staff, field notes also served as a record of non-verbal details of each patient and staff interview, as well as to place findings in the context of the researcher's own personal impressions.

The value of observation was not limited to learning about the language and behaviour of staff and patients in each geriatric assessment ward. Instead, it served as the basis for verification of research findings obtained from other methods used. What patients and staff reported in interviews did not always match what the researcher observed. Discharge planning policy contained in hospital documents was not always mirrored by ward practice. There was a gap between words, action and official documentation on certain issues that was only visible to the researcher after several months of observation on each ward. These observations thus enriched the eventual research findings.

INTERVIEWS

While observation informed the researcher about the stages of discharge planning and how they were carried out by ward staff, interviewing served as the main

⁴ Admittedly the staff who 'socialised' with the researcher were therapy, social work and nursing staff, not medical staff (with occasional exceptions, especially with the Canadian geriatricians). Therefore the informal information gathered and recorded in fieldnotes was *not* from the perspective of *all* multi-disciplinary team members.

method to ascertain the older patient's place in the process. For only by interacting with the patients, asking questions and then visiting them in the community to ask further questions could the study claim to examine patient participation in discharge planning. As Zelditch states (1969, pg.7): "...information difficult to infer can be readily and accurately obtained from verbal reports." Indeed, interview data has the added value of allowing material to be recorded and reported in the words of the respondent rather than the researcher. This was attempted in the present study, through three sets of interviews with older patients, and one set with multi-disciplinary team members.

PATIENT INTERVIEWS IN HOSPITAL

The average length of stay for patients in each ward was 21-25 days⁵. The researcher had five months in which to complete fieldwork in each research setting. Given these time limitations and the decision to follow-up patients at home one month post-discharge, the researcher decided, in consultation with the geriatrician in Edinburgh, that a sample of ten older patients would be realistic and appropriate. In order to facilitate comparison, the same number of patients was recruited to take part in the Canadian portion of the research. The first two to three weeks that the researcher spent on each ward was for the purpose of observation. Once this time had elapsed, suitable patients were approached to take part in the study. Each patient fitted the following criteria:

- 1 **Aged over 70.** The majority of patients admitted to both wards at the time of the research were over the age of 70. This criterion was chosen in order to maximise the number of potential subjects, while restricting it to those who would potentially require assistance from health and social services following discharge.
- 2 **Resident in the unit seven days or longer.** A recent study by Neill and Williams (1992) demonstrates that short stays in hospital (less than four days) are characterised by little or no discharge planning. Because this research aimed to study the process of decision-making during discharge planning, the researcher decided that a minimum period of time on the ward had to be established.

⁵ Average length of stay was 21-23 days in Scotland, and 23-25 days in Canada.

- 3 **Mentally alert**⁶. Before beginning to evaluate the patient's role in discharge decision-making, the researcher needed to establish that patients taking part in the study *were able to* participate. Once capability was established, the other variables affecting patient participation in discharge planning could be assessed. Thus mental competence (as far as it could be measured) was a key selection criterion.
- 4 **Returning to his/her own home**. One of the key aims of community care policy in both countries is to support older people in their own homes rather than in institutional care. Discharge planning has an important role to play in this policy, as careful planning and appropriate community service implementation can allow people to continue living independently. Patients returning home were also more likely to be mentally competent and therefore play a potentially active role in decision-making. So for policy reasons and for reasons relating to participation as a key concept in the research, returning home was a selection criterion for patients in this study.
- 5 **Living alone**. Other studies have shown that the main sources of support for older people returning home from hospital are friends and family (Jackson, 1990, Tierney et al, 1993). Co-resident carers are particularly important in assisting older people to recover from hospitalisation and avoid moving to a nursing or residential care home (Pereles et al, 1994). Older people who live alone are at a higher risk of falls or accidents leading to readmission (Seale, 1996). Those living alone require more help from community services following hospitalisation. This means that careful discharge planning for this group of older patients is particularly essential. The researcher chose the criterion of 'living alone' in the belief that it could select some of the most complex discharge planning cases for inclusion in the study, and also incorporate cases in which the views and preferences of the older patient would be an essential ingredient in the success or failure of the resulting discharge plan.

⁶ An assessment of mental state was obtained directly from ward staff and from patient records. In both wards, standardised mental state examinations of patients were carried out by staff on admission, and then included in the patient's records. In Scotland, this was the AMT - Abbreviated Mental Test. In Canada, this was the Folstein-Mini-Mental State Exam. Those patients who scored well on these tests, in the opinion of ward staff, were deemed to meet the selection criteria. Satisfactory mental state was the single most difficult criterion to meet. There were many patients admitted to each ward who fitted all the other criteria, but could not be included because of their mental state.

Twenty patients—ten in each country—met these selection criteria and consented to take part in the study. Fourteen of these patients were female (seven in each ward) and six male (three in each ward). These patients represented a convenience sample, in that, each time a patient was admitted to the ward who was potentially suitable, they were asked if they would like to participate. Staff on both wards were aware of the sampling criteria and informed the researcher when a potentially suitable patient had been admitted. The researcher then read through the relevant case notes. If all the criteria were met, the researcher was introduced to the patient by a staff member, usually a nurse. After the study had been explained to the patient, they were asked to sign the relevant consent form. As mentioned, the Scottish form was complex and appeared to deter two Scottish patients from participating. One Canadian also declined, for reasons unrelated to the consent form. Two patients who agreed to take part (one Scottish, one Canadian) died prior to discharge, and thus were not included in the analysis. With the exception of these cases, twenty patients were successfully recruited to participate in the study.

Three interviews were conducted with each patient. The first two took place in hospital, the third in the older person's home one month after discharge. All interviews were semi-structured. Bryman (1989, pg. 149) describes semi-structured interviewing as a technique in which "the investigator uses a schedule but recognises that departures will occur if interesting themes emerge from what respondents say." Some structure to each interview was deemed necessary in order to assist in the comparison between Canada and Scotland. Thus each interview consisted of open-ended questions covering a series of themes related to the patient's view of their own health, their experiences in hospital, their awareness of the discharge planning process and their concerns about returning home.

The first patient interview took place soon after the patient was admitted to the ward, usually within the first week. The aim of this interview was to explore the patient's perceptions of their time in hospital thus far, gauge their attitudes concerning the return home, and to identify whether they were aware of having yet engaged in any discharge planning with ward staff. This interview lasted between thirty minutes and an hour, and was tape-recorded. The second interview took place the day before discharge, or, in some cases, on the day of discharge. It was shorter (inquiring specifically about discharge arrangements and aftercare needs) and was not recorded; the researcher took written notes instead. Although formal patient interviewing in hospital was limited to these two instances, the researcher did speak informally with almost all the patients in the study on several other

occasions. Because participant observation was such a key method of data collection, the researcher frequently visited the ward and talked with patients, both those who had consented to participate in the study, and those who were not part of the study. This informal contact, particularly in the Canadian ward, improved the quality of the formal interviews. Most interviewees were more relaxed when the researcher was familiar to them. Informal discussions with patients were recorded in the researcher's fieldnotes.

PATIENT INTERVIEWS AT HOME

The third patient interview took place in the older person's home, four to five weeks following discharge. All twenty patients were still at home then, although one Scottish man was readmitted to hospital one week after the follow-up interview. Home interviews were the longest in duration, varying between forty minutes and three hours. Again this interview was semi-structured and tape-recorded. As the older people were at home and alone, many other topics which they perceived as relevant were discussed in addition to themes related to discharge planning. The third interview had several aims. Firstly, it attempted to solicit the opinions of interviewees with regard to their discharge outcomes. Were they satisfied with the planning done for them in hospital, had the promised services materialised, was there anything they wish they had asked or said to hospital staff? Secondly, it asked the older people how they felt at home, how they and their family were coping. Were their needs met, were there any outstanding unmet needs? Thirdly, the interview allowed the researcher to determine which services intended as part of the discharge plan had actually materialised. This was not always possible to determine beyond a doubt, as not all the older people could recall who had visited them since they left hospital. However, there were in several cases calendars that could be consulted, or often the researcher's visit overlapped with that of a family member or home help who could assist. Finally, the third interview provided the researcher with the unique opportunity of seeing the older person in their home environment. This observation provided an impression of how well the older person was coping, how satisfied they really were, and which needs remained unmet.

STAFF INTERVIEWS

Just prior to the completion of fieldwork in each ward, staff interviews were conducted. The criterion for subject selection was attendance at the multi-disciplinary ward meetings. If the staff member attended these regularly, then they were asked to consent to being interviewed. The only exception to this was nursing and auxiliary staff. The shifts of nurses in both wards meant that nursing was represented at team meetings, but not always by the same individuals. Therefore a convenience sample of nurses were interviewed - those that were present the day that the researcher was available to arrange interviews. This method permitted a sample of both senior and junior nurses to participate in the study. As an addition, one nursing auxiliary who did not attend meetings was interviewed in Scotland. There were no auxiliaries working on the Canadian ward.

Staff interviews were semi-structured and between thirty and ninety minutes in duration. All were tape-recorded. Questions related to discharge planning practice, patient involvement in planning, inter-professional teamwork and co-ordination between health and social services. Questions did not refer directly to patients involved in the study, although particular patients were used as examples by staff respondents.

PHENOMENAL SIMILARITY AND CONCEPTUAL EQUIVALENCE

Because interview data were collected for comparison, every effort was made to replicate interviewing techniques in both study settings. Phenomenal similarity, or the standardisation of research methods and instruments, was attempted in order to facilitate case comparison (Walton, 1973). Interviews were held in the same type of setting in each ward; a nursing office for staff and some patient interviews, a television room or by the bedside of the remaining patients. Recording procedure was the same in both settings. Most importantly, the researcher attempted to use identical interview schedules in each hospital. This final attempt at standardisation was the most problematic, because of issues of appropriateness and equivalence. As Armer (1973, pg.51) has stated:

[A] major methodological task in comparative research is to devise and select theoretical problems, conceptual schemes, samples, and measurement and analysis strategies that are comparable or equivalent across the societies involved in a particular study.

Using the same research instruments and methods in each setting is one way to try and ensure that findings will be comparable, and that the same phenomena are being measured in each place. However, standardisation does not guarantee *conceptual equivalence*. Conceptual equivalence means that the same concept is being measured in different societies, but not necessarily by identical research methods (Almond and Verba, 1970, Armer, 1973). Some aspects of instruments used may be *appropriate* for one setting, but not the other. Using an inappropriate instrument may distort results, negating the benefits of using standardised methods. The most obvious examples of this appear in comparative research conducted in very different cultural contexts. Certain questions or issues may be acceptable for discussion in one, whereas the same topics have to be approached with greater care or an alternative approach in the other culture. Language differences between two research settings may also necessitate translation of research questions. Direct translations may distort the concepts being explained, leading to problems of equivalence. In the research at hand, the cultural differences between Scotland and British Columbia were slight. There was no language barrier, and the phenomena being studied were not of a particularly sensitive nature. Despite these common factors, there were differences that arose and required alterations to be made, particularly in interviewing instruments.

Interview schedules for this study were designed in Scotland and first used in the Scottish research setting. The questions and themes raised were all appropriate for the Scottish context, and easily understood by both patients and staff. However, when fieldwork began in Canada it became apparent that some parts of both staff and patient interview schedules had to be changed in order to attain conceptual equivalence. Most apparent was terminology, which differed between the two countries. Terms relating to ward staff had to be changed. The term 'consultant' was not used by Canadian patients and had to be changed to 'geriatrician', or simply 'the ward doctor'. Home helps were referred to as 'home support workers' and 'nutritionists' were 'dieticians'. Multi-disciplinary team membership also differed between the two wards, team members such as a pharmacist and liaison-nurse were present in meetings and had to be added to patient questionnaires. Concepts such as 'community care' were not used or widely understood in Canada and alternative descriptive terms had to be used. The researcher used her discretion in changing terms and explaining concepts to respondents. The resulting interview schedules can be seen in Appendix 2.

DOCUMENTS

The third data collection technique was document review. The main documents used were patient records and hospital discharge planning policies. Government policy documents relating to health policy and discharge planning were also used; these have already been discussed⁷.

PATIENT RECORDS

Access to patient records was essential for this study. Records assisted the researcher in determining whether a new admission fitted the selection criteria. Once patients had consented to take part in the study, their records continued to be essential. Records permitted the researcher to learn about the patient's medical history, which was relevant to questions about previous hospitalisations and previous involvement with discharge planning. Records also contained basic details about existing family support and community services, which aided the researcher when interviewing each patient. As McCall and Simmons (1969) have indicated, document review is essential to gaining a more holistic view of both the individual and the organisation being studied. Documents provide information about situations which the researcher cannot observe; they place data from participant observation in the context of past events.

DISCHARGE PLANNING POLICY

Both hospitals had documents related to discharge planning, to which the researcher was given access. In Scotland the ward itself had no planning handbook but did have a series of documents (such as current and past versions of a discharge checklist) which were made available to the researcher. The local health board did have a general discharge planning document⁸ (which applied to all hospitals in the area) which was reviewed by the researcher. The Scottish ward team also invited the researcher to attend a training session in discharge planning practice. This was held for staff working in geriatric assessment and rehabilitation wards in that part of the city. Community health and social work staff also attended. The event was

⁷ See Chapter 1 'Introduction'.

⁸ Lothian Health (1993) *Discharge Planning: A Guide to Good Practice*, Edinburgh.

designed to foster hospital/community co-operation as well as knowledge of good discharge planning practice. As well as attending this event, the researcher retained the material from the workshop, which contained a series of guidelines written around several case studies of fictional patients. At the training session, the researcher engaged in team decision-making with the professionals attending, centred around one of these fictional cases. The event provided a unique view of some of the problems hospital and community staff perceived in local discharge planning, and revealed some of their strategies for improvement.

In British Columbia, the hospital had a general discharge planning guide. Each ward had a copy, which the researcher reviewed. This guide explained key procedural aspects of planning as well as the forms used in patient records. As well as reviewing this guide, the researcher also obtained permission from the nurse manager to attend a discharge planning training session. This session was organised for nurses as part of the hospital's professional development programme. Although the session was informative, it served most to reveal that discharge planning in geriatric medicine was conducted at a very different pace and by different professionals from those in acute care wards. Whereas nurses did most of the planning in acute care and patient through-put was rapid, the geriatric ward's planning was done by a team and the need for rehabilitation slowed the process down. The documents gathered at this discharge planning workshop were most useful for demonstrating how team-led decision-making differed from the alternative of nurse-led discharge planning.

Review of both patient records and discharge planning documents served as a 'confirmatory' method in this study (Kirk and Miller, 1986). The content of these documents were compared with what the researcher had observed and what she had learned from interviewees, and any inconsistencies investigated. If ward practice varied from what the researcher read in discharge planning policy documents, an explanation was sought from one of the ward team members⁹. Patient records also acted as an important source of verification for interview data in particular. If responses from interviews (primarily patient interviews) differed significantly from what was contained in the records, the researcher sought further

⁹ Ward practice and the content of discharge planning policy documents differed considerably in Canada. However, this was due to the fact that the documents were designed for acute care wards in the same hospital, not the post-acute geriatric assessment setting. While they remained valid as general guidelines, their applicability to the research setting was limited. This was considered by the researcher during data analysis.

information from staff or patients themselves. In this way, document review served to reinforce the validity of findings from the two other data collection methods used in this study.

ANALYSIS

The first step in understanding the mass of material gathered during a field study is to find some method of organising or categorising that material. As Barton and Lazarsfeld (1969) argue, raw observations must be organised into a descriptive system. Organisation in this study began by transcribing all interviews and arranging fieldnotes in chronological order. Once transcripts and fieldnotes were in an analysable format, all data was divided into three groups; material directly relevant to the older patients interviewed, material relevant to staff views¹⁰ and multi-disciplinary team working, and material relevant to the process of discharge planning (such as policy documents and observations of hospital/community co-ordination). These three groups of data were then reviewed in order to identify a set of preliminary categories within each. Codes, either letters or symbols, were attached to each general theme identified. Like any classification, these three groups contained overlapping material in some cases, but each had a core body of data. For patient data this was patient interview material, for staff it was staff interview material, and for the discharge process it was policy documentation. The latter category of data was reviewed and compared in some detail on its own both during and after fieldwork. Of all types of data collection used, it was patient and staff interview data which required the most labour intensive analysis. The analysis technique adopted was analytic induction.

¹⁰ The qualitative data analysis package NUDIST was used in the initial stages of analysis, for staff interviews only. Transcribed interviews were downloaded into NUDIST format and indexing begun. The package was useful for identifying key words and line-by-line review of transcripts, which resulted in the formulation of a basic coding scheme. However, due to limited access to computers which had the capacity to run the package and limited time available to learn how to use the package to its full capacity, NUDIST was not used to complete the analysis process. It was not used in the process of analytic induction or in any comparison between staff interviews. In retrospect, the package would only have proved useful if it had been available when the research began. Compiling fieldnotes and transcribing interviews directly into NUDIST would have provided an analytic framework from the start.

ANALYTIC INDUCTION

Inductive logic is that which moves from the particular to the more general. Analytic induction therefore, is the process of examining specific data in an attempt to reach more general explanations. Both Robinson (1969) and Burgess (1984) give a comprehensive account of this technique. Both agree that the procedure was first described by Znaniecki in his 1934 text, *The Method of Sociology*. He described it as the method of the physical and biological sciences, one in which "researchers could come to terms with the problem of causal inference while remaining faithful to their data" (Burgess, 1984, pg.179). While the approach is positivistic even when analysing qualitative data (in that it attempts to generalise from a small number of cases), it is particularly effective in comparative research. Comparative analysis is usually contextual, in that events are explained in terms of synchronical, or co-existent, variables. This means that units, rather than being causally related, are assumed to be independent of each other, while occurring at a similar point in time (Etzioni and Dubrow, 1970). Analytic induction is a technique that can reveal any causal similarities between the two research settings, in that it allows the researcher to test whether explanations which apply to one research setting can also be applied to the other setting. If the explanation cannot be generalised to both settings, then the researcher must reconfirm that it applies to all cases in one setting, and attempt to find another explanation which can be applied to all cases in the alternative setting. In this way, analytic induction allows the causal similarities and differences inherent in comparative research to be revealed.

Both Robinson and Burgess outline the steps involved in analytic induction. The process begins with the selection of a phenomenon to be explained. An example from this research would be the fact that patients in both countries agreed to accept community services on discharge, without questioning the recommendations of ward staff. Once this phenomenon has been chosen, a hypothetical explanation is formulated, such as the idea that patients consent to any services in the belief that compliance will speed up their discharge. With this hypothesis formed, individual cases (in this example, patient interview transcripts and fieldnotes) are then reviewed to see if the hypothesis fits. If not, the hypothesis is modified (such as adding the qualification that patients will agree to any services as long as the cost is not prohibitive) so that it fits each case. Negative cases disprove the explanation and require the hypothesis to be reformulated. During this process, the phenomenon itself may need to be redefined to exclude particular, exceptional cases. This does not completely negate the explanation, but rather implies that it is

applicable to some, but not all of the cases under analysis. As Dubs (in Robinson, 1969, pg 199) argues:

An exception, even though it is a real and not an apparent exception, may not overthrow a hypothesis, but may merely indicate that the hypothesis in question is a limited universal....If, then, a universal is only true within limits, it is important to know what those limits are and to consider the limits as well as the universal.

Recognising the limitations of any emergent 'hypothesis' was particularly important in this study because of the way in which interview data was analysed - patient interviews were analysed in two groups—Scottish and Canadian. They were then brought together and analysed as one group, in order to determine which phenomena and explanations applied to both research settings. Several themes in patient interviews (specifically relating to patient participation) were finally contrasted with staff views from both countries. Staff interviews were analysed first as two groups, and then compared. Comparison was further subdivided into professional groupings. This involved comparing the views of medical staff in Canada with doctors in Scotland to test the applicability of 'hypotheses' between the two; the same exercise was carried out with interview transcripts from nursing staff, therapy staff and social work staff. This process of examination, redefinition of phenomena and reformation of 'hypotheses' within and between different categories is inherent to analytic induction. The findings obtained from this process, combined with descriptive accounts drawn from document analysis and fieldnotes are reported in the chapters that follow.

CHAPTER 4

STRUCTURAL DIFFERENCES

The experience of older patients in hospital and subsequently at home was influenced in both British Columbia and Scotland by a variety of structural variables. These variables related to the organisation of in-patient and community care in each country. The way geriatric services were structured had implications for the type of care each patient received; such as the presence or absence of a day hospital on site. Staff to patient ratio impacted upon the contact patients had with different professionals. The arrangement and availability of community services in each region influenced discharge outcomes. This section attempts simply to describe some of these important differences between British Columbia and Scotland, with the aim of informing further analysis of the discharge planning process.

THE HOSPITAL SETTING

Research was conducted in the geriatric assessment and rehabilitation units of two general hospitals. Assessment and rehabilitation unit is the term used to describe wards which house older patients on a short term basis who have been admitted to hospital with complex needs, usually encompassing one or more chronic conditions and in some cases cognitive impairment. Older patients' needs are assessed and treated by a multi-disciplinary team of health and social care professionals, and rehabilitation is provided in the form of physio and occupational therapy¹. In both units the treatment emphasis was on rehabilitation with the ultimate aim being the return of patients to their own homes whenever medically and socially possible.

¹ Access to other rehab services such as speech therapy was available to all patients in both wards.

Those who could not return home were assessed and directed to residential, nursing or continuing care.

The two hospitals studied differed in both size and organisation. In British Columbia, the hospital was one of two large acute care institutions within a region of approximately 320,000 people. Both hospitals, plus a smaller hospital and a series of clinics were run by one governing body, the hospital society. The society received funding directly from the Ministry of Health for the province. Patients could be transferred between any of the service sites and indeed services for geriatric patients were divided between the two acute care hospitals. One hospital contained the assessment ward which served as the research setting for this study, plus an additional 20 bed unit for older people admitted directly from the community. The *other* acute care hospital had a psychogeriatric assessment unit (28 beds), two transitional care units (wards where older patients who had been assessed as requiring residential nursing home, or long stay care waited for an available place), a newly expanded geriatric day hospital (which serves approx. 520 patients a year) and a geriatric out-patient clinic (CRD, 1994). These were the only hospital-based services for older people in the municipality. In British Columbia, all long-stay beds exist outwith hospitals, in community institutions funded and registered by the province .

In Scotland, the hospital was one of several acute care institutions within a region of 761,094 people. The assessment and rehabilitation unit studied existed within an National Health Service (NHS) Trust. The Trust had a full range of geriatric services, contained within the same hospital. In addition to the 24 assessment beds in the hospital, there was also a day hospital with 30 places, an out-patient clinic and 78 long stay geriatric beds. The Trust was located within a region where there were a variety of other Trusts offering all types of geriatric provision - in total there were 660 assessment/respite beds in the region and 199 day hospital places (Lothian Health, 1995).

THE MULTI-DISCIPLINARY TEAM

The Scottish portion of the research took place in a teaching hospital. This had implications for the staffing of the unit, particularly the medical component. More doctors simply meant that the patients had more frequent contact with a medical

practitioner. It also affected the tasks that nurses were permitted to perform - routine medical procedures carried out by nurses on the Canadian ward were performed by junior doctors in the Scottish hospital. At the time of fieldwork, the medical team in Scotland consisted of two consultant geriatricians - one who was senior, had been there since the opening of the Unit in 1993 and chaired the team meetings, and one who was there on a short term basis - four months. Both consultants were responsible for beds in other parts of the hospital (assessment and long stay) and had teaching duties. Each did, however, do a ward round with junior medical staff and nurses twice a week, and attended the once-weekly team meeting. Each consultant had a registrar. In addition to that the senior consultant had a senior house officer and a junior house officer. These two individuals had the most contact with patients and were most often present on the ward.

In British Columbia there were two consultant geriatricians who worked in the twenty-bed assessment unit. One was head of department for all geriatric services within the hospital society. His post was 50% administration, 50% acute care consultation, and that consultation was divided between the unit and other parts of the geriatric programme in both hospitals. His contact with patients on the ward was therefore very limited. The other consultant, aside from staffing the out-patient clinic in the other hospital on rotation, was a full-time presence on the unit.

The number and level of nursing staff also differed between the wards studied. In British Columbia there was one nurse manager who divided her time between the two assessment units at one hospital and the psycho-geriatric unit at the other. Her post was largely administrative, direct contact with patients making up less than 10% of her working week. Other nurses were present in two grades - registered nurses and licensed practical nurses. During the working week there were two RNs and two LPNs for the twenty bed unit. After hours and on weekends there were three LPNs and one RN. Many of these nurses were drawn from a casual pool which meant that different individuals were working on the unit at different times. Some continuity was provided by one RN who was hired by the hospital to work daytime Monday to Friday on the assessment unit. There were no additional care staff (such as nursing auxiliaries) on the ward and none of the nurses were male, which had implications for the care of some male patients.

Nursing in Scotland consisted of a more complex hierarchy. A nurse manager for all geriatric beds in the Trust existed, but her office was located in the administrative section of the hospital and the researcher never saw her in the unit. There was a

full-time charge nurse for the unit whose time was divided between administrative duties (40%) and patient care (60%). During the working week there were two staff nurses and four enrolled nurses for all twenty four beds, plus two auxiliaries. The staffing mix changed on night duty, weekend and holidays when there were fewer staff nurses and enrolled nurses and a larger number of auxiliaries on duty. The nurse to patient ratio was lower in Scotland, meaning patients had more direct contact with nurses.

Both the Scottish and Canadian ward had one full-time physio-therapist. The Scottish ward had two full-time occupational therapists whereas the Canadian unit had one. At various times during the fieldwork period in both countries therapy staff hosted students on placements for several weeks at a time.

Both teams had one full-time social worker. However, the Scottish social worker was also responsible for six other geriatric beds in the hospital as well as the 78 long-stay beds in the hospital. The time she had available to spend with patients and their families in the assessment unit was therefore constrained by outside responsibilities.

Both teams had a member of community staff who sat in on each team meeting. In British Columbia, this was the 'long term care assessor', or *liaison nurse*. Her role is described below. In Scotland, this was the geriatric health visitor. Employed by the city's Community Health Trust, this health visitor attended team meetings at all the geriatric assessment units in the relevant part of the city and visited older people in their homes. Some patients admitted to the unit had seen the health visitor on previous occasions in the community. This meant she was able to convey valuable information about the patient's home environment and sources of support to the ward team. The health visitor did not have an active role to play in discharge planning, but once patients had returned to the community she could initiate any service changes necessary. She made follow-up visits to some patients discharged from the ward. Five of the ten Scottish subjects saw the health visitor post-discharge. Those follow-ups that were done were important for evaluating the appropriateness of the implemented discharge plan.

Other professionals sat in on team meetings in each country. In British Columbia, there was a dietician allocated to the ward on a part time basis. A pharmacist also attended meetings. Scottish patients could be seen by equivalent professionals but these professionals did not attend team meetings and would only visit the

assessment unit for specific referrals. Meetings in Scotland were however attended by a nurse from the geriatric day hospital and very occasionally by visiting professionals from the community - social workers and district nurses.

The two teams studied therefore varied in size, staffing and skills. These differences had some effect on the experiences of patients in hospital, the perceptions of the staff themselves and discharge planning methods employed.

THE GENERAL PRACTITIONERS

In both countries General Practitioners (GPs) had an important role to play in patient care. However, the involvement of family physicians differed significantly between the two research settings. Their role was observed to have a significant effect on both the discharge process and the perceptions of the older patient. GPs were not interviewed for the study. They, along with carers/family members, were one of the 'missing links' in understanding all aspects of return home for the older person.

In British Columbia, the vast majority of GPs in the region studied had 'hospital privileges' bestowed on them by the board of the hospital society. Hospital privileges implied that physicians could admit their patients directly to acute care wards. It also meant that the GP remained responsible for the patient throughout their hospital stay, prescribing all medications and supervising their care unless a specialist became involved, which happened in most acute admissions. Once specialist involvement commenced, the GP relinquished the title of 'Most Responsible Physician' (MRP), until such time as the patient was ready to be discharged back to the community. However, once the GP ceased to be MRP, his/her involvement with certain aspects of the patients stay did not cease. The GP with hospital privileges was still permitted to visit the patient, consult with other medical staff and write in case records, although the Consultant would prescribe medications. Some GPs also provided surgical assistance within the hospital studied, meaning they assisted the specialist in the operating theatre. Thus the involvement of the family physician straddled the boundaries between the hospital and community.

Within the Canadian unit studied, general practitioners had an active role. Although they did not attend ward rounds or family conferences during the fieldwork period, they were not excluded from attendance by any existing hospital

policy. Instead, it was not uncommon to see one or more family doctors visiting the ward in the early morning or weekend, consulting patient records, going to speak with their patients and then on leaving making additions to the medical case notes. GPs were required as part of their hospital privileges to record the details of each visit in the case notes.

Various factors affected which GPs retained an active role in care when one of their older patients went into hospital. Firstly, and most importantly, was time. The researcher observed GPs in the mornings, evenings or weekends because these were the times when they were free to leave their surgeries. GPs with busy practices and larger case loads naturally were restricted in their ability to see their patients in hospital. Secondly was distance. The Canadian hospital was located outside of the city. This meant some doctors required more travelling time to reach the wards. The other acute care hospital in the area was near the centre of the city and anecdotal evidence suggested that some patients who had been there prior to coming to the study hospital had received more frequent visits from their family doctors. The third factor affecting GP involvement was billing. Under the British Columbia Medical Services Plan (MSP), GPs could only be paid by the Ministry of Health for three hospital visits (allowing for less than half an hour per visit) to patients under the care of a consultant every nine days. GPs would not be paid for any visits above and beyond that.

The final factor affecting GP visits was attitude. Nurses and other members of the multi-disciplinary team informed the researcher that they believed some GPs took more of an interest in their geriatric patients than others. Some GPs were 'known' for their visits to the ward whenever one of their patients was admitted. Naturally other factors such as the GP's relationship with individual patients and the proportion of older patients in his/her practice could affect the frequency of visits above and beyond MSP allowances. Patients themselves were also aware of attitudes. Those who did not receive frequent visits from their GP questioned why when they realised other patients were being seen. One of the subjects in this study, a woman in her eighties who had had the same GP for over ten years informed the researcher that, after witnessing the frequent visits of one young family physician to the woman in the next bed, she herself was going to investigate switching practices and becoming one of his patients, once she had determined that his surgery was not far from her home.

The close involvement of some GPs with patients on the ward had repercussions for the way in which patients perceived the role of other medical staff. As interview data will demonstrate, several Canadian subjects wrongly believed that their family doctor was still directing their care and prescribing their medications while they were in hospital. This was compounded by an absence of ward rounds and the fact that many patients saw the consultant geriatrician on very few occasions during their hospital stay.

The role of the general practitioner was also affected by boundary issues concerning medication. Once a discharge date had been set for a patient, the GP was informed either in person or by telephone. It was then his or her responsibility to ensure that the patient had the correct medication at home. The GP could arrange to have discharge medication provided in one of several ways. The most common method was for the GP to write a prescription which ward nurses then ensured that the patient or carer had on discharge. The carer would then in most cases go and fill the prescription at a nearby pharmacy. Alternatively, the GP could phone the patient's pharmacy directly and request that medications be prepared for collection or delivered to the house. Another less common method was for GPs to arrange to visit their patients at home on the day of or after discharge. Finally, the GP could write a prescription for discharge medications in the hospital case notes in which case a dosette would be filled and the patient would return home with their medication in hand. In brief, the necessity of arranging medications meant that the family doctors of all ten Canadian subjects were aware of when and in what condition their patients were returning to the community.

An additional consequence of GP involvement concerned follow-up in the post discharge period. As will be discussed in Chapter 9, the presence of family physicians in the hospital meant that many of the older patients interviewed benefited from the continuity provided by having the same medical practitioner follow them from home to hospital and home again. The GP was a consistent reference for patients and their families.

General practitioners in Scotland were involved in the in-patient care of their patients to a lesser extent than in British Columbia. In Scotland, the division between primary and acute *medical* care appeared more pronounced to the researcher. None of the ten Scottish subjects were visited by their GP in hospital. GPs did not physically come into the assessment ward to consult with the geriatricians. GPs did not contribute to in-patient case records, although all

documentation relating to the *previous* condition of the patient in the community and reasons for admission (if the GP had been the one making the referral) were included in the case records. In the Scottish hospital, GPs ceased to be responsible for their patients as soon as an acute care admission occurred, and only recommenced responsibility once the patient had been returned to the community. There was no overlap. There appear to be several reasons for this.

The first relates to manpower. As mentioned above, the geriatric assessment unit studied in Scotland was located within a teaching hospital. There were a number of junior medical staff who were involved in patient care. This meant that the contact patients had with medical staff was far greater than in Canada where there were two doctors for twenty beds. Although the Canadian GPs did not engage in the active treatment of their patients in hospital, their involvement in other aspects of the system (such as acting as surgical assistants) was indicative of a non-teaching hospital where the medical input of community physicians was valued and indeed required.

Secondly, whereas in Canada it was the GPs who straddled the boundaries from the community to the hospital, in Scotland it was the geriatricians. The tradition of domiciliary visits by specialists in Britain began in the years before the NHS when consultants would go to see private patients in their own homes. Although the number and frequency of visits that specialists will do has decreased over the years, both the consultant geriatricians and their registrars in the Scottish hospital studied would go and see patients in their own homes². These visits occurred at the request of GPs. A domiciliary visit would result in one of four outcomes: firstly an assessment which would determine that the older patient was fit to remain in their own home under the supervision of the GP who would receive a copy of the consultant's examination; secondly an assessment which would decide that the older person could remain in their own home in the meantime but would require social work assessment either for domiciliary services or with a view to residential care or nursing home placement; thirdly an assessment which would determine that the older patient required medical intervention or therapy of some kind that could

² The Canadian geriatricians in this study did not do domiciliary visits. As a result, none of the ten Canadian patients were visited by a hospital doctor at home. However, the Canadian hospital in which the research took place contained another assessment unit for patients admitted directly from the community. The geriatrician in this unit did make a limited number of home visits.

be provided by attendance at the day hospital; and finally a domiciliary visit by a geriatrician could result in admission to hospital.

The researcher observed that domiciliary visits could have a positive impact on patient care in the geriatric assessment unit. Patients admitted following visits were known to at least one of the medical staff. Not only that, but the doctor had observed the patient in his/her home environment. This observation aided multi-disciplinary assessment of the patient because the doctor was then able to alert other team members of possible aids and adaptations or social services that might be required, or indeed be able to begin to assess whether a future change in housing would benefit the patient. The researcher also observed that domiciliary visits strengthened the link between the hospital and the community. Although the Scottish unit could accept patients from anywhere in the city, nine of the ten Scottish patients lived within a few miles of the hospital. This 'district' orientation meant that the senior consultant geriatrician knew the area well and in some cases had seen some patients at home, at the day hospital or on the ward on more than one occasion. One of the Scottish subjects had attended the day hospital, been seen by the geriatrician at home and had three separate admissions to the ward over two years. This patient had developed a relationship with the geriatrician as a result, and felt he could communicate with him. Domiciliary visits may also help to maintain a positive relationship between the consultants and GPs in the area. GPs were aware that they could solicit the support of the consultants for a second opinion or to facilitate a hospital admission.

The effect that the structural relationship between primary and acute medical care can have on the way staff and patients experienced the discharge planning process in each country will be discussed in later chapters. It is important to now turn to an explanation of how other aspects of multi-disciplinary discharge decision-making attempted to connect the provision of community services with those provided by nurses, therapists and other professionals in the hospital.

COMMUNITY LIAISON

Discharge planning for all the patients interviewed for the study involved the arrangement of domiciliary health and social care services. Some patients had a complex package of services arranged, others were to rely largely on their families, while others received very little in the way of care at home. The way that these services were organised differed between Scotland and British Columbia. The single

most significant difference related to the role of community staff involved in discharge planning.

In Scotland, the 1990 *NHS and Community Care Act* had expanded the role of local government in arranging home care services. Councils became 'enabling' authorities, meaning they had responsibility for arranging services from a variety of providers to meet the needs of individuals requiring community care. Social workers, as employees of the local authority, are the professionals who arrange packages of care. The social worker in the Scottish hospital studied was responsible for arranging social care services for all older patients about to be discharged. Her role was one of co-ordinator rather than direct provider. She could make referrals to a variety of community agencies, but could not determine the precise level or amount of service the older person would receive once at home. Her referrals were recommendations, subject to future decisions made by community agencies themselves.

The social worker was not the only member of the Scottish team who made community referrals. Occupational therapists could refer to many of the same services as social workers. Other professionals referred to their parallel agencies in the community, such as ward nurses to district nursing services. As analysis in later chapters will demonstrate, both planning and referral functions in the Scottish ward were shared between team members, making discharge planning a multi-disciplinary process.

In British Columbia, the discharge planning process was shaped by the presence of the 'long term care assessor', or liaison nurse. There was no equivalent position on the Scottish team studied. These individuals were employees of the municipality (local authority), who spent most of their working week in the hospital, assessing patients and attending discharge planning meetings. Liaison nurses in British Columbia were in most cases trained nurses, although professionals with a social work or therapy background held the position in other parts of the hospital society. In the area studied, the municipality was the co-ordinating agency for all social care services; meaning home help, meals on wheels, and community aids and adaptations. The same agency co-ordinated and provided community occupational and physio-therapy services, *and* home nursing. The 'package' of health and social care services which the municipality could provide (including arranging nursing home places) was referred to as 'long term care services'. The liaison nurses working in the hospital acted as 'gatekeepers' to these services.

On the ward studied, there was one liaison nurse position which was filled by two women as a job-share. The liaison nurses sat in on the bi-weekly ward round meetings and were thereby informed of the assessments conducted by medical, nursing and therapy staff. They also spent a considerable amount of time combing through case notes prior to assessing patients themselves. No patient could be discharged from the geriatric assessment unit without being assessed by one of these women. The only exception to that rule were those receiving no follow-up services or those who 'opted out' of public provision and arranged their own care through the private sector. The long term care assessment in British Columbia differed from that carried out by the social worker in Scotland. The most significant difference was that the liaison nurse determined the *amount or level* of community services that the older person would obtain following discharge from hospital. The liaison's own assessment of the functional, social and cognitive capabilities of the patient, combined with the multi-disciplinary assessment of ward professionals, resulted in the application of a 'Care Level' to each patient³. These levels dictated the nature and amount of services that the community could provide for the older person. As will be demonstrated in later chapters the liaison nurse was thus responsible for co-ordinating and implementing the hospital discharge plan for the Canadian patients in this study.

COMMUNITY SERVICES

Good discharge planning is dependent upon available community services. Ward staff in both countries identified gaps in community provision that affected their ability to arrange a comprehensive package of aftercare services. It is important to describe some of these differences in the *type* of community provision and its *availability* as they had implications for discharge outcomes.

³ There were five Care Levels, based on the cognitive and functional capabilities of the older person. These were dependency levels, ranging from 'personal care' (requiring cleaning and limited personal care assistance) to 'extended care' (requiring the equivalent of long stay hospital care). These Care Levels could be applied to older people receiving domiciliary OR institutional care services, as the municipality was responsible for arranging admission to (and in the case of some services and homes, directly providing) each.

HOME HELP

In British Columbia, the range of services provided by care workers in the home was referred to as 'home support'. The municipality in B.C. purchased home support services from fifteen registered private agencies. Home support workers carried out cleaning, laundry, shopping, meal preparation and personal care for older people. The range of personal care tasks they performed was broad, including bathing clients, changing dressings and administering medications⁴ - all tasks that were primarily done by community nurses in Scotland. The number of home support hours an older person could receive per week was based on their assessed 'Care Level'. Home support charges were based on net income and services were free for those on state benefit.

Home support availability changed significantly in the period just preceding data collection. These changes took two forms. Firstly, home support workers from several of the large private provider agencies were on strike for the first two months of the fieldwork period. All of the older people interviewed whose workers had come from these agencies were aware of the strike although the researcher also observed the liaison nurses informing patients about it. It was the responsibility of the municipality to find these older people other home helps until the strike ended. However it meant that some patients went home to a new worker rather than one they knew.

Secondly, due to cutbacks in long term care funding from the provincial Ministry of Health to the municipality, home support provision was reduced in February 1995. These reductions took the form of prioritising clients. Those with more complex needs continued to receive service as before. However, older people who had been using home support workers for cleaning tasks only lost the subsidised service and had to find alternative support. Those most affected by the cut-backs were older people assessed at the 'Personal Care Level', the lowest dependency level and the largest single group of clients in the municipality. The effect of these changes on the older people in this study will be discussed in Chapter 9.

⁴ Home Support workers could administer medications to clients provided they had received training from a registered nurse. All medication had to either be prepared by a nurse or packaged by a pharmacist.

The Care Levels attributed to individual older people appeared to the researcher to be quite rigid, meaning that additional requirements for service had to be paid for by the client. A lack of flexibility was apparent especially with reference to overnight sitting services, which were difficult to obtain. The care provided appeared to be moulded to the Care Level rather than to the needs of the older person.

In Scotland, the home help service was provided directly by the local authority. The range of tasks performed by home helps was similar to that in British Columbia, although home helps were not permitted to administer medications, perform some personal care tasks (such as catheter care) or bathe clients in some circumstances. Boundary disputes with district nursing concerning bathing were ongoing at the time of fieldwork. Charges for home help were based on a maximum hourly rate and the client's ability to pay. People on income support or very low income received the service free. The maximum cost for clients with resources was £4 per hour at the time of fieldwork; less than half of the full rate Canadians had to pay (\$14). Also home help provision in the relevant region of Scotland appeared greater than that in Canada. The principle of a needs-led service meant that the hours, at least during the day, could vary to suit each person discharged.

Changes in home help provision were also occurring in Scotland during the fieldwork period. As a concurrent Scottish Office study of the service was to demonstrate (SWSI, 1996a), the ratio of home helps to clients had been decreasing since 1990 with the result that the prioritising of clients was beginning to occur. Although there was no official limit on the number of home help hours one client could receive, older people needing assistance only with cleaning or substitute mobility tasks (not personal care) were no longer receiving service on the weekend, for holiday cover, or on public holidays. The implications of this were that some older people could be left alone without contact or services for several days in a row.

In October 1995 home help provision in Scottish region also changed. Although this did not affect any of the ten Scottish subjects during the *immediate* discharge period, it will affect those who still wish to remain at home in the future. Rather than the B.C. method of preserving resources by prioritising client needs and excluding clients who receive only cleaning, the Scottish region raised its maximum

hourly charge and ceased to make those on Income Support exempt from paying.⁵ These changes therefore affected older people of all ranges of dependency and particularly those on lower incomes.

HOME NURSING

In British Columbia, community nursing services were provided by the municipality. Home support and home nursing were administered from the same central office. From there, both services had access to the computerised records network of the hospitals⁶, meaning community services could find out basic information about a client's hospital admissions. Home nurses worked in teams throughout the city. There was no cost for services provided the older person had been resident in the province for three months and had a provincial health care card. Clients were however charged for medication and supplies used.

During the fieldwork period home nursing was still experiencing the effect of hospital bed closures. These had taken place at the end of 1993 and resulted in a reduction of 15% in total bed capacity. Acute care closures combined with a reduction in long-stay beds (148 closed in 1993) and earlier hospital discharge meant that there was increased demand for nursing services in the community. This resulted in delays in accessing home nursing care for patients.

In Scotland, community nursing was provided in the region by one of three NHS Community Trusts. The patients in this study received services from two Trusts; provision of services was determined by locality. Some nurses, although still employed by the Trusts, were attached to GP practices. District nurses performed most nursing tasks, including administering medication and doing personal care tasks, while health visitors were responsible for preventative health care. As mentioned above, there was a community geriatric health visitor attached to the

⁵ As of October 2nd 1995 the maximum hourly rate for home help in the Scottish region in question rose from £4 to £4.50. The maximum weekly charge anyone would pay regardless of their needs rose from £28 to £45. People on Income Support or Family Credit "will no longer automatically be entitled to a free home care service. However, it is still recognised that many of these people will continue to receive a free service" This would be determined by identifying what types of income and expenditure (such as Attendance Allowance) could be disregarded in a new financial assessment (Lothian Regional Council and Lothian Health, 1995).

⁶The municipality also received a discharge summary from the ward geriatrician, for each older person who had been assessed by the liaison nurse in hospital.

ward team studied. She visited a number of the Scottish subjects at home after discharge.

All community nursing services and supplies (with some exceptions) were provided free of charge in Scotland. Out of hours nursing was however of limited availability in Scotland, as was out of hours home help. This caused particular problems in the evening, when some patients required a tucking-in service.

COMMUNITY THERAPY

In British Columbia, community rehabilitation services were offered in the homes of older people who could not attend a clinic or the city's one geriatric day hospital. Both community occupational therapy and community physiotherapy were provided and administered by the municipality. As was the case with community nursing, all services were free of charge for permanent residents of the province.

As will be discussed in the analysis of interview data, several of the Canadian subjects received both OT and PT visits to their homes post-discharge. The type and duration of visits depended on the client's needs. The service itself appeared flexible but the provision of aids and adaptations was more problematic. Patients had to pay for all equipment. At the time of fieldwork the Red Cross would lend older people aids such as a bath rail or toilet seat but these had to be returned after three months. If the need for equipment persisted, the older person had to either rent or purchase the item.

In Scotland, the responsibility for the provision of therapy to people in the community was divided between health and social services. Occupational therapists were employed by the local authority and located within social work offices. From there they visited people in their homes to conduct assessments and provide any necessary equipment.

Community physiotherapy has been identified by the local authority and the health board in the region where the research took place as a gap in services. Older people requiring on-going physical therapy are required to attend a day hospital. Only in very exceptional cases will a hospital physiotherapist visit a patient in their own home to provide rehabilitation. None of the Scottish subjects had a physiotherapist treat them at home.

The provision of aids and adaptations in Scotland was less problematic than in Canada, although problems in procuring the correct equipment did delay discharge for one of the patients interviewed. Most aids were provided free of charge - walkers and bath rails being the most common. Other aids such as chair lifts and lumbar supports were provided at a cost to the user. However, the impression gained by the researcher was that NHS equipment was in most cases readily available and provided free of charge to patients returning home from hospital.

MEALS ON WHEELS

In British Columbia, the municipality directly provided meals to older people at home through home support workers or meal times at a day centre. Portable meals were provided by the municipality to a very small group of clients (30 people as of March 1994) through a special scheme called Project Assist (CRD, 1994). *All* other portable meals were provided by the independent sector - both private and voluntary agencies. The range of options for meals on wheels in the area was extensive - from several charitable organisations offering meals delivered hot to the door at a cost of \$4.50, to gourmet frozen meals delivered once or twice a week for \$5.50 per meal, with a range of menu options to choose from. Hospital social workers or liaison nurses could arrange for these meals on behalf of the older person but in most cases it was the family themselves who arranged provision. Within the city studied there were also a variety of amenity or sheltered housing complexes with meals provided on site.

In Scotland, private arrangements for meals could also be made but the researcher did not encounter any during the fieldwork period. Instead, the local authority provided meals on wheels as part of home care services. Although these meals were prepared by a voluntary agency (the WRVS), the cost was covered by the local authority as was transport. Hospital social workers, OTs or nurses making a referral for home help could simultaneously make one for meals on wheels for the same client. The client's contribution to the cost of meals was means-tested and charged in the same manner as for home help.

Home helps also engaged in meal preparation. The voluntary sector assisted through lunch clubs (often in a church or community centre) where people could meet for a subsidised or cheaply provided hot meal.

SOCIAL DAY CARE

In the Canadian region, eight adult day centres existed which provided social activities, meals and bathing assistance to older people living in the community. The charge was means tested in the same manner as home help. There was an additional charge for meals. Individuals attended one or two days a week and transport was provided. Adult day centres provided a valuable service especially given the relatively small proportion of older people who were referred to the city's one geriatric day hospital. However at the time of data collection there was a six month waiting list to attend one of these centres. In addition, one centre in the city was about to close due to lack of provincial funding for social care. The limited availability of day centres was identified by both staff and patient subjects as a shortcoming in the range of community services available in the area.

Day care provision in the Scottish region was much more readily available. At the time of fieldwork there were 13 units in operation offering 153 places each day they were open (Lothian Health, 1993). These centres were run by the local authority; meals and transport were provided free of charge. Some centres had bathing facilities but these were reported by people working in the field to be underused⁷. In addition to full day centres, the region supported 140 lunch clubs for mobile older people. These services when combined with day hospital provision in the region, and day services provided by the voluntary sector meant that there were social and therapeutic activities available to older people who chose to use them.

CRISIS CARE

Research has shown that hospital admission can in some cases be avoided by the early detection of health and social problems and intervention by intensive community services. In turn, early hospital discharge can be facilitated by the provision of round-the-clock support for the first few days at home. In both British Columbia and Scotland, crisis care teams had been developed to help keep older people at home and out of hospital. Although none of the Scottish patients in the

⁷ Age Concern Edinburgh

study had been recipients of the service, two Canadians were cared for by the B.C. equivalent.

In British Columbia, 'Quick Response Teams' (QRT) had been formed by the municipality in 1986. The programme was funded by the Ministry of Health. Teams were made up of physiotherapists, occupational therapists, nurses, social workers and home support workers. QRT was aimed at those over 60, or chronically ill adults, and targeted two groups of people (CRD,1994, pg.2):

People who are experiencing a crisis at home who do not need acute care, but who would be unable to stay at home unless they received immediate help....People who are in hospital who are over the acute illness, but who would be unable to return home without intensive rehabilitation and home support services.

QRT could provide 24-hour care, free of charge, although cleaning services were no longer provided free to all users.

In Scotland, the region studied had one Crisis Care Scheme which operated from one of the large acute care hospitals in the centre of the city. Similar to the Canadian team, it consisted of nursing, therapy and home help staff who provided personal and practical care to people who would otherwise require an admission to hospital or residential care. The service was free and available for up to 24 hours for a maximum of two weeks.

Although the team had a mandate to support people in all parts of the region, this was dependent on resources. The region notes in its *Joint Strategy for Services for Older People* (Lothian Regional Council, 1995) that some GPs commented that it can be difficult to get help through Crisis Care and that plans were underway to expand the service throughout the region.

OTHER SERVICES

In both Canada and Scotland there were a variety of other services provided by the statutory and independent sectors which contributed to the care package arranged for patients returning home from hospital. The role of these services in the discharge plan of patients will be discussed in later chapters. To summarise however, several services existed in both countries that were used by one or more of the patients interviewed. These were: chiropody/podiatry (provided by both the public and private sectors), community dieticians (employed by the health service - a scare

resource in both countries), community alarm schemes (both public and private) and volunteer visiting services, through publicly-funded voluntary groups (such as Age Concern in the UK) or through churches.

Services supported by public funds that existed in Scotland but not in B.C were community laundry services - where clothes were collected from the older person at home, washed and returned; and the 'Care and Repair' service run by a voluntary agency which did heavy household chores and repairs free of charge to older people in the community.

Services that were funded by the municipality in B.C. but had no direct equivalent in Scotland were 'Seniors serving Seniors', a network of older volunteers who would assist frailer individuals by providing shopping, transport and visiting services; and VISTA, a counselling service specifically for older people with drug or alcohol problems. VISTA would visit the patient in hospital as well as in the community.

THE HOME ENVIRONMENT

The older people interviewed for this study returned home to a variety of living arrangements. All lived alone, but as their personal finances differed so did the age, quality and accessibility of their accommodation. Although quality of housing was not specifically assessed in this study, the researcher did observe that the environment to which the older patient returned had implications for the implementation of the discharge plan.

The home setting was affected by some basic differences between the two study sites. Firstly, distance and transportation were issues. In the Scottish hospital all the older subjects lived no more than 15 minutes by car or bus from the hospital. The researcher attended one home visit in which the patient, OT and social worker all walked the short distance to the patient's house. Ambulances were readily used to take patients home, and taxis for home visits. In Canada, ambulance rides were charged to the patient, although taxis or specially adapted buses were also used for home visits.

The Canadian city had a large elderly population, 25.5% over 60, 18.6% over 75 (CRD, 1994). The variety of housing that had developed for older people as a result was extensive. Sheltered and amenity housing existed in a variety of forms, from

complexes with wardens to the more common apartment blocks with security entry systems. Many of these were 'designated buildings' which the municipality recognised as housing for older people. Residents in these buildings could receive more flexible home help and home nursing hours. Some of these buildings had dining rooms which the residents could choose to visit at a cost per meal, or have their food brought up to them by volunteers within the building. Most significantly perhaps, all of these buildings had lifts. Even the city's only subsidised housing - a large apartment complex in the city centre for low income residents - had lifts. This was a consequence of modern, if not ideal, housing.

Stairs were a tremendous barrier to discharge home for patients in the Scottish hospital. Occupational therapists could assist with a small number of stairs but many older people resided on the upper floors of tenements. Patients with mobility problems returning to this type of housing had to choose between becoming housebound or changing residences.

The neighbourhood surrounding the Scottish hospital had been identified as one of the region's 'Areas at Risk' based on analysis of the 1991 census. This label was applied as the area fitted a series of deprivation criteria concerning health, mortality, crime and also housing. The area had a slightly older population than the region as a whole, and had a higher proportion of residents aged 75 + with a limiting long term illness (44.3% of the age group in the area compared with 40.9% in the region). The area also had a higher proportion of residents living in public housing than in the region as a whole. Whereas 25.2% of people were local authority tenants in the region, 30% of people in the area around the Scottish hospital were living in rented public housing (Lothian Regional Council, 1995b). Four of the ten Scottish subjects lived in this type of housing although one older man had purchased his council house. Much of this housing was poorly constructed, insulated, ventilated or heated. None of the Scots who lived in this type of housing had central heating and one man lived in a two-room flat where rising damp was obviously a problem. The researcher observed that adequate provision of community services on discharge could not fully compensate for the effects that poor quality, restricted access housing could have on the quality of life of older people returning home from hospital.

CHAPTER 5

THE PATIENTS

The views of the twenty patients in this study created a unitary framework for the research. While the discharge planning process itself could be divided into four distinct stages (which will be described in Chapters 6-9), older people's perceptions of this process were not so easy to compartmentalise. There were striking similarities between the Scots and the Canadians in attitudes and experiences, both within and outwith the hospital. Indeed there were far more similarities than differences between patients in each setting. With some exceptions, it was predominantly the structural and organisational aspects of the two health care systems that caused patients in each country to have a different experience of discharge planning, rather than the expectations or beliefs of patients themselves.

This chapter presents the twenty older people who took part in this study. It begins with the patients' descriptions of the sources of social support available to them. Family background and the proximity of caring relatives were important components of each person's previous experiences of health and illness and affected the views expressed regarding hospitalisation and independence. This description of social support is followed by a discussion of the patients' views on several themes relevant to discharge planning. The first concerns attitudes towards health and illness and responsibility for health maintenance, which affected how older people viewed their admission to hospital. The second involves older people's attitudes regarding decision-making in general, including their expectations of themselves as patients and of staff and families engaged in planning. The third concerns older people's attitudes towards remaining independent in their own homes. All of these views serve to inform later discussions of the patient's role in discharge planning.

SOCIAL SUPPORT

Jackson (1994) in her review of the discharge planning literature, points out that a finding in studies on the use of community services has been that the major source of support for elderly discharged patients continues to be their families. Proctor et al (1996) found that 76% of the older patients in their study needed more assistance after leaving hospital than had been provided by the discharge plan. Families were the ones who arranged or provided this assistance. The support provided by some families to older people in the present study was tremendous, both before and after discharge.

Five patients in Scotland and five in Canada had close family living nearby who provided help on a regular basis. In Canada the principal carers were the daughters or daughters-in-law of patients. In Scotland three were daughters, one was a niece and another a sister in her seventies. The older patients who were supported by these family members had varied opinions on the type and amount of contact with their families. Each patient interviewed also had views on their dependence on their families and how that affected their relationships. These views were relevant to a study of discharge planning as they helped the researcher understand why some patients expected their families, rather than themselves, to take an active role in the planning process, and also revealed why some patients had positive discharge outcomes despite weaknesses in the implemented discharge plan.

Families supported their relatives in different ways. Some provided a high level of physical support, such as the daughter who came to bathe her mother post-discharge. Others (the majority) did a large number of substitute mobility tasks, such as shopping, collecting pensions/banking and heavy housework. A Scottish patient explained:

"My daughter does all my shopping and all my financial business....I see her every week, sometimes twice a week."

In Canada the decision to reduce home helps organised by the local authority contributed to the fact that four of the five daughters (in-law) did housekeeping/cooking for their mothers. One woman saw her daughter (who lived on the other side of the city) every day:

"Well, at least three times a week, and sometimes she just stops by. She phones every day, sometimes twice a day. If she is going to change what she is going to do, she always lets me know."

Some relatives were instrumental in arranging previous community services for their relatives, or at least convincing the older person to accept them. One Scottish patient explained how she started getting a home help:

"I think it was my niece who said to me well, you'll need to get somebody to help you. And she has been very good."

Other patients who had been admitted to hospital without significant levels of community support services told the researcher that their families had been trying to get them to accept services for a while, to no avail. Another Scottish patient described how her daughter had been trying to convince her to accept help:

"She wanted me to have somebody in for a long time...But I am so independent. I mean I am independent except for my daughter. She's been so kind, doing my washing and everything and bringing in fresh clothes, even here."

Another patient said:

"My sons, they're all for it, for me to get somebody to help; but I said, we'll wait and see, see how things work out."

Just as Isaacs found in his early investigation of geriatric admissions in Glasgow (Isaacs et al, 1972), there is an expectation amongst some older people that it is their family's duty to provide them with assistance. Some interviewees in this study preferred family support to a 'stranger' coming into their home. These views appeared to be partially financially motivated for those who would have to pay, but they were also very much a product of beliefs some patients had about their right to be supported by their children in old age. There was an expectation that families would do things that the services should/would not. One Scottish patient said:

"My daughter in law does all my washing. I wouldn't expect the home help to do that."

A Canadian patient stated:

"She [daughter] is *thinking* for me. We have a joint account at the bank, so she goes and straightens that all out."

Another Scottish patient explained why she felt she didn't need more services:

"Now I don't know who should be my home help other than my daughter in law. She does my shopping, she goes and gets my pension, she does my washing, does my ironing, and she does...well, she gets all my letters coming into the house. She lives up the road."

It is important to point out however that even those patients who expressed an expectation that their family would help them were still very grateful for all the support they received. Admittedly some patients (such as the Scottish woman above) had higher expectations of their families than others. But even those who appeared to take their family for granted were aware that their support was a crucial factor in being able to continue living alone.

Five patients in each country lived alone without close family nearby. Several had relatives in the city but saw them rarely. These relatives could not be described as caregivers because the older people in the study were by no means dependent upon them for assistance. One Scottish patient expressed her frustration with a niece and nephew who were supposed to escort her home from hospital but because of a misunderstanding did not turn up:

Researcher: So when did you first see your niece and nephew after that [day of discharge]?

Patient at home: It was days! So I just sort of said, well, I wash my hands of them. I think I have seen them once since then. They came in with no apology for what they had done, but I didn't say anything. They did phone, just before Christmas and said, well, we will be down to see you soon, but of course they didn't."

Of the ten patients without family caregivers, several were very isolated. This absence of support created awkwardness in the hospital where professionals expected the patient to provide them with the name of a relative to whom any inquiries or concerns could be directed. This assumption that 'everyone has someone' made those who were alone feel inferior. As one Scottish patient stated:

"I have no option, when they ask who my next of kin is....I just don't have a next of kin, but they [the staff] are never really interested....but eh, I always quote J's name [a friend] you know, they are always expecting somebody to have one."

Issacs et al (1972), Evandrou et al (1986) and Qureshi (1990) have pointed out that in the absence of kin, it is friends and neighbours who are more likely than statutory services to provide older people living alone in the community with support. In both Scotland and British Columbia, those patients without family caregivers did have friends or neighbours who either helped them with specific tasks or looked out for them. As one Canadian living alone in a trailer park explained:

"I'm not alone in this park. They all keep track of me, and if they don't see me around they come in and see how I am doing."

One Canadian and one Scottish woman depended on elderly female friends who were also frail. They had a mutually supportive relationship and lived in the same building. The Canadian told the researcher what she thought of her apartment:

"Its OK, except it's too big, but then if I moved I wouldn't have M [the friend] nearby. I chose it on the basis that it was in the same block as M on the same floor."

Another Canadian described how her neighbour in the apartment upstairs phoned her to remind her to take her medication:

"She'd phone me at breakfast, phone me in the afternoon, and again at 5:30. She is a very nice person."

However, the type of support provided was materially different from that given by close family. As Wenger (1987) and Qureshi (1990) agree, non-family members are seen as less obligated to provide practical assistance, and are most likely to help those with a lower level of dependency. Once dependency levels increase, friends or neighbours with their own responsibilities may not be able to provide the older person with the appropriate type or amount of assistance. As one Scottish patient pointed out:

"Mrs.R in number 65 has been very good...but as she said, she can't do much, she's 71 and her man's not well and she has a house like mine and can't look after both of them, so I just have to make some other arrangement."

Neill and Williams (1992) have pointed out that the older people in their study of discharge planning in England were often reluctant to identify non-family members as 'carers', even if these friends or neighbours provide a significant amount of support. One Canadian patient who had no family in the province relied heavily on a male friend, N, a fellow immigrant from Ireland. He was however very reluctant to ask this man for assistance, even when he had no other option. Although the friend voluntarily did a lot for the patient following discharge from hospital, for the patient to seek assistance would have been to change the nature of their friendship from one of companionship to one of dependency. Like the two women who lived close to elderly female friends, this man worried about putting any demands on someone who was not a family member:

Researcher: So would N bring you something you needed, if you asked him?

Patient: I would not ask him. We go out together. I would not ask him.

Two patients without family caregivers in Scotland, and one Canadian, had developed a close relationship with a specific home help before going into hospital. Other older people began to construct such relationships following discharge. These relationships, which will be discussed in later chapters, highlighted the place that community services have in providing isolated older people with social as well as physical support.

RESPONSIBILITY AND CONTROL

Irrespective of whether family carers were present or not, all twenty patients in this study expressed strikingly similar views on the subject of health and illness. They perceived their own health as something that they themselves should be capable of maintaining. This 'personal responsibility' for health appears widely in the patient participation literature. Models of the 'active' patient (Steele et al, 1987, Thomasma, 1983) describe behaviour in which patients assume responsibility for any deterioration in their health. Brearley (1990) points out that the avoidance of illness and hospitalisation involves the practice of self-care and health maintenance, both part of assuming responsibility for health. She cites studies that found that between 75-80% of all care is self-provided. The studies she describes all drew their data from community surveys, which illustrates one important component of responsibility for health; that it is assumed in one's own home, away from the medical expertise available in hospital. As McEwen et al (1983) point out "It is principally when in contact with health professionals that the least participation appears to take place." The older people interviewed for this study expressed an expectation that they were responsible for their own health and its maintenance at home, rather than in hospital where it became the domain of professionals.

Amongst the patients in this study, perception of responsibility for health took two forms. Firstly, subjects described to the researcher their methods of *remaining healthy and active* (health maintenance) in order to avoid hospitalisation. Secondly, patients saw themselves, rather than services, their doctor or their families as *accountable for any deterioration in health they had experienced*. This perception of personal culpability for falls or illness affected their description of their admission to hospital and possible reasons for readmission.

Older people interviewed in both countries were determined to return home from hospital and remain there. This was the case even for those patients (four in Canada, one in Scotland) who were considering a move to residential care. For some patients this determination took the form of active health promotion, while for others it involved recognising their limitations and attempting to maintain a basic level of functioning. Patients were most concerned about being able to 'keep moving' and perform basic daily tasks for themselves in order to remain independent. Findings from other studies (Stolar et al, 1992) have highlighted the relationship between life satisfaction and health problems. Functional disorders that affect the performance of activities of daily living can result in lower levels of life satisfaction. A Canadian patient explained his reluctance to use a walker:

"Somebody says 'why do you do it the difficult way? Well I says I've got to make some of these things work otherwise I would lose my muscle!"

A Scot described how he convinced himself to keep going:

"I make a move if I want to make a move , and if I find I can't, I talk to myself. I say 'come on now, stop it.' or come on now, get a move on."

Interviewees also displayed their determination to continue performing activities of daily living in accounts of what they did and did not want statutory services to assist them with. As one Scottish patient said:

"I always tell her [the home help] never to put anything away that she has bought for me. Never put it away . Just leave it there, which will make me get into the kitchen and put it away. Because if you sit on your backside and decide, 'well, that's it,' you'll get nowhere."

For Canadian patients, more than the Scots, exercise was seen as a necessary component of maintaining health at home. This perception undoubtedly stems for a more activity-oriented environment both within the community and on the ward where the research took place in British Columbia. One of the younger (age 73) patients related how she kept fit at home after two previous hip replacements:

"I have what they call Jakes exerciser...I like it though. It's to strengthen my legs. As long as my legs keep going I'm OK."

Another recounted how she kept doing the exercises she had learned during a previous admission:

"Ever since I came home from the hospital last time, I have always done my exercises. I do them at home, to try to strengthen my arms and legs, I lie on my bed and I do my back forty times and my legs forty times and my arms forty times."

Opinions about health maintenance at home also included risk reduction. Several patients had fixed ideas about their functional limitations and what was necessary to reduce further falls. Most who had been hospitalised following a fall had plans of action to reduce the chances that it would happen again. They saw it as their responsibility to eliminate risks, as far as possible. A Canadian patient described this:

"I try to be careful, and usually I have something to hold onto....I am afraid of getting down the curb you know, I am afraid of falling."

Another expressed annoyance that her daughter was always telling her to be careful:

"She thinks I take too many chances, but I don't.. I know what I have gone through and I don't want to go through it again."

One Scottish man explained how he reduced the risk of falling:

"I'm housebound. I've been housebound for over a year now. I did it voluntarily. Because when I got off the bus, I had to get off at my stop...I had to wait there because my legs were so unsteady, I had to wait there until someone came along and offered to help me across the road....when I was waiting on someone to help me across the road, I was putting them in danger. I didn't want to do that. So I decided to stay at home."

Personal responsibility for health also extended to self care and treatment at home. In the hospital, patients complied with all the clinical aspects of the treatment regime prescribed to them. However, once at home in the community, they regained their 'right' to make decisions concerning medication, diet and activity. This reassertion of control will be discussed later regarding compliance with the discharge plan. One housebound Canadian patient described how she identified her need for a minor remedy at home and went about obtaining it:

"I was a bit constipated there a couple of weeks back . I called my friend, she used to be my nurse. She said she used to take milk of magnesia - so she said try it, it will do you good. So I was on my own and nobody to get it for me so I phoned the pharmacy up here [they delivered it] and I was taking it up until yesterday..."

Another woman described how she changed her medication once at home without consulting her homecare nurse:

"She said to me one day something about three little pills I take at night time, she said they were sleeping pills. I thought 'well I don't need sleeping pills'. So I took it upon myself—it wasn't her doing—to cut them out."

These forms of health maintenance—from maintaining day to day activities, exercising, reducing risk and engaging in self care—were all ways of 'coping' with poor health and living alone. Thus it is not surprising that when these coping mechanisms broke down and a fall or deterioration in health occurred, interviewees claimed responsibility for the causes of their admission to hospital. Interviewees in both countries described their admission as something that could have been avoided, something that need not have occurred if they had been more careful or had a 'healthier' lifestyle. As McEwen et. al (1983) have pointed out, good or bad health defines us. Many of the patients interviewed interpreted their fall or crisis as failure. Not one interviewee attributed their admission to a lack of help at home, to the condition of their home or to services provided by health or social care staff. Although three surgical patients (gallstones, ureteronephrectomy, colectomy) and one medical patient with a heart complaint all pointed out that their conditions were such that no one was to blame, all other patients who described the circumstances of their admission viewed their condition as avoidable. The most extreme examples were two patients (one in each setting) who were admitted for alcoholism, malnutrition and lung complications (pneumonia and bronchitis) that occurred as a result. Both these men claimed full responsibility for their admission to hospital:

"I didn't have enough control over the decision to end up here, I can tell you, but in general I make my own decisions....I was vomiting, but I'll tell you the truth, I got pissed up and that's why I ended up in here."

Similar attitudes regarding responsibility for their condition were expressed by patients in regard to possible readmission to hospital. Patients were asked what they thought might cause a return to hospital. While other research (Proctor et al, 1996) has recently found that up to 50% of hospital readmissions amongst frail elderly were attributable to a lack of supportive services in the home, only one patient in this study (a Canadian) said that she believed a lack of home help or home nursing care could contribute to her return to hospital. All other patients who responded to the question attributed possible readmission to their own health problems.

Both men admitted with complications associated with their alcoholism stated that it would probably be their own fault if they had to return to hospital, although they had good intentions for remaining at home:

"I don't intend to end up back in hospital, that's for sure. ...it could be anything, a fall down or whatever, but it won't be some stupid thing like what I done before, that's for sure."

Other patients also viewed readmission as something that was avoidable, as long as they were careful and looked after themselves at home. One Scottish patient said:

"Oh, I reckon it would be my own fault because if you go away from here thinking that you're OK and then you have to come back again, there must be something wrong with yourself. But I wouldn't want to come back again..."

Another Scot agreed that readmission would be her 'fault':

"If I did anything stupid, it would be mine...just something stupid like falling out of bed."

Canadian and Scottish patients therefore conceptualised their own health status as something that they could, to a certain extent, control and maintain. However, it was apparent from interviews that this control was something that existed only in the older person's home environment, where they themselves could regulate their activities, choose what they did or did not do and reduce potential risks. Responsibility for their own health was something that they relinquished to professionals during consultation or admission to hospital.

This relinquishing of control had several implications for the patient's role in decision-making that will be discussed in later chapters. However, the most immediate consequence concerned the patient's physical presence in hospital. Occupying a hospital bed meant that the older patient was no longer free to control their own movements - they became part of a system that dictated for them where and in what matter they would be cared for. The common nature of the British and Canadian health services—free at the point of access—meant that there was no element of choice presented in the initial stages of contact with the system. This relinquishing of control appeared to begin for some patients during the process of admission to hospital. One Scottish patient described the circumstances of his admission:

"On the Friday, after being in the day hospital on a Thursday, I fell onto my back. The ambulance came and brought me in here....I don't know why...there really

wasn't anything wrong with me, I mean I had fallen before. But this time I think my doctor wanted someone else to have a look at me."

Another Scottish patient described a previous admission and the fact that he was still unsure how and why it had occurred:

"I was getting along fine, I hadn't seen a doctor for three years...It was a virus I had. So I decided to go and have a chat with the doctor, to ask him if he'd clear it up. So they sent me to the hospital. I'm not sure what they did to me there."

Three other patients (two in Scotland, one in Canada) related experiences they had while in hospital in which they were moved without recalling a prior warning - once in hospital, they were commodities rather than consumers, to be moved from place to place on the instruction of their doctors, whose opinions they did not question. As the Canadian patient stated:

"I wanted to be in the J hospital this time, because that was closer to my friends. I was admitted there, but they didn't have any space, so they pushed me over here."

Another experienced patient described the process of being moved within the hospital:

Researcher: You're lucky, you've got a room of your own.

Patient: Aye, but don't worry, I'll get thrown out of that on Monday, soon as there's another one coming in.

Researcher: Do you think they'll ask you if they can move you?

Patient: No, they'll just move me, they'll appear at my bed and I'll not know anything about it at all.

PARTICIPATION

The lack of control that patients experienced on admission and during their stay in hospital affected their role in discharge planning. The majority of patients in both countries did not take an active role in decision-making. Levels of participation were partially affected by organisational factors. However, there were also personal or psycho-social explanations for the role that patients played. Some of these

explanations were unique to certain individuals and their circumstances, while others were common to all or the majority of patients.

Four themes emerged from patient interviews relating to perceptions of participation. These were: belief in the superior knowledge of professionals; reluctance to ask questions; unwillingness to 'bother' staff members, and willingness to defer to families during discharge decision making.

PROFESSIONAL EXPERTISE

All patients interviewed expressed some willingness to defer to professional, particularly medical, authority during their time in hospital. The idea of professional 'ownership' of information and protection of that information has been well documented in the literature (Friedson, 1970). Ashworth et al (1992) attribute this to the social distribution of knowledge; that clinical staff have a stock of knowledge which patients are excluded from.

Patients' belief in the superiority of professional knowledge had two consequences. The first was the assumption that the professionals knew what was 'best' for them. One Scottish patient was unable to tell the interviewer the purpose of his medication. He explained his belief about the tablets he was taking:

"Well, they must help me otherwise I would not have been given them. I don't have much choice."

A Canadian patient explained why she did not want to play an active role in discharge planning :

"I think they are in a better position than me, they know about these things. I mean I don't know...they have been doing it for a long time, they should know how things work best for people."

Another Canadian stated:

"I let them [the ward staff] arrange everything. They know what works, they know all the rules."

There were some exceptions to this unquestioning acceptance of professional expertise. These came from patients (two in Scotland, one in Canada) *who had previous experience of being in hospital* and who wanted to be involved in decisions concerning functional/self-care rather than clinical decisions, which they left to ward staff. The opinions of these three older people echo Biley's findings (1992). She

found that patients accepted a passive role where technical issues were concerned, yet preferred to make decisions relating to activities of daily living. Similarly, Loughlin (1993) found that those who had worked in health services or were frequent users of services were less willing to accept professional opinions without questioning them. Brearley (1990) reviewed the patient participation literature and found that patients with long-standing or multiple chronic conditions (such as arthritis, hypertension) were more likely to challenge professional opinion as they were used to carrying out 'medical' tasks such as administering medication and had a stock of knowledge related to their disease. Nelson-Wernick et al (1981) also found that challenging behaviour was related to length of stay in hospital - that patients who spent long periods of time on one ward began to 'know' the system and become less convinced that the doctor (or nurse, see Biley, 1992) knew best. These more experienced patients were more likely to ask questions and state preferences. One experienced Scottish patient referred to his medication:

"I used to just take them and say nothing, but then I got to the stage where I wanted to ask what's this supposed to do."

This patient made the distinction between the areas in which he believed he should (daily activities) and should not (technical issues) participate in decision-making:

"They have the training, they are the people who are used to coping. It is all new to me. Me, I know what I need, but that's as far as I can go, to tell them."

A Canadian patient did the same:

"You have to help them [the professionals] know what your limitations are. That's where they step in. You make clear your limitations, and then they put in extra to cope with that, to help build that back up."

Ashworth et. al (1992) conceptualise patient participation as having two components; a 'membership' in the stock of knowledge at hand and the possession of a relatively unthreatened sense of selfhood. We see from the comments above that the patients interviewed either viewed their knowledge of their condition as inferior to the knowledge of the professionals or limited their contribution to providing ward staff with information about their everyday needs and capabilities. Part of this acceptance of the superiority of professional knowledge stems from the fact that many patients believed their contribution to decision-making would have no effect on the eventual result, that they were meant to be the objects rather than the subjects of discharge planning. As Ashworth et al (1992) have stated, "The sense

that one's contributions are not regarded as worthy of equal attention and consideration is more than likely to undermine one's sense of self-hood."

One Canadian patient elucidated how important recognition as a 'person' rather than a patient was to her willingness to express her opinions:

"Well, I don't mind saying what I think, if I get on well with the person, then I expect them to listen. For instance J [the physiotherapist] was talking to the girl from the other floor where I came from and she was saying how well we got on...."

Steele et al (1987) have pointed out that 'active' patients expect to be heard. Those patients in the study who felt that their contribution would not be considered were less likely to make their preferences clear to members of the ward team. A Scottish patient described one of the reasons why he didn't like most of the nurses on the ward (which he had visited several times) and preferred to communicate with the doctors instead:

"Yes, always the doctors. I'll tell you why. You get the ward nurse, or the staff nurse, she's got about three juniors 'round her, and they're all whispering "he's a drinker".....I mean that shouldn't be overheard by me! I've told them that. It should not be overheard...I don't like the wee lassies going 'tee hee hee'."

This patient obviously felt that his opinion was not going to be taken seriously by nursing staff who saw him as a 'problem'.

QUESTIONS

All patients were asked if they could recall a question they had asked ward staff in the days preceding the interview. The majority of patients in both settings could not recall questioning staff on any aspect of their in-patient or aftercare. Four Scots and four Canadians could recall a question. All but one question related to activities of daily living, an area in which patients felt they had sufficient knowledge of their own to broach the subject. Only one patient (in Scotland) could recall asking ward staff a question about a specific aspect of the treatment they were receiving. The woman in question recalled asking the junior house officer why he was taking another sample of blood from her and for what purpose.

The absence of questions concerning treatment did not mean that the older patients interviewed did not want information about their condition. Although several

expected their families to have been informed, others only reflected on the gaps in their knowledge once at home. When the researcher visited one Scottish patient at home she asked whether the researcher 'had her file'; did the researcher know what had really been wrong with her in hospital? A Canadian patient expressed her regret that she had not asked for more details concerning her second surgery to remove gallstones:

"I wish I had known more about what they did when I went back [to the hospital]. I didn't understand that, also they said there might be a little bit left from the last time, they couldn't get it all out. I wish I had asked why and what it meant that it was left. But I didn't want to ask."

Several studies have highlighted the fact that older patients are less likely to ask questions than younger patients. They are less positive in their desire for information (Reynolds, 1978, in Lonsdale and Hutchinson, 1991) and more likely to adopt a passive role than younger patients (Strull and Charles, 1984, Degner and Sloan, 1992). No comparison with younger patients was attempted in this study but interview data from both staff and patients support the assertion that this passivity may have generational explanations. Older patients in both countries were accepting of hierarchical ward structure, and recognition and acceptance of medical expertise was common to all patients. One Canadian patient who had emigrated from England summed up what she perceived as her generation's attitude to questioning doctors:

"We never asked questions until we were told...we never did...It had more to do with the way we were brought up. You just didn't ask."

Questioning was perceived by some older patients as trouble making. To ask was to interrupt, to take time away from busy staff. One Scottish patient explained:

"In real life, you don't tell a doctor, he tells you. And you don't argue, you do as you are told. That's my philosophy of life, on hospitals and doctors. I'm not a complainer."

COMPLIANCE

Unwillingness to ask questions was found to be related to the more general impression that the older people interviewed did not want to 'bother' others with their problems or needs. Several studies have found that older patients tend to express more satisfaction with health services than younger people, one possible

explanation being that they have more modest expectations (Cartwright, 1981, Nelson-Wernick et al, 1981, Harding and Modell, 1989). Older patients are more concerned with conforming to the hospital environment and not 'rocking the boat' than complaining about services (Waterworth and Luker, 1990) This means that they will follow instructions, agree with suggestions and comply with decisions made for them by others more readily than they would have before they became patients. Armitage (1981) has suggested that this may be because patients fear being seen as 'difficult' by ward staff. Allen, Hogg and Peace (1992) have argued that older people tend not to complain about services for fear of being accused of 'trouble-making'. Comments from the older people interviewed for this study support this view.

When asked if they thought it was important for patients to have a say in discharge planning, the majority of Scottish patients and several Canadian patients responded by praising the staff rather than answering the question. One exchange was:

Researcher: Do you think it's important for patients to have a say in planning for things at home?

Scottish patient: Yes, I do. But you know I think Dr. E is absolutely wonderful. He listens very well, and so does that young German doctor.

A reluctance to complain about aspects of their stay in hospital meant that the researcher had to assure most subjects that she was not evaluating staff or the hospital. Enquiries about question asking, specific staff or ward routine all could result in interviewees emphasising that they had no complaints. A typical response was:

"The service you get in hospital is so exceptional, you can't complain."

Most patients were however genuinely pleased with the service they received, and took every opportunity to express their satisfaction. Even criticism was couched in the gentlest of terms, as two similar statements, one from Scotland, one from Canada, show:

"Some of the ones [doctors] around here are a bit short with you, but they are all right."

"Its the way they talk to you. To my way of thinking some of them are too brisk. They say 'come on. come on'...but they are very rushed."

Any complaints patients had they usually excused by mentioning how busy the staff were, and that any services under the circumstances should be appreciated. Altshul (1983) found that patients were grateful for nursing care offered and tended to make allowances for the shortcomings of individual nurses, blaming any failures on 'the system'. As Congdon (1990) discovered in a small qualitative study of American patients, her older subjects 'normalised' the fact that they were not involved in decision-making by stating 'My opinion wouldn't count - they've got things to do.' This resulted in patients explaining to the researcher why they were not consulted on some aspects of the discharge plan:

"Sometimes they don't tell you what they are going to do. But that's all right. As far as I am concerned they can go ahead and do as much as they like."

FAMILIES AND PARTICIPATION

Family communication with hospital staff has been identified as an important factor in determining to what extent older patients are involved in discharge planning (Coulton et al, 1982, Simmons, 1986, Schaefer et al, 1990). In this study, family members were often the ones who asked questions or challenged professional opinions when patients would not. There were several explanations for this. The most apparent relates to the theme of 'compliance' mentioned above. Patients themselves did not want to bother the staff whom they were dependent upon for care and attention. So instead, the families were the ones who could question staff and spare the patient the trouble of being non-compliant. Several patients in each ward showed a willingness to defer to the opinions of their relatives when it came to decision-making.

Willingness to defer to families in discharge planning took two forms - advocacy and surrogacy. Both forms were observed in each study setting. Patient advocacy practised by the family occurred when an opinionated patient communicated their needs and expectations to their son or daughter and then expected them to be passed along to ward staff. In this way the relative became a mediator between staff and the patient. The patient could avoid 'pestering' the staff with questions or demands, retaining their role of a 'good', compliant patient while having their opinions aired by family members. In Scotland the best example of this was one older woman who was quiet and polite with staff but demanding and vocal with her son and daughter on their visits. Once discharged it was apparent to the

researcher just how much support the daughter provided her mother with at home. The mother had an assertive personality, but in hospital it was left to the daughter and son to 'deal' with staff and engage in discharge planning with the mother's instructions in mind. This was illustrated by the patient's version of how she had her discharge date delayed:

"That day the nurse came in and said I was going home on Thursday...and I thought 'Thursday? That's only the day after next! So Peter, my son, came in and I told him to go for the doctor. And the doctor came up here, and Peter explained...that was only giving me one day..."

The other form of deferral in decision-making took place when families acted not as advocates for the patient's wishes, but rather as surrogate decision makers. They engaged in discharge planning to the exclusion of the patient. Abramson's (1988) study of discharge planning for 20 older American patients found that family contact with staff could act as a barrier to patient participation. She found that those cases in which social workers spent the greatest number of hours with families had the lowest mean patient participation scores. Armitage (1981) also points out that anxious families often need to be convinced by staff that they can support their older relative at home with additional aftercare services. In this situation services are designed to meet the families' needs, excluding patients from the bargaining process.

Three Scottish patients and two Canadians had families who were very involved in discharge planning. Although there were organisational reasons for this, the older person's *acceptance* of their relatives' role as surrogate decision-makers contributed to their own exclusion. Like the Scottish patient mentioned above, these older people wished to avoid confrontation with staff and therefore revoked their rights to consultation by accepting their children's decisions of what was 'best' for them. In Canada particularly there was an often mistaken assumption by patients that home care (particularly meals, cleaning and equipment) would have to be arranged privately by the family in any case, which contributed to the patient's willingness to remain ignorant of plans being made on their behalf. Several comments from patient interviews elucidate this willingness to defer to families. One Canadian patient said:

"The last time I went home [from hospital] I didn't have any questions that I wanted to ask the doctor...The last time, my daughters were there. They asked the doctor questions. I don't know what the questions were, I didn't hear them. But Dr. D answered them."

A Scottish patient expressed her faith that her niece would take care of any unmet needs:

"The staff couldn't be better. But I'll tell you something, if I didn't ask, my niece would ask...she used to always enquire about my hearing aid for instance."

Scottish and Canadian patient's willingness to defer to their families in decision-making relates to the theme of 'compliance' mentioned above. Patients were reluctant to trouble staff, preferring to comply with instructions in hospital while encouraging their families to ask questions or challenge arrangements made by staff on their behalf.

INDEPENDENCE AT HOME

The older people in this study were very reluctant to become completely dependent upon anyone. Although grateful for the help they received, they viewed some of it as excessive and were determined to continue to manage for themselves. As one Scottish patient said of her niece's frequent visits post-discharge:

"I get very agitated. I don't want her to do all these things for me. I don't want her to bring all these things...."

Much of the determination to cope expressed by patients in both countries concerned the issue of returning to their own homes. Most were convinced that home was the right place for them to be, and were determined to do whatever they could to return there. This was despite the odds which indicated that the group of patients interviewed for this study were amongst those most likely to be institutionalised in both countries. In a Canadian study, Keating et al (1994) point out that those most likely to require nursing or residential care live alone, are frail and have little or no family support - a description that could have been applied to just over half of the patients in this study. Congdon (1990) also found that family support was a key determinant in discharge destination, meaning that frail people living alone were at higher risk of institutionalisation than those living with others. Carriere and Pelletier (1995) in a Canadian study, point out that age, then income followed by marital status and poor health are the strongest predictors of institutionalisation. The average age of Scottish subjects was eighty-one and

Canadians eighty-two, all were unmarried or widowed and the majority of patients in both countries lived on a low, fixed income.

Patients in both countries were aware that they were at risk of institutionalisation. Most knew people in care. Institutionalisation was not addressed directly in interviews. The researcher merely asked if hospital staff or anyone else had discussed with the older patient the possibility of not returning home. This question in many cases prompted comments on a move to nursing or residential care. The theme of institutionalisation was one that patients in both countries were eager to discuss.

Attitudes towards institutionalisation *varied significantly* between Scotland and Canada. Canadians were more likely to accept the idea of a move to residential or nursing home care in the future, whereas the majority of Scots refused to consider the idea of institutional care. Although there were psychological and personal reasons for this based on the views and experiences of the patients in the study, there also appear to be more general explanations that could apply to other people in similar circumstances in Scotland and British Columbia.

Patients expressed three types of views regarding a move to institutional care. The first was a general love of home and an eagerness to return there, even in the short term, that was common to older people interviewed in both countries. A Scottish patient expressed this:

"You can live in the greatest, most comfortable situation the world ever created, but there is still no place like your own home. Everybody knows that. It is not a new observation."

Similarly a Canadian said:

"I want to get home, naturally. I've been out long enough, what, six weeks, I don't know. Once you get feeling better you want to go back home. What's new about that?"

Although patients in both countries expressed a love of home, the majority of Scots qualified this by stating that home was where they were determined to stay. They were completely unwilling to consider a move to residential or nursing home care. Only two Canadians refused even to consider residential care in the future. One Scottish man who was returning to the home he was born in said:

"This [home] is where I want to be, definitely. I know that I have been well looked after in hospital, but that is not

like your own home. After all, eighty-one years is a long time."

One Scottish patient described how members of the ward team had raised the issue of residential care with him:

"Ah well, I have been through that with people. It's been discussed. I've no next of kin, so I just have to look after myself. I refuse to discuss any other options."

The only two Canadian patients who had ruled out the possibility of institutional care in the future was the youngest subject (73) who had ended up in the assessment and rehab unit after being treated following a traumatic car accident, and one very determined, very frail English immigrant who had been widowed over forty years and was adamant that she would not move from her apartment. She explained:

"My doctor, yes, she has tried to get me into a nursing home, but not me, not me, I would have to be bedridden....I am not moving until I am bedridden. Then somebody can shift me."

The second type of opinion regarding institutional care was expressed by the majority of Canadian patients and one Scottish patient. This was a willingness to consider a move from home in the future. The idea of institutional living was acceptable to these patients, although they hoped that it would not happen immediately and were content that they would be going back to their own homes from hospital, if only for a short time. A Canadian patient explained that he thought going into care was something everyone should consider and plan for if necessary:

"I've got to plan ahead, and if I get incapacitated to the point where I need extra help, then I've got to plan to go into an extended care place. Some place where there is help all the time."

The Scottish patient in question had been to visit a residential care home with the social worker from the hospital. She approved of it but was not immediately ready to move:

"It was a lovely place, but I said now, I am only here for one day remember, because I have got used to my own home."

Finally there were those patients who had decided to leave their homes and whose name was on the waiting list for a place in residential care. They had chosen to return to their own homes in the meantime, but they knew that within a year they would be faced with the choice of whether or not to move. No Scottish patients

were in this situation. It was unique to the Canadian subjects. Their acceptance of this situation was revealed in interview comments:

"Now I like my apartment but I have been looking at other places as well...I liked one where I already knew some of the people. So that might be the next step but not for a few months yet, they say...you have to wait for a place."

Four Canadians were on waiting lists . The decision to be on them was arranged prior to the current admission for all but one patient, who agreed to it after a poor home visit and discussions with staff and her daughter. These patients were in many ways going home to wait. When interviewed in her apartment one month post-discharge, one woman described why she had wanted to go home first:

"You know I have kind of forgotten the different things I have, for dividing them up amongst the family...but I think I have everything straightened up now, so they can just take over."

Another Canadian patient, a Dutch immigrant in his nineties, explained that he had accepted a future move but he hoped it would not be immediate; like the woman who refused to move unless she was bedridden, this older man saw functional independence as the key to remaining at home:

"I am on the list, I don't know where I am on it. If it is necessary I will go. I go by myself to bed at the moment, I can dress myself.....but if it is necessary, I will go to a rest home."

Canadian patients were more accepting of institutional care than their peers in Scotland. Why was this? For two women in particular it was related to their desire not to burden their families, whom they perceived as under strain in the post-discharge period:

"Yes, I want to go to Mt. E [residential care home], so that it does not put any more pressure on my family. They don't show that they are feeling it, but I know they are...because they spend a lot of time with me."

Although Scottish patients did express the worry that they were becoming too dependent upon families or friends and reluctant to trouble them, they never presented the researcher with the idea of a move into care as a possible solution. This prompted the researcher to consider other, structural explanations for this difference in attitude between the two countries.

The first structural explanation lies in the history of institutional care. In Canada, a higher proportion of the elderly population reside in care homes than do those in Britain. National figures for Canada suggest that up to 7.5% of those aged 65 years or older live in long term care homes, the 1992 figure for British Columbia being 6.5% (Gutman et al, 1995). In Scotland, 1993 figures suggest that only 4% of those aged 65 or older live in residential and nursing homes (Scottish Office, 1995). This history of the incidence of institutionalisation applies to other care groups in Canada, such as the physically handicapped and those with learning difficulties (Forbes et al, 1987). Therefore there may be a wider public acceptance of institutional care than in Scotland, where there is a certain stigma still attached to residential care homes¹.

An additional structural explanation may be financial. In British Columbia, all public services (community care and residential/nursing homes) for older people are financed as part of the province's long term care budget and administered by the local authority. As all long term care is provided in the community (there is no equivalent to the NHS long stay ward) there are flat rate charges for all levels of long term care. This means the province charges the same rate in any provincial home to all residents, regardless of means. William Laing, in his 1993 comparison of long term care financing in eight OECD countries, describes the Canadian system:

The entire population of Canada is covered by a state insurance scheme for long term care outside people's own homes on a non-means tested basis. Residents are however, liable for a charge (or co-payment) which is intended to go towards the board and housing element of cost. The co-payment varies from province to province but is typically about \$750 to \$800 per month [£375-£400] for a shared room (1992 figures). As the minimum pensioner income by comparison is about \$900 per month, this leaves the poorest individuals in long term care outside their own homes with some income for personal expenses. No claim is made on the individual's other private income or assets.

A means test is applied in British Columbia for the co-payment portion of long term care, but as Laing described, this does not mean that residents lose all of their income or assets. Although choice of home and size of room were limited and based on cost, the older people interviewed in British Columbia were living in a system where there was an entitlement to residential or nursing home care that was widely

¹ This stigma relates to local authority residential care in particular, largely because many homes were converted poor law workhouses. The sources for this historical stigma, with reference to England and Wales, but equally pertinent for Scotland, are described in many texts - one of the most prominent being Townsend's *The Last Refuge* (1962).

known, appreciated and expected. Lower cost combined with less stigma attached to moving into care may have made interviewees more accepting of an eventual move to institutional care.

In Britain since the 1990 *NHS and Community Care Act*, residential and nursing home fees are paid in full by those with savings over £8,000, and in part for those with savings between £3,000 and £8,000². These costs can range from £200-£500 *per week* (\$400-800 Canadian - so up to four times the cost of the British Columbia co-payment) depending on the type of residential or nursing home. *This implies the sale of property and possible exhaustion of all savings if care is required over a long period.* For those without savings, choice is limited to local authority homes or residence in another home at the local authority rate, which is often not enough to cover the cost of private residential or nursing homes. This means family members have to pay a 'top up' fee³ to permit the resident to stay in the home of their choice once the older person's own savings have been exhausted.

The Scottish patients interviewed were aware of the substance of these arrangements and expressed strong disapproval of the costs and limited choice involved. As part of a generation that had witnessed the formation of the NHS, paid national insurance contributions all their working lives and come to perceive publicly-provided health services as a right, they expressed their disapproval of current arrangements which exhausted the savings of those who had tried to accumulate some capital for themselves or their families. As one man who had recently bought his council house declared:

"You've no choice these days. Here, you've got to reduce your assets, you know what I mean. The poor, I find, get far more help than other folk."

Another Scottish patient related the story of friends she knew who were paying for care:

"One...has a sister in a home in L. She said, try to keep your own homes as long as you can...supposing you've got a

² In November 1995 these savings thresholds were raised slightly, meaning that older people could retain more of their savings before being liable to pay care costs. However, at the time of fieldwork £3,000 and £8000 were the limits.

³ At the time of fieldwork, a typical Scottish local authority contribution would be £211 for residential and £295 for nursing home care per week. Many private or voluntary sector homes had higher weekly rates - such as the Church of Scotland residential care homes at approximately £300 per week. If an older person's savings were exhausted and they could no longer cover the cost, their family would have to agree to pay a fee of £85 per week to keep their relative in that home, the alternative being a move to a cheaper home.

wee bit of money, and selling your home, it doesn't last very long. Because she's paying almost £400 a week, in that home...You save up for your old age and try to look after your family but money's not long in going."

CONCLUSION

The views of patients concerning responsibility and control, participation in planning, social support and remaining independent have been presented here. In relation to these themes, only two areas of significant difference were identified between the responses of Scottish and Canadian patients. Firstly, Canadian patients' views on personal responsibility for health maintenance included an acceptance of regular physical exercise as a component of recovery following hospitalisation. This difference in attitude has been attributed to a greater emphasis on activity in the Canadian geriatric rehabilitation and assessment unit and a wider promotion of physical fitness in the community where the hospital was located.

Secondly, Canadians expressed greater acceptance of a future move to residential care than their Scottish peers. This acceptance has been primarily attributed to differences in the organisation and financing of long term care between British Columbia and Scotland.

Similar views were expressed by patients in both countries regarding the other themes raised here. Both groups of patients expressed responsibility for their own health and its maintenance, and viewed themselves as culpable if coping mechanisms failed and hospital admission occurred. Both groups of patients expressed a willingness to accept professional advice once in hospital. While some accepted this advice without question, others expressed opinions or stated preferences restricted to activities of daily living and medication, rather than technical or treatment issues.

Half the patients in both countries had families who played an active role in discharge planning. Patients expressed a willingness to let their families speak for them, either as advocates, or as surrogate decision-makers. Patients were grateful for the support provided by their families, but those without close relatives nearby expressed a reluctance to become dependent upon friends or neighbours.

Reluctance to burden friends or family was found to contribute to the decision of several Canadian patients to accept a future move to residential care. However, all but one Scottish patient and the majority of Canadians stated that they were determined to remain in their own homes indefinitely following hospitalisation.

Personal independence was something valued by all twenty older people interviewed, but their commitment to the maintenance of that independence varied, depending upon the extent of control over the environment in which they found themselves. The interview data presented here illustrates that patients relinquished some of their independence and with it responsibility for their own health when they entered hospital. To what extent the older people in this study were permitted to regain any sense of independence during their time as a patient was very much dependent upon the organisation of discharge planning in the two wards studied. This organisation will be described within the context of the four stages of the discharge planning process.

CHAPTER 6

ASSESSMENT

“The very word ‘assessment’ strikes discordant notes for many practitioners in the field of care of the elderly. The instability of their medical diseases and the variability in the function of patients from day to day, and often from hour to hour, can make a one time only or even a repeat assessment somewhat limited.”

Dr. D. Wooldridge, 1987.

Discharge planning should begin on admission. This ideal—presented in the literature—was echoed by hospital policy documents in both Scotland and British Columbia.¹ It rests on the premise that any assessment undertaken while the patient is in hospital should constitute the foundation of the final discharge plan. What is assessment? At its most basic, the purpose of assessment is *to define or evaluate an individual patient’s needs*, be they health or social needs (DoH, 1991). Assessment means something different for each professional involved. For medical staff, it involves diagnosis and prognosis. For occupational therapists, an evaluation of functional ability and home environment. For social workers, assessment is the identification of social background, support and expectations, motivations and financial situation of the patient. Effective discharge planning cannot begin without assessment information gathered by all team members. Assessment however is not an event isolated to the earlier stages of planning, but rather is a continuous process, one that all team members carry out on admission and throughout the patient’s stay.

Findings from this study indicate that assessment is not always immediate or multi-disciplinary, nor does it always include the views of the patient. Gaps in

¹ NHS in Scotland (1993) *Discharge Planning: A Guide to Good Practice*. also Greater Victoria Hospital Society *Discharge Planning Resource Manual*, June 1992.

information and strengths and weaknesses in the assessment procedures used were identified in both study sites. These will be discussed below.

Assessment as an ongoing process can be divided into two further components in order to facilitate presentation of evidence from staff and patient interviews. The first phase concerns admission circumstances, or the older patient's experience of their illness at home followed by admission to hospital and transfer to the geriatric ward. The second phase is the multi-disciplinary assessment, consisting of patient and staff experiences of the procedures used to gather information necessary to begin developing the discharge plan. This stage also incorporates the assessment undertaken during the formulation of the discharge plan, including the home visit assessment.

It is important to point out that, for all twenty patients participating in the study, events relevant to the assessment process itself occurred before they became patients in a geriatric ward. These events were not observed by the researcher, and thus any reference to them is based on case notes and references made in interviews.

ADMISSION CIRCUMSTANCES

All of the Canadian patients in this study were admitted to another hospital ward before being transferred to the geriatric assessment and rehabilitation unit. All but three of the Scottish patients had a similar experience. Admission circumstances shaped their impressions of assessment in hospital. These circumstances can be discussed from the point of view of the patients and through a discussion of processes witnessed by the researcher. How patients described admission circumstances is the first point in this discussion of the period prior to arrival in the geriatric unit.

REASONS FOR ADMISSION

Patients interviewed in both countries recounted to the researcher the events that had prompted their admission to hospital. All patients had experienced a crisis or significant deterioration in health. Twelve patients (six in each country) were admitted following a fall of some kind. Patient accounts of the events that led to

their admission were very much coloured by a sense of personal responsibility for health. Patients in both countries viewed their admission as something that could have been prevented if only they had been more careful.

One older man in British Columbia and one in Scotland were admitted for malnutrition and alcohol poisoning. They had fallen over and were discovered by a home help (Scotland) and a friend (British Columbia) following a drinking binge. Both these men recognised that their behaviour had directly led to admission; they blamed no one but themselves. Yet other patients, particularly those who had had a fall, also felt as though they could have avoided hospitalisation. One Canadian who broke her hip crossing the street wished she had paid more attention to where she was placing her feet. A Scottish patient wished he had altered his kitchen so that he 'always had something to hang onto' that would have prevented his fall. Another Canadian recounted how she broke her ribs:

"Well it was my own stupidity really because I got up in the middle of the night and did not take my walker. Unfortunately, I walked into a door and the handle went right into my ribs."

In addition to feeling that their admission could have been prevented if they had been more responsible, sentiments of personal responsibility and a desire to remain independent by not 'bothering' others were expressed. Some patients revealed that *after* becoming ill they had delayed asking for help. One woman who was later diagnosed as having diverticulitis waited six hours before calling her daughter (who was going on holiday the next day) after she became ill. Another Canadian was discovered by her home help 24 hours after becoming ill. This woman could have phoned a friend upstairs who volunteered in a local hospital. She decided not to phone however, declaring that her friend "shouldn't have to attend to me when I am sick." One Scottish patient initially refused to permit his home help to phone the GP after he fell. He explained his reluctance:

"I hated having to call the doctor out once I was at home. But the attitude was 'that's what he's there for'. Well, I don't agree with that. A lot of people just think the doctor has just been invented to help them. I don't agree with that."

ADMISSION ASSESSMENT

Following illness or a fall, the majority of patients were not admitted directly to the geriatric assessment and rehabilitation unit but rather arrived there following

contact with other parts of the health care system. The diagram below demonstrates this.

SCOTTISH PATIENTS:
Emergency services(ambulance)--->General medical or surgical ward--->Geriatric assessment unit (3 patients)
GP visit--->GP communicates with Geriatrician--->Geriatric Assessment Unit (5 patients)
Day Hospital attendance--->Geriatric Assessment Unit (2 patients)
Geriatrician home visit--->Geriatric Assessment Unit (1 patient)
CANADIAN PATIENTS:
Emergency services (ambulance)--->General medical or surgical ward --->Geriatric Assessment Unit (7 patients)
GP visit--->General medical/surgical ward--->Geriatric Assessment Unit (3 patients)

The most common method of admission for Canadian patients was by ambulance following an emergency. Three Scottish patients also had this experience. They were found by either their home help (two Scottish patients, one Canadian patient), a son/daughter (one Scot, four Canadian patients) or a friend (two Canadian patients) who phoned emergency services. These individuals received their first assessment from medical and nursing staff on the admitting unit.

Those patients in both countries who were admitted to hospital after being seen by their family doctor had a medical assessment in the community that was communicated to hospital staff either in person (as was sometimes the case in Canada) or by letter (as was always the case in Scotland). This communication was found to be consistently entered in case files on the Canadian unit but in Scotland one of the five patients had no GP note in his file. Other case file reviews confirmed that this was not an isolated incident as did subsequent comments from medical staff²

Three Scottish patients were admitted directly by the geriatrician. One patient he visited at home following a request from her GP; he then arranged for her to be brought into the assessment and rehab unit that same week. The other two were

² Recorded in fieldnotes following attendance at the North-East Edinburgh Discharge Planning seminar, held at the Royal Victoria Hospital, November 1994.

weekly patients in the on-site day hospital. Both were admitted for a period of assessment and therapy.

Pre-admission screening in the literature usually refers to questions posed and diagnostic tests carried out on the patient prior to admission into the hospital or a specific unit. Once in the hospital, all patients (with the exception of the three above admitted directly to the geriatric ward) spent some time on another unit, either general medical or surgical. While on this unit a referral was made by ward staff there for a period of rehabilitation in the geriatric ward. This referral was followed up by a visit from a member of the medical team attached to each unit. The visit's aim was to determine the suitability of the patient for the assessment and rehab programme, given that the goal of each unit was to return patients to the maximum level of independence and hopefully to their own homes whenever possible.

The pattern of pre-admission screening visits was observed to differ between the ward in Scotland and that in British Columbia. In Scotland, all but one patient was initially admitted to a ward within the *same* hospital. The geriatrician therefore personally visited and assessed all ten subjects prior to their transfer. In Canada, this was not the case as eight of the ten patients were initially admitted to wards in the other general hospital within the city. These patients were visited by one of the geriatricians based at that hospital. Their assessment of some patient's suitability for the assessment and rehab unit was questioned if those patients became 'bed-blockers'. Assessment documentation between the two hospitals was also criticised as incomplete by some ward staff.

The pre-admission screening visit had implications for patient participation in the planning process. These implications took two forms. The first was in the relationship between patients and medical staff. In Scotland, patients were more likely to convey to the researcher the belief that their care was being 'supervised' or 'guided' by the geriatrician. This was based on the fact that they had met him prior to their transfer to the assessment and rehab unit and strengthened by the ward round that will be discussed below. Familiarity was seen to encourage rather than inhibit communication between patient and doctor.

The second implication for patient participation present in the pre-admission screening visit was the form and type of information made available to the patient

as a result of this encounter. This relates to the concept of an 'informed referral' (Klop et al 1991) They explain:

Informed referral refers to the information given to patients before being referred to hospital, which entails, for example, information about a specific hospital or special unit. This information helps the patient to choose. In addition, this information will encourage him to ask questions.

In Scotland, a printed information sheet was made available to patients and their families either before being transferred to the ward or on transfer. This sheet contained information about the assessment and rehabilitation unit, visiting times, the name of the consultant(s), details of the Trust's address for comments/complaints as well as other useful information. Armed with this information families could determine such things as when to come to the ward to meet the consultant and social worker for the carers' evening; the main forum for family involvement in discharge planning. There was no equivalent information sheet for the ward in British Columbia. This was recognised as a gap by both staff and patients³.

TRANSFER

Relocation from one ward to another was a difficult experience for some patients in the study, especially those (primarily in Canada) who did not know what to expect in the geriatric ward. Interviewees expressed their opinions on the transfer and compared their new surroundings with the environment in acute care. These opinions covered two main themes. The first was the difference in pace experienced in the assessment and rehabilitation unit. Patients found it much slower than other wards. To one Scottish patient and one Canadian, this was a welcome change. The Scottish patient relates his last in-patient experience for a prostate procedure:

"You go there at night, they look at you, the consultant he comes down to see you at eight o'clock in the morning, he tells you what is going to happen, you are wheeled up, operated on, thrown out - its all a bit, processional, you know?"

Another Canadian patient found the slower pace frustrating. She did not see herself as a 'geriatric' like the other patients and wished to continue her recovery at home:

³The Canadian team considered the development of a ward information sheet at the end of the data collection period. This was raised by the nurse manager in a team meeting 21/4/95. Subsequent correspondence with the geriatrician and social worker confirmed that this sheet was introduced in 1996.

"Things are slower moving here. You know in the other ward, people would be having their operations and two days later they would be out...But people are here [on the geriatric ward] longer. And they are older, they seem to be between 80 and 90, most of them. At that age, you have to go slower. But I'd prefer to be in a ward with younger people."

One other Canadian and two Scottish patients stated in interviews that they were distressed by their move to the assessment and rehabilitation unit. When questioned as to why, it was not staff, facilities or time frame that displeased them but rather the other patients. A Scottish patient explained this to the researcher once she had returned home:

"I was in Ward Y when I first came into the hospital. It was funny, I think I was only a couple of days on that unit before they arrived one day and told me they were taking me down here to Ward X. And to me that was a terrible place. I was very impatient to get home from there....there was nothing really bad, but the patient next to me, I used to actually worry about her sometimes. She'd suddenly get up and wander into the corridor - well - I couldn't get up after her..."

Similarly a Canadian patient stated:

"There are so many patients here, they can't do anything for themselves, some are certainly confused. the lady across the way, she fell the other night, I jumped out of bed. I know I shouldn't get up and help, because it bothers my head, but I just can't sit here and wait for someone to arrive."

Both wards had patients with some degree of dementia. Those patients who were cognitively intact were on occasion disrupted by their confused neighbours. They felt a sense of responsibility for their peers although there was little they could do to assist them and the nurses could not be in each room at all times. But the long period of rehabilitation without alert patients beside them to converse with appeared to hinder rather than help the morale of patients interviewed. Above all, the alert patients resented being grouped, and therefore categorised, with confused older people.

THE MULTI-DISCIPLINARY ASSESSMENT

Multi-disciplinary assessment of patients in both wards took three forms. The first was individual assessment, carried out by a single practitioner with a single patient. The results of this assessment were recorded in the case records. The second was the ward round in which a group of practitioners discussed the patient's case and in Scotland included the patient in this discussion. The third was the home visit, carried out to assess the patient's environment and their ability to function in that environment after leaving hospital. Once these assessments had been completed, their results were discussed in the multi-disciplinary team meetings held in each ward. These meetings were the formal setting for discharge planning, and will be dealt with in the next chapter.

INDIVIDUAL ASSESSMENT

On arrival at either hospital, patients received an assessment from staff in the admitting ward. In Scotland this was always carried out by a doctor, usually a house officer. In Canada a registered nurse carried this out. Each hospital had a specific admission assessment form which was then included in the patient's notes. These forms were reviewed by the researcher for all twenty subjects. Following this initial admission assessment, patients were re-assessed in the assessment and rehabilitation ward by members of the multi-disciplinary team. In Scotland, this always involved an assessment by the ward geriatrician, as has been mentioned. In British Columbia this was not always the case. Hodkinson (1981) has defined the assessment duties of the medical professional as diagnosis, prognosis and treatment. In Canada, elements of all three duties were carried out by registered nurses.

Nursing staff in both countries carried out an initial assessment of the patient's functional needs, including ambulation, toileting, nutritional and mental functioning. Therapy staff consisting of physio and occupational therapists (and a rehabilitation therapist in Canada) assessed mobility and function, including the use of mobility aids (PT) and activities of daily living (OT). A speech therapist assessed one Scottish patient. Social workers had slightly different assessment responsibilities in each country, but several in common: financial assessment, identifying the needs of carers and sources of social support, and providing information about services.

There were several 'grey areas' of assessment responsibility. The first was the nutritional needs of the patient. All Canadian patients received a separate nutritional assessment from the part-time dietician on the ward. In Scotland, nutritional needs were screened by nursing staff with the exception of patients with special dietary problems, who were referred to a nutritionist who then visited the ward to assess them (one Scottish subject saw a nutritionist). The second grey area was mental functioning. Wooldridge (1987) has indicated that the cognitive assessment forms part of the duties of the geriatrician. Consultants in both countries carried out mental testing⁴, but nursing and occupational therapy staff also fulfilled this function.

The third grey area was the needs of caregivers. Roden and Taft (1990) have noted that "a complete assessment of needs cannot be carried out unless the professional is given access to information held only by the patient and family." This was really an area in which *all* staff participated in gathering information. Although the social workers in both wards were the professionals most likely to formally seek and document social information, nursing and therapy staff also played an active role, particularly when carers visited the ward. In Scotland, the geriatrician also obtained valuable information from families during his weekly carers' evenings.

The final grey area concerned the views, opinions and preferences of patients throughout the assessment period. All staff claimed to consider the needs of the patient, *but actual concerns raised by the patient during a ward round or an assessment were rarely documented*. Those staff members who were most likely to hear the worries of patients were those who spent the most time with patients doing everyday activities. In Scotland these were the auxiliaries who bathed and provided hands on care to patients. In Canada this was the rehab therapist who took all patients for group activity/exercise sessions each day. Neither the auxiliaries nor the rehab therapist wrote in the case records on either ward.

RECORDS

Once individual assessments had been carried out, they were documented by staff. Case record review of all twenty patient subjects revealed significant structural and interprofessional differences in the way patient needs were documented on each

⁴ See details of standardised tests described in Chapter 3 'Methods'

ward. In British Columbia, patient notes were kept in the central nurse's station. Each patient was allocated a binder to which all team members contributed individual assessment reports and contributed to 'interdisciplinary' notes. In Scotland the patients' medical notes, including all past records, test results and correspondence, were kept in the medical office. Nursing notes were kept separately at the nursing station. Other team members contributed to both the nursing and medical notes, although more often formal documentation was kept in the medical notes (such as the record of an OT home visit) whereas day-to-day progress was noted in the nursing notes. In addition, each Scottish professional kept their own notes and social work documentation was kept completely separate as the social worker was an employee of the local authority rather than the hospital.

Differing methods of record keeping had implications for the availability and comprehensiveness of information in each unit. In British Columbia, the central location and unified format of the case notes meant that patient details were accessible and information requested by GPs, relatives or other wards could be obtained quickly and easily. Duplication was also avoided with this format. This became particularly important in the latter stages of the discharge planning process, when the liaison nurse relied on case records to make appropriate and accurate referrals for home care.

The separation of medical and nursing case notes in Scotland meant that there was frequent duplication of information, as other recent British research has indicated (Closs, 1997). This occurred primarily in the case of therapy staff who recorded similar information on both sets of notes. The social worker also had to transfer any relevant information from her notes into both sets of case records. As she explained:

"If I've been doing a lot of work and I think its important that it is in the medical records, or that I think it's important that the medics read it, I might include something. I will write in the nurses kardex as well if that is appropriate."

There was a general consensus amongst staff interviewed in Scotland that separate record keeping was not ideal, especially if other team members did not have the time to read notes from other disciplines. As a staff nurse said:

"There have been occasions [in meetings] when I have actually said what I am saying the week before and it's all documented in the nursing notes. I have felt that perhaps they [medical staff] have been frustrated with us, but really it is a bit of a two-way thing because they should

read our nursing notes. I go through and read their case notes if I want to find out, so I don't see any reason why they can't read our nursing notes."

Another nurse suggested a solution:

"I would prefer it if they used inter-disciplinary notes rather than everyone using their own notes, because then we would have direct access to everyone else's notes."

ASSESSMENT DELAYS

Were there any gaps in the individual assessment procedures observed in each ward? The vast majority of patients were seen by all the relevant professionals and their needs recorded. However in both settings there were assessment delays. These occurred in Scotland over the Christmas holiday period when the absence of senior medical and social work staff meant shortfalls. One subject was admitted with an admission assessment done but no further medical details noted until five days into her stay on the unit. Social work assessments were also a source of delay in the Scottish ward. The social worker's duties in other parts of the hospital meant that she could not respond to assessment requests as quickly as her Canadian counterpart, who was permanently assigned to the twenty-bed unit.

Holidays in the Canadian unit also created a significant problem over the summer months when the hospital only provided half-time replacements for staff. One Canadian subject was on the ward eleven days before she received an occupational therapy assessment. This type of wait can result in delayed discharge. Another Canadian patient who required home care was discharged without receiving a comprehensive socialwork assessment. He recalled:

"She [the replacement social worker] was only half time and she was offering me room and board. I told her I didn't want any room and board. She said that the other one had left her a note on her desk saying that was all I wanted. But that wasn't true. She said she would come back but I never saw her again."

THE WARD ROUND

McKeehan (1981) has defined ward rounds as "an activity in which individuals meet to review the current status of numerous patients on a particular unit." Following individual assessments, rounds are the next step in the assessment process as they allow the team to discuss the needs of a patient together and in

some cases with the patient him/herself. Traditional ward rounds are those conducted as walking rounds, in which the consultant, other medical staff and nurses move from bed to bed, reviewing case notes and addressing the occupant of that bed. Another increasingly common version of the ward round no longer involves the team seeing the patient together. Instead, rounds are held as team meetings, in which each professional's assessment is considered in order to obtain a holistic view of the patient's condition. Rounds in this latter format often assimilate discharge planning into an existing meeting.

The two wards studied here provided good examples of each form of ward round. In Scotland, the traditional model was used. In Canada, ward rounds were team meetings.

Traditional ward rounds have received considerable criticism in the patient participation literature (Bennet, 1979). The most common criticisms are: traditional rounds are intellectual exercises for the improvement of medical staff, and thus not designed to meet the needs of patients; the style of the ward round is dominated by the consultant and creates an unfavourable power dynamic around one individual; and the presence of a group of clinicians all focusing on one patient inhibits and hinders dialogue.

Each of these points can be addressed with reference to the Scottish ward. In the unit studied, the consultant held ward rounds twice a week. He was accompanied on his rounds by the registrar and/or senior house officer, the junior house officer and one staff nurse. Junior medical staff wheeled the case notes to each bed and the nurse consulted separate nursing notes. Junior medical staff would summarise the assessment already carried out on the patient and the nurse would indicate any concerns from nursing assessments. This information would then be considered by the consultant and any appropriate questions posed to the patient. Necessary information was obtained from patients this way and added to the assessment. When needed, the consultant would draw the curtains around the patient's bed and carry out any further examination.

One of the criticisms of the traditional ward round mentioned above is the fact that they are for the improvement of medical staff rather than designed to meet the needs of patients. In Scotland, the walking ward round was indeed part of the training process for junior medical staff. Much of the routine consultation between the consultant and his house officers occurred during the round, either right in front

of the patient in lowered tones or in the hallway outside each bay. However, it is important to point out that the Scottish patients were aware of this teaching function and accepted it as a necessary part of ward routine. In fact, some expressed their support for the exercise. They were happy to assist the younger medical staff, whom they saw more frequently than the consultant. As one older woman described:

"I've had one or two young men, they have asked me, 'Do you mind if so and so comes along and watches?' and I always say 'not at all'. I don't mind that, it is helping their training."

One additional way in which ward rounds may have been designed to meet the needs of medical staff rather than patients was in the effect they had on team decision-making. Because only medical staff and a nurse did formal ward rounds together, other professionals were not part of any decisions that were made as a result of observations made during the round. Staff on the Scottish ward were aware that rounds often resulted in changed plans. A consultant explained why rounds could merge assessment with planning for some patients:

"There are one or two patients that have purely medical problems, very independent people, who I think on the ward round you can start looking at discharging because there is less of a need for a social input."

Ward round discharge planning was in part inevitable on the Scottish ward because multi-disciplinary planning meetings only took place once a week, on Thursday, and patient's conditions changed more frequently than that. As the junior house officer pointed out:

"Most of them [discharge decisions] are made on a ward round because once a week basically isn't enough. If you say you are going to review a patient on Monday, you can't then say 'It is fine to go home tomorrow, but we'll leave it until Thursday to make a decision.'"

However ward-round discharge planning could result in communication gaps with other team members as a physiotherapist pointed out:

"Consultants maybe when they come to a patient get a slightly different picture and they make a decision and therefore the information should get fed back to us, but it doesn't always."

A second criticism of ward rounds is that they are dominated by the consultant. Rounds in the Scottish hospital were very much consultant-led as they could not

begin without his presence (unless pre-arranged) and it was he who addressed the patient. The researcher followed several ward rounds and observed that the other medical staff rarely asked patients a question unless directed to by the consultant. The nurse spoke even more rarely. The pace of the round and the manner adopted by junior medical staff was very much dictated by the personality of the consultant. In this way, rounds could be said to cater to the assessment and information needs of medical staff rather than the patients.

Patients recognised that the ward round was led by the consultant, and that it was a hurried procedure. It emphasised to them how 'busy' the doctors were, that they should not be 'bothered' by unnecessary questions. One patient described this:

"Well now they all come round and there is always one who does the talking, who talks to you, and ...the others listen. When they do come, they ask you some questions...it could be that some of them are easier to talk to than others, but you don't get a chance to find out."

The senior consultant recognised that it was a hurried procedure. He said:

"I can't sit and blether with them all for as long as I would like to...I don't know what they [the patients] say about it, whether they feel they have the opportunity to raise their problems with me or not."

A third criticism of the ward round is that being faced by a group of clinicians may be an intimidating experience for some patients, and thus hinder dialogue. As one older man (who was later to be diagnosed with lung cancer) described:

"Just before I left the hospital this time I developed this chesty cough and it has not gone away. In fact before I left there were these two medical students. They had a good look at me. And they just turned away for a couple of seconds and said something to one another. But of course you can't ask questions."

Clinicians themselves were aware that some patients did not question doctors during the ward round. As a senior house officer stated:

"The ward round tends to be a stressful event for patients, because there are a group of people who are not always talking directly to the patient who put them on the spot and I think older people tend to get a bit flustered about that."

The researcher observed that some patients were more likely to raise concerns about going home to *other* team members than to the medical team during a formal ward round. Some patients would not ask questions of the consultant during the ward

round although there were things (some of which were raised with the researcher in interviews) that they wanted more information about. When patients do not ask, doctors are given the impression that they have the necessary information and are satisfied (Annas, 1975, McEwen et al, 1983). In this way questions remain unanswered. Therefore based on the perceptions of the Scottish patients in this study and the impressions of the researcher, some of the arguments against traditional ward rounds are justified. They do serve the information needs of staff more than patients. They do create an unfavourable power dynamic that inhibits some patients from making a contribution. However, do *current alternatives* to the walking ward round promote more patient participation?

Findings from this study would indicate that the practice of replacing walking rounds with meetings in fact *eliminates an important source of doctor-patient interaction*. Staff on the unit in British Columbia met four times a week (compared with the Scottish ward, which held only one team meeting per week). On Monday and Friday mornings the consultant met briefly with the team to review the status of patients over the weekend. Following the meeting, he then visited those patients who required further assessment. On Tuesdays and Wednesdays formal rounds as meetings were held which included discharge planning. When a patient was newly arrived on the ward, each professional in turn would present the findings of their initial assessment to the rest of the team. In this way a holistic view of the patient's needs could be obtained and discharge planning could commence. The frequency of meetings also meant that all team members were included in any formulation of discharge plans that took place. However, one important contribution was missing from this assessment and that was the patient's view. The staff interviewed were aware of this gap. For a brief period in previous years, a senior consultant, the head of department, had attempted to remedy this absence by bringing patients into the team meeting room as their case was being discussed. He explained the advantages of this:

"I thought that was a good idea, because I could turn right to the patient and say now, you heard what these people had to say about you, have you any questions?"

The practice of bringing patients into meetings was discontinued as it was found to be unsuitable for an increasing number of cognitively impaired patients, and also because it proved too time-consuming. As the senior consultant explained:

"The reason why it doesn't happen now is primarily time. If I had my wish, I would have them thereI found in the

case conference they would ask questions. Now I am not sure that it is happening to the same extent."

Once the practice of bringing patients into meetings had ceased, all professionals (especially nurses, therapy staff and the social worker) attempted to bring forward the patient's view. However, a representation of their views could not replace the opportunity for the patient to express an opinion directly to the team. The regular consultant on the ward admitted regret that he did not have more regular patient contact:

"I also think that in using [the present] format for rounds I think the patients miss out a bit on physician contact....we talk about these people and they're not there and that sometimes worries me."

The two consultants differed in their views on the traditional ward round as a method of ensuring regular patient contact. The senior consultant viewed them as old-fashioned and out-dated, whereas the regular consultant for the ward admitted that they did have their advantages:

"You know, in a lot of ways communication was probably better in the old fashioned wards where there were lines of beds...you went and stood around the bed and talked to the patients...I think in some ways in the best of the old tradition of ward rounds, communication was not too bad."

Rigid and hurried as the traditional ward round may have been, at least patients knew they would see the doctor at regular intervals. In the absence of walking rounds, there was no such guarantee on the ward in British Columbia.

The absence of walking rounds, like the issue of pre-admission screening visits discussed at the beginning of this chapter, raises the issue of patient awareness of who is directing their care and how available he/she is to talk to. As described in Chapter 4, general practitioners played a more active role in ongoing patient care in the B.C hospital than in the Scottish institution. However, the fact that two doctors were involved in care was not sufficient to explain why such a large proportion of the Canadian sample failed to recognise who the geriatrician was or what his role was.

In Scotland, eight of the ten patients interviewed could identify the consultant by name. Two could not remember his name but accurately described him. In British Columbia, only four patients could identify the geriatrician by name, and four could describe him. One woman who could describe the consultant explained that he was

'much too busy to talk to old ladies'. The remaining two patients did not recall seeing the consultant. The researcher pointed out the consultant to one of these patients as he passed in the hall but she insisted she had not spoken to him. The other patient indicated that he assumed the geriatrician was the second name printed on his admitting wrist band. On prompting this patient recalled that a doctor had come to look at his leg wound but he had been unaware that he was the consultant for the ward.

In short, these findings indicate that patients on the geriatric assessment and rehabilitation ward in British Columbia saw a geriatrician less frequently than those in Scotland. Why is this significant for patient participation in discharge planning? It meant that Canadian patients were less aware of the geriatrician's role and less certain of his ability to listen to their concerns about going home or arrange services for them. They relied more heavily on communicating their medical needs and often discharge needs to their family doctor. All ten subjects were visited by their GPs regularly while in the geriatric ward; at least once a week.

There may be one additional reason why regular contact with the consultant had implications for the patient's role in planning. Although the fact that most older patients were more likely to express their needs to junior or non-medical staff has been well documented in the literature (Brearley, 1990, Thomas, 1994), there were several patients who insisted on their needs being discussed directly with the consultant, either themselves or via family members. As the Scottish consultant said:

"It depends on their personality. Some store it up until the consultant comes 'round."

These individuals viewed the senior doctor on the ward as 'the man in charge', the authority figure who could arrange desired services or make changes to discharge dates or arrangements. This faith in authority was something that staff in Scotland identified as a characteristic of the generation of older patients they were treating. The consultant described this as part of the culture of that age group. He said:

"I just mean the Scottish personality of their generation which is that doctors are gods, hospital doctors in particular are gods, you are the boss and they are a very accepting generation...happier to take on authority figures and all that sort of thing."

The occupational therapist on the Scottish ward described how the doctor's authority was used by staff:

"Sometimes the medical staff, I would ask them to go and encourage them [the patient]. 'Next time you go round, could you encourage them to do such and such.', because it is the business of the lady in the white coat. There is nothing quite like the lady in the white coat for this generation."

In Scotland, two patients made it very clear that, despite the limitations of ward-round interaction, and despite their being other (junior) medical staff around, the consultant was in charge and therefore was the man who could 'get things done'. They made sure either directly or through family members that their discharge needs were expressed to the geriatrician. A Scottish patient described this:

"I told the doctor, I don't care doctor, as long as I can get moving about. So he says, I'll get things organised for you. So he is getting me a home help...the doctor says I'm not to do anything for myself. He said you have to have a hot meal every day, you have to build your strength up."

This faith in the authority of the consultant existed in Canada, but not to the same extent. It could be argued that this implied a more egalitarian team structure, a system less centred around medical expertise and an in-patient setting in which primary care physicians made a valuable contribution. All these arguments are valid, but from the researcher's point of view the lack of geriatrician/patient interaction eliminated an important opportunity for patients to contribute to planning. It was observed that older patients in both settings responded to authority and a more hierarchical staffing structure - witness the four patients in Canada who expressed the fact that they were confused as to whom to ask for things - they were trying to identify a 'head nurse' on the ward. There was no head nurse for the patients to see - only equally-qualified registered nurses and a nurse manager who was not involved in patient care. This lack of a clear chain of command on the ward helps explain why patients viewed their GP as someone who had the independent authority to listen to their concerns and then make arrangements.

Were there other reasons for the lack of geriatrician/patient interaction on the ward in British Columbia? The ward round was only one reason. In addition to that, there were variables to consider such as a highly-skilled nursing team who were more assertive in claiming ownership over aspects of patient care conducted only by medical staff in Scotland. The position of the Canadian hospital must also be considered. With no junior medical staff the consultant had to carry out a full range of duties - from case note and documentation upkeep, to discharge correspondence

and referrals - all the domain of house officers in the UK. These duties, when combined with more frequent team meetings and clinical responsibility for 20 beds meant that the time available for direct communication with patients was strictly limited.

THE HOME VISIT

Several of the patients in the study were taken back to their homes by ward staff as part of assessment procedures. Home visits were done by occupational therapists, occasionally with other staff (physiotherapists and a social worker) in attendance. Some writers have indicated that the practice may be hastily and inappropriately carried out (Clark et al, 1996) or is too costly and time-consuming, taking away from team assessment and planning (Fowlie, 1993). Findings from this study do not support these arguments. The home visit in both countries was found to be an essential part of the assessment process, both from the point of view of the patients and of staff.

Jackson (1994) indicated that the practice of occupational therapy home visits is more the norm in British medical, surgical and geriatric wards than in the North American equivalent. Amongst the small sample of patients followed through the system in this study, the opposite was found to be true. Of ten Scottish patients, only three had a home visit assessment. Six Canadian patients had one⁵.

This finding of a greater number of home visits in British Columbia was surprising for two reasons. Firstly, there was a lower level of occupational therapy staffing on the Canadian ward. As a home visit is extremely time-consuming and means that other patients cannot benefit from the therapist's services while she is away, the assumption would be that scarce OT hours would mean fewer home visits. This was not the case. Secondly, distances were much greater in British Columbia, as has been mentioned. In Scotland most patients on the ward and all of those in the study lived within a fifteen-minute taxi or ambulance ride of the hospital, facilitating access to their homes for a short visit. In Canada this was not the case, yet visits still occurred more frequently.

⁵ In each country there was one patient who had stayed in the same assessment ward earlier the same year, and had gone on a home visit at that time. This would bring the total number of home visits to 4 and 7 - or 40% of Scottish subjects, compared with 70% of Canadian patients.

Frequency of home visits was undoubtedly partially influenced by resource and manpower issues in both settings, but it also appears to have been affected by the team's perception of which patients required this type of assessment during their hospital stay. In Scotland personal contacts between the hospital and the community such as geriatrician pre-admission home visits or previous presence of the liaison health visitor in the patient's home meant that some patients had *already had a hospital team member see them at home*. OTs in Scotland also explained to the researcher their criteria for a home visit in a materially different manner from their Canadian counterparts. The Scottish OTs limited their home visits by defining which types of patients required them - namely someone whose home circumstances they were unsure of, who was using a new aid or adaptation, whose physical state had changed significantly (i.e. after a stroke) or someone who required a complex package of services to be arranged. Canadian OTs appeared to have broader criteria including evaluating carer support, assessing anyone at risk for falls, trying to gain a more accurate picture of the financial situation if aids and adaptations were needed. One Canadian OT described her criteria for a home visit in terms of the patients she would exclude rather than defining the characteristics of those who 'merited' one:

"We would not do a home visit for instance if it was a very sort of medically-oriented family who have lists of things and gave a really good account of the home situation that seems genuine, or someone who is very independent and seems low risk. Most others we would do a home visit for."

Those home visits that did take place were an important component of discharge planning for both professionals and patients in both countries. They revealed aspects of each patient's needs that were not immediately apparent during assessment on the ward. Comments from the patients indicated that visits tended to achieve one of three aims. Firstly, the home visit could confirm the patient's desire to go home as soon as possible to an environment they knew and was confirmed as 'safe' by a professional. As one Canadian patient explained:

"W [the OT] came out to my house to see if I was able to go out, how many steps I had, she came out with me and we looked at the house together. Everything was perfect."

Alternatively, the home visit could calm fears the patient might have had about leaving hospital by demonstrating how the home could be adapted to facilitate mobility. One exchange between the researcher and a Scottish patient demonstrates this:

R: When they took you back to your own house and they had a look at everything, was that helpful?

Patient: Yes. Now I have got everything in, I've got a commode now and everything. I've got a trolley at home too, because the doctor has said: 'No running about!'

Home visits could also demonstrate to patients that they were not really ready to go home, in which case a discussion of alternatives usually ensued. This was the case for one Canadian and one Scottish patient.:

R: And what about the home visit, was that helpful?

Scottish patient: In a way, it just brought home to me that I was not fit to go home. That was a week ago now of course, but I am still not sure.

The Canadian patient described what the OT had done during the visit:

"She had a look at me doing things, getting on and off the bed and that sort of thing. It was OK. But actually after today I feel like I am willing to stay here [in hospital] a bit longer. I wouldn't mind that at all."

For staff and indeed for the planning process in general, home visits achieved an additional set of assessment objectives. They allowed the occupational therapist to gain an impression of how the patient coped in their own environment, in a manner that was often very different from their movements on the ward. The researcher attended one home visit in Scotland with the OT and a patient not recruited for the study which demonstrated this admirably. In hospital the woman was hesitant on her feet, relying heavily on a stick. Once at home in her small flat however, she gained confidence and was able to abandon her stick in the living room and kitchen, where distances were small and the surroundings familiar. A Scottish OT explained that the home visit gave patients a chance to demonstrate their capabilities:

"It's to give them the best chance possible in their own home, which I think is the best place to assess them because you are not in a hospital ward."

Home visits also allowed the OT to gather information otherwise not available to the team. The home environment is a familiar one for patients, one in which they can relax and communicate with the OT or other accompanying team member one to one. As one Scottish OT described:

"Overall it is a more natural environment for them to be in and they tend to relax and you can get a lot of information over a cup of tea with somebody, especially if they have performed quite well. You can get a lot of information."

By assessing the older person's physical environment, the OT could construct a picture of their needs for aids and adaptations or alterations to the home that could not be envisaged in the ward occupational therapy kitchen or assessment gym. These impressions could then be brought to the team meeting for discussion and incorporation into the discharge plan. Home visits gave OTs a realistic picture of the patient's capabilities, motivations and resources that the rest of the hospital team knew of only at second hand. A Canadian OT described how this might result in a different assessment of the patient from that made by other staff on the ward:

"As an OT you get out to do home visits so you can actually see how some people manage with very little versus some who have every resource available to them. If you are a team member who normally doesn't get out to do that, you might have unrealistic expectations of patients."

Perhaps most importantly, the home visit also allowed therapy staff to gather valuable information concerning available social support for the older person from friends, neighbours (involving simple things such as who holds a spare key, and when are they available, the proximity of neighbours) and family. One Canadian OT described this:

"You often [identify] a neighbour or someone like that, if it is a little five-foot woman trying to help her six-foot husband to get up the stairs, that wouldn't be very safe, but maybe somebody could help them."

Following a home visit where family were present, OTs in both research settings were able more accurately to assess the amount of caregiver stress and advise how the needs of carers might be incorporated into the discharge plan.

CONCLUSION

Important differences were found in the structure of assessment procedures in British Columbia and Scotland. These differences affected the experience of the patient in hospital and their participation in the early stages of discharge planning.

The consultant geriatrician in Scotland had more direct contact with patients in the assessment period than his counterpart in British Columbia. This was based on pre-admission screening visits and reinforced by the practice of walking ward rounds. A higher proportion of Scottish patients recognised the geriatrician as the one directing their care. Although the ward round was found to be hierarchical and

intimidating for some patients, others responded favourably to more frequent contact with the geriatrician by addressing their concerns directly to him.

The absence of walking ward rounds combined with admission procedures and other responsibilities of the geriatrician in British Columbia meant that the Canadian patients had less frequent contact with a hospital doctor. As a result, they communicated more consistently with their GP concerning medical and aftercare needs.

Personal factors common to patients in both countries were found to affect their experience of admission and assessment. Patients felt responsible for their deterioration in health, were reluctant to solicit help when they became ill and did not feel they were given a choice about admission to hospital. Once on the geriatric ward, patients found the pace slower than in acute care. Older people in both countries felt that being grouped with confused and disruptive patients hindered rather than helped their recovery while in the assessment and rehabilitation unit.

Individual assessment of patients was found to differ in practice and in documentation. Professionals in both wards were responsible for assessing similar aspects of patients' needs but several grey areas of assessment were identified where roles overlapped. These were: nutrition, cognitive assessment, carers' needs and most significantly, the views of patients, which no particular professional on either ward was responsible for recording.

Documentation of assessments was more comprehensive, more easily accessible and more interdisciplinary in the Canadian unit than in Scotland where professional divisions extended to case records. This separation resulted in duplication and made information harder to obtain for families and others involved in the patient's care.

Finally findings from this study indicate that the occupational therapy home visit was a valuable part of the discharge planning process for both staff and patients. A higher proportion of patients in British Columbia went on home visits than did those in Scotland. Home visits were found to be particularly beneficial for patient participation as they provided an opportunity for patients to express their views one-to-one with the professional in a familiar environment.

No significant evidence was found to suggest that patients played a more active role in assessment in one ward than the other. Barriers and opportunities for

patient input were found in both. While preadmission contact and the walking ward round encouraged greater staff/patient interaction in Scotland, individual assessment and home visits appeared to provide more consistent patient input in British Columbia. However, each of these phases of assessment and the role that individual patients played in them was found to have implications for later stages of the discharge planning process.

CHAPTER 7

PLANNING

“Writers disagree on who should be responsible for discharge planning, who should be involved, and how and to whom discharge plans should be communicated. Planners vary from multi-disciplinary discharge planning teams led by geriatricians to a single nurse, usually a geriatric clinical nurse specialist.”

M. Jackson, 1994.

Planning is the second stage of the discharge process. It involves matching available community services to patient needs identified during assessment. Several studies have attempted to pinpoint the factors that determine an older patient's involvement in discharge planning. Patient characteristics such as state of health, knowledge of their condition, perceptions of choices and, most importantly, cognitive competence have been described as key factors (Simmons 1986, Biley, 1992). Kadushin and Kulys (1994) consider not only the characteristics of individual patients as important, but also the type of discharge decisions that need to be made and the form of interaction between the patient, family and health care providers. The extent of family involvement in planning is also seen as a predictor of the level of patient involvement by Coulton et al (1982), Simmons (1986) and Abramson (1994). Coulton and her colleagues describe a series of other factors influencing patient involvement; including the behaviour of health professionals, particularly the physicians. Kruse (1985) describes interpersonal and interprofessional barriers to patient involvement, and indicates that organisational constraints (particularly time; including length of stay, frequency of planning meetings and other responsibilities of team members) can affect the extent to which an older patient is involved in the formulation of the discharge plan.

In this study, characteristics of the patients, their families/caregivers, the behaviour of the ward team and the constraints of hospital and community organisations all

contributed to the outcomes observed by the researcher. This chapter will attempt to describe those factors most relevant to the active formulation of the plan. At this stage in the process, elements of teamwork, ward organisation and formal mechanisms for consulting the patient and family all became important issues. This chapter will begin by addressing the structure of each team, its members and the roles of each professional. Secondly, team processes, including team meetings and family conferences will be discussed. Finally, team members' expectations for patient involvement in planning will be presented, and contrasted with the expectations of the patients themselves.

TEAMWORK

The complex and interacting health and social care needs of older patients necessitate the involvement of a wide range of professionals. Geriatrics is one medical speciality where a multi-disciplinary approach is now the recognised norm in patient care¹. Contributions from a variety of individuals working in a co-operative context are promoted as advantageous not only in terms of positive treatment outcomes but also in the job satisfaction of the professionals involved, who are said to benefit from the expertise of others while being permitted to spend maximum time performing their most specialised skills (Kane, 1975). Poulin et al (1994) interviewed 2,700 gerontological social workers in the U.S.A. and found that 87% had a moderate to high satisfaction with multi-disciplinary team membership. Positive aspects of teamwork were identified as shared responsibility, being presented with another perspective on a case, and learning from the skills of other professionals.

Team members interviewed in both Scotland and British Columbia identified many positive aspects of working with a team. Some of the most favourable responses came from professionals who had previously worked in other health care settings dealing with different patient populations. The physiotherapist in Canada described what she saw as the advantages of team work:

"I think it is very important when you are working in a team to be really aware of what the other team members are doing for the patients and you get a much more...overall

¹ For a definition of teamwork and the multi-disciplinary team, see Chapter 2 'Literature Review'.

picture of the patient and know that everybody is trying to address it."

The majority of team members in both wards agreed that discharge planning was a team activity and, although dominated at times by one or more professionals, consultation with other team members usually occurred. As one Scottish staff nurse explained:

"It can't be just a doctor's decision that somebody should be going home...Always somebody, everybody else - the OT, the physio, the doctor, the nurse and anybody else who is involved with the patient is asked first; it is not taken upon one particular person to say that person is going home on that day, without any feedback from anybody else first."

TEAM STRUCTURE

Kelly and McClelland (1985) devised a typology of discharge planning models which are useful in describing the structural differences between the planning process in Scotland and British Columbia. Although their description is based on examples from American hospitals, the Canadian and Scottish team structure have the characteristics of one of their models. The Scottish team is closest to the *multi-professional collaboration model*. Anderson and Helms (1993, pg.43) describe this as a team structure which:

assign[s] decisions concerning discharge planning to an appropriate mix of health team members. Discharge planning and referral are the responsibility of the interdisciplinary team members.

This model of discharge planning involves a variety of professionals coming together to formulate a discharge plan. Although the decision-making process may be led by one individual (usually the doctor), the opinions and assessments of each team member contribute to the final discharge plan. Implementation of this plan (which will be discussed in the next chapter) is then carried out through a series of discipline-specific referrals. *Each* team member has responsibility for contacting relevant community agencies in order to make referrals for aftercare services.

In British Columbia, the method of discharge planning fitted the 'liaison nurse' model. Anderson and Helms (1993, pg.42) provide a description of this:

[it] employs a nurse based in a community agency who serves as a link between the agency and the hospital. The nurse evaluates clients referred for home care, consults with health professionals, facilitates communication between the hospital and community agencies, and

serves as a resource person to hospital personnel regarding community resources and home care practices.

The liaison nurse role has been described in Chapter 4 and widely discussed in the literature (Gatt and Taylor, 1973, Krommiga and Ostwald, 1987, Naylor, 1990, McWilliams and Sangster, 1994). In some American studies, it has been contrasted with the multi-disciplinary model to identify outcome differences (Kelly and McClelland, 1985, Jowett and Armitage, 1988, Mamon et al, 1992). The main structural difference between the liaison and multi-disciplinary models lies in the referral aspect of discharge planning. While decisions about the type and amount of support needed by the older patient are decided by the ward team in multi-disciplinary meetings, the liaison nurse is responsible for implementing these decisions. As a community employee, she determines the level of service the elderly person can actually receive within available resources. She then makes the majority of referrals to community agencies. This model places the primary responsibility for deciding the type and amount of community services with the nurse him/herself. Ward staff in British Columbia, particularly the nurses, appreciated the role of the liaisons and felt their involvement facilitated the discharge planning process. One nurse said:

"I think it really cuts down on the paperwork and it really cuts down on a bunch of unnecessary phone calls and frustration, and we just don't have the time either. I think they are far more familiar with what's out there and what would be most appropriate for this particular patient. I think it works. It works for me."

The implications of the liaison nurse and multi-disciplinary models for discharge outcomes will be discussed in later chapters.

CO-OPERATION

Both teams in this study faced problems of teamworking. Conflict between individuals and professional groups limited the ability of both groups to engage in effective discharge planning. These problems can be grouped around two themes: co-operation and communication. Co-operation in teamwork implies members acting jointly with one another, or uniting for a common effort (Ovretveit, 1993). Co-operation as an ideal means that team members value the contributions of other

team members and negotiate with them about tasks. Co-operation between team members is necessary to co-ordinate ward activities. Roden and Taft (1990, pg.137) describe co-ordination:

Good team co-ordination occurs when members are secure enough in their own roles and confident enough in what their colleagues have to offer that they can interpret those to patients accurately.

Discharge planning is about co-ordinating appropriate services to meet the needs of patients. However, the two teams observed for this study each encountered problems of co-operation and co-ordination during the data collection period². The majority of these problems concerned the roles of various team members. These roles were either inadequately understood, undervalued or in conflict with those of other team members.

ROLES

The researcher observed that professional roles were more rigid in British Columbia than in Scotland. Evidence for this came from several sources. The first was in the distinction between therapy and nursing staff. In Scotland, physios and occupational therapists were involved to a greater extent in the everyday activities of patients; transferring, toileting and taking them to the dining room. In Canada these were perceived as nursing duties by therapy staff, who saw their responsibilities as clearly defined. The researcher asked the Canadian OT whether she thought that other team members knew what her professional responsibilities were. She replied:

"I think they have a fair idea, concerning the home visits etc., but I think there are a few grey areas, in terms of how much involvement I actually have in the day to day routine of patients...transfers, dressing, toileting, things like that."

The Canadian PT clearly saw boundaries to her role:

"I'm often asked to change somebody's wheelchair or something, and I say well, actually W (OT) does wheelchairs...and so they don't always remember... that there are some things I don't do."

² An excellent account of some of the problems inherent in multi-disciplinary team work within geriatric *long-stay wards* in the U.K can be found in Evers (1982). Evers uses a case study approach to demonstrate how problems of leadership, role conflict and staff shortages can contribute to the absence of patient or family involvement in any decisions about care of the individual older patient.

Nursing staff on the ward in Canada resented the therapists' reluctance to be involved in the day to day care of patients. One senior nurse said:

"I don't think it would hurt anyone physically in another discipline to actually bring someone into a bathroom...I don't think it would kill them to wander around the dining room and assist in setting up trays and watching how people eat...I don't think it would hurt them to get more involved...I think there are a lot of egos at play."

Part of this role rigidity can be assigned to the reluctance of some professionals to engage in personal care or non-technical treatment, what Lauder (1991) has called 'invisible work'; work that is furthest removed from a medical model of care. It appears to have more to do with compassion or common sense than clinical expertise. The absence of auxiliaries on the ward in Canada and the higher density of degree-holding nurses (RNs) meant that they as a profession were eager to be recognised for their skill rather than their care, and were resentful when other professionals left the 'hands on' tasks to them. One of the liaison nurses described the recent professionalisation of nursing in British Columbia:

"The way it is now, there are RNs who choose not even to touch a patient and I don't approve, I don't agree with that. You can't learn anything about a patient without actually going in and getting down and dirty with them."

Nurses in both countries, but on the Canadian ward in particular, emphasised the twenty-four hour approach they brought to discharge planning and stated that their reports of patient functioning at night were in some cases ignored in favour of the more 'professional' opinion of the physio or occupational therapist who had carried out a 'formal' assessment during the day. There appeared to be an ongoing struggle to identify the legitimacy of different types of assessments between nursing and therapy staff. One possible explanation for this has been offered by Reed (1993) who examined the relationship between physiotherapists and nurses in geriatric assessment and long-term care wards in the U.K. She states:

In essence, the medical model appears to have a 'divide and rule' effect on the semi-professions. Instead of developing solidarity and sympathy among groups who have, at least in their professional literature, espoused an anti-medical stance, medical values may have led to the semi-professionals 'fighting among themselves' rather than working together.

Canadian nurses felt that their contributions to patient care and to discharge planning were not appreciated by other team members. This resulted in regular

confrontation between nurses, the consultant and social workers, especially in team meetings. As one senior nurse stated:

"I don't think there is a lot of respect for nursing up here and for the expertise that we bring in. That is just my perspective...We sort of go out there and advocate for the patient and do the best we can, but it gets very frustrating...fighting with these people and trying to get our point across"

There appeared to be discrepancies amongst nursing staff as to their loyalty between their own discipline and the team as a whole. This has been identified in other studies (Poulin et al, 1994) and described as a professional 'subculture', with its own value system and ways of operating, that can grow up in an organisation and serve to hinder attempts at group co-operation (Compton and Galaway, 1989). It was evident to the researcher that the rigidity of professional roles on the Canadian ward, combined with individual practitioners' desire to protect and promote their professional group, presented a serious challenge to teamwork and co-operative working. The geriatrician in Canada described his view of the conflicts between nursing and other professions. He stated:

"If there was one thing I would change it would be the feeling that individual team members are, if you like, controlled by separate departments...there would be more of a programme feeling. And in particular if nursing staff could feel more a part of the team. They seem to have problems about feeling valued. I would in my ideal world, that nursing leadership would be able to be programme, team-oriented and not have this corporate, autocratic mentality."

What are some possible explanations for the rigid adherence of Canadian team members to their assigned professional roles? The professionalisation or 'medicalisation' of nursing is definitely one cause. This process has also occurred amongst nurses in the United Kingdom but the effect was diminished in the Scottish research setting for several reasons. Firstly, as mentioned, in the Scottish ward there were fewer staff nurses and a greater number of auxiliaries and enrolled nurses than in Canada. The skill mix was therefore greater and the provision of hands-on care was less of an issue for the lower nursing grades. Secondly, the environment of a teaching hospital in Scotland meant that a junior house officer, senior house officer and registrar were assigned to the ward. Therefore even in the absence of the consultant, medical tasks were more clearly defined and separated from nursing tasks by the junior doctors. Junior doctors carried out these tasks, whereas in Canada *nurses* were playing a more active role in the treatment, diagnosis (in terms

of diagnostic test and sample taking) and counselling of patients about medical issues.

Finally, there were leadership issues that affected the division between professions on each ward. In Canada, the position of head nurse had been eliminated some years before. This meant that there was no permanent nurse leader on the ward who was involved in patient care. Instead there was a nurse manager who was also responsible for three other wards and had little or no contact with patients. Although she held workshops to improve team functioning, her presence on the ward served to create a nursing 'camp', in which meetings took place behind her closed office door.

The role of the nursing manager in Canada also related to the second leadership issue, which concerned the Consultant as team 'co-ordinator'. Kapp (1987) has pointed out that interprofessional co-operation on behalf of the patient's best interests derives from the physician's legal duty of non-abandonment. In other words, as the doctor has a duty to treat the patient and is ultimately responsible for the welfare of the patient, it is in his interest to promote effective team working. However, if this leadership is questioned and challenged by others, team co-operation can be endangered. The nurse manager and the consultant in Canada did not share the same view as to how teamwork on the ward could be improved. She challenged his authority.

In Scotland, the senior consultant was a clear and uncontested leader in the conduct of discharge planning meetings, final decisions concerning discharge dates and contact with patients and families. He had been partially responsible for setting up the geriatric rehabilitation and assessment ward three years before. In addition, the Scottish consultant's authority was 'validated' by his junior medical staff and largely unchallenged by staff nurses or the charge nurse on the ward.

COMMUNICATION

Communication between team members takes many forms. Two of these—ward rounds and written case records—have already been touched upon. Within the planning stage of the discharge process, a third form of communication—meetings—was the main forum for decision-making. These took place formally

between team members, informally between professionals and patients and both formally and informally between professionals and family caregivers. The structure, frequency and content of team meetings were particularly important in this study as meetings were the formal setting for discharge planning. The extent to which patient's views were included in planning depended very much on whether or not staff had sufficient contact with patients prior to meetings, and whether they considered it part of their role to act as advocates for the older people in their care. Staff representation of patient views in both wards was motivated by a desire to discharge patients to a safe environment. But staff and patients' views of what constituted 'safety' and 'risk' were often different, which created conflicts for staff assuming the role of patient advocate in discharge planning. Team meetings, advocacy and the management of risk in discharge decision-making were all central to the planning process in both wards in this study.

THE TEAM MEETING

The formal forum for verbal interaction and discharge planning on both wards was the multi-disciplinary team meeting. Patients and families were excluded from this forum in both geriatric wards. Team members in both countries acknowledged that the majority of discharge planning took place in these meetings. The senior Scottish consultant stated:

"The decisions about dates are sometimes taken at other times and obviously there are lots of discussions going on all the time between individual members of the team ...but it is the only forum where everyone is together."

Similarly, the Canadian OT said:

"I think that every team member does their little bit that helps towards that process, but the focus towards meshing it and putting it all together in one probably comes more at those team meetings on Tuesday and Wednesday."

All team members were asked what they saw as the main purpose of their team meetings. Responses from staff in Scotland and British Columbia were similar. Professionals in both countries considered the meetings an inter-disciplinary exchange of information, an opportunity to share perspectives concerning the progress of patients. Meetings in both wards were also seen as an opportunity to update the team on any changes in the condition of a patient that would necessitate alteration to the discharge plan. Staff in both countries also stated that meetings served to inform the team of discharge delays, whether caused by events on the

ward or due to lack of co-ordination with community agencies. One important difference noted between the responses of the Scottish and Canadian teams however was in regard to including the patients' view in meetings. Raising the opinions of patients was not reported by any of the Scottish professionals as one of the purposes of a team meeting. Amongst Canadian interviewees however, four of the sixteen professionals interviewed mentioned it. These were: an OT, the rehab therapist, a nurse and the senior consultant. The OT summed up the purposes of the meeting:

"To communicate between disciplines and to come up with a consistent and a clear plan for the patients, so to monitor progress and to plan, and of course to raise any issues that the patient or family might have with the team."

Team members in both countries considered discharge planning meetings important, but all had suggestions as to how they could be improved. Again there were striking similarities in responses. Therapists, nurses and social workers in both wards agreed that the meetings were consultant-led, and that the format, length and timing of meetings was dictated by medicine. Para-professionals in both wards were critical of medical dominance. The Scottish social worker said:

"It is still a Consultant's meeting...there are times when A, or whoever the Consultant is, will actually cut you short and move onto the next person...it means it is the consultant who is establishing how much you say."

A Canadian OT stated:

"I think we are doctor-driven, and I would like to see, well, us as therapists would like to see less of that...I think there may be other ways we could structure the meetings so they were less directed by and dependent upon medical staff."

Consultants in both wards defended the fact that they began the meeting and directed the order of speaking, although this was more rigidly applied in Scotland than Canada where anyone was free to speak 'out of turn', particularly for patients who had been discussed in previous meetings. The Scottish consultant explained why he felt it was appropriate that he direct the meeting:

"I think it is reasonable to do it that way, because, ultimately, the responsibility for the clinical ...and the discharge is mine and so it has to be me who has the last word."

Ironically, while rejecting medical dominance, staff in both wards considered leadership an important ingredient in conducting meetings effectively. They wanted the process to be controlled by someone. This control was provided in Scotland by the consultant. Scottish staff, despite being critical of medical dominance, did not challenge the consultant's role as chair of team meetings. In British Columbia however, staff did not feel that the consultant's 'chairmanship' of meetings was adequate, and questioned whether other professionals should not have the opportunity to lead the meeting. The liaison nurse said:

"I think that each person, each discipline, has a very valuable part to contribute. I feel they need a very firm leader in the meeting who says that's it, on to the next ...there is far too much wandering through it."

Aside from the length, format and structure of meetings, one additional theme emerged in interviews when team members were asked how the process could be improved. This concerned including patients or the views of patients. Once again, this issue was not raised by Scottish team members. They viewed the walking ward round and individual assessments as sufficient opportunities for patients to express any views they had. Making sure that these views were discussed at the team meeting was not raised as an issue of concern by any of the Scottish team members interviewed. This was not necessarily because all Scottish professionals thought that patients were adequately involved in discharge planning, but rather because they were less questioning of the manner in which discharge planning took place. They just accepted that patients had no direct role to play in planning done within the multi-disciplinary team meeting.

In contrast, including patients or the views of patients in meetings was a recurring theme amongst Canadian interviewees. Comments took three forms. They were either a description of how patients had been invited into the meeting in the past and the reasons why that had been abandoned³; comments about how staff should make more of an effort to raise the concerns of patients in meetings, or suggestions as to how planning done in meetings could be more effectively communicated to patients so that they were aware of how the discharge plan was developing.

Comments concerning feedback to patients demonstrated the Canadian team's awareness that the older people they were discussing did not have an opportunity to contribute to decision-making in meetings. Staff were aware that this was an

³ See Chapter 6- Assessment

omission and were attempting to identify ways that it could be remedied. One LPN explained why she thought discharge plans made in meetings were not always communicated to patients:

"I think some of it gets reported back, but often it has been twisted a bit or it's a little behind...it should have been said sooner, or somebody is often left in limbo and the nursing staff are not always aware that the patient is not aware of what is going on."

A registered nurse described what she saw as a typical scenario:

"And then we go into a meeting on the Wednesday and the patient is told they are going home on Friday. I don't think they are told as often as they should be that we're looking at doing this or doing that and there is a potential date. I think we should be better with our potential dates of discharge to give them a chance to start planning what it will be like to be on their own."

Several nurses suggested in interviews that one team member should be responsible for reporting to patients what had occurred in meetings, soliciting their opinions and then taking it back to the team during the next meeting. Although the Canadian team did recognise that there was an absence of communication with patients concerning discharge-planning meetings, they had few constructive suggestions to remedy this omission. Their concerns about a lack of patient participation appeared to the researcher to be admissions that the issue of involvement was one they 'should' be aware of, rather than one they were genuinely willing to alter their decision-making structures to accommodate.

ADVOCACY

Given that patients were not present at team meetings, staff in both wards were asked directly whose responsibility it was to represent the patient's view in the meeting. The majority of staff responded to this question by indicating that it was *every* team member's responsibility to report anything 'relevant' that patients had mentioned. Interviewees in both Scotland and Canada indicated that nurses did have an advocacy role to play given their 24 hour perspective on patient care. Nurses themselves were happy to describe patient advocacy as a nursing duty. As one Scottish nurse explained:

"Yes, the nurses are advocates because often the person has nobody to speak for them and you are closely involved with them and everything. Here sometimes it is more important

because sometimes you have to be an advocate against other disciplines and the family and the physician."

Nurses in Canada were equally adamant that they were the best qualified to bring the patient's view to team meetings:

"I think it is nursing, I really do. I think it is up to nursing to put the patient's view forward."

In Canada it was acknowledged that the lower grade practical nurses and the rehab therapist, who did daily activities with patients, could perhaps draw the most accurate picture of the patient's real feelings about going home. As the senior consultant in Canada explained:

"Quite often the nurses' aides will know more about the patient than we do...because they sit down on the bed and they do talk to them. Quite often someone like that at the lower end of the totem pole may know a hell of a lot more about the patient than we do."

Nursing auxiliaries were not present in the meeting in Scotland, nor were they permitted to write in case notes. Their contribution to discharge planning had to be communicated through senior nursing staff.

Finally, social work was described as the profession most likely to bring the patient's view to meetings in both wards. The social worker's role as patient advocate was mentioned by four team members in Scotland and five in Canada. In Scotland the social worker was willing to accept this description, for two reasons. Firstly, she did speak to most patients individually in order to assess their needs and determine their preferences for homecare services. In the absence of a liaison nurse, she was one of the team members most often engaged in discussing discharge details with the patients themselves. Secondly, the social worker routinely accompanied the patient and occupational therapist on home visits. These visits were a unique opportunity for communication between the older person and the professionals concerning aftercare needs.

In Canada the social worker did not see herself as the most qualified to represent the absent patient's views in ward meetings, despite the following comments from other team members:

"Social workers tend to be better at advocating than nursing staff, because they have different perceptions and training."

"I would think the social worker has more of a handle on what the patient's thoughts and desires are."

The Canadian social worker actually interviewed patients very rarely. She viewed her role as that of bridging the gap between the family or caregivers, community resources and the hospital team. She recognised that other professionals such as nurses and therapy staff had consistent contact with patients and thus communicated with them on a more regular basis. The social worker did not accompany the OT and patient on home visits and did not formally ask patients which services they would need at home as this was one of the duties of the liaison nurse. Therefore the Canadian social worker saw her role as that of an advocate for the family rather than the individual patient. She explained:

"Personally I don't think I do a really good job in that area. If I was just representing ...if I was the sole voice for the patient I feel I would stop putting as much energy as I do into the family side of it and the resources and the community information...I don't feel I am in any better position to represent the patient's view, and probably less, because I have less daily frequent contact with them."

Several recent North American studies of the role of social workers in geriatric wards have found that they spend less time with patients than with their families (Abramson, 1988, Kadushin and Kulys 1994, Poulin et al, 1994). This was certainly the case in the Canadian ward studied. In Scotland, the expanded role of hospital social workers in 'enabling' community-care access means that their contact with patients has become essential as the *Patients Charter* and care management guidelines (DoH SWSG, 1991) have emphasised issues of consent. In Canada, agreement to the discharge plan was obtained from patients by other members of the multi-disciplinary team. This meant that soliciting information from and explaining services to carers and families rather than patients fell to the Canadian social worker.

COMMUNICATION WITH CARERS

How did staff on both wards include carers and families in discharge planning? Carers were not invited to attend team meetings in either ward. Communication with professionals therefore came in three forms. Firstly, family members had informal contact with staff on both wards. This came in the form of communication

between nursing, therapy or medical staff and carers who came to visit the ward. Nurses in both countries saw it as part of their job to raise carer's concerns in team meetings as they were most likely to see them at times when other team members were not working.

Secondly, some team members met carers during home visits. In Scotland, the geriatric health visitor met many families this way. Because she received referrals from both hospitals and the community, she visited people at home both preceding and following admission to hospital, with the latter being more common. Her contribution to team meetings in the cases of older people she had seen at home was crucial, as she was able to paint a picture of what social support the patient had available, what kinds of services they had used previously and what kinds of alterations might be required to realise more positive discharge outcomes this time around.

Finally, formal communication between caregivers and staff took place in specific meetings. In British Columbia these were called family conferences; in Scotland, carers' evenings.

Every Monday evening, the Scottish consultant made himself available to families. Times when he could be seen were posted inside the ward where visiting relatives would see them. In addition, the evening was mentioned in the information sheet given to patients and their families on admission. Although both the information sheet and the posted notices mentioned only the consultant, the ward social worker also met with carers that evening. She met them either with the geriatrician or separately. The carers' evening was conducted rather like a clinic; in that carers arrived on the ward, informed nursing staff they were there to see the doctor, and then took a seat in a small waiting area near the door of the unit. The consultant then ushered them into an office where they could discuss their concerns in private.

The social worker pointed out that the carers' evenings gave family members a chance to ask any questions before their relative returned home. For some their relative's imminent return was a shock they were unprepared for. The carers' evening meant they could air their worries to the consultant personally who could then modify the discharge plan to account for any reduced level of carer support. She said:

"It is usually that they have seen A [the Consultant] on a Monday evening. They've heard that the person is coming home during the week and they might not have shown

themselves very much before then, or not said quite so much because they thought everything was OK and then suddenly they panic."

In British Columbia, family conferences were meetings arranged and chaired by the social worker. In attendance were the family, the consultant, nursing and therapy staff. These meetings were always during the working day and could be over an hour in duration. Team members could make their contribution and then return to the ward. The social worker summarised the meeting and then counselled the family on the choices available. The doctor's contribution was no more important than any other team member's. He did not control the meetings; they were very much the domain of the social worker.

Family conferences took place at the request of either the family or the team. Team members suggested family conferences for a variety of reasons. They could be called if there was any doubt about the family's willingness to support their relative in their home, or if the family and patient or team disagreed on the need for a move to institutional care. The meetings served several purposes, from discussing aids and adaptations needed at home to reinforcing medication or instruction compliance. However, most commonly they served to 'inform' the family of the post-discharge needs of their relative in the hope that appropriate choices would be made for care. In more than one case during the data-collection period, team members did not believe that the family had an accurate picture of their relative's condition and needed to be 'convinced' that the team's discharge decisions were in the best interest of the patient. As a nurse explained:

"If they [the family] have unrealistic expectations, it helps them resolve some of their conflicts so that you can get them on track."

Although the conferences were criticised as too long and too time-consuming by some team members, most recognised their value in the discharge planning process. The main source of controversy regarding the conferences was whether or not the patients should be invited to attend.

Patient attendance at family conferences occurred in a minority of cases. Whether or not the patient would attend was decided by the social worker in consultation with the geriatrician and in some cases, other team members. Only those patients who were considered cognitively intact were invited to attend. As the consultant explained:

"The criterion for me is, for the most part, cognitive function. It is much easier to discuss a patient's cognitive function and any behavioural overlays or psychological overlays involved with just the family, because often the family fail to realise the full extent of the problem. Afterwards, if appropriate, the patient can then be brought in and we can discuss other parts of the plan with them."

When patients did attend, positive outcomes could result. Differences between the patient and the family member, such as one older woman who did not want to burden her daughter by moving in with her temporarily, could be resolved and a satisfactory compromise reached. However, when the patient was not invited to attend, even for a portion of the meeting, the result was that discharge planning was essentially carried out by professionals and the family, *to the exclusion of the patient*.

Discharge planning without the patient was acceptable to Canadian team members as long as cognition could be used as a ground for exclusion. As the physiotherapist argued:

"I think a lot of decisions are made based on what the family really feels and in many cases not what the patient is feeling. Then of course, so many of our patients are not really...they don't have the insight and the judgement. As they get older they lose the ability to make rational decisions for themselves, so then you don't really take notice of what their desires are."

The researcher attended one family conference when a confused patient⁴ was brought in largely to demonstrate to the daughter and son (who were convinced they could care for their mother and blamed her confusion on alcohol abuse) that she was not capable of making decisions and that the team's proposals for the discharge plan should be accepted. Among the ten older people interviewed for this study in Canada, three had family conferences. Only one of these patients was invited to attend, despite all three having scored highly in routine mental testing. Although in each of these cases there were issues that the team wanted to discuss with the family alone (or that the family wanted aired without the patient present) the exclusion of the patients from attending even a portion of the meeting demonstrated that, as other studies have found (Hasselkuss, 1992, Abramson, 1988) family participation in discharge planning does not guarantee greater involvement for the patient. Indeed, carer and professional discharge planning may take place to

⁴ This patient did not make up part of the study sample.

the exclusion of the patient. Family conferences could inhibit rather than encourage patient participation in discharge planning.

RISK

Many of the concerns raised by caregivers and discussed in team meetings in British Columbia and Scotland addressed the concept of risk. Families wanted their older relative discharged to an environment where they could live safely, with minimal danger to themselves and others. These concerns were usually raised in relation to difficulties with safety in walking, using equipment, transferring or fear of falling (Hasselkuss, 1992). Hospital professionals were also concerned about risk. Because they were responsible for maximising the functional capabilities of the patient, it was their duty to design a discharge plan which would minimise the chance of readmission.

As Chadwick and Russel (1989) point out, a dilemma in discharge planning is how to balance risk and autonomy. Multi-disciplinary team members may have respect for the autonomy of the older person, but they also want to refrain from exposing him/her to risk of harm. When the wishes of the patient and the team's perception of risk are in conflict, judgments are made based on the team's assessment of the *responsibility* of the older person and, in some cases, the availability of family caregivers. Judgement of responsibility involves cognitive assessment. If the team thinks that the person is capable of making their own choices and determined to pursue a certain course of action, then the patient's wishes can be incorporated into the discharge plan. If however, his/her ability to make decisions is at all in question, the team feel justified in forcefully promoting their plan of action. If the patient's and team's view of a safe plan are incompatible, the team may be more likely to question the patient's cognitive functioning. As Silberfeld (1992, pg.125) points out:

The word risk is used in a variety of ways to provide compelling justification for the protectionist recommendations of caregivers....In all cases the perception and evaluation of risks becomes a persuasive determinant of decision outcome.

The cognitive abilities of an older patient in hospital can vary. Factors such as extent of illness, drug reactions, sleep disturbance, pain, loneliness and depression can affect functioning (Kadushin and Kulys, 1994). Formal cognitive assessments in both wards studied took place on only one, or in some cases, two, occasions during

the patient's stay. Ward staff themselves agreed that this meant results could be inaccurate and that the tests used were only 'benchmarks'. Despite this, judgments were made about patients based on these tests. Another means by which team members formed an opinion on the cognitive abilities of patients was through observation of behaviour. Those patients who demanded attention, were angry or criticised the efforts of staff were branded as 'difficult' or 'confused'. Patients who refused to comply with aspects of ward routine such as exercise classes or meals had their judgment questioned by informal comments from staff. In Canada, one of the patient interviewees was a woman in her early seventies who resented being on a geriatric ward and was desperate to return home. She refused to participate in any activities and communicated primarily with her GP, ignoring some hospital staff. Therapy staff made comments questioning her ability to make choices. These doubts were also noted in the patient's case files.

Staff in both countries were asked what they saw as the patient's role in discharge planning. Some of their responses addressed the theme of risk and illustrated the connection between the patient's conception of risk and the team's perceptions of whether or not patients were able to make 'responsible' decisions. A nurse in Canada explained how staff definitions of risk could restrict the patient's role in planning:

"I think it [the patient's view] is often overlooked....either their family or the professional staff take over and feel what's best for them and sort it out. Often I think their wishes are set aside - mostly for safety reasons."

Staff in both countries stated that they expected patients to be realistic about going home. This meant accepting the team's assessment of risk and agreeing to the necessary changes proposed in the discharge plan. The Scottish social worker said:

"I think they have a responsibility to be realistic about how things are going to be at home, which they often aren't."

Similarly a Canadian OT stated:

"Competency can be an issue. The patient's role really is to take responsibility for themselves and for their safety. If they are at risk, to ask themselves; Can I do this? or Do I need support? "

Risk was a difficult concept for both teams to deal with, and one that was considered for each patient and each discharge plan. In some cases the family or

caregiver's conception of risk was at odds with that of the patient. In these cases, cognitive assessment again became an issue. If the patient was judged impaired, the family's wishes would take precedence. If however, the team felt the patient was capable of more than the family believed, the professionals were willing to act as advocate, especially in the case of patients who wished to remain at home while their families thought they would be 'safer' in long-term care. As one of the Canadian liaison nurses put it:

"The family are the ones who are going to have to pick up the pieces, so that you really have to make it clear to them, or make it very clear to them that I have no say—I have to do what this person wants me to do—I cannot put something in against their will....yet for some reason, everyone thinks that we can just send them off, throw away the key. What a scary concept."

The geriatricians in both British Columbia and Scotland admitted that risk was a concept they had to accept. Their ability to provide patients with a protected environment ended on discharge. That protection could only be provided in the community if the patient agreed to accept services.

STAFF PERCEPTIONS OF PARTICIPATION

Team members in both countries were invited to come up with a definition of what the phrase 'patient participation' meant on their ward. Again staff agreed that an important element of participation was the statement of choices and preferences. As the locum consultant in Scotland stated:

"I hope we would all ask patients what they would wish, or where they saw themselves in the future...that they are having the opportunity to express what they would like, that is their participation."

An OT in Canada agreed that it meant:

"...to be able to participate in the discharge planning process by letting the team know what they need, what they have to be able to accomplish to get through the day, who is going to help them with that process. "

Jewel (1994) asked British nurses working in a geriatric ward what patient participation meant to them: they also raised the issue of choice, but indicated that this was dependent upon nursing staff assisting patients to state their preferences,

through helping them to feel comfortable asking questions. The Scottish consultant in this study pointed out that creating an atmosphere that encouraged an expression of views was an important component of participation:

"...that people are given the opportunity, in an environment in which they feel comfortable, to talk about issues around going home...just making them feel as comfortable as possible in talking to you personally and to the other folk in the ward about things that concern them."

The definitions offered by staff in Scotland thus illustrated their view of patient participation. This consisted almost entirely of helping patients to feel comfortable talking to them, and from there attempting to identify the needs and preferences of that older person. In essence this meant that they saw participation as an *information-gathering exercise*, that the patient's views were just one more thing—along with functional ability and home situation—to be considered when *the team* sat down to formulate the discharge plan. The health visitor pointed out the implications of this view. Patient participation to her meant:

"In real terms? It actually doesn't mean anything at the moment. I don't think the patients do participate. The only time that they do is when there is an identified problem, where we arrange to perhaps discuss how we can plan for someone to go home where it involved the carer and the client themselves."

In Canada staff definitions of patient participation had an added dimension. In asking the question "What does the phrase patient participation mean on this ward?" some professionals interpreted participation to mean physical activity rather than participation in decision-making⁵. This could have been perceived as an entirely separate definition but upon probing it was discovered that staff views of a patient's willingness to take part in ward activities also affected to what extent that patient was allowed to contribute to discharge planning.

⁵ Research into professional/client relationships within the literature on *disability* has revealed a gap between how professionals and disabled people define the term 'independence'. Oliver (1993, pg.54) has argued that:

"professionals tend to define independence in terms of self-care activities such as washing, dressing, toileting, cooking and eating without assistance. Disabled people, however, define independence differently, seeing it as the ability to be in control of and make decisions about one's life, rather than doing things alone or without help."

This professional/client divide could be extended to the discussion of defining participation in the geriatric in-patient setting. While patients, and most staff, interpreted 'patient participation' in the context of the study to mean taking part in decision-making, a minority of professionals viewed it in terms of self-care and exercise. This may reflect one type of view of the older patient as dependent, emphasising physical limitations rather than the capacity to make independent choices.

A wider variety of ward activities existed in Canada than in Scotland, where the focus was on individual therapy sessions. On the Canadian ward individual therapy sessions also took place, but these were combined with group exercises each morning and activities such as music, current affairs and crafts in the afternoon. This greater emphasis on activity explained this professional's interpretation of patient participation:

"I guess I would define it as getting up and getting their clothes on and then getting down to the dining room or being taken to the dining room and then attending the exercise group."

Those patients who would not participate in group activities disrupted ward routine and were more difficult for staff to accommodate than those who complied with all instructions. Non-compliance was interpreted as non-participation. Refusing to attend activities was the 'wrong' choice in the eyes of professionals whose job it was to rehabilitate the older patients. If 'wrong' decisions were made in that sphere, it was not difficult for staff to assume that the non-compliant patient might make 'wrong' decisions in other spheres, such as following dietary or medication instructions at home. One of the liaison nurses explained:

"...you know when you talk about participation—that the patient is not participating in what they are supposed to be doing—it's because they want to do something that we don't want them to do."

PATIENT PERCEPTIONS OF PARTICIPATION

To what extent did patient expectations for participation in discharge planning correspond with those of ward staff? Staff had low expectations for patient involvement in decision-making, but *those of the patients themselves were equally low*. This finding corresponds to those explored in Chapter 5, relating to older people's views of appropriate behaviour while in hospital. They did not ask for information, and as a result, did not receive it. Patients were by and large unaware of discharge planning processes such as team meetings and family conferences. Most knew that arrangements were being made for their return home but were not sure who was making them. The following exchange between the researcher and a Scottish patient illustrates this:

Patient: They are talking about getting a home help for me now.

Researcher: And who here in the hospital has talked with you about that?

Patient: Well, there have been two or three of them, they've also mentioned it to my daughters-in-law. And there is supposed to be someone coming to talk to me about it, they said that yesterday, someone from the health place, but I've not seen her yet."

Patients in both countries expected to be told what type of aftercare services would be best for them, rather than expecting to be consulted. Like staff in Scotland, patients viewed their contribution as limited to a statement of preferences, rather than one of negotiation or engaging in active decision-making. A Scottish patient explained how he viewed his input as limited to a statement of preferences:

"I mean I can make a suggestion or two, but in the end I don't think it makes much difference. They know what they are doing."

Patients in both countries were not only unaware of the process but they also did not understand that discharge planning was a team activity and that a group of professionals were planning it together. Instead, they looked for someone 'in charge' who they believed was making the decisions, be that the hospital doctor, the head nurse, or in Canada, the patient's own GP who visited them on the ward. One Scottish patient stated:

"It's Dr.E [the consultant] who is organising *everything* for me."

The following exchange between the researcher and a Canadian patient illustrates that he viewed discharge planning as his GP's responsibility:

Researcher: Let's talk about the contact you've had with the nurses and doctors here....do you think its important that they ask your opinion about the kinds of things you might need at home? Do you think they ask you that?

Patient: Aye, well, it's really just my own doctor, who said he's going to get me this home care stuff.

Finally both staff and patients agreed that patient participation in planning often meant carer input in place of their older relative. The Canadian nutritionist interpreted patient participation:

"What it means is theoretically, is they should be involved in all the decision-making....[but] sometimes patient participation means family participation because sometimes it is the family who decide."

Carer participation either took place as advocacy on behalf of the older person, or with the carer as surrogate patient, meaning their views took precedence over those of the older person.⁶ Carers in both countries discussed the discharge plan with hospital staff and then 'updated' their relative on its progress. As a Scottish patient said:

" I think they are now wanting to heighten my toilet seat. That's what my daughter said...I think someone told my daughter they would be coming next week."

RECOGNITION

One explanation for patients' lack of understanding concerning the discharge planning process is that they were unaware of the responsibilities of the various professionals on the ward. Although they could differentiate between doctors and nurses, the roles of other team members were less clear. Inability to recognise different team members had two consequences.

The first was that patients, and in some cases their families, were unaware that they were being treated by a team of professionals working together, or that these same professionals were responsible for discharge planning. The second consequence of patients' inability to differentiate between different team members was that if a patient had a specific request, they were unsure who to ask. Those that were afraid of appearing ignorant or ill-informed were hesitant to bother the wrong person. This was certainly the case with one Scottish patient:

'I don't know if I would ask anybody. Because if I don't think anybody could answer my question, I would probably be reluctant to ask.'

The majority of patients were however, not afraid of asking the wrong person but rather simply confused about the ability of certain team members to answer their questions or respond to their requests. The researcher asked patients in both countries to identify, by name or description, the different professionals that were involved in their care. The results for each of the ten patients interviewed in each ward are summarised in the table below.

⁶ See Chapter 5 - Patients' Views.

	Junior Dr.	Nurse	Auxiliary	Physio	O.T.	Social W.	Dietician
Scotland (n=10)	7	10	9	7	2	3	n/a
B.C. (n=10)	n/a	10	n/a	8	3	4	5

All patients were able to identify the nurses on the ward but differences between grades of nursing staff were largely unknown. One patient in Canada did point out that some of the nurses (the RNs) distributed medicine whereas the practical nurses did not. No other differences were identified. The majority of Scottish patients knew that auxiliaries were different from nurses. This was based on the fact that the auxiliaries wore yellow uniforms and no caps, unlike other nursing staff. Junior doctors were identified by the majority of Scottish patients as distinct from the consultant. This recognition was based on the ward round and the routine medical tasks (such as taking blood samples) that the house officers carried out. Therapy staff were the most difficult to distinguish for patients in both countries. The term 'occupational therapy' meant little to patients, and indeed in Canada patients confused both the physio and OTs with the rehab therapist who co-ordinated group activities. Social workers were not easily identified by patients in either ward, suggesting that their role was more ambiguous or they had less frequent contact with patients than other team members did.

As team members had different responsibilities in the discharge planning process, the researcher asked patients to identify which hospital professional they would ask about any services they might need at home. The staff identified by each of the twenty patients are shown in the table below:

	Dr.	GP	Nurse	Physio	O.T.	Rehab	Soc. W.	Liaison	Anyone	Carer
Scotland	2	n/a	4	0	0	n/a	1	n/a	2	1
B.C.	0	2	3	1	0	1	0	1	1	1

The table above shows that nurses were the team members most frequently asked about homecare. One reason for this was the visibility and frequent contact patients had with nurses. In Scotland, the authority of the consultant was recognised as two patients indicated they would ask him about services at home. The Scottish woman who said she would ask her relatives about home care indicated that she expected her son and daughter to ask the doctor on her behalf. No Canadian patients said they would ask the geriatrician about post-discharge services, but two indicated that they would refer to their GP when he visited them in hospital. Only two patients, one in each ward, could identify the *appropriate professional* who was responsible for making homecare referrals. In Scotland this duty fell to the OT and social worker. One patient identified the social worker. In Canada, the liaison nurse arranged homecare. She was identified by one patient.

Both these older people who were able to identify the right professional were 'experienced' patients. The Scottish patient had previous admissions to that ward and the Canadian woman had long term contact with a community case manager. This woman explained to the researcher that the ward social worker had discussed returning home with her and informed her that the liaison nurse would be in to assess her prior to discharge. This woman's familiarity with the system combined with information given to her by the social worker afforded her a greater understanding of the discharge planning process.

The liaison nurses were difficult for Canadian patients to identify. This was due to the fact that they met most patients only once, a few days prior to discharge. Although the liaison nurses were responsible for planning and implementing an important part of the discharge plan, they were not easily accessible to patients. Their ability to facilitate patient involvement throughout the discharge planning process was thus limited. Based on the relative anonymity of the liaison nurse, the Scottish consultant explained why his understanding of this method of discharge planning would not assist patients in knowing who to ask about homecare:

"I think the patients would find it difficult to understand who this discharge planning co-ordinator person was who came 'round and said 'I just want to check that everything is OK'...'Is there anything you have thought of that we haven't thought of?' They would probably think of something an hour after the discharge planning co-ordinator had gone and not know who to ask anyway."

Why were patients unable to identify different professionals? Reasons relating to the patient's health status have to be considered, although staff recognition

questions were posed on the day of or the day before discharge, meaning that the patient's condition had stabilised. Cognition must be considered as there were several patients who were anxious about going home and unsure about all the details. In addition, different staff members were providing them with a variety of kinds of information just prior to going home that may have added to their confusion. But there were clearly also organisational reasons for Scottish and Canadian patients' inability to identify different professionals. Several of these reasons were identified by older people and by staff.

The number of staff on the ward was given as a reason for confusion. This was especially the case with nurses whose shift changes meant the same individuals were not always treating the same patients. Role blurring was also a cause, as some types of staff performed similar tasks; such as the presence of both the social worker and occupational therapist on home visits in Scotland. A recent British study identified role blurring as a cause of inability to recognise professionals amongst older people returning home from hospital. As Clark, Dyer and Hartman (1996, pg. 2) state: "The older people interviewed were often confused about who was responsible for what". Patients in both wards in this study indicated that they found it difficult to 'keep track' of who everyone was. When asked whom she would speak to about home care, one Canadian patient simply stated:

"I don't know. There are so many of them and I don't know their names."

Patients were also unclear about the names of different professionals and their duties. A Scottish patient said:

"Well, you see there are some of them around and I know they are not just nurses, but I don't know who they are really."

The physiotherapist in Canada indicated that one reason patients might have trouble identifying team members was that, unlike in Scotland, the hospital in British Columbia did not expect staff to wear specific uniforms or other identification. Some nurses wore name tags but this did not extend to medical or therapy staff. If patients were unsure who someone was, they had to ask. This was problematic because, as the liaison nurse pointed out:

"I think it can be a problem. Because not everyone is comfortable asking. If they don't know who to ask they feel stupid."

Staff differed on whether or not patient recognition of different professionals was important in discharge planning. The OTs in both Scotland and Canada and one liaison nurse said it was an important deficit, and could result in staff being unable to assess whether or not a patient was satisfied with the choices that were being made. The Canadian OT pointed out that discussing discharge plans with only certain team members could result in omissions:

“..especially if that professional, for whatever reason, didn't bring up an area that was important to the patient, because sometimes you have to pull out of them what their priorities are.”

The majority of staff in both wards emphasised however that *effective multi-disciplinary team work should compensate for any confusion patients had in determining whom to talk to about the discharge plan*. A need or question raised with one staff member, be it an auxiliary or the consultant, should be passed on to the professional most able to respond. As the Canadian physiotherapist pointed out:

“I suppose as long as they ask somebody and the staff member passes that question on to the appropriate staff member, it would be OK.”

Patient involvement in discharge planning was thus dependent on effective multi-disciplinary teamworking not only from the point of view of involving patients and family formally in meetings and consultation but also in ensuring that any uncertainty about staff roles was compensated for by communication between team members. The findings presented here also suggest that staff in both countries could have been more diligent in explaining their role to patients. Staff underestimated the older patient's need for information concerning professional responsibilities in day-to-day patient care and in discharge planning. This information should have been imparted during the initial admission assessment and reinforced at later stages in the patient's stay.

CONCLUSION

Patient involvement in the planning stage of the discharge process was affected by a range of factors in both Scotland and British Columbia. Patient understanding of team structure and processes was found to be minimal in both wards. Patients were unable to identify the staff responsible for making discharge planning referrals in either Scotland or Canada. Patient expectations for inclusion in formal planning

were low. Although the majority of patients felt they should be consulted concerning their preferences, neither group of older people was concerned about their exclusion from formal decision-making. Instead, patients looked to carers, senior nurses or medical staff to make discharge decisions for them.

Professionals in both wards identified team meetings as the main forum for discharge planning. Patients and families were excluded from these meetings in both wards. Carers' contributions were solicited in family conferences and carers' evenings. Patients' contributions were expected to be communicated by team members at meetings, despite the absence of some ward staff (such as auxiliaries) and disagreement concerning the advocacy role of some professionals.

Based on the evidence presented in this chapter, the planning style of the Scottish multi-disciplinary team could be described as 'benevolent paternalism'. The geriatrician had ownership of the process through his direction of multi-disciplinary team meetings and control of carers' evenings. His authority was validated by patients, nurses and junior medical staff. Scottish team members did not identify lack of patient involvement in team meetings as a deficit or suggest any means by which patients could be permitted to take a more active role in planning. To Scottish ward staff, patient participation was limited to obtaining information from the older people under their care. Scottish staff wished to minimise any risk patients or families might face following release from hospital and considered themselves responsible for discharge planning *on behalf of the patient*.

Planning in British Columbia could be described as 'inclusive protectionism'. Inclusive because the team viewed patient involvement in decision-making as important, but protective because that involvement was limited to settings that the team viewed as appropriate and non-threatening for the patient. Professionals had a very specific view of what constituted a 'safe' discharge. Patients' wishes inconsistent with that view of safety were excluded from the planning process. Inclusion of some patient views was facilitated by the style of team decision-making in the Canadian unit, which was more democratic than in Scotland, in the sense that power and control was not completely centred in the team leader, but rather responsibility was devolved from the geriatrician to other team members, such as the social worker, ward and liaison nurses. This style of decision-making did, however, result in struggles between disciplines to control some aspects of patient care. Team members differed in their interpretation of patient participation and judgement of which patients were capable of making 'responsible' decisions. Team

members considered it their duty to protect the older people on the ward from possible problems following discharge and were thus willing to impose their views on any patients not considered competent. Canadian staff were aware of the importance of patient involvement in decision-making and were willing to discuss several means of facilitating it, but in reality had few formal methods of realising it. Patients had been invited to team meetings in the past but the practice had been discontinued. Patients were rarely asked to attend family conferences. Involvement occurred more as tokenism than as an exercise in the promotion of patient autonomy.

CHAPTER 8

IMPLEMENTATION

Implementation follows the planning stage of the discharge process. At its most simple, implementation is about putting the discharge plan into action. Defining this stage as distinct from other parts of the discharge process is problematic. This is largely due to the fact that implementation occurs both while the patient is in hospital and once they have returned to the community. Other writers have recognised the bridging nature of implementation. Kruse (1985) defines this stage as the transfer of the patient from hospital to home, interim or long-term care. King and Macmillan (1994) and Tierney and Closs (1993) both adopt the definition put forward by Mamon et al (1992) who define implementation as *the provision of services, including patient and family education and service referrals*. This definition accurately describes those aspects of the findings to be presented in this chapter. Implementation is about communicating and explaining discharge arrangements and their possible consequences to patients and their families. It involves providing patients with the necessary information to make choices about how different aspects of the plan will fit into their life at home. Implementation is about communicating discharge plans to community agencies through formal referrals. Referrals then translate into the provision of services. This chapter will describe these communication processes in both wards studied, and then examine how services were provided to older people at home in the few days immediately following discharge.

IMPLEMENTATION INFORMATION TO PATIENTS AND THEIR FAMILIES

While in hospital, the health and activities of the older patient are managed and regulated by ward staff. Once at home, these become the responsibility of the older person him/herself. Even for those patients who receive a high level of community

service in the home, the decision on how to use services and what to do with medication, exercise or nutritional information obtained in hospital falls to the discretion of the older person. If aspects of the discharge plan have not been accurately conveyed to the patient, and it is unclear what services are for or what instructions mean, then even the most carefully arranged aftercare package can fail and result in readmission or a move to residential care. Older people leaving hospital need clear and concise information, more than at other points in their contact with health or social services. As Tester (1992) points out:

The information needs of older or disabled people or carers are, of course, similar to those of any other member of the population....It is when people have limited access to such information at a time when their needs for services are increasing or when they are at a critical point that information becomes more crucial. Then they desire or need information that will help them to make choices about appropriate services.

Other studies have indicated that, of all older people in hospital, those over the age of eighty and living alone are most in need of accurate information (Epstein, 1980). This is related to the finding that people living alone rely more heavily on formal services than those living with family or carers (Ginn and Arber, 1991, Seale, 1996). However this group of older people are also those least likely to ask for information. Epstein (1980) points out that impaired mobility, isolation, sensory impairment, and lack of motivation can all contribute to a reluctance to seek explanations. Tester (1992) also indicates that older patients are often unaware of the information that could be potentially useful to them and thus do not express a need for it unless their attention is specifically drawn to it by someone else. Despite these findings, other studies have indicated that health and social care staff still expect older people to ask for any information they require (Henwood et al, 1996, SWSI, 1996b). If patients don't ask, doctors assume they already know (Annas, 1975, McEwen et al, 1983). One of the liaison nurses in Canada pointed out what can happen when hospital staff assume that a patient will ask for further information:

"I know that people who have been in hospital, have had teaching in hospital, they go home, they are seen by the home care nurse and the home care nurse repeats it all over again, because they have not retained a thing...they don't feel comfortable coming forward and saying "I don't understand this, who do I ask?"

Hospital staff's assumption that patients will ask, combined with older people's reluctance to ask, can result in inadequate information being given to the patient and the family on discharge. These inadequacies have been found in several studies of older people regarding community services and benefits (Skeet, 1970, Tester,

1992, SWSI 1996a, 1996b), medication, treatment, diet, or activity instructions (Magnusson-Arenth and Mamon, 1985, McWilliams and Sangster, 1994, Mistiaen et al, 1997). Inadequate information can result in: inability to plan ahead (Johnson and Fethke, 1985); inability to contact needed services once at home (Skeet, 1970, Koch et.al, 1995); unmet treatments or therapy needs (Kruse, 1985, Magnusson Arenth and Mamon, 1985), and perhaps most importantly, decreased compliance with medication, activity or nutritional regimes (Annas, 1975, Johnson and Fethke, 1985, Jackson, 1990).

Findings from this study indicate that older people discharged from the wards in both Scotland and Canada returned home with inadequate information about some aspects of the discharge plan. Inadequacies were found either in the content of information conveyed, or (often more importantly) in the format in which the information was presented.

WRITTEN INFORMATION

The two wards studied differed significantly in the methods they used to convey discharge information to patients. In Scotland, most information was conveyed verbally - either directly to patients or to their carers. In Canada, patients were more likely to receive written information, but this was usually given out at the last minute, was discipline-specific, and was inadequately explained.

Scottish professionals were more likely to promote the values of 'face to face' transfer of information with older patients. As the locum consultant explained:

"I think the verbal thing works better. We don't actually...give people any written instructions. But I sit down and speak to them about what we are planning to do, what the follow-up is and what the plans are."

Patients appreciated the doctor's willingness to discuss plans with them but there was a danger that restricting discussion of discharge arrangements to this form would result in the patient forgetting details shortly after the discussion had taken place. The locum consultant admitted this:

"Even that fails and we get people coming back to the clinic and discuss things you have tried to set up and they have no idea that those things were in action or were being set up."

Some written instructions were given out in Scotland, but predominantly by therapy staff regarding activities or following a home visit in which recommendations for alterations to the home were made. However, even among therapy staff this practice was rare. The researcher asked one of the Scottish OTs how often she gave patients a piece of written information. She replied:

"Not often, certainly not on a weekly basis. I do a lot of work with patients and I tend to do a lot of reinforcement, but it is more practical."

The younger Scottish OT, who had worked on the unit for five months at the time of the interview, stated:

"I have never actually done it myself, given them written instructions...If they need written instructions to remember to do something, they are not going to look at a bit of paper really."

There was no programme of formal self-medication teaching on the Scottish ward (by contrast with Canada, where the OT and nurses attempted teaching with all patients going home), although discussions were underway to institute a programme¹. In the meantime, nurses provided patients with a basic explanation of their medication prior to discharge. Once again, however, documentation of this teaching was very rare. As a Scottish staff nurse explained:

"...with regards to their tablets, they may be able to read labels on tablets but they don't know what time to take them at and then you would write that down. That might happen once every couple of months or so."

Written information regarding community services was also rarely provided to patients in Scotland, despite the existence of a series of new community care leaflets which had been made available by the local authority. The social worker on the ward in Scotland did use these leaflets, but not for all patients. As far as the researcher could determine, of all ten Scottish subjects who were to receive community services, only two were given a copy of the new leaflet describing the home help service. In the case of one man, this was with the aim of explaining changes in the cost of home care. The other individual who was given a leaflet was

¹ The senior OT explained the unit's plans to reserve one area of the ward for those patients about to go home. She stated:

"I think I would like to see, when we get the pre-discharge unit running, patients able to self-medicate within that. That is a strong bit of participation from patients in their own care. But that is going to be difficult."

an older woman whose private home help was to be supplemented by public provision on discharge. However, in the hurry to have her discharged to a waiting ambulance the following morning, the nurses failed to pack the leaflet amongst her belongings and it was left by her bedside.

Patients themselves recognised that written information was rarely given out in the Scottish hospital, as this exchange during a follow-up interview demonstrates:

Patient: ...The doctor at the [out-patient] clinic, he had a list as long as this saying what I could, and what I could'nt do.

Researcher: Did he write that down for you?

Patient: Oh no, They never put things in writing.

Researcher: They never do?

Patient: No.

The senior geriatrician in Scotland recognised that written information was something that patients rarely received on his ward:

"I think we are pretty sketchy about the way we do that sometimes. It should be more standardised. I mean, I just think there are times when it would have been more useful to give things to a patient, especially with the drugs or diet."

WRITTEN INFORMATION IN BRITISH COLUMBIA

In British Columbia, professionals attached a greater value to written information than their counterparts in Scotland. None of the Canadian interviewees stated that verbal communication of discharge arrangements was as valuable as documentation, although several stated that a combination of the two methods was the ideal². The community liaison nurses in particular emphasised the merit of written information, and indeed they were the team members who relayed the largest amount of written discharge information to patients. The researcher asked a liaison nurse if written information was important for older patients. She responded:

² The Canadian Nurse Manager stated:

"I think they should have both, because patients don't hear well, because they are anxious, they don't understand our terminology and if it is written down for their level, I think they should."

"Yes. Absolutely crucial. It is important for me and I am a lot younger than they are."

The geriatrician agreed:

"Very important, yes they are. Because, well, you know our patients range from intact to those with major cognitive impairments I think written instructions are important for the patient."

Several Canadian staff members emphasised that written instructions were important to assist the patient in remembering what they had heard in hospital prior to discharge. As the OT explained:

"It is primarily because of mental status generally...[It] is harder to learn as an adult and remember and retain information. I think, what do they say, maybe 40% of what you take in verbally you might remember."

Canadian staff demonstrated a genuine willingness to provide the patient with information even when he/she was cognitively impaired. In these situations it was imperative that the family receive the information as well. As the Canadian OT explained:

"Sometimes when a patient needs cueing as to what to do in their daily routine, I might give them instructions about that....when we go on a home visit, I either write down recommendations to the family or to the patient, so usually one or the other has a copy, or both."

This finding is in direct contrast to the attitude of some of the ward staff in Scotland, that written information was valuable *only for the carer, to the exclusion of the patient*. Scottish staff, with some notable exceptions³, viewed many of their patients as incapable of keeping or referring to written instructions. The comments of two of the junior medical staff illustrate this. The junior house officer stated:

"I think written is probably more important for the carers than for the patients themselves. It is very unlikely that they are going to be able to read it for a start and then the chances of them being able to interpret it - most of these patients are in hospital through confusion and very few of them get back to 100%, so I think it is more useful for carers at home to read it and then restate the verbal things that they have been told in the first place."

³ The Scottish social worker did give written information - such as the above mentioned community service leaflets, to both patients and family. Patients were provided with information by her even in cases where there was some cognitive impairment.

The senior house officer agreed:

"I think it is probably more helpful to go through a protocol with the relative or friendly carer of the patient...I mean the patient should obviously be told, but I think it would be more important to have a carer involved."

Canadian staff (a nurse and one of the liaison nurses) emphasised the importance of written information to assist in compliance with the discharge plan, particularly medication compliance. The liaison stated:

"The thing that I think about the most is med compliance. The timing, and there are so many medications interacting with each other and so many multiple system problems these patients go home with, that really medication compliance is a major factor."

Drew et al (1988) identified medication confusion as a main factor in readmission of older patients. This confusion can be lessened by patient teaching, thus lowering the incidence of readmission (Naylor, 1992). One aspect of patient teaching is the provision of written information about medication, combined with verbal explanations. Jackson (1994) in reviewing other discharge planning studies, emphasised that leaving clearly typed instructions with patients and family members had been found to be effective in achieving increased medication compliance. Results from follow-up interviews with Canadian patients at home indicated that written instructions, combined with supervision (from carers or community practitioners) served to reinforce knowledge of medications.

One final point made by Canadian staff concerning the value of written information was its role in replacing or supplementing patient instruction that had been hurried or inadequate due to time pressures. Nurses and the nutritionist in Canada explained that there were occasions when patients could be discharged without having one of more aspects of the discharge plan—such as activity or diet instructions—explained to them or reinforced just prior to discharge. In these cases, leaflets served as some information rather than none. The nutritionist explained:

"Sometimes I give it to the patient and hopefully they remember that they have them and it has been passed on, and sometimes I am not around here enough to do some of the teaching that I think I should, that is part of my job that falls down a lot."

It is questionable whether written instructions without prior explanation are an effective way of communicating discharge arrangements to older people and their

carers. In this case, the Scottish approach of face to face instruction with the patient is probably better than only providing the patient with a generic leaflet. A Canadian nurse described how the ideal is a time-consuming combination of the two:

"The time factor. ...It would be a wonderful plan. You could teach them—you could show it to them—you could have them demonstrated, you could give them the stuff. But that would require a one on one."

WRITTEN INFORMATION ON THE DAY OF DISCHARGE

Johnson and Fethke (1985), in their survey of post-discharge outcomes of the hospitalised elderly, found that compliance problems at home might have been related to brief and late instruction and communication of the discharge plan to patients. In their study, medication and care instructions were given to patients on the day of discharge. They point out that this last-minute provision deprived patients of the opportunity to plan ahead, obtain answers to questions they might have thought of on reflection, or absorb details at a time when they were distracted by the prospect of immediate discharge.

In both Scotland and Canada, the majority of verbal information concerning discharge was communicated to patients the evening before or the day of discharge. Written information was given out in the vast majority of cases on the day of discharge. While this held the advantage that the material was less likely to be discarded and more likely to return home with the patient, it also contributed to the confusion experienced by some patients faced with a flurry of activity and instructions after several weeks of predictable, scheduled existence on the ward.

In Scotland the single most important piece of information given to patients just before they left the hospital was their copy of the discharge checklist, which will be discussed in the next section. Apart from this piece of paper, they were given a discharge summary to convey to their GP. They were also provided with enough medication to last until their family doctor was able to visit them at home. Most commonly, this medication was taken home in a pre-filled dosette box. Unless they had received any other material from social work or therapy staff previously, this was the only information that Scottish patients were given on discharge. There was no formal notification of telephone numbers for community services⁴ or the day

⁴ Unless they had received a social work leaflet in which case there were numbers on the back.

hospital . Hospital follow-up appointments for either the out-patient clinic or the day hospital may have been made before the patient left hospital, but formal notification was done by post once the patient had returned home. *No community contact numbers were given*, as the OT described:

"If I am dealing with them and we are talking about 'we will supply this chair for you at home' I will tell them it is a community occupational therapist and once she visits she will leave her card and you will have her number and you can contact her if you have any problems."

Scottish staff relied on verbally explaining to patients that community services would visit them, rather than giving them written details from the community agencies themselves. Ward staff could only tell the patient what they assumed community agencies would do based on referral, and who would see them at home. There were no guarantees. The senior consultant explained how this affected the contents of written information given to patients on discharge:

"I think that patients and their families might find it helpful to have something written on what you have organised, set up, recommended, some time scales, but you need to be careful with the wording because we can't say 'This will be provided'; we can only say 'we have recommended that home care provides...'"

In Canada, patients were given more written information on discharge. This included details of their community case manager, home care agency phone number and proposed first visit, as well as the equivalent information for home nursing services. This information was provided by the liaison nurses along with ward nurses. Because of the liaison link, patients could be informed what level and frequency of service they would receive, at least for the first few days at home.

Although Canadian patients were given more written information by ward staff, the researcher found patient recall poor. One possible reason for this was the method by which the information was conveyed. Just prior to, or on the day of, discharge each team member would approach the patient separately and summarise any instructions or referrals that had been made. They would also give the patient any written material relating to services. Often this communication was rushed. Once at home, the patient was unsure who had said what and whom each sheet was from. A Canadian nurse stated:

"At the point when they are actually leaving, I think that is getting a little late then. They need time to digest it and think it over and work through it a few days before. It

is too late then, because it is like another thing they have to learn at the last minute, something new."

The liaison nurses were also aware of the volume of last-minute information that patients received on discharge. One explained her doubts about how much of it was actually read:

"I feel that the patient has already been bombarded with a lot of information...I know they've got some dietary, I know they've got some from physio or OT, equipment needs, there's a whole list of things that they have to do. I sometimes wonder if they just go home and throw it all away."

The liaison nurses attempted to streamline their own information, which informed patients about arranged homecare services. The same liaison explained:

"I make mine absolutely minimal amount of information, because I don't feel that much of it goes in and stays in. What I do is to ensure that the patient has a name and a phone number of someone they can call, or their significant other can call to confirm what my plan is."

PATIENTS' VIEWS OF INFORMATION PROVISION

Magnusson Arenth and Mamon (1985) have pointed out that patient recall of instruction is crucial to their continued recovery at home following hospitalisation. Their study found that older patients frequently do not remember advice or directions received prior to discharge. Three days following discharge, they found that 25% of patients could not recall instructions about exercise/ambulation and 22% could not remember instructions to avoid infection. In Scotland, Tierney et al (1993) found that, two weeks following discharge, 48% (n=326) of the aged 75+ patients they interviewed were unable to recall receiving any information on any topic prior to discharge. Jackson (1989) found that none of her small sample of patients discharged from a hospital in Manchester could recall receiving any teaching while in hospital.

There are several reasons why older patients may not recall teaching or instructions following discharge. The first and most obvious reason is that they did not receive any. Jackson (1989) compared her interviewees' absence of recall with nursing records from the ward. She found that no teaching was recorded in the records. Other evidence for lack of instructions/teaching and poor patient recall of information was found by McWilliams and Sangster (1994). They interviewed patients, their families and health care professionals in Canada and discovered that

all three groups complained of inadequate discharge teaching related to medication, supplies, specific treatment protocols, diet and home care service. Neill and Williams (1992) surveyed 71 wards with older patients in England and Wales and found that only one in three wards routinely gave out written information about medication on discharge.

A second reason for poor recall is that most information conveyed to patients prior to discharge is verbal. Jackson (1989), mentioned above, also noted that information shared verbally on the ward she studied was not normally recorded on the nurses' notes. As has been pointed out, older patients are more likely to forget verbal instructions if they are not reinforced by written information provided to them or their carers.

Finally, poor patient recall of pre-discharge information must be attributed to poor memory or cognitive impairment. However, poor memory cannot explain all reports of lack of information, nor account for all the unmet information needs found post-discharge in other studies (Koch et al, 1995, Henwood et al 1996).

The patients in this study were interviewed in their own homes four weeks after discharge. At this time, *the majority of patients in Scotland could not recall any written information they had received prior to discharge*. Only three of the Scottish patients could recall receiving written information from hospital staff before they were sent home. For each, this included a copy of the discharge checklist which will be discussed below. Other information recalled was nutritionist's instructions in the case of one man and a homecare leaflet for another man.

In Canada, *the majority of patients (6 of the 10) did recall being given written information on discharge*. For four, this was the homecare or home nursing hand-out, with contact numbers and details of the first visit. As one woman explained to the researcher on the day of her discharge:

"Well she [the liaison nurse] told me what they could give me and then this morning one of the nurses from the ward came and she gave me a schedule, like when the district nurse would be in to see me."

One Canadian patient recalled being given dietary instructions and another man acknowledged receipt of contact telephone numbers for his community case manager and the OT that was to visit him at home following discharge. One other patient recalled that she had been offered dietary instructions but had refused them.

Another patient commented while in hospital that her carer had been given some information:

"They gave W [carer] some things to take home and read - they gave them to her over the weekend, one of the nurses did."

However, there were four Canadians who recalled no written information at all. One man had no community services provided as part of a discharge plan. He therefore received no written information, as this exchange with the researcher illustrates:

Researcher: When you left the hospital, Mr. D, do you remember them giving you any sheets of paper at all, any written information of any kind?

Patient: Eh, no, no I don't.

Researcher: So they didn't give you anything, you just walked out?

Patient: Yes.

Despite the lack of information provided to patients, the majority of older people in both countries did not express any unmet information needs following discharge. They did not expect to have been provided with any more explanation of the discharge plan than had been offered. In Scotland, only two patients stated that they wished the hospital had provided them with more information about the discharge plan. One man was still concerned about his medication and wished he had been told what all the pills were for. Another patient had unanswered questions about the management of his condition. In Canada, four patients⁵ said they wished they had received more information. Two of these information needs concerned details of their condition, and one concerned medication. The man who had received no discharge planning wished he had been informed how to go about procuring home maker services for himself.

The fact that interviewees in both countries did not expect to be given detailed information about their discharge plan further supports the finding from this study that older people have low expectations of involvement in the discharge planning process. Not only were patients willing to allow professionals to make decisions about treatment and services on their behalf, they were also willing to permit the

⁵ Two of these patients had already received some written information but had other information needs that were not met.

plan to be implemented without being fully aware of which services they would receive when and for what reason.

Despite the low incidence of unmet need for information reported by the older people themselves, the researcher observed several cases where more comprehensive information could have improved discharge outcomes. These observations were made during the follow-up interview carried out in the home of each older person. In Scotland, one man had been told in hospital that he would receive a new walker once at home, but four weeks post-discharge it had still not materialised. The older man did not know whom to contact concerning this need and had made no further inquiries himself. One woman in Scotland and one in Canada asked the researcher about their medication during the follow-up interview. Neither had a home help or community nurse monitoring their medication. From what the researcher could observe, both women had been taking their pills incorrectly for several days.

THE DISCHARGE CHECKLIST

The 1992 Scottish Office guidelines for good practice in discharge planning contain a series of recommendations for all Scottish hospitals (NHS, 1992). One of the key concepts in the guidelines was that of a Discharge Checklist, designed to be adapted and used by ward staff. It contained a list of things that should be done prior to releasing a patient from hospital. The intention of the checklist was to facilitate comprehensive discharge planning, to keep track of arrangements to ensure that nothing was forgotten.

Tierney et al surveyed eight wards in one Edinburgh hospital in 1993 and found that only one used a checklist. Later that year they surveyed 319 wards throughout the country (Tierney et al, 1994), and although use of checklists was not specifically recorded, only 50% of the wards reported having any kind of written discharge policy. Following this study the authors recommended that every ward in Scotland should adopt a discharge planning proforma for multi-disciplinary use.

THE CHECKLIST IN SCOTLAND

The Scottish ward studied here had designed their own discharge checklist. It had been developed soon after the unit opened in 1993, and at the time of fieldwork was in its second draft. The checklist consisted of one sheet containing different aspects of the discharge plan, which team members checked off once they had done the necessary task. Contents included service referrals, the arrangement of transport, informing the GP, ensuring that the patient had food at home, and other aspects of the plan.

The checklist had four duplicate sheets. One copy stayed in the patient's hospital records, one went to home care nursing services, one was conveyed to the GP and the final, white copy was given to the patient on discharge. The patient's copy was in itself an innovation and indicated the geriatrician and team's willingness to inform the patient of the details of the discharge plan.

The checklist was kept in the nursing records and nurses filled out most of it. Nursing were also responsible for distributing the copies on discharge. A staff nurse explained:

"It is the nurses' job usually to start the yellow, quadruple discharge planning sheet and to make sure that is all carried out and completed at the right time. To make sure that people phone the appropriate places, if it is not me it is someone else who phones."

Medical staff had little to do with the checklist. They informed nurses once the GP had been contacted, otherwise they did not refer to it. Nursing and therapy staff appreciated the checklist and considered it an effective means of keeping track of the varied responsibilities of different team members. An OT explained:

"I see it as a checklist to make sure that everything is in place for that patient's discharge. I think it helps to focus the team on their responsibilities and if something hasn't been signed off then people check....I think its difficult to find a document that...covers everybody's needs and I think it goes quite a long way to meeting the needs and it is a focus."

Staff did however point out weaknesses in the checklist. It was considered too brief, with too few details. Most importantly, although it indicated if a referral had been made, it gave no indication of contact telephone numbers for community agencies, or when services would start. As the social worker explained:

"I don't think it works so well because it's just too simple a checklist. There's no space to say 'Yes, the home help has been organised but in fact she is not coming until next Thursday . Or to give a contact number and address 'if your high chair is not delivered by Wednesday, please phone so and so.' That kind of info is not on it. That would probably be more useful for the individual."

Completion of the checklist was time-consuming for nurses. The researcher observed that the checklist was not always filled out prior to discharge. Some sections were left until after the patient had gone home, or, to save time, filled out in advance before the necessary arrangements had been made. One example of this was the section asking if the patient had received their drugs, clothing, valuables and/or dressings prior to departure. In the case of one female patient, the researcher found that this section had been filled out four days before the woman went home, at a time when she could not have possibly received these items.

Nursing staff were not diligent about giving the patient his/her copy. On two occasions the researcher found that the patient's copy was left behind amongst the case notes after she had gone home. Only two patients could recall receiving a copy when interviewed one month post discharge. When staff were asked if it was important that patients got their copy, it was apparent that few considered it a priority. These sentiments suggest that failing to give the patients their copy was not limited to simple carelessness but rather implied that some staff thought there was no point, as patients would either not read or understand it anyway. This attitude negated the potential the checklist held for involving patients in discharge planning. The researcher asked the senior consultant if he considered it important that patients receive their copy. He replied:

"No, actually I don't, I think most of them will have no idea what it's about and be totally disinterested , and lose it quickly."

The locum consultant agreed:

"The patient—one example I saw in the [out-patient] clinic yesterday—must have got her checklist, but it made little difference. She still had really no idea of what was being planned...it probably just does get lost or put aside and I am not sure they go back and refer to it."

THE DISCHARGE CHECKLIST IN BRITISH COLUMBIA

The ward in Canada did not use a discharge checklist at the time of data collection for this study. The team had tried to implement one eighteen months before, a version for the use of staff only, with no patient or GP copies attached. This checklist was used only for a few months. There were several reasons why it was not permanently adopted. Originally drawn up by a senior nurse and the social worker, the checklist went through two drafts but emerged as a very cluttered document as team members suggested that more and more information be included. More importantly perhaps, the model checklist was not included in the main interdisciplinary team records as it had not been officially approved by the hospital administration. This separation contributed to its failure to become a permanent part of the planning process on the ward.

When asked about checklists, team members in Canada pointed to existing documentation, particularly the sheets filled out by the liaison nurses detailing past and future home care, and one other sheet completed by the social worker entitled 'Patient Care Plan - Discharge Planning'. Nurses were also in the practice of ticking off when the GP had been contacted and medication arranged - this was taped to the front of the patient's record or included in the interdisciplinary notes. However, none of these documents listed *all* arrangements for the patients' discharge nor indicated when all referrals had been made.

REFERRALS

The main source of communication between hospital and community staff in both Scotland and British Columbia was referrals. Referrals were made either in writing or by telephone in order to alert community agencies that the older person was returning home and would require new or continued services. One of the most important referrals made by hospital staff was to the patient's family physician. The format of GP referrals differed between the two wards.

GP REFERRALS IN SCOTLAND

In Scotland, GPs did not visit the ward and were thus largely unaware of the progress of their patient in hospital. The referral therefore conveyed essential

information which assisted the GP to continue the care of their patient in the community following discharge. Referrals took two forms. Firstly, Scottish patients were themselves provided with a one page-discharge summary that they took home with them on discharge and were supposed to give to their GPs as soon as they saw them. Secondly, a more detailed discharge letter was written by hospital medical staff and conveyed to the GP by post.

There have been numerous British studies that describe problems in the format and/or timing of GP referrals. Tierney et al (1994) state that, in 1993, 97% of the Scottish GPs they interviewed (n=303) reported that hospitals were still relying on patient or carer transmission of the discharge summary, which they believed was an unreliable way for information to be conveyed, especially in the case of older patients. Scottish Office guidelines state that the more detailed discharge letter should be sent out within 5 days of discharge but Tierney and her colleagues found that 23% of the hospital wards they surveyed took up to a week to send the letter. Other British studies have recorded similar delays, beginning with Lockwood and McCallum (1970) who reported that only 15% of GPs they surveyed had received the full discharge letter at first consultation with a newly discharged patient. Other delays in referral were subsequently reported by Howard (1986), Curran, Gilmore and Beringer (1992), Anderson and Helms (1993), and by Closs (1997) in a recent review of the hospital/community communication literature.

Junior medical staff in the Scottish ward were responsible for GP referrals. The junior house officer described his role:

"I am rated as the person who has to know everything because I am the only link between everybody and the one who writes the silly forms and talks to the GP and tells everyone what is going on and the one who writes the discharge summary. If I haven't written the discharge, they don't get any medication and they can't go home."

The discharge summary did contain details of medication. This information needed to be quickly conveyed to GPs, because although patients were sent home from the Scottish ward with medication to 'tide them over', repeat prescriptions had to be made by the family physician. Once the one-page summary had been written and given to patients or their carers, the discharge letter was dictated and always countersigned by one of the senior house officers. However, these letters were in some cases not sent out until the week following the patient's discharge. This was an administrative problem, as the senior geriatrician explained:

" Well, now there's a tale. They should be out within the week, but they are not and that is a resource problem, we are not adequately staffed to produce those. It is a matter of great concern."

Although there were many factors that affected when Scottish GPs visited their older patients post-discharge, lack of information from the hospital must be included as one reason. Only three of the patients interviewed at home in Scotland saw their GP within one week of being discharged.

GP REFERRALS IN BRITISH COLUMBIA

Family physicians in Canada were able to visit their patients in hospital and be involved in their care. For some patients, this meant continuous monitoring by one doctor and thus no interruption in continuity of care. In these cases, GP referrals were not as important as they were in Scotland. Nevertheless, GPs were phoned by nursing staff when their patients were about to go home. This form of referral was then followed by a discharge letter written by the geriatrician. He described feedback he had received from GPs regarding his letters:

"I do know that they appreciate the documentation from this department because it is excellent. I do my discharge summaries either the day before they go home, or the same day. The only delay in that is the time it takes to type it and get it out. I do my discharge summaries in an absolutely timely fashion."

Like the ward in Scotland, there were administrative delays in sending out some letters, although the researcher did not obtain any concrete evidence of this for any of the ten patients interviewed in Canada, six of whom saw their GP within their first week at home.⁶ Interestingly enough, copies of the geriatrician's discharge letter were also sent to the community case manager of the patient, meaning that home help and home nursing services received the same medical information as the family doctor.

⁶ Fewer patients were housebound in Canada than in Scotland. Therefore a higher proportion were able to travel to their GP's offices, which must be considered as one reason why a greater proportion saw their family doctor within the first week post-discharge.

COMMUNITY SERVICE REFERRALS IN SCOTLAND

The method of referral to community health and social services differed between the two wards studied, because of team structure. In Scotland, the multi-disciplinary team divided referrals responsibilities amongst themselves. While most were discipline-specific, some services could be accessed by more than one professional. As one of the OTs in Scotland described:

"The areas that tend to be grey are things like home care, because sometimes we do homecare restarts and sometimes we don't...other things like CCAS alarms, they can be done by the social worker as well, as those things are agreed between us."

The way that responsibility for making these types of referrals was decided was through informal negotiation between team members. This was determined either on the basis of the person who had the best or most frequent contact with an outside agency, or on the basis of who knew the patient best. As one of the OTs described:

"On this ward, it's whoever knows the patient best really, who has been dealing with that patient. Referrals to home help are split between myself, other OT staff and social work. If I know the patient then I just go ahead and do the referral."

There were significant advantages to this approach from the patient's point of view. It meant that almost all aftercare issues could be discussed with one team member. Although the patients were unaware that this was occurring, they became more familiar with the one staff member who was asking them questions about home care or telling them things about services on more than one occasion. Perhaps the best example of this was one older man who had had previous admissions to the ward and knew the social worker was the one who would restart services when he went home. He knew her by name, trusted her and on several occasions asked nurses if they could locate her for him as there was an issue he wanted to discuss with her.

There were, however, some weaknesses in the Scottish ward's informal referral structure. It could lead to duplication and to crossed lines of communication. Another OT described how carers or agencies could often receive more than one inquiry from team members:

"...no-one is ever quite sure who is supposed to be doing what. Sometimes I presume it will be irritating for the relatives to get more than two phone calls about exactly the same thing, or someone to cancel and we phone up to

make sure it is still OK. I am sure there is quite a lot, a fair amount of that going on."

Crossed lines of communication could arise if team members did not keep each other informed as to which referrals they had already made. A nurse explained:

"Sometimes it does if they don't come back and relay the information to you, if they just go ahead and do something. I had a case that....when I came on a late shift, the doctor was under the impression that it was Monday they [a patient] were going home, the discharge letter had been written for Monday, but the OT had gone ahead and ordered an ambulance for Tuesday but it turned out the person was not going home until the Wednesday. We had to chase 'round everybody."

COMMUNITY SERVICE REFERRALS IN BRITISH COLUMBIA

The OT in British Columbia confirmed that there was a formal structure for referrals on the ward:

Researcher: Would you say as far as referrals are concerned, it is fairly clear cut as to who does what?

OT: Yes, it is. Definitely.

The liaison nurses made all written referrals to public community agencies except home nursing which was done by ward nurses. There is some evidence from other studies (Waters, 1987, Jowett and Armitage, 1988, Anderson and Helms, 1993, Closs, 1997) to suggest that this method of referral results in more information being conveyed to community agencies, particularly background and social details that ward staff may not send on in documented form. The liaison nurses also frequently met case managers and home nurses face to face, which was not the case between community and hospital staff in Scotland.

Comprehensive information may have benefited the patient in that services were more rapidly deployed in Canada, as will be described in the next chapter. However, this referral structure did not in any way assist the patient in participating in decisions about home care. The liaison nurse was not a recognisable figure to the patient in the way that the OT or social worker were to the older people on the ward in Scotland.

In British Columbia, there was a greater variety of private and voluntary agencies involved in the aftercare of patients than there were in Scotland. Referrals to these agencies were divided between the OT and the social worker in most cases, with

some involvement from ward nurses or liaison nurses. One of the liaisons described how voluntary agency referrals were done:

"Between M [the social worker] and myself we try to cover it, let's put it that way. So we sort of discuss who wants to....Because M and I talk a lot, so if she is away then I will take on a lot more of her role in communication. But if M is here then she is often talking to them a lot more than we do."

To summarise, the differences in referral method between Scotland and British Columbia can be accounted for by the structure of the discharge planning models employed in each ward; the multi-disciplinary team model in Scotland meant that staff engaged in a greater division of referral responsibilities, based on their knowledge of individual patients and the services required. This division is consistent with the more 'blurred' roles adopted by Scottish team members and demonstrates how discharge planning was a process of negotiation between those involved. The liaison nurse model employed in British Columbia meant that referral responsibilities were more defined, mirroring the more rigid nature of professional roles on the ward. In both settings there were 'grey areas' of responsibility, but these centred around informal sources of support for the patient following discharge - family members/carers, voluntary agencies and private services.

DISCHARGE DELAYS

Once health and social care agencies in the community had received notification that a patient was to be discharged and would require services, the hospital teams could make the final arrangements for the patient to return home. However, on several occasions in both wards studied, delays occurred in this process. Although the discharge plan had been made, the patient did not return home on the appointed day. There were a wide variety of reasons why delays occurred.

Staff in both wards were asked to list the most common causes of discharge delay. Their responses conveyed a great deal of information about the structure of hospital/community relations in their area. In Scotland, staff believed delay to be primarily caused by sources *outside* the hospital. In British Columbia, staff believed that delays were caused by the organisation of care or events that occurred *within* the hospital. This difference served to illustrate yet another implication of the two different models of discharge planning employed in the wards. In Scotland, the

organisational divide between the hospital and the community inhibited continuity of care for the older patients sent home. In Canada, the liaison nurse brought the community into the hospital and into the planning process, meaning that she could ensure which services would be provided and when they would begin. But delays still occurred in Canada—caused by those involved in the planning process while the patient was in hospital.

COMMUNITY-DRIVEN DELAYS IN SCOTLAND

Scottish Office discharge planning guidelines following the implementation of the 1990 *NHS and Community Care Act* (NHS, 1992) state:

Proposed discharge from hospital should be discussed in advance with the local authority and should not take place until an agreed package of community care services is available.

This guideline demonstrates the separation between in-patient and community services in the UK. The hospital and the community are two distinct entities who must negotiate the package of services required for each older person returning home. One of the Scottish staff nurses elucidated this:

"We hand over our assessments and they say they are going to restart. As soon as they say 'Yes, we'll pick them up at such and such a date it becomes their responsibility because they are in the community after that, they are not the hospital's responsibility."

The most common reasons for discharge delay mentioned by Scottish ward staff concerned the arrangement of community services. Seven of the eleven ward staff asked about discharge delays mentioned this as a principal cause. As the health visitor explained:

"A delayed discharge is often because it is difficult to initiate services at home at the right time, and to get them all to start together. One thing I think is lack of communication and the variation in reports you can get."

The junior house officer agreed:

"Organising home help, organising railings in, getting some sort of support at home, that is usually the number one reason for things to be delayed."

The community service most frequently mentioned as a source of delay was the home help service. The senior consultant explained that ward staff needed to know

that home helps would be available to assist an older person before discharge could go ahead. They were dependent on the co-operation of home care:

"[we have] difficulty in organising home care immediately. We have reasonably good liaison and they try their hardest to give us that, but I don't have any control over that...all we can say is what we recommend "Can you fill in please?" Sometimes they can...We have to put up with it because there is no alternative basically. You are there for the good of the patients and if I spring them home to a poorly-set-up situation, they'll be back - maybe not to my ward, but to someone else's ward and that is not good."

The installation of aids and equipment was another source of community-driven delay mentioned by Scottish ward staff (mentioned by 6 of the 11 who responded).

As one OT said:

"Another thing that holds them up is the delivery of equipment, all the basic things that really shouldn't hold them up at all. But again it is down to resources which makes them have to stay in hospital for longer than necessary."

One of the older people who took part in this study had his discharge delayed because the right equipment had not been installed in his flat on time. This man was sent home in an ambulance. When he got home, it was discovered that the necessary railings had not been installed on his stairs. As a result, he was put back into the ambulance and returned to the hospital until the repairs could be completed. The patient himself was very unhappy with this discharge delay. When he did finally go home for good, he was unable to use the railings anyway. When he was interviewed one month post-discharge he was still not using them, despite further alterations⁷. He explained:

"Well, there is no point in taking me back because I wasn't going down the stairs anyway. I can't, I've never been downstairs since I came home. I can't...yesterday I still had people in there sorting out those rails...after all this time.!"

The delay encountered by this man was actually due to a lack of communication between the ward social worker, the joiners and one of the patient's neighbours who had a key for the property and had spoken to the joiners.

⁷ For more details of this case, see Chapter 9

Jackson (1993), Tierney et al (1994), Skeet (1970) and Neill and Williams (1992) have all documented how difficulties of communication between community agencies and hospital staff in the U.K can result in discharge delays. One communication between ward and community staff was in some cases insufficient in Scotland and could result in delays. A Scottish staff nurse explained how this could occur:

"I got a phone call from a district nurse who didn't know about a discharge, but one of her colleagues had been at the [ward] meeting on Thursday and hadn't passed the message on. I had also phoned and spoken to a receptionist who took messages for the district nurses and hadn't...so that was actually two levels where information could have been passed on and I didn't presume but felt that it had been done, but it hadn't."

Hospital staff in Scotland felt that fewer discharge delays would occur if hospital-community communication could be improved. One staff nurse described what she saw as the problem:

"It is quite one way. It's us to them, rather than them to us."

One-way communication had been addressed by discharge planning workshops held for all hospital and community services working with the elderly in that part of the city. However, these workshops did not involve all staff. The consultant stated that he would prefer more consistent community input in discharge planning and suggested that an alternative might be to have more community staff attend the multi-disciplinary team meetings:

"It would be nice to have more representation from the community there, either all the time like somebody from Home Care, have a district nurse there...There are times when it would be useful to have a GP there, but then you are getting into the realms of having individual case conferences...on a routine basis, it would be nice to have someone from Home Care."

The Scottish consultant was suggesting that the regular presence of a community employee at ward team meetings would be one solution to solving communication problems and reducing discharge delays. In essence he was advocating the liaison model that existed on the Canadian ward studied.

COMMUNITY-DRIVEN DELAYS IN CANADA

The Scottish Consultant's promotion of community liaison as contributing to a reduction in discharge delays is supported by evidence from this study. The

researcher found that fewer community-driven delays occurred in Canada. In British Columbia, not one hospital team member listed home care services as a cause of discharge delay. Similarly, not one team member listed the provision of aids or adaptations as a cause of delay. On the contrary, when questioned about causes of discharge delay, four Canadian team members pointed out that community services were normally NOT a cause. The geriatrician said:

"I don't think there are too many community driven delays...I think that [this city] is probably luckier than most places as far as the range of community services that are available."

The presence of the liaison nurse on the unit was also mentioned as a reason why community-driven delays rarely occurred. The services she was responsible for arranging would be promptly put in place. As the social worker explained:

"I find that long term care [liaison] are very efficient if you catch them OK. They are efficient once they are up here and they make the calls to homemaker agencies and if they need someone in by the next day, they usually get it done."

However, liaison could not fill all the gaps in community provision. Patients going home who required home nursing services needed to have their discharge date set well in advance. Home nurses, although coming from the same central community agency as the liaisons, needed five days notice before they could initiate services. This was seen as a resource problem rather than one of communication. As the social worker said:

"Home nursing care is the only major delay. You have to have five days notice, period. And that is a well-known delay. The home care nurses, they can't handle the volume of referrals."

Smooth and timely discharge from the hospital in British Columbia was however very much dependent on resources; the resources of the community, the hospital and the patient themselves. Although none of the ten Canadian patients were delayed in their return home by problems in providing home helps, home nurses or temporary equipment from the Red Cross, there was one patient who was forced to stay in hospital two weeks longer than medically necessary because of the team's inability to have all the necessary adaptations made to his home. This delay was caused not by a communication breakdown but rather by the fact that the patient, an 82 year old who had post-polio syndrome, required a significant amount of new equipment, including a new wheelchair, electric scooter, raised chair and electric mattress. He had no income other than his disability pension, which was

insufficient. As there were no family to cover the cost, a special grant had to be applied for through the Ministry of Social Services. The delay caused between applying for the grant, the receipt of the funds and the provision of the equipment was a source of frustration to the patient and ward staff. In the end, the grant was still not enough to cover the raised chair, the least essential item. The patient was disappointed and pointed out the irony of the delay, in which public funds were being used to keep him in an expensive hospital bed:

"Now they could have got me a proper lift for that chair for five hundred dollars or thereabouts, and instead they spent thousands keeping me in hospital for all that time."

HEALTH DETERIORATION DELAYS

In both Scotland and Canada, discharge delays were caused by an unforeseen deterioration in a patient's condition. Discharge dates were set based on the fact that the patient's health had improved enough to justify discharge. If this changed, the patient was either retained within the geriatric assessment and rehab unit or moved to acute care. As the Canadian consultant stated:

"That is probably the commonest cause of a delayed discharge, is that something else happens to them. They end up going back to acute or they are just delayed here."

One of the ten Scottish patients developed a chest infection days before he was due to be discharged. This extended his in-patient stay by one week. He explained:

"Oh aye, well, I took a thingmy. It wasn't complicated or nothing...it went down into my chest. And here they were letting me out on Monday. The night before, I took a bad turn. I had double pneumonia...I was in there for another week."

In Canada, a woman who had been sent to the assessment and rehab unit following a gallbladder operation returned to a surgical unit to have a basket extraction to remove a remaining gallstone. After returning to the geriatric ward her discharge occurred later than anticipated as she was extremely weak following the second procedure.

HOSPITAL DRIVEN DELAYS

Events other than a deterioration in health could occur in hospital and delay the return of patients to the community. Disagreement within the multi-disciplinary

team could cause delay. As Jackson (1994) has pointed out, there is a relationship between staff attitudes and patient outcomes, especially when there is a high patient turnover - meaning that team problems may become a source of delay when a high volume of patients are passing through the ward. However, staff interviewed in Scotland did not consider team-driven delays to be a frequent occurrence. They were mentioned by only two team members as a cause of delayed discharge. One nurse said:

"Doctors not being happy with their discharge, nurses not being happy with their discharge, any one of the multi-disciplinary team not being happy with discharge, making their opinion known and voiced pretty early on. That can hold things up."

Team-driven delays were mentioned more frequently by staff interviewed in British Columbia. In fact, the decision of professionals to keep a patient in hospital longer was the most frequently mentioned cause of delayed discharge in B.C. Ten of the fifteen team members interviewed in B.C mentioned team driven delays. As one nurse simply stated:

"It's the priorities of the team that count, not the patient."

Team driven delays were described as decisions by one or more team members to keep a patient on the ward longer than medically necessary. These delays occurred when the team was under pressure; because of high turnover of patients, high acuteness (so that one or more patients required special attention) or team shortages due to holidays or illnesses. During the data-collection period, the ward consistently had a 100% occupancy rate and a waiting list of up to 25 patients. The decision to keep patients due to these pressures was in most cases made by the geriatrician, who considered himself responsible for ensuring that the team was not put under pressure. He explained:

"I don't regard team-driven things particularly as delays, but there may be other factors which a team member brings up or has concerns about, and we then attempt as a team to validate those concerns and build a consensus, rather than just ignoring them."

Other staff questioned the right of the physician to keep patients in for 'convenience'. A nurse stated:

"I think sometimes the patient's timetable is not respected the way the health-care worker's timetable is respected. I think sometimes we put precedence over what we can handle

on the unit at a particular time, so the patient....I think sometimes the patient comes second."

The social worker agreed:

"I am very aware that he [the geriatrician] is trying to halt the system. I hope it is out of a belief that older people need time and we shouldn't be rushing them. That is what I would like to think, but sometimes I think it is too much for the convenience of staff."

A higher incidence of team-driven delays was consistent with the nature of the multi-disciplinary team in British Columbia. Team leadership by the geriatrician was questioned by other professionals, which was not the case in Scotland. Inter-disciplinary conflict was also more prevalent in B.C. Whereas in Scotland 'the community' was blamed for discharge delays, turning the focus away from any internal problems, in B.C the liaison structure largely removed this source of criticism and served to further highlight the divisions within the Canadian multi-disciplinary team.

PATIENT AND FAMILY-DRIVEN DELAYS

Staff in both Scotland and British Columbia mentioned families as a cause of delayed discharge. Other studies have noted that families may only discuss their needs with hospital staff when discharge is imminent (Armitage, 1981, Drew et al, 1988). A Scottish nurse confirmed this:

"The day before discharge the relatives come in with different problems that they have identified but never brought forward before until the day before discharge and thinking that somehow it can be miraculously sorted out."

Two of the ten Canadian geriatric patients interviewed in McWilliam and Sangster's 1994 study of a rural hospital were kept in past the original discharge date at their family's insistence. Similar results were noted in this study. In the Scottish hospital, one patient had her discharge date moved ahead to the following week after her daughter informed nurses that she felt she could no longer manage to assist her mother at home to the same extent as she had prior to her hospitalisation. In Canada, two patients were kept in on their family's insistence: one because the principal carer of the patient was very busy with her daughter's wedding; the other until her son and daughter had returned from holiday.

The patient's wishes were *not* seen as a common cause of discharge delay in either ward studied. In fact, patient choice was mentioned by only one Scottish team member as a reason to delay discharge. This was the physiotherapist, who pointed out that some patients could have last-minute nerves which could affect their health or behaviour and necessitate a delay. One of the Scottish patients interviewed was indeed anxious just prior to being sent home. He told the researcher on the day of discharge:

"They treat you here, don't they. You don't have to worry. If I go home, I've got to sort everything out. In fact I hardly slept last night as I was thinking about all the things that need to be done."

Patient choice was mentioned by a higher proportion of Canadian ward staff as a cause of delay. Five of the fifteen staff interviewees mentioned it. The doctor stated that a deterioration in health necessitating a hospital admission could lead to contemplation of a move to a nursing home, which was a difficult choice to make. Other patients argued that they were not yet ready to go home. In these difficult cases, Canadian staff could choose to accept the patient's wish and allow them to remain in hospital for a few more days. As one of the nurses stated:

"Sometimes the patient's themselves aren't ready to go home and we sometimes need to give them a few days to get used to it. Its pretty scary after having been institutionalised for months and they usually are for months, after being in acute and then up here."

Other occasions when patient choice would play a role in delayed discharge were if the family and patient disagreed on the discharge plan. Another nurse explained:

"Sometimes its the family. Sometimes the family is really pushing for something and the patient doesn't want that, so you have to sort of mediate between the family and the patient."

The fact that Canadian staff considered patient choice as a reason to delay discharge supports evidence presented in the previous chapter⁸. The team in British Columbia were willing to recognise that the patient's preferences should be considered in decisions surrounding discharge, but in reality had few formal methods for soliciting their opinion before the discharge date was set.

⁸ See Chapter 7, sections on 'Advocacy' and 'Staff perceptions of participation'.

DISCHARGE READINESS

Several studies have examined whether patients' perceptions of when they felt ready to go home from hospital have matched the date chosen by hospital staff. The majority of studies of in-patients aged 60 or above have shown that, in recent years, older people have been discharged before they themselves felt ready to leave hospital (Skeet, 1970, Victor and Vetter, 1988, Harding and Modell, 1989). However, these studies have surveyed older patients discharged from medical or surgical units, not geriatric assessment and rehabilitation units. As Jackson (1989) points out, the average length of stay for an older patient in a geriatric unit in the U.K is almost double that of general medical wards - 3.3 weeks vs. 1.8. weeks. It is therefore hardly surprising that studies focusing on the discharge readiness of patients in geriatric assessment units have found that older people there are more likely to feel they could have gone home *before* the prescribed discharge date (NCCOP, 1978, Schaefer et al, 1989, Congdon, 1990).

Patients in this study were interviewed at home one month post discharge. They were asked if they felt they had been discharged too early, too late or at the right time. The majority of patients in both Scotland and British Columbia felt they had been discharged *at the right time*; seven patients in each country, so 70% of all patients interviewed. Patients felt the discharge date had been appropriate for a number of reasons. The most common response was that they had 'recovered' or were 'feeling better', indicating they saw no further reason to be kept in hospital.

Other reasons for discharge readiness were related to the ward atmosphere. Some patients viewed the occupants of the beds around them as much more in need of attention than themselves. The following exchange between the researcher and an older woman in Scotland demonstrates this:

Researcher: So do you feel you were discharged at the right time?

Patient: Yes. I mean, there were plenty of people who were more ill than I was.

Only one patient in each country felt that they should have been permitted to stay in hospital longer, that they were discharged too early. In Scotland, the patient who had not felt ready for discharge had been admitted following a stroke shortly after the death of her husband. Her speech was affected and she was extremely anxious about going home alone. In Canada, one woman felt she could have stayed in

hospital longer because she felt that the food and company were preferable to her own apartment. Her uncertainty had arisen after a home visit with the occupational therapist. The woman was discharged before she would have preferred, but her name was put on the waiting list for residential care; she subsequently moved there four months later.

Patients in this study were more likely to report that they could have been discharged earlier rather than later. Three patients in each country (30% of all interviewees) felt that they had been kept in hospital *longer than necessary*. Two patients in Canada and two in Scotland had experienced discharge delays which they resented. One patient in British Columbia who was kept in for the convenience of his family was aware that the leg dressings he received during his last weeks in hospital could have easily been applied at home by a district nurse. He had pointed this out to ward staff and resented being kept in hospital.

Two patients who did not encounter any discharge delay still felt that they had been discharged too late. Both these individuals had been very eager to get home, primarily because they disliked being in hospital and were anxious about having left their homes unoccupied.

Patients in neither Scotland nor British Columbia discussed their discharge date as something that they had any control over. It was a time chosen by professionals on the patient's behalf. Only one patient reported questioning a date, but had her son and daughter raise it with the geriatrician rather than asking staff herself. The timing of discharge was one aspect of planning in hospital which patients completely relinquished to ward staff. A jocular comment from one of the Canadian patients nonetheless demonstrates the truth of this:

"Oh well, he [the doctor] thought I had smartened up enough to let me out of hospital. I suppose that was it."

Staff agreed that the discharge date was decided by the team who then 'informed' the patient rather than involving them in the decision. In some cases this meant that valuable information—such as relatives/carers would be away at that time—was not communicated between patient and staff until after the date had been set. A Canadian nurse described one case which demonstrated the value of discussing the timing of discharge with patients:

"I don't think we really involve them in discharge planning, they get told. It's like me telling Mrs. R today 'have they told you you're going home? Apparently it has

been said [amongst staff] for a couple of days, and she still doesn't know....I said I'm telling you that it will probably be Thursday....and then she was able to give me the information that her son comes down every Thursday evening. Thursday evening from Nanaimo and so she really wouldn't want a day discharge, she'd want an evening discharge....sometimes they can give us a lot of information."

IMMEDIATE DISCHARGE ARRANGEMENTS

Once a discharge date has been set, arrangements are made for the patient's return home. Aside from final notification to services (such as the GP), these arrangements include the provision of transport from hospital to home, notification of carers and informal support, prescription or medication preparation and the provision of information and instructions on leaving. Inquiring as to whether the patient has food and heating⁹ is an additional task for staff discharging patients, as these basic arrangements can ease the transition from hospital to home.

The first three days at home following discharge from hospital have been recognised as a crucial period (Wilson and Wilson 1971, Harding and Modell, 1989, Jackson, 1989, Fethke and Smith, 1991, Proctor et. al, 1996). During this time, the patient is readapting to his/her surroundings after an often lengthy period of dependence on hospital staff. His/her functional status is often lower than it was prior to hospitalisation and support networks and mechanisms have to adjust and readapt to the presence of the older person at home. As Proctor et al (1996) point out:

Individuals generally leave the hospital at a lower level of functioning than that before hospitalisation, thereby requiring assistance with medical treatment and activities of daily living...Patients entering home care as opposed to institutional care after hospitalisation are particularly vulnerable because those in home care do not receive around the clock personal monitoring as do those in nursing homes or rehab settings. In addition, home care is usually provided by a greater variety of sources - friends, family and formal home care workers. Thus, there are more 'pieces' of care to arrange.

⁹ Heating and food were included on the Scottish ward's discharge checklist, but not on any of the Canadian ward's discharge documentation.

Immediate discharge arrangements and the first few days at home were examined in this study. Neill and Williams constructed a useful means of measuring the implementation of discharge arrangements in their 1992 study of hospital and community services in 71 local authorities in England and Wales. Their indicators were noted and addressed in the questionnaire design of the present study.

Neill and William's components deal with the actual discharge event—the transfer from hospital to home—they do not evaluate the provision of community services or follow-up visits from/to health and social care professionals (these issues will be dealt with in the next chapter). Instead, they focus on the successful transition of the patient from the hospital back to their own surroundings in the community, and list the arrangements necessary for that to take place smoothly and at the appointed time.

The researcher evaluated the immediate discharge arrangements of the twenty older people in Scotland and British Columbia who took part in this study. The evaluation was based on data from: patient interview responses the day before or on the day of discharge; information gathered from patient records on each ward; and patient interview responses one month post-discharge. Neill and Williams define a 'successful' discharge as one that:

- a) Provides the patient with at least 24 hours advance notice of discharge.
- b) Gives the patient an opportunity to discuss how they will manage at home.
- c) Ensures that the patient is accompanied on their voyage home.
- d) Ensures that someone is at home to be with the patient on the day of discharge.
- e) Ensures that someone visits them on the day of discharge.

The researcher added two components to Neill and William's definition. A successful discharge is one that:

- f) Ensures that the patient has food during their first day at home.
- g) Ensures that the patient returns to a heated home (in winter) on the day of discharge.

Based on Neill and William's components listed above (a to g) the following arrangements were made to transfer the patients in this study from the hospital to the community:

IMMEDIATE DISCHARGE ARRANGEMENTS

	a	b	c	d	e	f	g
Scotland (n=10)	9	10	10	5	5	9	7
B.C. (n=10)	9	9	10	5	8	7	n/a

All but one patient in each ward was given at least 24 hours notice of discharge (a)¹⁰. Compared with other studies, this is an extremely positive finding. Studies of older patients have found that between one third and one half of patients have been given less than 24 hours notice of discharge (Skeet, 1970, Victor and Vetter, 1988, Harding and Modell, 1989, Tierney et al, 1993). These studies were however not limited to geriatric assessment and rehab units; therefore the average length of stay of their subjects would have been shorter than those in this study. Neill and Williams themselves point out that people who have been in hospital longer receive more notice of discharge.

All but one patient (in Canada¹¹) was given the opportunity to discuss with members of the multi-disciplinary team how they would manage at home (b). Neill and Williams do not specify how they defined 'discuss'. The simplicity of this component for 'successful' discharge may have been included because the majority of older patients they interviewed were discharged from wards other than assessment and rehabilitation units. Comprehensive discharge planning assessing the patient's background and social circumstances may not have been addressed in surgical/general medical units. Within the geriatric assessment and rehabilitation units studied here, assessment by the occupational therapist, physiotherapist or social worker would be enough to fulfil this requirement of a 'successful' discharge.

All twenty patients were accompanied home (c) - either collected from hospital by their families or taken home in an ambulance or patient transport vehicle with attendants. None of the delays for ambulance service noted in other British studies (Simpson and Levitt, 1981, Harding and Modell, 1989, Neill and Williams, 1992) were encountered by any of the Scottish patients returning home.

¹⁰ Both patients who received less than 24 hours of notice were the two men whose discharge delay was caused by failure to obtain aids and adaptations - as mentioned in this chapter.

¹¹ This Canadian patient was sent home with no discharge plan. No community services were set up by the hospital team and no follow-up appointments were booked. The patient considered his GP responsible for his care in hospital and the GP was a frequent visitor. More information on this case can be found in Chapter 9.

Only half of the patients in each country had someone waiting for them at home (d). This 50% includes those who were taken home by relatives, as in these cases the relatives stayed for at least a short while to ensure that the older person was comfortable. As all the patients in this study lived alone, they were more likely to return to an empty house or apartment than others of their age group. Five Scottish patients were visited by someone during their first day at home (e). For three of these patients, the visitors were friends or relatives. Only two Scottish patients received visits from a formal service provider (home help in both cases) during their first day at home. All other Scottish patients had to wait between two days and two weeks¹² for home help services. Reassessment was the cause of this delay. Except for those returning to the same level of service, home help organisers had to come and assess patients once they had returned home, to determine how much service they would require.

Canadian patients were more likely to be visited during their first day at home (e). Three of the ten Canadians received a visit from either a relative, friend or neighbour. Five patients received a visit from a home help, home care nurse or both. Two of these patients received 'Quick Response Team'¹³ services which meant home help and home nursing within the first day, plus an attendant to stay overnight. Although the numbers are small, it was apparent from follow-up interviews with patients in Canada that the community services visited them at home immediately following discharge, whereas home helps and home nurses in Scotland were more likely to visit one or several days after discharge. Canadian patients experienced fewer care gaps in the transition from hospital to home.

Food and heating (f,g) were important prerequisites to a comfortable return home. As Harding and Modell (1989) have pointed out, older people living alone are less likely to return to a heated home with food than those resident with others. The researcher did not ask Canadian patients whether the house/apartment had been heated for their arrival as these patients were discharged between April and July. However, in Scotland (discharges from November to January), there were three patients who returned to flats that had not been cleaned or heated while they were in hospital.

¹² Home help for two Scottish patients commenced two weeks post-discharge. Both patients had significant support from family members in the interim.

¹³ For a description of the Quick Response Team (QRT), see Chapter 4.

All patients were asked if someone had prepared food for them on the day of discharge. In Canada the hospital did not provide patients with any food to take home. However, seven Canadian patients recalled that either relatives or the home help had prepared a meal for them on the day of discharge. In Scotland, nine patients had food, including those who returned home to an empty house. This was due to the fact that the Scottish ward prepared generous packages of sandwiches, fruit and other necessities such as tea bags, coffee and milk for patients about to be sent home. This food could last beyond the first day of discharge and was very much appreciated by several of the Scottish patients interviewed.

CONCLUSION

This chapter has addressed the steps taken by hospital teams in each country to implement discharge plans. Communicating discharge arrangements to patients and their families has been examined through a discussion of the provision of written and verbal information. Communication with outside agencies has been discussed through an analysis of referral structures on each ward. Relationships with the community and within each multi-disciplinary team were raised as causes of delayed discharge. Finally, the provision of services on the day of and the days immediately following discharge was examined, revealing how differences in the model of planning used by each ward can affect the transition of the older patient from hospital to home.

Information about the discharge plan was communicated to Scottish patients primarily by verbal means. Scottish staff demonstrated a reluctance to consider the importance of written information for older patients. This attitude appeared to be based on the belief that, if the patient could not comprehend and recall verbal instructions, they were unlikely to refer to a written sheet even if provided with one. Instead, Scottish staff emphasised the importance of providing families and carers with information, although this was also communicated verbally in most cases. Scottish patients rarely received written self-medication information from nurses or instructions from therapists. A discharge checklist was used, listing community services to be provided, but gave no details of the timing or amount of service, or contact phone numbers. A copy of the checklist was intended for the patient, but evidence was gathered to suggest that this was not always distributed.

Information about the discharge plan was more likely to be communicated by written means in British Columbia. Community liaison nurses provided the most written information to patients, and were found to be the greatest advocates of this method of communication. On discharge, patients were given instructions, service details and community contact numbers by several members of the multi-disciplinary team. Time pressure meant that this information was sometimes provided at the last minute and without adequate verbal explanation. This last-minute provision led to confusion, suggesting that a more unified approach to providing patients with discharge information would be desirable.

Follow-up interviews with patients confirmed that more written information was provided in B.C than in Scotland. Whereas six of the ten Canadian patients recalled receiving written information, only three of the ten Scottish patients reported that they received any. Despite this finding, very few patients expressed any unmet information needs. This suggests that the low expectation for involvement in decision-making expressed by both groups of older patients in relation to other parts of the planning process also extends to the implementation stage. Patients did not expect to be informed about the details of services that would be provided at home or expect to be given instructions. Similarly, they did not expect to be involved in the decision as to when they would return home. Discharge dates were set by the multi-disciplinary team in both wards, with minimal input from patients.

Referral structure and discharge delays in Scotland and British Columbia reveal how the decision-making structure on each ward can have an impact on the implementation of the discharge plan. In Scotland, the manner in which referral responsibility was delegated allowed the patient to communicate primarily with one recognisable professional, expanding the possibility of patient input in planning. This was due to the fact that referrals for some services could be done by one or more team members, based on who knew the patient best. In British Columbia, referral responsibilities were more firmly divided, with the liaison nurse (whom patients met on only one or two occasions) responsible for the greatest portion of referrals.

In Scotland, the divide between hospital and community services was more distinct than in Canada. As general practitioners did not see their patients in hospital, referrals to them had to be communicated quickly and effectively. Staff reported delay in sending out discharge letters which was reflected in the fact that only three of the ten Scottish patients saw their GP within one week of being discharged.

Referrals to other community agencies were made without hospital staff being able to tell patients what level or frequency of service they would receive. This was based on the fact that community agencies did their own assessments once the patient had returned home. This need for reassessment resulted in gaps in the immediate discharge period. Fewer Scottish patients were visited by a formal service provider on their first day at home and some had to wait up to two weeks until home care services started. The community/hospital divide meant that ward staff could not predict or ensure what community services would be provided, which also resulted in discharge delays. Problems in setting up home help services and the provision of aids and adaptations were two of the most common causes of delayed discharge.

Community services were provided more quickly to newly discharged patients in British Columbia. This was due to the liaison nurse. The direct links the liaisons had with home care and home nursing services meant that they were able to inform team members and patients how much community service could be supplied, and when. Discharge delays were just as likely to occur in British Columbia, but rather than being caused by breakdowns in hospital/community communication as they were in Scotland, in Canada they were caused by problems within the multi-disciplinary team. Patients were kept in hospital longer than medically necessary if the geriatrician felt team members were under too much pressure. The needs of the team rather than those of the patient could dictate discharge dates in British Columbia.

CHAPTER 9

FOLLOW-UP

Because most hospitals do not follow patients to see what happens after discharge, little is known about the implementation of arranged care. The extent to which arranged care is actually implemented and the consequences of implementation problems or gaps in care have not been sufficiently studied, nor have patients at risk of care gaps been identified.

Proctor et al, 1996.

Follow up is the most neglected stage of the discharge planning process. Despite consensus in the literature on the need for evaluative studies of discharge outcomes (Lindenberg and Coulton, 1980, Kruse, 1985, Jackson, 1994, Tierney et al, 1994) some models of discharge planning do not even include follow-up as a separate component (McKeehan and Coulton, 1985). Yet without monitoring of the implemented discharge plan, it is impossible to assess the value of earlier stages of the process in providing continuity of care for older patients. Without feedback about how older people are faring in the community, hospital teams cannot determine whether their discharge planning methods are adequately addressing the needs of their patients.

Follow-up is necessary not only for clinical audit. It can also contribute to the prevention of readmission or admission to residential care (Townsend et al, 1988, Naylor, 1990). Needs identified at the time of discharge can change once the older patient has returned home. Follow-up can provide reassessment to insure that unmet needs do not compromise the older person's ability to live independently. Follow-up is necessary to identify how informal carers are coping and whether the formal services arranged by discharge planners are complementing or compromising any informal support available. Follow-up initiated by the hospital team is also important from the point of view of the patients themselves, many of

whom have spent long periods of time in hospital and appreciate the reassurance of out-patient or home visit contact with team members (Haddock, 1991).

As Simpson and Levitt (1981) have pointed out, there are two main strategies for follow-up of patients discharged to the community. The first involves reporting which is principally directed back to hospital staff. The second strategy consists of follow-up oriented towards the general practitioner and primary care team. In this study, the Scottish hospital adopted the former strategy. In British Columbia, the latter strategy was more commonly used. The difference in these approaches will be described in this chapter. Differing methods of follow-up were found to have implications for the speed and accuracy of service implementation following discharge. Gaps and deficiencies in the amount of post-discharge monitoring were found in both study settings. Other factors, such as resource constraints in the community and the presence or absence of informal support also affected the implementation of the discharge plan and the ability of patients to cope at home one month after discharge.

The evidence in this chapter originates from interviews with the twenty older patients one month after discharge. At that time, the researcher visited all twenty in their own homes to determine how they were coping and evaluate to what extent the discharge plan had been implemented. The provision of follow-up and implementation of community services reported by patients was then compared with the case notes and comments of ward staff regarding aspects of the discharge plan. In some cases, the researcher also encountered family carers and home helps during the follow-up interview.

This chapter will begin with a description of how recently discharged patients managed with day-to-day living, and evaluate whether this level of coping matched their own expectations. Community service provision will then be described, evaluating to what extent services included in the discharge plan were implemented, and what role community agencies played in follow-up. Community follow-up will then be contrasted with follow-up provided by the hospital. This chapter will conclude with a discussion of the extent to which these hospital and community-based services were adequate to meet the needs of the older patients in this study, and describe patients' reported satisfaction with the discharge plan.

DISCHARGE OUTCOMES

Evaluating discharge planning is notoriously complex (Muenchow and Carlson, 1985, Wooldridge et al, 1987, Fethke and Smith, 1994). This is due to the multiple and interacting variables associated with the patient's health status and living arrangements following release from hospital. One of the most common measures of evaluating discharge planning for older patients is readmission rates. Discharge planning is judged successful if it manages to keep the patient out of hospital. This measure of success is based on findings that readmission rates amongst the elderly in American studies of discharge planning have ranged from 22-37% within the first year following discharge (Naylor, 1990). Quantitative studies of discharge planning have therefore tried to measure which planning models or strategies result in the lowest readmission rates (Townsend et al, 1988, Naylor, 1990).

Readmission rates were not used as a measure of discharge outcomes in this study, for reasons of design¹ as well as containment². Other writers have pointed out the limitations of using readmission rates to judge the success or failure of discharge planning. As Wertheimer and Keunman (1990, pg.839) explain:

Readmissions, for example, may not be the result of poor discharge planning, but [may stem] from new and unforeseeable problems or from unpreventable exacerbations of chronic conditions. Although length of stay and readmissions are measures of the success of discharge planning, other outcomes such as access to health care systems, financial barriers, patient satisfaction and the use of entitled services should be examined.

Other research has measured outcomes by judging how successful the discharge plan is in meeting patients' needs. In some studies, these needs have been quantified into needs for medication, therapy, counselling or home care (Krommiga and Ostwald, 1987, Waters, 1987, Mamon et al 1992, Oktay et al, 1992). Evaluation of discharge outcomes in this study did involve assessing unmet need through the words of the patients and the observations of the researcher when she visited them at home. The extent of unmet need identified will be discussed later in this chapter.

¹ Qualitative research attempts to explore the experiences of study informants, through representations of their own interpretation of events. The discharge planning process studied here has been reported through comments from staff and patients, combined with the observations of the researcher. Using quantifiable outcome measures such as readmission rates would have implied generalisable findings which were not identified in this study.

² Measurement of readmission rates would have only been possible with a larger sample of older patients over a longer period of time. Outcomes in this study were evaluated through the patient's eyes one month post-discharge. Four weeks post-discharge, all twenty patients were still at home - indicating 'positive' discharge outcomes at that point in time. One Scottish patient was readmitted at five weeks, for falling at home following a drinking binge.

Outcome evaluation in this study was not limited to an assessment of unmet need. The patients' functional status post-discharge was discussed in interviews one month after release from hospital. They were asked to reflect to what extent their self-assessed needs were met by the discharge plan and to what extent their ability to cope at home met their expectations.

COPING AT HOME: FUNCTIONAL ABILITY

The ability of patients to carry out everyday tasks in their own home following discharge was found to have a significant impact on their quality of life. The researcher was able to assess changes in the patient's ability to function independently by two means. The first of these was through comparison of a series of questions posed to patients prior to discharge and then raised again at home. These questions consisted of a list of the activities of daily living (ADL) (Katz et al, 1963) with the addition of three domestic activities of daily living³. Patients were asked how they managed with each of these tasks one month prior to admission and just before admission. Other studies (Victor and Vetter, 1989, Guadagnoli cited in Mistiaen, 1997) have demonstrated that older patients discharged from hospital are able to report their previous functional ability reliably. In order to compare previous function with that experienced post-discharge, the older people in this study were then asked during the home interview how they were managing with these same activities once at home. The second assessment of changes in the older person's functional ability was obtained through comments from patients themselves, who volunteered information about how they were coping with everyday tasks following discharge.

There is significant evidence from other studies to suggest that older patients experience a general decrease in functional ability following hospitalisation (Davis et al, 1984, Waters, 1987, Wachtel et al, 1987, Harding and Modell, 1989, Tierney et al, 1993, Mistiaen et al, 1997). For some older people, this loss of ability is temporary, and linked to increased dependence during hospitalisation, combined with the effects of recovering from surgery or illness. This has been found

³ The domestic activities of daily living chosen were those that other studies have considered most essential to *independent* functioning at home (Waters, 1987, Neill and Williams, 1992) - they were: Preparing food and cooking, heavy housework (with hoovering/vacuuming as the chosen example) and going shopping.

particularly with reference to mobility (Jackson, 1989). However, for other patients this loss in function can be permanent and, if not adequately compensated for by aftercare services, can result in further deterioration once at home.

Although follow-up for this study took place too soon after discharge to determine whether loss of function was temporary or permanent for some patients, each patient in the study reported a decrease in ability to carry out at least one activity of daily living post-discharge. Decline ranged from a loss of one ability (two patients in Scotland and two in Canada), to a new deficit in four activities (reported by one patient in each country).

MOBILITY

Loss of functional ability was most frequently reported with reference to mobility⁴. For some this took the form of general inability to move about the house in the manner to which they were accustomed. This inability meant a new dependence on aids such as walkers. As one Canadian patient described:

"I did not need the walker before I went in. I mean I needed it before if I went out, if I went walking around Hudson's Bay [store] say, but I need it much more now."

Loss of mobility was also expressed by three people who felt unable to negotiate their stairs post-discharge, something of which they had been capable before going into hospital. A Scottish patient explained:

"I can't go down the steps anymore. I'd fall flat on my face...before, these things were nothing to me. My steps were nothing to me. They were there. But now I'm afraid, to go out there."

Another Scottish patient found she was unable to walk down her steep indoor steps following her return home from hospital. She demonstrated to the researcher how she negotiated them by hanging onto a railing and going down slowly on her bottom. Loss of mobility also meant that the two Canadian patients who had been driving prior to discharge had yet to recommence this activity when the researcher saw them at home one month after release from hospital.

⁴ Mobility here was defined as walking, transferring and climbing stairs.

BATHING

The second most frequently reported functional loss in both countries was bathing. There were three patients in Scotland and two in Canada who had been able to carry out this activity unaided (albeit with difficulty) prior to admission who required assistance post discharge. Not all received the necessary assistance, a finding which will be discussed later in this chapter. A Scottish woman described how she managed:

"Well, I have not been in the bath since I got home, because I can't get out.....I'll tell you what I do. I start at the top, and I get so far down, that's the top half, and then I put my feet in a bucket, and I sit with them in the bucket."

OTHER ACTIVITIES

Other ADL that the older people interviewed reported they had lost following admission to hospital were dressing, and preparing food. While the majority of people in both countries were still able to carry out these tasks, those who were most disabled⁵ were not. This is consistent with other studies of functional ability in the elderly which attribute an order to the loss of independence in self-care⁶.

In interviews with the older people in this study, it became apparent that the loss of functional ability in one or more areas affected the kind of household tasks they could perform. For instance, those with mobility problems (the majority of people) could no longer shop for themselves, vacuum or do heavy housework. Inability to carry out household tasks restricted their *independence* and *narrowed their range of social contacts*. These losses seemed almost more important to the older people interviewed here than the absence of function itself.

One Canadian patient described how his loss of mobility had resulted in his sons' decision to unplug his stove. This suggestion had first been raised by the occupational therapist during a home visit, and promoted by his daughter who was present. He had reacted furiously to his daughter when this suggestion was made. By the time of the post-discharge interview, the older man was more resigned to his

⁵ One Scottish patient was unable to dress herself but was considerably more mobile than other patients. The loss of this ability was related to deterioration in her sight.

⁶ Waters (1987) points out that functional independence is most commonly lost in the following order; bathing, dressing, toileting, transfer, continence, feeding.

family's decision, but nonetheless regretted the lost opportunity to cook 'real' meals for himself:

"The boys shut the stove off. So I can only use the microwave. The boys they said 'father, it is too dangerous. You could carry something to the counter, and maybe you fall, and you burn yourself....So I had to say 'OK'."

Loss of functional ability had implications for the social life of the older people interviewed in both Scotland and British Columbia. A Scottish patient regretted that her general inability to carry out household tasks post-discharge meant she could no longer entertain her friends as she had in the past:

"Well, I cope, I would say, as well as I can. But I don't have anyone for a meal, or a coffee morning. I used to have a trolley there and I used to have coffee mornings but I don't have them anymore. Because I feel it is just too much for me."

However, the most significant consequence of loss of functional ability for the older patients in this study was that some were housebound. For several this was not a new phenomenon. For others, being unable to leave the house was a consequence of the loss of functional ability they experienced as a result of hospitalisation.

HOUSEBOUND

Eight Scottish and six Canadian patients were housebound four weeks post-discharge. Only one patient in this study stated that he was housebound by choice. This older Scottish man had stopped going out (pre-admission) once he realised that he could not get on and off the bus or cross the street unaided. The other seven Scottish patients and six Canadian patients who were housebound at the time of the follow-up interview were not remaining at home by choice. Rather, a combination of loss of functional ability combined with unsuitable housing meant they had to rely on others to go outside.

Those who were housebound fell into two groups at the time of the follow-up interview. One group consisted of those who had not been out of the house at all since discharge four weeks before. The second group consisted of those who had left the home accompanied by carers or homecare/hospital staff.

From observation and the reports of patients during the follow-up interview, the researcher determined that three Scottish and two Canadian patients had not left the house at all since discharge. One Scottish man had not left his room since

discharge, a portable toilet having been placed there by community staff. The two remaining Scottish patients had experienced a loss in mobility but were more seriously compromised by their housing. Both lived in tenement flats, several floors up. Both had required two people to transport them up the stairs following discharge from hospital. This meant that they could not leave the house with just their home help or female carer; the stairs were just too difficult to negotiate. All services, including a hairdresser and chiropodist, were visiting these women at home. The researcher observed in both cases that an elevator could have made leaving the home possible for the women. All the Canadian patients who lived in apartment buildings (seven people) had elevators, which made getting out much easier.

The two Canadian patients who had not left their home since discharge were the most frail of the Canadian sample. One woman had been fairly active prior to hospitalisation, walking to the post-box and going shopping in her friend's car. However, four weeks after discharge she had not yet asked her friend to accompany her outside, although she wanted to. Instead, her friend was bringing the shopping in. Worries over 'bothering' this friend contributed to her housebound status. The other Canadian patient had been housebound prior to hospitalisation. Four weeks post-discharge she was still too unsure of her mobility to attempt to leave her apartment.

The second group of older people had left their homes since discharge, but only with the assistance of others. For three Scottish patients, this had been to attend the day hospital. They were transported to the day hospital by ambulance. One Canadian patient had been out only with her home help. Another had left the apartment with a community physiotherapist. Others had gone out only with the assistance of their carers, as one Scottish patient reported:

"I've not been out...not been out on my own. I mean I've been out with my son, in his car, he comes and takes me down for my tea. But as I say, I've not been out on my own."

This reliance on carers to assist them in leaving the house put the older patients interviewed in the position of being even more dependent on their families than they had been prior to hospitalisation. A Canadian patient described her fear of falling without her daughter's assistance:

"I try and be careful, when my daughter takes me out, I am afraid of going down the kerb—I'm afraid of falling...There

is always somebody with me when I do this though, I never go out on my own."

Older people in both countries worried about being reliant on carers for transport as well as shopping and substitute mobility tasks. This was especially apparent amongst three women (one in Scotland, two in Canada) whose female relatives were visiting every day and taking them out a few times a week. These women worried that the implications of being housebound meant that they were becoming a burden on their carers:

"Well, they come here at lunch time and they'll maybe have their meal with me, she'll maybe wash the dishes and she will always take me out when she can. But she has her own friends and I don't feel that it is right that she spend all this time with me."

Being housebound was not viewed as a permanent state by all the older people who found themselves restricted in their mobility following hospitalisation. In Scotland, the follow-up interviews took place in the winter. Two patients expressed an intention to try and get out alone when the weather got better. In Canada, two patients told the researcher about their efforts to improve their mobility by remaining active and building up their strength. One woman described how community physiotherapy was helping her regain the confidence to get out on her own:

"The therapist was here just before you, around one o'clock. She asked me if I wanted to go down to the street and walk a bit outside. So I did. That's the first time I have felt able to do that since I came home from the hospital. I've been home now for about four weeks. Anyway I did really well outside. So starting tomorrow I am going to try and go out and walk around the block."

The effect of therapy services on the continued recovery of patients at home will be discussed later in this chapter. One disabled Canadian patient who was receiving no ongoing therapy was however also determined to change his housebound status:

Researcher: Would you like to get out more?

Mr.P: Not like to, I'm GOING to get out more. I have to. I have to start rolling that thing [electric scooter] up and down the road.

The four patients in Canada and two in Scotland who were not housebound had only walked short distances alone. One Scottish man had walked to the pub, a Scottish woman only as far as the corner shop. Amongst the Canadians, two had

visited their general practitioner by walking to a nearby bus stop and taking the bus, one had walked to a neighbourhood park and to the shops, and the remaining woman had walked around her building and roof garden. For all these individuals, getting out was still difficult. All except one relied on sticks or walkers. They expressed disappointment that their ability to move around independently had deteriorated. Disappointment was a common theme in follow-up interviews. The older people in this study had expected to recover more quickly after they left hospital. They had expected life at home to be easier, or had expected to cope the same as they had before admission.

EXPECTATIONS

Prior to discharge, patients in both countries were asked how they expected to cope at home. Did they think they would cope with day-to-day activities better than before their admission, the same as before their admission, or not as well as before their admission. At home four weeks after discharge, patients were asked if their ability to cope at home had met their expectations. Were they coping as well as they had thought they would?

The expectations of the majority of patients in each country were not met. Only three patients in Scotland accurately predicted how they would cope at home. When interviewed in hospital, two of these individuals expected to cope as well at home as they had before admission. Once at home, they were coping as well as they had expected. One older Scottish man who had been admitted to hospital after repeated falls expected to cope better at home as his balance and mobility had been treated by physiotherapy, which he was to continue to receive post-discharge at the day hospital. Once at home, he reported that he was coping better than he had before admission.

In Canada, two patients accurately predicted how they would cope at home. Both expected not to cope as well at home as they had before admission. When interviewed following discharge, they confirmed that they were not coping as well at home as previously. Hence their expectations were accurate.

Other than these five individuals, all the remaining patients reported that they were not doing as well at home as they had expected. Their hopes had been 'too high',

life at home following discharge was harder than expected. This hardship was caused by problems with functional ability, pain, being housebound, being more dependent on family or services than they had expected, or not receiving as much help as they had expected.

REASONS FOR HIGH EXPECTATIONS

Other research has suggested possible reasons why older patients fail to cope as well as expected upon returning home. One explanation may involve the trauma associated with the transfer to an 'unprotected' environment after a long stay in hospital (Johnson and Fethke, 1985). Victor and Vetter (1988) have suggested that patients take time to readjust to independent living following hospitalisation. Kane (1989, cited in Schaefer et al, 1990) has indicated that the ability to perform activities of daily living is the key to independence. Functional losses, however temporary, may affect the patient's attempts to readjust to the home environment. The geriatric assessment and rehabilitation environment is one in which the patient's needs are met and functional deficits are addressed through therapy. As a liaison nurse in Canada described:

"The patient becomes more dependent in the hospital, through no fault of their own. It's just that with staffing the way it is and the way the hospital is set up, it is much easier to do it for them than to wait until they do it for themselves."

Patients recognised that being in hospital had affected their ability to do day-to-day tasks. One Scottish woman commented on her ability to move around her flat post-discharge:

"Well, in the meantime it's not so good. I think it's just because I am just getting out of hospital. I really thought I would have been better than I am."

A Canadian explained that he had expected he would be able to do more for himself following discharge:

"I guess walking around and doing things I am getting too tired, it's not comfortable. Like I say, I am not happy with myself yet."

A Scottish patient commented how hospitalisation could affect not only her physical, but her mental state as well:

"I don't think I am any worse, but at the same time I don't think I am any better. I'm still normal...well, you know

I've been in the hospital four or five times now, in the last wee while and I do get, well, a wee bit depressed, now and then."

Despite patients' recognising the consequences of hospitalisation as one reason for their lower level of coping, not one interviewee blamed ward staff for making them more dependent, or acknowledged that lack of discharge planning might have contributed to their inability to cope at home. Instead, they attributed their unmet expectations to their own inability to manage their fatigue, discomfort, stiffness or fear. The most common explanation offered by patients to account for why they were not coping as well as they expected was their particular illness or condition, or 'old age'. These explanations related to patients' desire to take responsibility for their own health, rather than blaming deficiencies on formal or informal support. As the Canadian patient who had suffered from polio as a child explained:

"...sometimes I say to myself, Ralph, you are not as young as you used to be...its going to come back, but not that much, because post-polio is a one-way street. Once you've got it, you are gradually going to fall over the cliff."

Once at home, patients who were not coping as well as they had expected commented that the way they had visualised life at home might have been unrealistic. A Scottish woman explained:

"I was very hopeful. I thought it would be great coming home, when the weather would be so much better and I'd be able to get out...I think I was just too hopeful, you know what I mean. I was just expecting too much."

STAFF VIEWS OF EXPECTATIONS

Staff in both Scotland and British Columbia were asked to attempt to generalise about how realistic patients⁷ were about going home. The Scottish consultant summed up the majority view of staff in both countries:

"If I had to give them a mark overall, they would come out on the unrealistic side rather than the realistic."

Staff offered several explanations for why patients' expectations often turned out to be too high. In their view, patients were either unrealistic because they had not 'accepted' the limitations of illness or old age, they believed that their own home

⁷ Several staff replied to this question with reference to all patients on their ward, including those with dementia. Replies relating to cognitively impaired patients were not included in the analysis.

environment would be easier to function within than the hospital ward, or they were so desperate to get home that they were denying any problems they might have.

The locum Scottish consultant explained that, in her experience, some older patients had not come to terms with new functional limitations associated with the ageing process:

"I think a lot of people still expect themselves to be doing what they were doing at 50 and I think sometimes they can't always get to grips with the fact that things have changed."

The senior Canadian consultant pointed out that unrealistic conceptions of ability when combined with the twenty-four hour care offered in hospital gave patients a false sense of security concerning their abilities to function at home;

"Do I think they are realistic about it? No, not at all. I think they think in many cases, they think they can do more than they can. What bothers me there is the treatment they have had here to bring them back to that level of function is not going to be there [at home]. We put in the supports we think they need, but it's not going to be the same."

Staff also described patients' attitudes towards their own homes. Home was seen as a haven, a familiar environment in which 'coping' would be easier than in the hospital. This image of home as safety could lead to unrealistic expectations according to one of the Canadian nurses:

"I think they talk a good game, and they know they are going to fail when they get home, but they are going to hang on by the skin of their teeth in living conditions that we can't even begin to contemplate, but it's their house and they are in control and that is so important."

Staff also pointed out that patients would agree to accept community services upon discharge in order to speed up the process of going home. Staff asserted that some older people did this without giving adequate thought to what kinds of support they might really need at home. As the Scottish junior house officer pointed out:

"Basically the majority of them are quite unrealistic and you always get the occasional one who is quite happy to do whatever we say...the majority of patients here want to go home and look after themselves and tend to deny that there is a problem they can't cope with."

Similarly, the Scottish consultant said:

"...many elderly people are so keen to go on living in their own home; whilst they will accept that there are problems, they will play them down; they won't volunteer them to you, they won't make much of them. They will want to give it a go. Sometimes that verges on being unrealistic."

This desire to return home as quickly as possible can act as a barrier to patient participation. This barrier relates to problems of compliance with the suggestions of staff purely in the interests of speeding up discharge. Instead of making choices, some older patients in this study passively accepted discharge planning done for them by staff and family members rather than asking questions or contributing. This theme of compliance has been mentioned⁸ and will be discussed later in this chapter with reference to services received at home. The Scottish OT drew the link between compliance with staff suggestions and engaging patients in decision-making:

"Sometimes [patients are] very unrealistic, which is the whole problem of patient participation really. If they are very unrealistic about the future and what they can manage, that's where the problems start."

If staff approach discharge planning with the assumption that most older patients are unrealistic about their chances of coping at home, it is hardly surprising that the opinion of the patient is not considered as seriously as those of other professionals or carers. From the comments above, it is apparent that staff in both the Scottish and Canadian wards viewed the ability of their patients to make 'appropriate' discharge planning decisions as limited.

COMMUNITY FOLLOW-UP SERVICES

HOME HELP

Home help was the most frequently used community service for patients in both Scotland and British Columbia. Following discharge, all ten Scottish patients received home help. Nine of the ten Canadians also received home help. This level

⁸See Chapter 7 - Planning

of service receipt is significantly higher than other studies of post-discharge services amongst people of a similar age. Neill and Williams found 50% of the older patients they surveyed received home help post discharge, while Tierney et al. found that 18 of their 34 patients did so. However, the higher rate of service receipt found in this study can be attributed to the fact that all patients lived alone and had a longer average length of stay than those in the studies mentioned above. Discharge from a geriatric unit rather than medical or surgical wards also meant patients in this study were more likely to have a home help referral made for them (Jackson, 1990).

TIMING OF SERVICE

When did the home help appear for each of these nineteen patients? The Canadians were more likely to see their home help immediately following discharge than the Scots. All nine Canadian patients had a home help visit them either on the day of or the day following discharge. One Scottish patient had the home help visit the day of discharge. Five received home help services the day following discharge. Two patients first saw a home help three days after discharge, and two Scottish patients did not see a home help until they had been at home for almost two weeks.

LEVEL OF SERVICE

What level of service did these older people receive? *No patients in either country received fewer home help hours than they had before admission.* Two patients in each country had never had a home help before leaving hospital. The discharge plan provided them with this new service. Three Scottish patients returned home to exactly the same home help hours as they had had before coming into hospital, meaning that no changes were made as a result of discharge planning.

By the end of the first week post-discharge, seven Canadians and five Scots were receiving more home help hours than they had pre-admission. However, the number of hours of service the Canadians received was significantly higher than the Scots. Only two Scottish patients received home help seven days a week. This finding supports that of other British studies which have suggested that very few older discharge patients in Britain see a home help every day (Dexter and Herbert, 1983, Neill and Williams, 1992, SWSI, 1996a). In contrast, seven people in British Columbia were receiving a seven-day service during their first week at home.

Four weeks after discharge, the five Scots who were receiving a higher level of service than they had prior to admission retained that level of service. However, only two Canadians were still receiving a higher level of service.

Why was there a reduction in home help hours between the first and the fourth week post-discharge amongst Canadian patients? These reductions in home help hours were instigated by the older people themselves rather than community services. All five individuals telephoned either the homemaker agency or their case manager and reduced the number of hours they were receiving, as well as the type of tasks that the home helps were performing. The timing of this reduction was in all cases shortly after discharge. One woman dismissed the community home help after two days, preferring to return to having only her private cleaner. The four other Canadians reduced their home help at the end of the first week or the beginning of the second week following discharge. They reported two main reasons for doing this. The first was simply that there was not enough for the home help to do around the house or to assist them. Some tasks they felt they could manage themselves, and they did not want to 'waste' a service they were receiving free of charge. As one Canadian man said:

"They came the next day [following discharge], the homemakers. They were here every day until the weekend, when I told them, forget it, because I don't need it, because I don't mess up the place that much; see, I was finding it hard to find them anything to do."

The second reason was that homemakers were performing tasks that the older people did not want done for them. In the case of two people this involved bathing. In Canada, home help was not provided free of charge post-discharge unless the patient had some personal needs - straight housework alone was offered to no-one. However, some Canadians only wanted cleaning and could not understand why home helps turned up to help them in the bath:

Researcher: When did you phone and cut it down to one hour?

Patient: It was on the fourth day I think, because there was one woman who turned up and said that she was there to give me a bath and not to clean although she did make my bed. I told her I could get right into the bath and that I didn't need any help. I phoned them after that and cut it down.

Reducing home help was clearly one way that Canadian patients declared their independence following discharge. They chose not to comply with one portion of the plan staff had made for them, rejecting the level of assistance the hospital team

had dictated they would need, and determining which tasks they would do alone or with assistance.

Why were Canadian patients given this high level of home support post-discharge when 50% of them did not need it, according to self-assessment? The first explanation concerns the *speed* of services. The hospital team dictated the level of home support that Canadian patients received. This level was then communicated by the liaison nurses to the community agencies and activated on discharge. This quick communication accounted for the speed with which home helps were provided to Canadian patients. In contrast, the Scottish hospital could only recommend to home care what level of service the newly-discharged patient would need. In most cases, this meant that a home help organiser would visit the patient at home before services really began. This accounted for some delay in the provision of Scottish home helps. One patient described why he hadn't needed to give the new home help directions when she appeared for the first time two weeks following discharge:

Patient: Well, I just told her to do the dusting and that. But I didn't actually need to ask her that. I think her boss, I cannae mind her boss's name, would tell her.

Researcher: Did the boss come and see you?

Patient: Aye. Well, she just really asked me what I needed done and that.

In effect, the Scottish model of discharge planning meant that community staff (in this case the home help organiser) did a *reassessment* of the patient's needs after discharge before beginning services. Although this reassessment delayed the commencement of services, it did account for the fact that the level of service implemented probably more accurately reflected the needs of the patients once at home, and partially explains why no home help service changes were initiated by Scottish patients. The Scottish social worker agreed with this system of reassessment:

Researcher: You wouldn't advocate community services just accepting the hospital assessment?

SW: No. I would advocate them saying that is the assessment that was made at that time...but I think there can be changes along the way. Because here in hospital you don't know what's going to happen a fortnight later.

In Canada, the home help assessment was done in hospital, and although case managers did follow up patients at home and make service changes, this did not occur until several weeks after discharge⁹. The service levels reported by patients during the follow-up interview were those that had been determined by hospital discharge planning. Based on observation by the researcher, comments from some ward staff, and evidence gathered from the patient after leaving hospital, it was apparent that in Canada, the hospital team tended to implement a higher level of home support for some patients than they really required. One liaison nurse described this:

"That is the whole philosophy of hospital-based personnel, let's do it all for them and make sure than they are going to be safe, absolutely safe, cushioned for twenty-four hours a day and that is not realistic."

This level of assistance, although designed to be sustained only for the first few weeks, was more than the older people themselves wanted. Hospital staff chose to implement services they thought were required, rather than allowing the patient to participate in planning by dictating the level of service they would feel comfortable with. As the same liaison nurse explained:

"The patient says they can do such and so, the team may think that they can't do quite as much, but experience has shown that they usually can function quite a bit better in their own surroundings....than we believe they really can."

Because the Canadian patients had not participated in the decision to have a certain level of home help assistance included in the discharge plan, they had no reservations about reducing it when they returned home. Reduction of services following discharge was the Canadian patients' way of reasserting the control they had lost in hospital.

HOME HELP TASKS

One other reason why hospital staff in Canada incorporated a high level of home support into discharge planning concerned the tasks that home helps could do. Just prior to the data-collection period in British Columbia, community care reforms had cut off access to free cleaning services for new home help clients. This meant that, unless the older person had a personal care need (for bathing, dressing, managing

⁹ Based on follow-up interviews, fewer than half of the Canadian patients receiving home help reported having any contact with their case managers four weeks post-discharge

incontinence for example) they would have to pay for cleaning services. If they did have personal care needs, some cleaning could be done by the home help who was assisting them in the bath or with their clothing, etc. Aware of this new restriction, hospital staff and liaison nurses were attempting to recommend personal care services for patients who may not have wanted bathing or dressing assistance. The two women who reduced their level of home support were examples of this type of discharge planning. In an attempt to provide the patient with services they did need, (cleaning and substitute mobility tasks), hospital staff had to justify that the older person was of a sufficiently high dependency level to merit comprehensive support services, which had to include personal care.

In Scotland, home helps carried out very different tasks to their counterparts in Canada. Although some recent research has shown that more personal care is being provided by home helps in the UK and that there is more pressure on local authorities to charge for cleaning services (Neill and Williams, 1992, SWSI, 1996a), the Scottish patients in this study were receiving a more flexible and more 'traditional' (Simpson and Levitt, 1981) home help service than those in Canada. As a very recent survey of Scottish home help users and carers shows, 54% of home help users still have their shopping done by home helps (SWSI, 1996a). None of the Canadian patients in this study had their shopping done by community staff; they had to rely on friends or family. In the same SWSI study, vacuuming was found to be the most frequent task carried out by home helps in Scotland. As will be discussed below, housework made up a decreasing proportion of home help tasks in B.C. Cleaning and substitute mobility tasks remained the domain of Scottish home helps, as shown by one older woman in this study who described what the home help did for her:

"She does my kitchenette and she does my bathroom, and she does my Hoovering, but I take my trolley and I do my dusting myself, I like to do my own dusting. But I like the heavy work done for me."

This same woman was, for the first time, unable to bathe herself post-discharge. Her daughter was now assisting her in the bathroom. As far as the researcher could determine, only one Scottish patient was being bathed by her (private) home help, another was having her feet and legs washed. Two Scottish patients were being assisted by relatives in the bath, and four more appeared to be having only sponge baths which they managed with some difficulty alone. The Scottish patients in this study appear to have fallen between the domains of health and social care when it came to bathing. So, although the housework was being done, personal care needs

were unmet. In British Columbia, the reverse was true. Personal care needs were met, but cleaning services were scarce.

PAYING FOR HOME HELP

In Scotland all home help was means-tested. Two patients in this study had income and capital above the cut-off¹⁰, which meant they each paid £4.50 an hour for their home help. Neither considered the cost prohibitive. In Canada, the change in homehelp targeting in British Columbia meant that two Canadian patients had to pay for community agency cleaning services which they would have previously been entitled to free of charge. The hourly charge for cleaning was fourteen dollars, twice as much as in Scotland. Both patients considered this to be expensive, largely because they knew they could obtain private services at a lower cost. One woman had previously hired a university student on a casual basis. She felt she had been pressured into accepting and paying for statutory services by her case manager, but had been too tired following discharge to make her own arrangements:

"I wish I still did have her, because she phoned, just two days after I signed up with the homemakers you know, otherwise I would have had the university student, she was very very good and much cheaper."

Unfortunately, the majority of patients in this study did not have the resources to pick and choose between services. This meant that they had no choice but to accept the type and level of home support offered to them by the hospital team and community staff. In British Columbia this meant no home help if cleaning was all that was required, as the social worker explained:

"Unless you need personal care, in the last five months that's been a big gap. Like my 93 year-old patient I talked to today, going home next week and she is not going to be able to get any cleaning. If she was incontinent that might help, but it's just a big gap."

One Canadian patient in this study had cleaning needs only; but the new targeting restrictions, combined with poor discharge planning, prevented him from obtaining even that. Although the hospital team had not asked him about home help, his GP, who regularly visited the hospital, had raised the issue with him. The patient had

¹⁰ At the time of data collection, older people with savings over £8,000 were charged for home help services, up to a maximum of £25 per week. Neither woman who was paying for home help reached the maximum. One had two hours of help per week, the other four hours.

informed the GP that he would be happy to have a home help for cleaning and doing his washing. Unfortunately, the GP had been unclear about the new charging arrangements and the combination of his ignorance and lack of action from any member of the hospital team meant the patient went home with no planned community supports at all, including no home help. The patient described the situation:

Patient: I don't understand it, because when I was in the hospital he [GP] told me that I would get cleaning no matter what. He told me that himself. Then that changed...he said that what I was down under, they have cut them off.

Researcher: He was telling you they'd cut down on the cleaning?

Patient: Aye.

COMPANIONSHIP

Home helps provide a valuable source of social support to their older clients. They are a familiar face who can become a friend as well as someone who is regularly able to assess how the older person is coping. Both the monitoring and companionship aspects of the service have been well documented in the British and North American literature (Simpson and Levitt, 1981, Eustis and Fisher, 1991, Neill and Williams, 1992, Edelbank et al, 1995, Krach et al, 1996). Older people in both countries appreciated their home helps but were especially willing to praise those they had got to know and trust, whom they saw as reliable and as friends. The following comments from older people in both countries demonstrate this:

Scottish man: "I've had her for seven or eight years now...she's always done everything for me."

Canadian woman; "Diana is becoming like one of the family. She's a great wee worker."

Scottish man: "She does more work than any home help I've ever had. And all the home helps have been good people, nice people. But Gemma, she's what you might call the jewel in the crown."

Home helps were therefore the single most important source of formal support for all but one patient in this study. Problems with implementation of the service occurred in the form of delays in Scotland—caused by the divide between hospital and community services that necessitated reassessment; and targeting in Canada—which deprived some patients of cleaning services and forced others to pay. A

similar dichotomy - between the speed and adequacy of provision - was to be found in relation to other services implemented as part of the discharge plan.

COMMUNITY NURSES

Community nurses visited the majority of patients in this study following discharge. Other studies have indicated that community nurses are the most important service for newly-discharged older patients, following home help (Skeet, 1970, Jackson, 1990, Neill and Williams, 1992). The proportion of older people receiving nursing services in the first month at home following discharge has varied in these other studies. While the British literature indicates levels between 30-40% of newly discharged older patients receiving at least one visit from a district nurse (Victor and Vetter, 1984, Jackson, 1990, Neill and Williams, 1992), the North American literature indicates a lower level of service and unmet nursing needs in some cases (Lindenberg and Coulton, 1980, Krommiga and Ostwald, 1987, Krach et al, 1996).

Twice as many Scottish as Canadian patients saw a community nurse in this study (six Scots, three Canadians). Victor and Vetter (1984) have indicated that housebound patients are more likely to see a district nurse than those who are more mobile. Therefore the slightly higher proportion of housebound Scots may partially account for the fact that more of them saw a nurse than their Canadian counterparts. However, this is only one explanatory factor. Others may be prescribed professional roles and resource restrictions in the Canadian context which limited the availability of nurses.

TIMING OF SERVICE

The three Canadians who were visited by nurses indicated that the service had commenced within three days of discharge. Although it was more difficult to determine precisely when nurses had visited the Scottish patients¹¹, the researcher was aware of one significant delay. This delay occurred due to ward staff's being

¹¹ The researcher relied on patient recall to identify when nurses had visited. Several Scottish patients were unable to recall when the first visit had taken place and did not have the date of the visit written down.

unable to contact a nurse prior to the patient's discharge by telephone. The researcher then overheard them making the referral almost a week after the patient had returned home.

COMMUNITY NURSING TASKS

Nurses in both countries carried out duties related to wound management and medication monitoring, bathing and bringing continence supplies. In relation to wound management, three Scots and two Canadians were having a nurse come to dress their legs or feet. At the time of the follow-up interview, all patients were still receiving this service. As one Canadian man described:

"...afterwards, the nurse comes and she puts a new dressing on. She checks it, to see that I have no fluid in there, she's a really good nurse. She has stuff in a tube and she puts that on for healing."

Three Scots and two Canadians (one who was also having his wound managed) had the nurse visit to fill their dosette with the appropriate medication, although the nurse was not necessarily monitoring how and when the older person took that medication. As one of the Scottish men described:

"My own nurse, to save me going down to the practice, she brings my medicines."

One Scottish man who had a nurse visit to fill his dosette was also receiving assistance in the bath from this nurse, as well as some help (joint with a home help) transferring on and off the toilet. None of the older people interviewed in Canada were receiving bathing assistance from nurses, primarily because their home support workers were meeting this need.

MEALS ON WHEELS

The level of community meal provision provided to patients in this study varied between the time of discharge and the follow-up interview four weeks later. At the time of discharge, the hospital teams had made referrals for three Scottish and two Canadian patients to receive meals on wheels (a service which has been described in Chapter 4). By the time of the follow-up interview, only one Scot was still receiving meals on wheels, while the two Canadians had retained the service.

This change in the discharge plan for two Scottish patients was caused by the reassessment that took place after they had been discharged home. Following visits by home help organisers, two of the three Scottish patients receiving meals on wheels were told that the service could be replaced with extended home help hours in which meals were prepared. Both accepted this change. The researcher asked one Scottish man to explain why his meals on wheels had stopped being delivered:

"I think it is because the home help is cooking. Well, I will say no more..they try and I am grateful for what she does."

Although this man was not particularly fond of his home help's cooking, the other Scottish patient who had meals on wheels replaced was delighted with the change and described the new evening service as 'a real bonus'. In the case of these two older people, community reassessment involved tailoring services to meet their individual needs more closely .

One Canadian and one Scottish patient did receive meals on wheels after they left hospital, but not as part of the hospital or community team's plan. Instead, this service was arranged for them by a friend of the Canadian and the son of the Scottish patient, both within the first week at home.

PHYSIOTHERAPY

Physiotherapy services following hospitalisation can improve the functional abilities of older people returning home (Ebrahim et al cited in Jackson, 1994). Sudden termination of therapy following a period of rehabilitation can cause new skills or returning strength to be lost . Follow-up therapy can be provided in one of two forms; as community physiotherapy services in the home, or as part of ongoing treatment at a day hospital. In British Columbia, three patients received community physiotherapy as part of the discharge plan. No patients in Scotland received this service. Instead, four attended the day hospital where they were seen by a physiotherapist. Why was therapy offered at home in Canada and only in the hospital in Scotland?

In the city where the research took place in British Columbia, there was only one day hospital and access to this service was limited. As a result, community physiotherapy had developed in which physiotherapists employed at one of the

two general hospitals made home visits. Each of the three Canadians who received therapy at home were treated by hospital physios working in the community.

In Scotland, the greater availability of day hospital places meant that any ongoing therapy needs could, in theory, be met at the day hospital. In exceptional circumstances home therapy could be obtained from the local authority but the researcher did not observe any examples of this during the fieldwork period. Several reasons for this situation were offered by hospital staff. The first was that, if the patient needed follow-up physiotherapy, they often had additional treatment needs that could be met all at once at the day hospital where they would be seen by a team of professionals. The second was the scarcity of therapy services in the community so that home physiotherapy was only considered as a last resort for those too fragile or difficult to transport to the day hospital by ambulance. Thirdly, during the fieldwork period there was a waiting list for referral to community physiotherapy of up to three weeks. This delay endangered rapid provision of services, so as a result referrals were not made.

TIMING OF SERVICE

For three Scottish patients, physiotherapy at the day hospital continued the week after discharge. However, for the remaining patient referred to day hospital, the service still had not commenced four weeks after discharge. At the time of the interview, this man had still not moved from the room to which he had been brought post-discharge and still has difficulty transferring to the toilet unassisted. He had received physiotherapy in hospital for his back injury, but any benefit he had gained from that has been lost during four weeks with no service. If a community physiotherapy referral had been made for this man as part of the discharge plan, his needs could have been more effectively met. The researcher questioned the ward physiotherapist specifically about this patient:

Researcher: Do you think he might have missed a bit of his momentum because he had four weeks without any physiotherapy?

Physio: Yes, he could have done. The problem is with referring to community physiotherapy, it takes about three weeks to get it processed, so you might not actually get physio for the first three weeks at all."

This service gap in physiotherapy did not happen in British Columbia, where discharge referrals to community physiotherapy were processed quickly and all

three patients who received visits had their first therapy session within one week of being sent home.

LEVEL OF SERVICE

Community physiotherapy in British Columbia was activated quickly, but was also in short supply. This meant that two of the three patients receiving the service felt that it had been reduced too early. Although all three were still receiving visits four weeks post-discharge, four to six weeks was the usual cut-off date and all had been informed that they would shortly no longer be receiving any therapy. As one Canadian described:

"She is still coming, but today when I walked around outside she said she would give me another week...She says if I can manage to walk around the block on my own she doesn't think I'll need her services any more."

Although carers were not interviewed in this study, one daughter whose mother was receiving physiotherapy visited during the follow-up interview. She informed the researcher that she felt her mother had benefited tremendously from the ongoing therapy, but was afraid that she would deteriorate when it was withdrawn the following week. She explained that the service had been most useful for building up her mother's confidence. This confidence was still lacking as her mother was still unwilling to walk in the garden alone, something she had done frequently before admission. As Oktay et al (1992) found that the most common concern amongst hospital staff concerning formal services was that they will be cut off too soon. The hospital physiotherapist in Canada was aware of the shortage in community physiotherapy:

"One thing I do know is that they are not going to get as much physiotherapy as they really probably need to because they are only seen once or maybe twice at the most by the [community], so I mean, it's not ideal out there, that's for sure."

AIDS AND ADAPTATIONS

Simmons (1986) have pointed out that the two major threats to successful implementation of the discharge plan are, firstly, the refusal of needed services by the patient, and secondly, a lack of adequate finances to fund needed services. Both

these 'threats' impacted on the implementation of the aids and adaptations portion of discharge planning in Scotland and British Columbia.

Funding affected the provision of aids to a greater extent in British Columbia than in Scotland. In B.C., the hospital did not provide any aids to discharged patients. Instead, home aids were rented from the Red Cross, at a monthly cost billed directly to the patient. All other equipment needs not met by the Red Cross had to be paid for. If there was no family or no resources were available to the patient, the alternative was to apply for special funding through the Ministry of Social Services, as was the case with one patient in the study¹². Seeking this funding was time-consuming and resulted in a discharge delay. Even when the funding was secured, it was insufficient to meet all the needs of the patient.

Five Canadian patients went home with rented equipment from the Red Cross. Four of the five patients appreciated the equipment and were still using it and paying for it one month post-discharge. One woman had told the researcher how much her equipment cost her:

Patient: The toilet seat alone is forty [dollars] I think.

Researcher: And what do you think about the cost of them, is it OK? Do you think it is rather a high cost for something like that?

Patient: It's worth it, I would not say that it is too much, I wouldn't say that at all. Because it helps me so much.

Cost may have played a part however, in the refusal of some Canadian patients to accept or use aids. Two patients refused to apply for a community alarm they would have to pay for. Another patient accepted a new walker and pole (to help her out of bed) as part of the discharge plan, but then returned them to the Red Cross within one week of returning home. Another patient refused to buy a new set of orthopaedic shoes recommended by the occupational therapist.

In Scotland, basic aids such as walkers, orthopaedic aids, bath rails and seats were provided free of charge to patients. These aids were given to patients as part of this discharge plan in one of three ways. Firstly, mobility aids were given to patients in hospital, as in the case of two patients who returned home with walkers. Secondly, patients who had been on a home visit with the ward occupational therapist could

¹² See Chapter 8 'Discharge Delays'.

have adjustments made to their home while they were still in hospital, or thirdly and more commonly, a referral was made to community occupational therapy. This was the case for five Scottish patients.

Community OTs visited the patients at home following discharge. These assessment visits took place at different times, but two patients were not visited until their third week at home. This delay meant that, at the time of the follow-up interview, several patients were still waiting for equipment, such as a raised toilet seat, new chair and rail adjustments. The free community alarm referrals made by the hospital OT for three patients would take two months or more to process, as the waiting list was so long. Free services meant greater shortages and more delay.

Free services also meant that the Scottish patients accepted aids more readily than those in Canada, although it did not guarantee that they used them. The researcher observed that one woman kept her raised toilet seat in her unused bath. She said she did not need the seat. Another Scottish man stated:

"I've got a liquidiser though. Some nurse came and gave it to me."

Despite swallowing difficulties, this man was not using the liquidiser, nor was his home help. A Canadian OT pointed out some of the pros and cons of two systems where aids and adaptations are free or have to be paid for by patients:

"There is an advantage to being somewhat responsible for it financially, because there is a value added to it. For example, I came from Saskatchewan where all kinds of equipment, if it was needed, it was given to the patient, but if they didn't value it, nurses said they would find them in their basements, in their attics and they weren't using it because there wasn't any value attached to it."

The cost associated with aids and adaptations in British Columbia forced the Canadian patients in this study to become 'consumers' in that they had the power to accept what they needed and reject other suggestions from hospital and community staff. Scottish patients on the other hand, remained passive recipients of services they were 'entitled' to. They did not criticise or refuse the aids they were offered. However, the Canadian system also completely removed choice from those who did not have the resources to rent or buy equipment. The older man in this study whose discharge was delayed for two weeks while waiting for a grant from social services still returned home with unmet equipment needs and resentment towards the

'system' that had delayed his discharge and forced him to accept 'handouts'¹³ from the government.

DAY CENTRES

Day centres provide an opportunity for older people to get out of the house, meet others, have a meal and engage in activities (Simpson and Levitt, 1981). In both Scotland and British Columbia, transportation was available to centres run by the local authority/municipality or by voluntary organisations. This transport meant that day centres could be accessed by housebound and isolated older people. Attendance can provide companionship, activity, and help alleviate feelings of loneliness. Recent research into user participation in the planning of activities at a British day centre found that the majority of attenders believed that the service was vital to their well-being, some describing it as a 'lifeline' (Cox, 1996). Neill and Williams (1992) have pointed out that attendance at a day centre for newly discharged patients can build on the experiences of social interaction they had become used to in hospital, lowering the risk of loneliness and depression that can be associated with being housebound. As early as 1968, Brocklehurst and Shergold described a lack of social day care as detrimental to the recovery of older patients going home from hospital. This assertion was later echoed by other writers (Gay and Pitkeathley, 1978, Jackson, 1989).

Only one patient in this study had a referral made to social day care as part of the discharge plan. This Canadian woman had attended the day centre once a week prior to her admission to hospital. The ward team were able to restart the service for her by a phone call between the ward social worker and the day centre manager. However, this woman was the exception to the rule. During the fieldwork period in British Columbia, there was a chronic shortage of day centre places for older people in the city where the research took place. The problem was a waiting list caused by the closure of some centres (due to cuts in government funding) and increased demand for the remaining spaces. The Canadian social worker explained:

"The waiting list has never been this bad. Six months and up is what they are saying for all the social day centres. So it is a major problem now...you have a lack of choices."

¹³ Interviewee's own words

In Scotland, there were a variety of day centres that the patients in this study could have attended if they had chosen or if it had been suggested as part of this discharge plan. One man had gone to a local lunch club prior to admission. Another woman had attended a day centre for several years in the past. However, neither of these individuals returned to these centres. One reason for this was that both were referred to the day hospital. As mentioned above, three Scottish patients were attending day hospital at the time of the follow-up interview. Through observation at the day hospital and an interview with the day hospital charge nurse, the researcher determined that this service had an important social component as well as providing ongoing treatment and therapy to those attending. This was illustrated by the comments of one patient who felt it was too social, and avoided attending once he had been discharged home:

'You know I hate that, the day hospital...you see everybody there but a doctor ...singing, dancing and bingo. And if you don't do that, you just sit there.'

The fact that the day hospital was easily accessible meant that community alternatives were not actively explored or offered as choices to patients by ward staff. The day hospital in this Scottish hospital was therefore used as a way to ease the transition home for recently discharged patients; fulfilling their social as well as treatment needs.

In British Columbia, a shortage of both day centre and day hospital places meant that day hospital referrals were made only for patients whose ongoing treatment needs could not be met in any other setting. No Canadian patients were referred to day hospital in this study. The only day hospital in the city received most of its patients direct from the community in an effort to avoid acute care admissions. As a result, it was rare for patients from the geriatric assessment ward to go there following discharge, as this exchange with the Canadian physiotherapist shows:

Researcher: How many patients would you say, in the last few months, have been referred to day hospital?

Physio: I think probably only one actually. We have not been doing much in the way of referring to day hospital at all, which is too bad."

The shortage of both day hospital and day centre provision in British Columbia meant patients had little or no input into which service they were offered. In the case of the patients in this study, there was no choice. In Scotland, the relative availability of both social day care and day hospital provision should have meant

more choice for patients. Instead, day centres were not presented as an option to any of the Scottish patients in this study. Day hospital attendance was 'prescribed' for those patients that staff believed required continued monitoring, irrespective of whether the referral was suitable (as in the case of the housebound man who was too weak to attend for four weeks) or desired by the older person.

THE GENERAL PRACTITIONER

British studies have documented the amount of GP follow-up to older people returning home from hospital. All but one reported a higher rate of follow-up than was found in this study. Brocklehurst and Shergold (1968) recorded that 63% of the patients in their study saw their GP within four weeks of discharge. Both Gay and Pitkeathley (1978) and Neill and Williams (1992) found that 70% of the older people they surveyed in England were seen by their GP two to three weeks post-discharge. Most recently, Tierney et. al (1994) found that 20 of the 34 older people in their study of discharge planning in Scotland saw their GP within ten days of going home. Only Jackson (1990) in her study of discharge planning in Manchester - recorded a poor rate of follow-up. Only one of the twenty six patients in her study had received a GP visit by six weeks after discharge.

In this study, only four (40%) of the Scottish patients had seen their GP by the time of the follow-up interview, one month post-discharge. One Scottish woman, who had not been outside since returning home, described how she had not seen her GP. This was despite the fact that his practice was actually located around the corner from her house:

"No, I haven't seen Dr. M. I mean I don't like phoning, and there hasn't been anything really urgent. I certainly could go to him...and if I was going to the surgery, Isabelle [neighbour] would go with me. I couldn't go on my own, I am too uncertain."

Why did the Scottish patients not see their GP? Without interviewing the GP it is impossible accurately to determine this, but there are several possible explanations. The first was that the majority of Scottish patients were housebound and GP contact would have meant a house call. As Young (1996) recently pointed out in a survey of older patients in England, there is better GP follow-up for those older people who are mobile and can get to the surgery themselves. The second reason was that GPs

were aware that the older person had been discharged, had been as yet unable to make a visit, but would in the weeks to come. The consultant on the Scottish ward believed that discharge documentation did not often convey to GPs the importance of visiting patients who had just returned to the community. He argued:

"I think there should be more responsibility on the community as well to follow them up, you know, perhaps the GP. There have been some discussions about the pink letter, the immediate discharge letter than goes out, about changing that. I was very keen to see that we should be able to recommend to GPs that they visit the patient in five days, seven days, or ten days, or a visit was not necessary or whatever."

The delays observed in sending out the final discharge letter in Scotland (described in the last chapter) may also explain why some GPs had not visited their patients. Finally, delays can be attributed to the fact that the hospital *did* inform GPs when their patients would be attending day hospital or the out-patient clinic. In these cases, GPs may have felt their visit was not necessary if the hospital was assuming responsibility for follow-up. As the junior house officer explained:

"I'll phone the GP and just say they are coming home this day and that's all I basically say to them...usually I'll tell them if there's any follow-up, if there is day hospital."

Thus the lack of GP visits in Scotland can be attributed to the expectation that the hospital would follow-up older patients discharged from the geriatric assessment and rehabilitation unit. Poor communication between hospital staff and GPs is another explanation, as is Scottish GPs' reluctance to do house-calls.

Eight of the ten patients in British Columbia had seen their GP at least once within a month of discharge. A ninth patient had not seen her GP at home but had received a visit from her on the day of discharge, in hospital. The consistency of GP follow-up in B.C can be attributed to the more active and continuous role Canadian GPs played while their patients were in hospital, which has been described in Chapter 4. In addition to visiting the ward however, Canadian GPs also had responsibility for organising discharge medications. Whereas in Scotland patients went home with medication prescribed by the geriatrician, in B.C it could only be prescribed by the GP. The senior consultant in Canada explained how this practice began:

"The other thing we insisted on was not doing the discharge meds. We thought it was important that the family physician know the patient was going home and what they were going home on. So therefore what we do is we phone up his office and tell him that the patient is being discharged and ask

him to phone in the discharge meds. In many cases they do it from the unit - they are visiting and they do it from the unit."

HOSPITAL FOLLOW-UP

Wilson and Wilson (1971) have pointed out that no news of disaster or trouble in the period following discharge does not mean that no harm is occurring. Muenchow and Carlson (1985) found that the largest gaps in the discharge-planning cycle were in feedback to the discharging agency. Feedback to professionals involved in discharge planning is needed, in order to allow them to evaluate the strengths and weaknesses of the plan and assist the patient and community agencies in altering services to better meet the patient's needs. In this study, both hospitals had mechanisms for following up their patients, but these mechanisms were used to a far greater extent in Scotland than in British Columbia.

OUT-PATIENT CLINICS

Both hospitals in this study had out-patient departments which allowed newly discharged patients to have a follow-up appointment with a geriatrician. In Scotland, this service was located in the same hospital and patients saw the consultant who had treated them on the ward. In British Columbia, the service was located in the other general hospital in the city, with geriatricians from both hospitals taking turns to staff the out-patient department. Three patients in Scotland and one in Canada had an out-patient appointment made for them as part of the discharge plan.

All three Scottish patients saw the senior geriatrician who checked their condition and rate of recovery. One woman had been admitted to hospital with severe palpitations and a heart condition. During the clinic visit, the consultant asked her about her symptoms and reassured her that if they worsened she should phone him. He also expressed concern that her GP had not been to see her, as the patient reported to the researcher during the follow-up interview:

"That's one thing Dr.E was not pleased with. Because he said 'I wrote to your GP when you left hospital first' and

he asked me if my GP had been. I said no and he said 'I'm writing to him again. "

The other two Scottish patients who had an out-patient appointment had ongoing medical needs. One woman was recovering from a stroke, while the remaining man had persistent and untreated symptoms that required further tests. He was also attending day hospital, and some months later was diagnosed with lung cancer. Six months following his original discharge he died.

The one Canadian patient who had an out-patient appointment as part of this discharge plan was the man with post-polio syndrome. His discharge had been delayed while waiting for equipment and his medical needs were complex. He was asked to return to the hospital and described the visit thus:

"Yes, I went to the clinic, and I got a good report from Dr. B [geriatrician from the other hospital], he just checked me over and we talked a lot. He was going to weigh me but they didn't have a seat and I was too tired to stand up with crutches so he just said forget it, I know you are in good health."

Fewer out-patient appointments appeared to be made for Canadian patients because of the belief that patients going home were being seen by their GPs. In Scotland, the geriatricians were more sceptical about GP follow-up and more likely to want to see any patients with complex medical needs themselves. If we combine the number of Scottish patients who returned to the hospital for an out-patient appointment with those who attended the day hospital, we see that *six of ten Scottish patients were actually followed up post-discharge by the same geriatrician who had treated them in hospital.*

SOCIAL WORK FOLLOW-UP

Two professionals that the Scottish patients had seen in hospital were able to make home visits following discharge. These were the hospital social worker and the geriatric health visitor. Between the two of them, the majority of newly discharged patients received one home visit. Who made that visit was determined by the patient's needs and the availability of either professional.

A significant proportion of patients leaving the geriatric ward were discharged to residential or nursing homes, each of whom the social worker was responsible for

following-up for at least three months. However, she did also visit some patients who returned to their own homes. This was particularly the case if the person needed extra services that they or conventional community services could not provide¹⁴. The social worker explained her follow-up role:

"I am the only one who probably does follow-up from the hospital. If someone leaves the hospital, the occupational therapist will say that is community work now, unless the person is coming to day hospital. So in terms of someone needing an extra service a week later, it might come to me."

One Scottish patient in this study received a visit from the social worker post-discharge. She was a lady who was considering a future move to local authority residential care. The social worker visited her at home and accompanied her to the residential care home in order for her to have a look around. Although the patient decided not to move immediately, she did consent for her name to be put on the waiting list. She subsequently moved into this home four months after discharge.

In British Columbia, none of the staff that patients had seen in hospital visited them at home. The role of the liaison nurse on the ward was to set up services for patients returning home, and also to assign them a community case manager, who then became responsible for meeting their needs at home and making any alterations to services initiated by the discharge plan. Although hospital staff claimed that these case managers visited newly discharged patients approximately two weeks after they had returned home, the researcher determined that the majority of patients had received no visit four weeks post-discharge, although several had spoken with their case managers on the phone. Only one Canadian mentioned a personal visit from his case manager in the follow-up interview: She had visited with occupational therapists from the out-patient service:

" There were two of them that came in, and the Long Term Care lady, she was in later to check that everything was OK."

Ward staff in B.C appeared to accept the view that follow-up was the responsibility of community agencies. To them, the liaison nurse who attended the multi-disciplinary ward meetings was the only link between their discharge planning and

¹⁴ If the patient had special needs, such as for expensive equipment, the social worker could access the community care budget held by the local authorities. In the case of these patients (noone in the study fell into this category) the hospital social worker followed them up for one month post-discharge.

community services. Their domain was the hospital - the community belonged to case managers and GPs. As the Canadian social worker said:

"I wish I knew better how they actually do at home. I don't see it first hand."

Once the patient left the ward Canadian team members rarely had any further contact. This was revealed by the curiosity demonstrated by ward staff regarding follow-up research interviews. They were interested to learn how patients were progressing at home.

HEALTH VISITOR FOLLOW-UP

In Scotland, the geriatric health visitor, an employee of the community health care trust, attended all team meetings, spoke with patients and their carers on the ward, and then visited them at home. Half of the Scottish patients, five people, were visited by her within the first month post-discharge. To all she was a familiar face that they had seen in hospital. As one patient reported:

"J [health visitor] was here yesterday. She wanted to know how I was doing at home. She said 'you've lost a lot of weight.'"

The health visitor saw her role as one that of monitoring the progress of patients who had ongoing nursing needs but were not receiving a great deal of service from district nurses. She explained:

"If there is a district nurse heavily involved, I wouldn't normally duplicate a visit because district nurse training is such that they are very similar to health visitors except they do hands on work whereas we do more advisory."

The health visitor and the social worker divided follow-up visits on an informal basis. The researcher observed this being done on several occasions during team meetings. The social worker explained:

"J [health visitor] should generally do everyone, but we have established between ourselves that if there is someone I am seeing anyway that doesn't have particular medical needs, then I will say 'I am seeing them anyway, but if you think there is anything....' Obviously I will let her know."

This informal division of follow-up between the health visitor and the social worker was characteristic of the less rigid professional roles that the researcher observed in

Scotland¹⁵ The health visitor was able to contact all community agencies if services received after discharge were unsuitable. The researcher attended one follow-up visit to a patient in the study with the health visitor. During this visit she checked the patient's medication, asked about his new home help and responded to unanswered questions the patient had about what had happened during his hospital stay. She explained how this occurred during her visits:

"I think a lot of them tend to come home and ask a lot of questions once they are home, A.N. was one. He said 'Do you know what is wrong with me?' He didn't ask while he was here and nobody told him."

In this way, the health visitor provided the patient with information he would not have been able to obtain from community staff. She was able to relay details from ward meetings and case notes. Haddock (1991) has emphasised the reassurance that a follow-up visit can give patients and families after discharge from hospital. The researcher observed that the health visitor fulfilled this supportive role in her visits. She acted as a source of information as well as determining to what extent aftercare services had been implemented as planned.

THE PATIENTS' VIEW OF HOSPITAL VS. COMMUNITY FOLLOW-UP

In Scotland, the hospital was the source of follow-up services for the patients in this study. In British Columbia, almost all follow-up services were provided by the community. Additional evidence confirming this fundamental structural difference in the organisation of health and social care services was provided by the patients themselves. Scottish patients believed that questions or needs they identified post-discharge should be directed back to the hospital. An example was one man who, after being at home for a month, was running out of continence supplies:

Researcher: And if you needed any more pads for any reason, who would you ask?

Patient: Oh well, I'd ask at the hospital.

Scottish staff too identified themselves as a continuous source of contact for patients after they had been discharged. As the physiotherapist explained:

¹⁵ See Chapter 7 -Planning- "Roles" section.

"We are a point of contact for them, they obviously know us from being in. So even if we can't help them personally, we can get in touch with people who can or give it to the health visitor if they are going in or get them re-referred to the day hospital, or re-referred to out-patients or something, just for a one-of-a-visit."

In contrast, Canadian patients looked to community services to monitor their health and answer queries about aspects of the implemented discharge plan. No Canadian patients saw any of the professionals from the ward once they returned home. The termination of this personal contact with hospital staff meant that the older Canadians in this study were more likely to direct questions to professionals they could identify in the community; the case manager (whose phone number appeared on the back of discharge documentation) or their GP, as one Canadian patient explained:

"I take his advice. Because he's been looking after me the whole time I was sick, he's seen me all the way through."

UNMET NEEDS

Roberts pointed out that discharge planning is successful if it counteracts the disabling effects of illness/disability by "making good any deficiency in an individual's ability to care for himself" (Roberts, 1975). Compensation for the loss of self-care skills means identifying and meeting the patient's individual needs once they have returned home from hospital. Several studies have suggested that unmet needs post-discharge can lead to poorer health outcomes, resulting in greater risk of readmission (Krommiga and Ostwald, 1987, Mamon et. al, 1992, Proctor et. al, 1996). Unmet needs were identified amongst patients in both Scotland and British Columbia. The type of need that was not addressed by the discharge plan varied amongst the patients. However, there were three common causes for these unmet needs that could be applied to both study settings. These causes were: inadequate assessment in hospital; lack of flexibility in community services; and lack of community resources.

INADEQUATE ASSESSMENT: SCOTLAND

Examples of inadequate assessment occurred in both Scotland and British Columbia. In Scotland, the most extreme example of this was the case of one male

patient (previously mentioned) who was discharged home after six weeks in the geriatric assessment and rehab unit. Admitted with severe back pain and falls, the patient was diagnosed as having a collapsed vertebra due to osteoporosis. The result was extremely limited mobility following discharge¹⁶. His release from hospital had been delayed as joiners had failed to put in a rail to the basement of his house. Although this man had been on a home visit with the occupational therapist from the ward, the aids and adaptations planned for him at home were inadequate and inappropriate for his needs. One month post-discharge, this man was still unable to get to his basement—the rails had still not been fitted—and he also needed a new stick to give him enough support to go downstairs, as his walker was too broad. He explained this unmet equipment need:

"I can manage fine with this [walker], but its no use going downstairs, the base is too broad, it leans. I need a wee stick with three prongs, not this one."

The implications of inappropriate assessment of this man's equipment needs were that he could not reach his kitchen, which was downstairs. This meant he was dependent upon meal preparation done by his home help. She arrived at eleven in the morning, meaning he had to wait for his breakfast until that hour. His walker was also inappropriate as its base was too broad to fit through his bathroom door. As a result, a portable toilet had to be put in his bedroom by community occupational therapy staff. His home help told the researcher that she could not understand why a rail had not been fitted to the bathroom to assist him in using it while leaving the walker at the door. The older man was not happy with his bathroom arrangements, but had not complained to anyone. What really bothered him was the fact that the ambulance men had moved him into a different bedroom from the one he was used to sleeping in, probably because the new room had a single bed¹⁷. This man had actually been born in the home he still occupied and had always slept in the other room. He did not understand why he had been moved:

"I used the other one. When I came home they moved me into this room. I don't know why - next door was where I lived - in a sense that is where I am at my best."

¹⁶ The patient was also partially-sighted - a long standing condition.

¹⁷ Neither the home help, the older man, or the researcher could understand why the ambulance men had put the older man in his spare room. This was not a recommendation from the hospital OT as it was not recorded on the home visit assessment record. The bed in the spare room was actually higher off the ground than the double one in the man's usual bedroom. In addition, the mattress was so poor that community OTs had placed a board underneath it. As far as the researcher could determine, no-one had taken the time to ask the older man where he would prefer to sleep.

This Scottish patient had also been referred to day hospital due to his ongoing need for physiotherapy. However, as has been mentioned, he was unable to attend for the first few weeks because of his immobility, pain and the difficulties he felt he would encounter getting in and out of the ambulance, even with assistance. Yet the physiotherapist on the ward had assessed him as a suitable candidate for day hospital. This assessment meant that community physiotherapy had not been considered as an option early enough, resulting in the loss of some of the functional ability this man had regained in hospital.

A more thorough assessment of this man's needs and preferences could have solved many of the problems he encountered after discharge. Much of this assessment should have been achieved during the home visit. The impression that the researcher had when visiting the man at home was that the hospital team had not succeeded in obtaining enough information during home visit or from the patient himself about his home situation. This was confirmed by reading the home visit assessment records which did not include needed aids such as the rail in the bathroom or the new stick. A successful discharge plan should ease the transition from hospital to home. The plan made for this man made him more dependent and less mobile than he could have been had his needs been adequately assessed.

INADEQUATE ASSESSMENT: BRITISH COLUMBIA

A male patient in British Columbia also had unmet needs due to lack of assessment in hospital. In his case however, lack of assessment resulted in *no* community services being arranged for him post-discharge. Because his needs had not been assessed, he and his friends and neighbours were left to determine how he could get help at home, within his limited resources.

This patient had been admitted following a collapse due to malnutrition and liver disease caused by alcohol. He was suffering from pneumonia when admitted and was later diagnosed as having a lung abscess. After spending six weeks in a medical ward, he spent just over two weeks in the geriatric assessment and rehabilitation unit. During his stay he was fully assessed by all members of the multi-disciplinary team except the social worker, occupational therapist and ward nutritionist¹⁸. These

¹⁸ He received a full assessment from a nutritionist during his stay on the medical ward, but did not receive a follow-up from the nutritionist on the geriatric unit. The significance of this was that no nutrition discharge planning was done for this man.

omissions occurred because social work and OT staff were on holiday and had been replaced by staff who were part time. Both part-time staff saw the patient only once. The replacement social worker was under the impression that the patient was a candidate for a local residential care home that specialised in care for people with a history of alcoholism. She suggested this move to the patient, who rejected her suggestion. She did not see him again to continue the social work assessment. As a result no referral was made for him to be seen by one of the liaison nurses on the ward who made community service referrals. The geriatrician, after consulting with the patient's GP who had visited him several times in hospital, decided that the patient could be discharged as soon as his lungs had improved. He was sent home the next day without any discharge planning information or services.

Before being transferred to the geriatric ward, this patient had been assessed by another geriatrician. The assessment was in the patient's case notes. It made the following recommendations for discharge planning, none of which were implemented by staff in the geriatric unit:

If he is discharged and well enough in the near future, I would suggest long term care services to be involved to provide homemakers as well as concern regarding Meals on Wheels, social day care and follow-up through VISTA¹⁹ to make sure he does not lapse with alcohol. He would also then be an ideal candidate to be admitted to day hospital... through the geriatric services to follow-up on all these issues.

This Canadian patient was an Irish immigrant, a bachelor with no family in the city. He had one close male friend who had actually found him new, ground floor accommodation while he was in hospital. The patient moved into this apartment shortly after discharge, with significant assistance from this friend and two others. When the researcher visited him at home one month later, the new apartment was in some disarray. Boxes remained unpacked and the kitchen floor was littered with empty food cartons. His bathroom was soiled and his removable shower head had still not been attached to the bath faucet. He informed the researcher that he had difficulty getting into the bath so had not managed to have one in the month since he had returned home. He did not have a vacuum cleaner in the new flat and admitted that he had done no cleaning since he got home. Although he was mobile and had been to see his GP several times on the bus, he clearly had need of

¹⁹ VISTA is a voluntary organisation which offers support and counselling to seniors with alcohol or drug problems. The service visit the patient in hospital and at home.(see Chapter 4). The researcher asked the patient if anyone (usually a social worker) had mentioned VISTA to him as an option. He said no. In addition, the researcher found no evidence of VISTA being offered to the patient in the case notes. No referral was made.

assistance. Cooking, cleaning and assistance with personal care were needs that could have been addressed if he had received a comprehensive assessment in hospital.

Despite the complete absence of any discharge planning for this Canadian, he and his friends had managed to meet some of his needs. He was receiving meals on wheels which one of his friends had arranged. These were arriving five days a week. The same friend had also arranged to have a local woman visit to take away the laundry once every two weeks. Both these services were paid for by the patient. Finally, the same friend (who was a volunteer in a local rehabilitation hospital) had managed to obtain a new walking stick for the patient. In this way, most of the patient's needs had been met by his own informal support network. The GP was the only source of follow-up for the patient, yet he had not arranged any additional services.

The lack of discharge planning done for this patient was a product of several interacting circumstances. During the time of his admission there was a waiting list for places on the ward, and as his condition had stabilised, he was discharged before all team members had assessed him. These assessments took longer to obtain because of the part-time replacements for team members that were on holiday. Assumptions about the man's needs - that he was an alcoholic who would be 'better off' in supervised care - also hindered staff from considering home care options for him. Finally, as far as the researcher could determine, none of the ward staff had taken the time to ask what the patient might need or accept at home. Instead, the attention of his GP had been observed by ward staff and assumptions were made that the family doctor's ongoing care would be adequate to address the patient's needs in the community. Indeed, in the patient's hospital record, the ward nurse who had discharged him actually wrote that he was "returning to apartment with homemaker assist", which was not the case. But one month after discharge, the patient was coping entirely due to his own efforts and those of his friends. As so many writers have demonstrated (Bornat et al, 1985, Krommiga and Ostwald, 1987, Waters, 1987, Ginn and Arber, 1991) older people themselves and their informal carers are left to cope in the absence of support from formal services.

LACK OF RESOURCES IN THE COMMUNITY

Hospital staff in both Scotland and British Columbia identified areas in which they felt that patients would not be able to obtain adequate support from community

services. In each study setting there were shortages in some services. These shortages meant that patients who could have benefited from receiving services either did not obtain them at all or received them less frequently or for a shorter duration than they really needed. The social worker in Canada expressed her general frustration with the funding of community services, which she saw as insufficient to meet the needs of older people returning home from hospital:

"The limitations of the home services, in spite of all the talk, they don't walk the talk. Closer to home, closer to home; but you actually get closer to home and have had 24-hour care here and you go home and at best you might have two hours."

Discharge planning is only effective if the services identified by hospital staff as being suitable to meet the needs of patients are actually available. One of the occupational therapists in Scotland expressed her frustration at resource restrictions that limited the amount of service hospital staff could recommend for the patient:

"Not being able to get in the home care that they need is a big problem. It's all very well assessing and saying this person needs so much home care, but if there isn't that home care available, then they could be unsafe."

The older people interviewed were also aware that resource limitations were the cause of insufficient or unavailable service. Interviewees in both countries identified unmet needs that arose directly because of a shortage of services. In Scotland, the most common examples of this involved occupational therapy equipment that had still not arrived one month post-discharge. Four Scottish patients were waiting for free equipment which would make their day-to-day lives easier. One woman explained that she was waiting for an adaptation to her bath, which would allow her to bathe herself:

"I wanted a spray for my bath, because my daughter has to come down and bathe me now, you see I can't get in because of this hip. But J [daughter] says, you can't force them. Everything's so expensive now. They said they would keep me on the waiting list."

Other shortages in Scotland were community physiotherapy (which has been mentioned) and community alarms. These alarms were installed by the social work department. Referrals had been made by the ward team, but there was a three-month wait for them at the time of the fieldwork. This meant that people at risk of falling at home were unable to have easy access to a system that would have alerted services if they did have an accident. At the time of the follow-up interview, all of

the three Scottish patients who had alarm referrals made for them as part of the discharge plan were without this service.

In British Columbia, the resource limitations that had caused reductions in home help cleaning services have been mentioned above. This was the most serious restriction on the discharge plan that the researcher witnessed. However, the insufficient duration of community physiotherapy also resulted in unmet needs for two of the three patients receiving it. Both informed the researcher that they felt they would continue to benefit from the service after it ceased four to five weeks after discharge. The shortage of social day care in British Columbia meant that none of the Canadian patients were offered this service as part of the discharge plan. Although no patients identified lack of day centres as an unmet need, the researcher formed the opinion that at least two of the patients in the study would have enjoyed the social contact the centres provided if attendance had been offered to them as part of the discharge plan.

Unmet equipment needs were a problem for only one patient in British Columbia. As others receiving equipment had all bought or rented it, availability was not restricted in the way it was in Scotland. The Canadian man who returned home without the aids he needed was the same individual who had been delayed two weeks in hospital waiting for social services funding. The funding he did receive was still not enough to purchase all the adaptations he needed.

INFLEXIBLE COMMUNITY SERVICES

Discharge planning is an activity that requires a certain amount of imagination on the part of hospital staff. They have to imagine how the patient will cope at home, based on information gleaned from other professionals, carers and the patient him/herself. This image of the patient at home also involves predicting how community agencies will act to provide the support that hospital staff have recommended. The researcher found that these predictions did not always match the assistance that the patient received at home. The needs of several patients were unmet because community agencies did not consider it within their remit to assist older people with certain tasks. This mismatch of services to needs occurred for several reasons: firstly, because community services had not been given sufficient information by ward staff, meaning they did not know that a specific type of assistance was required; secondly, because the older person had failed to admit the need to either hospital or community staff; and thirdly, because the patient's needs

changed at home but services failed to adapt. The result of any of these three reasons for need/service mismatch was that several patients in this study 'fell between the cracks' of the health and social care system.

Medication monitoring and bathing assistance were unmet needs identified during follow-up interviews. These tasks could be carried out by home helps, community nurses and informal carers in both research settings. However, because of the inflexible nature of services, several patients did not have these needs met by any of the possible sources of support. In Scotland, assistance with bathing was the single most frequently occurring unmet need. Medication monitoring was also a problem for two patients in Scotland. In British Columbia there were no cases of unmet need for bathing assistance, but medication monitoring was a problem for at least two patients interviewed.

BATHING ASSISTANCE IN SCOTLAND

A recent inspection of the home help service in Scotland (SWSI, 1996a), as well as research recently done in England (Twigg, 1997) has identified the need for joint funding between health and social services to supply older people with bathing assistance. At present, bathing is only provided by district nurses if the patient requires a 'clinical bath', meaning they must have other health problems (such as incontinence) that necessitate cleaning by a trained nurse. Even in these cases, patients who have received a bath in hospital every day can return home to district nursing services that provide bathing assistance only once every two weeks. Yet, at the time of fieldwork, home help services were not yet filling this gap. Relatively few home helps in Scotland are trained to bathe their clients. Bathing is not one of the 'traditional' home help tasks and it is only recently that local authorities have begun to offer courses in personal care for their homecare workers. Six of the older Scots in this study could not bathe themselves without assistance when they returned home. Only one of these was receiving assistance with bathing from their home help, and this was the lady who had a private helper who had been with her for years. None of the local authority home helps caring for older people in this study were assisting them in the bath.

How did Scottish interviewees manage to bathe without assistance from services? Most managed with a sponge bath alone. Two had help from their daughter. Ward staff expected as part of the discharge plan that family members would provide

assistance with bathing if they were willing. In the case of one patient with Parkinson's disease, this assumption turned out to be premature:

"Well, my brother used to come and help me, but he's no well and that, so I use a chair. Because I need to hold on with my hands. But one starts shaking and then the other one starts shaking. But I got in the bath alright, one time. But to get out...well, I just fell back in again [instead] I do a body wash now and again you know."

As this man's brother was no longer able to help him bathe, he had to manage alone. Other studies have found unmet needs post-discharge when informal caregivers have been expected to provide personal care assistance. For instance, Proctor et al (1996) found that 20% of patients whom social workers expected to get informal caregiver assistance with bathing showed discrepancies. Family members as well as older people themselves may not be comfortable with a relative providing assistance with intimate tasks such as dressing and bathing. However, family help or no assistance at all was the choice for the majority of Scottish patients.

MEDICATION MONITORING

Previous studies have found that medication information and monitoring can be an area of unmet need for newly-discharged hospital patients (Skeet, 1970, Krommiga and Ostwald, 1987, Proctor et al, 1996). Incorrect administration of medications can have potentially serious consequences for health outcomes. In an American study, Wolfe et al (1993, cited in Krach et al, 1996) estimated that up to 31% of geriatric hospital admissions are due to adverse drug reactions, due to incorrect dosage or interaction with other medications.

As has been previously described, the provision of medication information was poor on both the Scottish and Canadian wards in this study²⁰. Medication compliance teaching was found to take place on the ward in British Columbia on a regular basis, but rarely on the Scottish ward. When patients return home with incomplete knowledge of their medications, assistance in taking them becomes especially important. Despite this, evidence of unmet needs for assistance was found in both Scotland and British Columbia.

²⁰ See Chapter 8

MEDICATION MONITORING IN SCOTLAND

In Scotland, patients were discharged with their appropriate medications, usually in a dosette box. Most patients were discharged with at least one new medication which they had not been taking prior to admission. They were expected to continue to take these at home, usually without assistance until either a home help or district nurse arrived to monitor them. Without this monitoring, the risk of taking the medication incorrectly rose. One Scottish patient admitted that he would probably not take his medication correctly if his home help was not present:

L: If the home help wasn't here to give them to you would you take them yourself?

R: The answer truthfully is sometimes yes, sometimes no.

Based on the follow-up interview with patients, the researcher determined that only three home helps (one private) were monitoring the medication of the older people they cared for. This proportion is slightly higher than that found in other recent British studies (Neill and Williams, 1992, SWSI, 1996a)²¹. One older person was having his medication monitored by a district nurse. The remaining people were taking their own medication, with the assistance of informal carers who in most cases collected their medicines and/or filled the dosette. When questioned by the researcher, only one of the patients who was taking his own medication displayed a clear knowledge of what each pill was for and when they should be taken. Others displayed little knowledge, and little retention of any teaching they might have received:

Researcher: Before you went into hospital, were you taking any medication?

Patient: Yes, roughly something like this. Mind you, I don't know what these new ones are about.

Researcher: Did they tell you what each of them was for?

P: Not really...there are painkillers in them, that's all I understand.

One woman had been discharged before her medications were properly explained to her. The hospital had arranged for a nurse to visit her at home to go through them with her. When the researcher visited her one month later, she was taking her

²¹ Neill and Williams found that only 4% of the older people in their study (n=69) were given their medication by a home help.

medication without any supervision, but could not recall any information this woman had given her:

Researcher: In the hospital I remember somebody told you that someone was going to come and visit you at home and explain all about your new medicine, your pills and when you were to take them. Do you remember anybody coming to the house in your first few days?

Patient: ...now I believe someone did come, a young woman, and she sat here and talked away. I am not sure what she was talking about.

This same woman was unsure when she should take her next set of pills and asked the researcher when they should be taken. The impression of the researcher with reference to medications in Scotland was that the home help service did not consider it within their remit to administer medications, yet the district nursing service did not visit frequently enough to perform this task either. The result was that older people and their families were expected to manage medications unassisted.

MEDICATION MONITORING IN BRITISH COLUMBIA

In British Columbia, patients received some medication teaching on the ward. They also received a visit from either a GP, nurse or pharmacist within their first few days at home in order to supply them with medication, as it was not sent home with them. This visit usually involved some reinforcement of teaching. Therefore the Canadian patients were more likely to have a more detailed knowledge of their medications than the Scots. However, this did not improve individual problems of recall which the researcher identified during the follow-up visit.

Two Canadians were having their medication monitored by a nurse who was visiting every day, in both cases to dress a wound as well as check the dosette. Four other Canadians were receiving assistance with their medication from home helps. In most cases this involved checking that the older patient had taken the pill in the correct section of a 'bubble pack', sheets of pills in plastic sections made up individually for each patient by a community pharmacist. Two patients were using these bubble packs with no assistance. Despite having the medication explained to them and the individual 'bubbles' arranged by day and time, there were still discrepancies in when they took which medicine. One woman asked the researcher:

"D[daughter] picks them up, and actually at the moment I am not sure if I am supposed to take three across or what I am supposed to do, do you want to take a look?"

This woman had been taking her pills incorrectly for several days. Her daughter was away on holiday and her home help had not been asked to check if the bubble packs were being used appropriately. Instead, this woman asked the researcher for advice.

Again in Canada, informal carers played a tremendously important role in collecting as well as monitoring medication for their relatives:

Researcher: And how is your medication working, I see you have your dosette box there.

Patient: Yes, perfectly, because it just tells you what to omit, that's all..I am taking them myself. And J[daughter] makes sure I am taking them as well.

Without the involvement of family members, older people in both Scotland and Canada would have been at higher risk of negative health outcomes due to medication complications. Medication monitoring was a boundary issue that was inadequately serviced by either community nursing or home helps, especially in Scotland.

SATISFACTION

Other studies have generalised that older people tend to have low expectations of health and social care services and express high levels of satisfaction with any assistance they receive (Abramson, 1988, Cox, 1996, SWSI, 1996a). In a recent British study, Allen et al (1992) have suggested that older people may express satisfaction in order to avoid being accused of 'trouble-making' or to avoid support being withdrawn. This avoidance is consistent with the high levels of compliance with discharge planning suggestions in hospital witnessed by the researcher. Patients accepted services in order to speed up their discharge. Expressing an alternative opinion they feared would be seen as 'being difficult' and might endanger their quick return home. Similarly, many older people during the follow-up interview interpreted questions about satisfaction with planning/services to mean 'did they have anything they wanted to complain about?'. Very few people were willing to

complain about any aspect of the implemented discharge plan and instead expressed high levels of satisfaction with both services and follow-up.

Coulton et al (1982) found an important link between patient participation in discharge planning and satisfaction with the plan. As far as the researcher could determine, no other studies since have firmly supported Coulton et al's findings, which were based on satisfaction measured in the hospital, after the plan had been formulated, but before the patient went home. Unlike Coulton and her colleagues, the study at hand did not attempt to measure satisfaction in any quantifiable way (Coulton ranked patients as minimally, partially or fully involved and rated satisfaction as fair-excellent). Instead, the older people in this study were asked: "All in all, how satisfied are you with the arrangements the hospital has made for you at home?". They were asked to express their satisfaction or lack of it with reference to the discharge plan *as a whole* as well as to evaluate the adequacy of individual services such as home help and meals on wheels.

Only one patient in the study stated that he was dissatisfied with the discharge plan. This was the Canadian man who had no services arranged for him on discharge. In his view, no discharge planning had actually been done for him, a statement the researcher agreed with based on observation and case-note review. All the other patients in this study said they were satisfied with the way the hospital had arranged things. They viewed the overall management of their case as good or satisfactory. Even the Canadian man who had his discharge delayed while ward staff waited for social-services funding to buy equipment viewed his discharge plan as adequate. He said:

"I think I should be satisfied because it was the best they could do under the circumstances. They did their best. They were very good to me and I have no complaints with the service."

Interestingly enough, interviewees did not consider hospital staff who did discharge planning as responsible for any *problems* encountered with community services. However, they were willing to credit them with the appearance of services that they were satisfied with, as this comment from a Canadian woman shows:

"Aye, they have done a good job on me, this time. You realise that once you are away from there and can think about it. I'm doing pretty good. I have my own wee walker, and now the physio girl has tried me on a cane, and that was alright."

Even when things went wrong with community services, patients in both countries were also unwilling to directly criticise community service agencies. Instead, the overriding attitude expressed was one of gratitude for any help they were receiving, even if it was insufficient to meet their needs. Two Canadians who had their home help cleaning services reduced so they had to pay for extra were 'just grateful' that they were still getting the remaining help free of charge. As one stated:

"It's hard with the home support, it's a pity that they have had to cut it down for so many people...I feel guilty at having my home support when other people don't get it."

Others expressed high satisfaction with specific services, most often their home helps. As one Scottish man said:

"Well, I'm pleased, not half. Things look much better, I need her to keep my house. Well, you see it for yourself."

A Canadian woman said:

"I'd say I am very satisfied, I am very pleased with the girls, these people who complain about the service don't realise how fortunate we are to have it. I'm just so lucky. Probably if it wasn't for the service I would probably end up in a nursing home."

Very few older people made any negative comments about services they were receiving at home. In Canada, the five people who had voluntarily reduced their home help did not criticise the service during interviews but rather explained that they had merely been given more help than they needed post-discharge. Only one Canadian woman complained about a specific home help, a young worker who had been sent to give bathing assistance. The older woman had felt unsafe with this worker. She did not voluntarily complain however. Instead, the older woman's concerns were discovered when her case manager phoned. The case manager then arranged for a replacement worker. Those Canadians who were receiving community physiotherapy but who were to have it cut off after four weeks did not complain either. While they commented that they felt they could benefit from continued therapy, they accepted its termination as inevitable. They believed that health care resources were scarce and thought that others needed the service more than they did.

In Scotland, none of the older people interviewed had personally initiated any change to the implemented discharge plan. Instead, they accepted whatever they had been offered, without question. Even those still waiting for equipment one

month after discharge did not criticise either the hospital team or community services. Several who had not seen their GP commented that the fact that he/she had not visited was unusual. However, none of the Scottish patients accused the ward team of not contacting their GP or criticised their GP for not visiting. Overall, the Scottish patients were even more accepting and less critical than their Canadian counterparts, largely because they were receiving a higher proportion of services free of charge. The *only* critical comment about services recorded in a Scottish follow-up interview came from one woman who was waiting for her chiropodist to visit. She was frustrated that her district nurse could not carry out the same tasks:

"Well, I am still waiting, my toenails are needing cut...but they've all got their different jobs, they [the district nurses] can't do anything like that."

In the researcher's opinion, one Canadian woman summed up the attitude that was common to both sets of older people interviewed in this study:

Mrs. F: There's only one thing that annoys me.

Researcher: What's that?

Mrs. F: People who complain. They should be grateful for all they get, instead of whining.

The high expectations interviewees had for their continued recovery at home were not fully realised, as has been discussed above. However, rather than attributing their inability to cope at home to insufficient discharge planning, the older people in this study blamed their health. Rather than claiming that they should have had more or different services, interviewees viewed their limitations as caused by their condition. This finding is consistent with the high level of personal responsibility for health displayed by interviewees and discussed in previous chapters. For instance, the Scottish patient who was unable to attend day hospital for a month and unable to get downstairs to his kitchen did not attribute these situations to the discharge plan. Rather than arguing that the hospital should have provided him with therapy at home or given him more suitable mobility aids, this man accepted the situation as the inevitable consequence of his back injury. He stated:

"...from the very beginning the doctor said 'you've got a bit missing from the bottom of your spine, and we can't cure it, so you'll be on painkillers for the rest of your life. That was it, I had to accept that."

A Canadian woman who had her discharge delayed due to a second surgical procedure displayed a similar attitude. She had been provided with few details

about the second procedure and actually asked the researcher what it had involved during the follow-up interview one month post-discharge. She was unclear why it had taken her so long to recover or why she had been provided with daily homemaker help and bathing assistance (which she felt she did not need) following discharge. However, she blamed herself for not asking professionals the necessary questions rather than criticising any of the actions of the ward staff:

"Oh, I am very satisfied. I mean I have all the help I need and other than not recovering quickly from the second operation, I think things went pretty smoothly. The nurses were wonderful."

CONCLUSION

The organisation of health and social care in the community had a far greater impact on follow-up than on any other stage of the discharge planning process. These external factors made the final stage of discharge planning process the most problematic for the professionals and patients involved in this study. Although the Scottish and Canadian wards adopted very different strategies for follow-up, the researcher observed deficiencies in each. In Scotland, follow-up was organised and implemented by ward staff. The availability of day hospital places and the practice of health visitor and social worker home visits meant that Scottish patients were seen following discharge by the same people who had cared for them in hospital. The implications of hospital follow-up were that patients viewed ward staff as a point of contact and assistance, even post-discharge. This reliance on the hospital was exacerbated by the poor rate of GP follow-up found in this study. Fewer than half of the Scottish patients were seen by their GP during the first four weeks at home. Patients and their families continued to rely on hospital resources for support, even when they had returned to the community.

In British Columbia, follow-up was directed towards the general practitioner and community services. Once they had returned home, not one Canadian patient saw any of the professionals who had cared for them in hospital. Only one patient visited an out-patient clinic, where he was seen by another geriatrician. Day hospital places were scarce and none of the ward team made home visits after discharge. Instead, the structure of care for elderly people in British Columbia made follow-up a community responsibility. GPs visited patients on the ward and arranged their discharge medications. This ongoing involvement resulted in eight of

the ten Canadian patients seeing their GP within the first month at home. Liaison nurses in hospital assigned community case managers to all patients receiving homecare services. These managers were responsible for monitoring the needs of older people in the community, and although their role in follow-up was not consistent for all interviewees, the majority of Canadian patients did view their GP or case manager as the appropriate point of contact following discharge. In British Columbia, the lines of responsibility for care between the hospital and the community were drawn clearly at the point of discharge.

With one Canadian exception, all older people in this study received community services as part of the discharge plan. Home helps were the most common form of assistance, followed by community nurses and other services. The structure of discharge planning in each hospital affected both the speed and appropriateness with which services were provided.

In Scotland, community-service provision began later than in British Columbia. All services took more time to be put in place and in some cases, patients were still waiting for them four weeks post-discharge. One reason for this delay was the division between acute and community care services in the U.K. Discharge planning in hospital consisted of a series of recommendations made to community agencies who in turn visited the patient to conduct their own assessment before commencing provision. This reassessment meant that two patients did not receive a home help until their second week at home, while others waited the same period or longer to receive a community OT visit for aids and adaptations. Inadequate assessment by the hospital team also contributed to this delay, as was the case with the man who did not attend day hospital until four weeks post-discharge, or the man who did not receive a district nurse visit for the first week at home because the ward team had not yet made the referral.

In British Columbia, services were provided to newly discharged patients almost immediately. This was due to the involvement of the liaison nurse in discharge planning. Because she was an employee of the same organisation that provided home care services, no reassessment was necessary. She and the ward team decided on the appropriate level of service, which was then implemented .

However, speedy provision of services does not guarantee that an appropriate level of care will be provided. On the contrary, this study found that the amount of homecare provided to patients in Scotland was, in the short term, more appropriate

in meeting their needs than that provided in British Columbia. Although service initiation was slower in Scotland, reassessment meant that home circumstances and the extent to which the patient was coping at home were taken into account and modifications made within the first few weeks post discharge. The two older people who had their meals on wheels replaced by home help cooking were a good example of this.

In British Columbia, the level of service planned by the hospital team was provided at home in the first few weeks following discharge. The fact that four of the Canadian patients reduced their number of home help hours while others returned equipment indicated that this level of assistance was considered inappropriate by a significant proportion of older people. In short, a balance of appropriate and adequate services provided immediately following discharge was not struck in either research setting.

The older people in this study did not cope as well at home as they had expected. The majority of patients in both countries experienced a decrease in their functional ability between admission and the follow-up interview four weeks post-discharge. Limited mobility was the most common loss, followed by bathing, dressing and other self-care abilities. Functional limitations restricted independence and narrowed the range of social contacts available to the older people in this study. For 80% of Scots and 60% of Canadians, functional limitations meant that they were housebound at the time of the follow-up interview. Being housebound made both groups of older people more dependent on their carers and community services for support.

Discharge planning did not entirely compensate for the functional limitations patients experienced at home. At least one unmet need was identified by the researcher for every patient in this study. These needs arose partially as a result of poor assessment by ward staff, but also more commonly as a result of resource restrictions in the community. No amount of diligent discharge planning by either multi-disciplinary team could compensate for unmet need caused by unavailable community services. Access to services such as community physiotherapy and district nursing was restricted in Scotland. In B.C, home help cutbacks, few day hospital places and waiting lists for day centres limited the likelihood of Canadian patients receiving these services.

The range of service choices offered by ward staff during discharge planning was restricted by what they considered most easily accessible. Choice was also affected by the cost of services. In B.C., charging for aids and adaptations as well as home help cleaning services ensured quick access and availability, but only for those older people who could afford them. In Scotland, free or subsidised services ensured equitable provision, but demand resulted in waiting lists which delayed delivery. Free services also limited the choice of older people and reduced their role in the implementation of the discharge plan to one of gratitude and acceptance of what was offered.

Acceptance of services was reflected in the high levels of satisfaction reported by interviewees in both Scotland and British Columbia. All ten Scottish interviewees and nine Canadians reported that they were satisfied with the discharge plan. High levels of satisfaction were also recorded for community services. This satisfaction was expressed despite the fact that interviewees reported unmet needs and identified problems with the level, cost, duration and timing of some services. Older people in both countries failed to attribute any service deficiencies to the discharge planning process in hospital. Instead, they viewed their health and its maintenance as their own responsibility once they had returned home. Failure to cope was blamed on illness or slow recovery, rather than lack of support. Difficulties with tasks such as bathing, cleaning and taking medication were viewed as the responsibility of the older person him/herself or their family rather than something that should have been made easier by community agencies. Overall, older people in both Scotland and Canada had low expectations for planned services. They expressed gratitude for help they did receive, and acknowledged the role of services in assisting them to live independently in their own homes.

CHAPTER 10

CONCLUSION

This study has examined the concept of patient participation in discharge planning. The extent of participation has been assessed through the eyes of the researcher, the experiences of older people, and reports from hospital-based practitioners in both Scotland and British Columbia. It has been demonstrated that the extent to which older people are involved in discharge planning depends on a variety of factors. The most significant of these are the expectations and beliefs of patients and staff, the specific roles of ward professionals, the structure of ward and hospital discharge planning procedures, and the extent of carer involvement. Each of these factors related to one or more of the research questions in this study. These questions were formulated around topics relevant to discharge planning and the concept of patient participation. Findings can be summarised with reference to these topics, which were: how older patients were involved in discharge planning; how health and social care staff perceived the role of the patient in decision-making; how patients themselves saw their role, and whether staff and patient views were congruent; what patients saw as their discharge needs; and whether the needs of the patient were met by the implemented discharge plan.

PATIENT INVOLVEMENT IN DISCHARGE PLANNING

The extent to which patients were involved in discharge planning was most significantly determined by the *structure* of team discharge decision-making in each ward. Team structure in this study was analysed using a typology of teams developed by Kelly and McClelland (1985) and later described by Anderson and Helms (1993). In Scotland, discharge planning followed a *multi-professional collaboration model*, whereas in British Columbia, the *liaison nurse model* of discharge planning was used. The Scottish method of planning meant that discharge-planning tasks were divided amongst team members. Professionals had shared responsibility

for planning and implementation through a series of discipline-specific referrals. In British Columbia, a liaison nurse (who was an employee of the community health organisation) was a member of the hospital team. While all team members engaged in planning, she was responsible for making referrals and determining the appropriate level of community services for each discharged patient.

While the multi-professional and the liaison nurse models had significant implications for the adequacy and appropriateness of the implemented discharge plan, they also had some effect on the experience of the older person in hospital. The multi-professional model allowed greater patient participation in the earlier stages of discharge planning. Those team members with whom the patient had the most frequent contact were also those who played an active role in deciding which services the older person would require at home. Opinions conveyed from the patient to a familiar nurse, social worker or therapist could be conveyed back to team meetings and incorporated into the discharge plan. The liaison nurse model failed to provide the same continuous contact between the patient and the professionals engaged in discharge planning. The liaison nurse herself met the patients only once or twice, just prior to discharge. She was not a familiar figure with whom patients felt comfortable expressing any anxieties or queries about going home. The presence of the liaison nurse meant that other professionals, most notably the social worker, did not always need to see the patient to determine discharge needs and instead normally restricted inquiries to family members and carers. The professionals with whom the Canadian patients had most contact—nursing and therapy staff—did not play the same role in organising aftercare services as their Scottish equivalents did.

Team meetings in both wards served as the main forum for discharge planning. Professionals agreed that this was where most discharge decisions were made. Patients did not attend in either ward. As a result, the patient's view had to be brought to these meetings by team members acting as advocates. Professionals in each country differed in the degree of importance they attached to patient advocacy. While all agreed that it was every staff member's duty to report any relevant patient opinions, Canadian staff were more aware that this was a necessary part of good discharge planning. When staff were asked what the purposes of team meetings were, none of the Scottish staff mentioned representing patients' views as a purpose. In contrast, four of the sixteen Canadian professionals interviewed saw it as a main purpose. Similarly, when asked how the meeting could be improved, Canadians pointed out that greater consideration of the wishes of patients was

needed, whereas no Scottish interviewees mentioned this. Canadian professionals supported the idea that patients should be involved in discharge decision-making, even if they had few formal mechanisms to do so.

A recurring theme in this study was the importance that older patients attached to relationships with their family, friends, neighbours, home helps and others who assisted them at home. The significance of this type of one-to-one relationship extended to the hospital ward, where patients looked for a familiar professional to whom they could express any concerns. Patients were asked which hospital professional they would talk to regarding assistance they might need at home following discharge. Nurses were mentioned most frequently by patients in both countries. Therapy staff were almost completely excluded from discharge planning in patients' minds, with only one older person in B.C. identifying the physiotherapist as an appropriate person with whom to discuss discharge arrangements. In both wards, doctors were the second (following nurses) most frequently mentioned professional. Many patients valued contact with a doctor, and viewed him as 'directing' their care. The Scottish and Canadian systems differed significantly in the access patients had to both geriatricians and general practitioners.

The structure of the Scottish system meant that patients had more continuous contact with the *same* doctor - the geriatrician - from pre-admission to follow-up. The tradition of pre-admission domiciliary visits meant that three of the ten Scottish patients had seen the geriatrician at home before admission. Two more had previously attended the day hospital. Thus half of the Scottish patients were familiar with the ward geriatrician before admission. Following admission, the contact between geriatrician and patient was reinforced by the practice of twice-weekly walking ward rounds. These rounds, although serving the needs of medical staff rather than the patient, did provide the older people on the ward with an opportunity to direct questions to the doctor. Following discharge, six of the ten Scottish patients were followed-up by the same geriatrician who had treated them in hospital. Follow-up occurred through either the day hospital, or out-patient clinic. The importance of contact with the physician was revealed in patient interviews. One Scottish man who had previously been admitted to the ward said that he did not feel comfortable with most doctors, but 'knew' the geriatrician and thus trusted him. For another Scottish woman, the geriatrician was the 'man in charge', through whom all arrangements for discharge should be made. Scottish patients expected the doctor to be an authority figure and for that reason, an

opportunity to ask him questions or receive information from him was viewed as valuable by patients.

The geriatrician was not however the only Scottish professional to provide continuity between hospital and home. This was also the role of the health visitor, who saw patients on the ward and then visited five of the ten patients at home post-discharge. This continuity did not necessarily provide any better treatment outcomes, but the researcher observed that it meant patients were more familiar with who was caring for them and who they should talk to if they had any concerns. In Scotland, patients believed any questions or needs they had following discharge should be directed back to the hospital team, whom they viewed as a continuing source of support.

In British Columbia, the amount of contact patients had with the ward geriatrician was limited by a range of organisational factors. Firstly, the ward geriatrician did not do domiciliary visits for reasons of time, distance and resources¹. This—combined with the fact that any of the geriatricians in the hospital could do a pre-admission assessment—meant that the likelihood of the ward geriatrician meeting patients before they were transferred to the unit was reduced. Secondly, there were no walking ward rounds in British Columbia. Thirdly, out-patient and day hospital places in the city were scarce and located within another hospital. Only one patient in this study received hospital follow-up. These circumstances reduced the likelihood that the geriatrician would see his patients consistently. Finally, the role of the general practitioner in B.C meant that the patients had an alternative source of continuous medical contact. The non-teaching hospital in B.C granted hospital privileges to local family physicians. This meant they retained a role in the treatment of their patients, if only consultative, throughout the hospital stay. Each Canadian patient in this study was visited at least once a week in the unit by their family physician. Canadians viewed their GP as ultimately responsible for their care. This meant that issues and concerns about discharge arrangements were expressed to the GP rather than hospital staff. This communication reduced the patient's role in active discharge planning on the unit, especially if the GP did not convey these concerns directly to ward staff. No Canadians saw any of the

¹ Another reason why the Canadian geriatrician did not do domiciliary visits was for the important reason that all his patients came to the assessment unit from another acute care ward. There was *another* geriatrician in the hospital who did a limited number of home visits for patients admitted to his ward directly from the community, but none of the patients in this study were visited by him.

professionals who had treated them in hospital once they returned home. Canadians identified their GP, rather than the hospital team, as the person to whom any concerns following discharge should be expressed.

Because patients in both countries were excluded from formal discharge planning, informal contact between professionals and patients was the only way in which patients could participate in decision-making. It was contact with those professionals most heavily involved in making final discharge decisions - the geriatrician, and the liaison nurse in B.C.- which was the key to patient input. When this contact was limited, and when patients were reluctant to contribute, ward professionals looked to carers and family members to speak for the patient. The role of the family figured largely in the next research topic addressed in this study; how health and social care staff viewed the role of the patient in decision-making.

STAFF PERCEPTIONS OF PARTICIPATION

Views of what constitutes 'patient participation' differed between professionals in British Columbia and Scotland. In Scotland, encouraging patients to participate amounted to little more than an information-gathering exercise. Scottish staff saw it as part of their role to establish an environment in which patients felt comfortable expressing their views, but acceptance of these views was limited to statements of need or preferences. These preferences were just another element to be considered by staff in the team meeting, along with functional ability, home situation and other information gathered during assessment. All these factors would be considered by staff before they drew up a discharge plan *on behalf of* the patient.

In British Columbia, staff also viewed patient participation as the expression of needs and preferences. But there was an additional element to definition in the Canadian ward, and this was based on the willingness of patients to conform to ward routine. If patients went to the dining room on time, and attended activities as instructed, they were 'participating'. Those patients who complied with ward routine were more likely to have their thoughts and opinions taken seriously by staff. Those patients who did not comply or actively refused to follow the advice of professionals had their mental competence questioned. Staff judgements of competence were key in determining to what extent patients' views would be considered in the discharge planning process.

There were older people with significant cognitive impairments who were treated in both geriatric assessment and rehabilitation units. But each of the twenty patients in this study were deemed cognitively intact by routine testing done by staff on admission². Despite this, patients had their decision-making ability questioned during the course of their stay in hospital. This occurred only if patients failed either to comply with staff instructions or be realistic about their home situation and services that might be needed post-discharge. Unfortunately, staff and patient views of what was 'realistic' did not always co-incide. Both hospital teams saw themselves as responsible for ensuring a safe and timely discharge for patients. Safety included returning patients to a home environment in which adequate adaptations and services were in place to prevent readmission to hospital or institutional care. If patients failed to agree with suggested discharge arrangements, they were 'labelled' as lacking in judgement or insight. Assumptions of questionable competence³ allowed staff to discount patient opinion.

Decisions about competence also played a role in the amount of information provided to patients, and the extent to which carers were involved in discharge planning. The importance of adequate information has been emphasised in this study. Information is required regarding medication, activity and nutrition, as well as community services. The information needs of older people were largely discounted in Scotland. Staff depended on verbal information, but with little expectation that patients would remember what they had been told in hospital. No written medication instructions were provided, only rarely were therapy or nutritional instructions handed out, and only rarely were leaflets regarding community services provided. A discharge checklist was used, but evidence from this study found that this was not always correctly completed or distributed to patients. No contact numbers or details of community service providers were given to patients. Staff demonstrated some willingness to provide carers with written information, rather than patients themselves. There was a common perception that patients would only lose or forget information, which was given as a reason for not providing any in the first place.

² See Chapter 3 - 'Methods'

³ This was the case particularly with men in Scotland and Canada who had a history of alcohol abuse and one Canadian woman who failed to participate in any ward activities or verbally consent to any aftercare services.

In British Columbia, there was evidence of a more genuine commitment to providing patients with written and verbal information. Information was distributed regarding medication, activities, nutrition and community services. In addition, the liaison nurse was able to provide patients with full details of which services had been arranged, when they were due to appear, and whom to contact in case of any concerns. Staff in British Columbia did however recognise that information was often given to patients at the last minute, by a variety of team members, and was often inadequately explained. Evidence from follow-up interviews with older people in both study settings revealed some of the problems encountered when inadequate information, combined with inadequate monitoring, was provided. Most obvious of these was medication compliance. One woman in each country asked the researcher for assistance with medication that they had been taking incorrectly. Last-minute information inhibited the ability of Canadian patients to plan ahead and decide which services they were willing to accept at home. The absence of contact numbers and information for services in Scotland left one man in particular with an unsuitable walking aid that he had been unable to change since leaving hospital, as he had not known how to contact the relevant services.

Staff in both countries demonstrated a willingness to involve carers in discharge planning, not only through the provision of information, but via formal mechanisms such as family conferences in British Columbia and carers' evenings in Scotland. These meetings allowed family members and friends of patients to meet with members of the multi-disciplinary team. In Scotland, patients were not invited to attend. In Canada, the possibility of attendance was offered, but rarely occurred. The decision was made not by asking the patient whether he/she would like to attend, but rather by consulting the family. The most important factor in determining whether the patient would attend the meeting was, however, the ward team's assessment of cognitive competence. If competence was in doubt, the patient did not attend.

Family conferences were generally a very valuable forum for discharge planning, as carers' input was crucial in determining the kind of support the older person would require following discharge. Formal services in both Scotland and B.C were arranged in order to complement rather than replace existing informal support. Overall however, family conferences and carers evenings did not enhance patient participation in any way. Patients were usually completely unaware that these meetings were being held, could not contribute to them, and in some cases had their

own wishes ignored in favour of those of their carers. Meetings with carers allowed ward staff to obtain valuable information necessary for discharge planning, reducing the need to obtain that information from patients directly. Carer involvement in discharge planning could thus take place at the expense of patient participation.

PATIENTS' PERCEPTIONS OF PARTICIPATION

The multi-disciplinary team members in this study had low expectations for patient input in discharge planning. These low expectations were shared by the patients themselves. There was a definite divide between the determination that older people demonstrated to control their own lives at home, in the community, and their willingness to surrender this control while in hospital. The Canadians and the Scots were strikingly similar in their belief that discharge planning was something done for them, rather than by them. Low expectations for involvement were based on a series of common beliefs about the appropriate role of patients and professionals in hospital.

The first of these was a shared belief in the superior knowledge of professionals. Patients were willing to allow staff to make decisions for them based on the idea that staff had skills and training which put them in a position to decide what was 'best'. This kind of deference to medical opinion was most evident in relation to issues regarding treatment or medication, rather than self-care or functional issues, which patients were more willing to express an opinion about. Patients only challenged professional opinion in two types of circumstances: when they knew the professional well, and felt comfortable expressing their views; or when they had previous experience in hospital. Patients with more experience of being in hospital (such as the Canadian with post-polio syndrome) were more willing to express an opinion. However, even when these opinions had been expressed, patients had little expectation that they would be included in the discharge planning process. A second belief patients shared was that they would be told what type of aftercare services were best for them, rather than being consulted. Just like the Scottish staff members' views of patient participation, patients believed that their role in discharge planning was limited to a statement of preferences (if asked), rather than negotiation.

The older people in this study also shared beliefs about the 'appropriate' role of the patient in hospital. Staff were perceived as caring but busy people, who should not

be unnecessarily 'bothered' by patients' concerns. This belief translated into a reluctance to ask questions or express opinions. Patients were afraid of being perceived as 'difficult' or 'troublesome'. In order to avoid these labels, they were willing to comply with instructions and advice. Most importantly, patients believed that compliance would speed up their discharge. The vast majority of patients in both countries were desperate to return to their own homes, apprehensive about the possibility of admission to residential or nursing home care, and reluctant to do anything that would complicate discharge planning. Patients agreed to accept community services that they felt they neither wanted nor needed, in order to get home quickly. Those patients that refused to comply (such as the 73 year-old Canadian woman who did not want any services other than her existing private home help) had their ability to make decisions questioned by staff. Unquestioning compliance- expected by staff and honoured by patients - was a barrier to active patient involvement in decision-making.

Another perception shared by patients in Scotland and British Columbia related to the structure of discharge planning in both wards. Patients were generally unaware that this activity was carried out by a team of professionals. Patients were unclear about professional roles, and, with two exceptions, unable to identify the appropriate professional with whom to discuss any concerns about going home. Most patients, particularly those in Scotland, looked for someone 'in charge', usually the geriatrician, and viewed this individual as responsible for making discharge arrangements. Along with misconceptions about the roles of professionals, patients were also unaware that discharge planning was taking place in team meetings, or that family conferences/carers' evenings took place. In general, patients were unaware of the structure of discharge planning in both wards. This was entirely due to the fact that the planning process was not explained to patients. An information sheet about the ward was available in Scotland, but this was usually provided to carers rather than patients. At the time of fieldwork, no information sheet existed in British Columbia. Along with lack of explanation about team structure, feedback from team meetings was identified by Canadian staff as an area that required improvement. Neither team had any standardised procedure for informing patients what had been discussed in meetings. In both wards, the researcher observed that discharge dates were set and community referrals made without the patient being told. An information gap existed between patients and professionals with regard to discharge planning. There was little opportunity for patient involvement in a process that remained unclear and unexplained.

PATIENTS' PERCEPTIONS OF THEIR DISCHARGE NEEDS

All the patients in this study shared a common aim following discharge from hospital. They all wished to return to their own homes and continue living there independently, even if they knew there would be a change of residence some time in the future. This desire to remain independent affected what patients saw as their discharge needs. Firstly, all patients demonstrated a willingness to take responsibility for their health. This took two forms - a belief that they, and not the professionals, were accountable for any deterioration in health, and a determination to keep active in order to remain independent. Accountability for changes in health status was demonstrated by patients' beliefs about the reasons for their original admission to hospital, which interviewees in both B.C and Scotland saw as avoidable and in some cases their 'own fault'. This accountability extended to attitudes about readmission. All but two patients believed readmission to hospital would be due to their own actions rather than a lack of support from community services. Patients' determination to keep healthy and active was in part an exercise in prevention - preventing readmission or admission to a care home. Efforts to remain healthy ranged from maintaining fitness routines at home (more common amongst the Canadians) to self-care and treatment. Attitudes about activity affected the amount of help patients were willing to accept following discharge. Several Canadians cancelled their home helps on the basis that they considered themselves capable of doing the tasks the home helps had been sent to perform. It is important to point out, however, that while attitudes concerning independence affected patients' perceptions of their discharge needs, these views were not considered in the formulation of the discharge plan. Most patients did not express them to hospital staff, or staff discounted them in favour of a 'safe' package of services. Assertions of independence came in the period following discharge, when the older people in this study had regained the control they had lost while in hospital.

Patients' perceptions of their discharge needs were also affected by fears of future dependence on their family and friends. Half of the patients in this study received regular help from their families. While one Scottish woman viewed it as her daughter's appropriate role to act as home help and carer, the majority of other patients were willing to accept home helps and other services in order to alleviate the burden on their carers, several of whom visited on a daily basis. This was also the case for those patients who had no family living nearby, but who received assistance from friends and neighbours. These older people were even more

reluctant to become dependent on their carers, and more willing to accept formal assistance as a result.

Given patients' common desire to return to their own homes, *timely discharge* was a need expressed by interviewees. Patients were eager to return home as soon as possible. Unlike other studies which have found older people being discharged too early, with possible negative health implications, this study found that the majority of patients felt they had been discharged at the right time, with only one patient in each ward stating that they had been discharged too early. Later discharge in this study was undoubtedly due to the fact that both wards were assessment and rehabilitation units, designed to return patients to a stable condition with the express aim of avoiding future readmission. Six patients - three in each ward - would have liked to return home sooner than they did. As far as the researcher could determine, no patients were consulted prior to their discharge date being set by the respective multi-disciplinary teams. Consultation occurred after the decision was made.

Despite patients' wishes for timely discharge, delays did occur in both wards studied. Causes differed between the two wards. In Scotland, community-driven delays were the most common. The divide between hospital and community services in Scotland was larger than in Canada - not merely because of the absence of a liaison nurse, but also because of communication problems between the hospital and a range of services, from GPs to home helps. The most common cause of discharge delay mentioned by staff in the Scottish ward was the home help service, followed by aids and adaptations. In Canada, the most common causes of discharge delay identified by ward staff were team rather than community driven. Disagreement between team members and pressure on team members were the most common causes of delay. Resources were also an issue in Canada. Whereas most community services could be provided in Scotland free of charge or for minimal cost, older people in British Columbia were expected to contribute more to the costs of aftercare.

Patients' perceptions of their discharge needs were very much shaped by what they imagined life at home would be like following a long stay in hospital. Staff in both countries described patients' expectations as unrealistic in many cases. This assumption amongst staff contributed to the exclusion of patients' opinions from discharge planning. If staff assumed that most patients were unrealistic, it inhibited their ability to take patients' preferences seriously. Staff may however have been

correct in their assessment of patient expectations. Only three Scots and two Canadians were able to accurately predict how they would cope at home post-discharge. The researcher had asked patients just prior to discharge how they thought they would manage at home, and then compared their answers with those given during the follow-up interview four weeks post-discharge. Older people in both countries were generally disappointed. They had expected life at home to be easier, or at least the same as it was before they went into hospital. Once they returned home, they found they could not do the things they had been used to doing. Problems related to functional ability, pain, being housebound or becoming too dependent on formal and informal support. But older people did not attribute their increased dependency to a lack of community services. Instead, the explanations they offered related to their sense of responsibility for their own health. Difficulties at home following discharge were attributed to old age or loss of motivation, rather than deficiencies in discharge planning.

PATIENTS' NEEDS AND THE IMPLEMENTED DISCHARGE PLAN

Every patient in this study required some form of domiciliary service after discharge. The level of support received ranged from one Canadian man who had meals on wheels organised by a friend, to several patients who received seven-day-a-week support from a range of services. Services were required because patients had greater needs following discharge from hospital than they had previously had prior to admission. As other studies have found, older people experience a general decrease in functional ability following discharge from hospital (Davis et al, 1984, Wachtel et al, 1987, Waters, 1987, Harding and Modell, 1989, Tierney et al, 1993). Every patient in this study experienced a decrease in ability to carry out at least one activity of daily living. This loss of ability, combined with poor housing in Scotland, resulted in eight Scots and six Canadians being housebound following release from hospital. All the older people in this study were thus in need of the support that services could provide. In most cases, these services were key in assisting these older people to continue living in the community. But the speed with which services were mobilised and the extent to which these services met the needs of the older people varied.

The discharge plan was implemented more rapidly in British Columbia than in Scotland. This meant that the Scots in this study did not have all of their immediate discharge needs met. Other studies have indicated that the first three days

following discharge are the most crucial (Wilson and Wilson, 1971, Harding and Modell, 1989, Jackson, 1989, Fethke and Smith, 1991, Proctor et al, 1996) yet four of the Scots in this study did not receive any formal services within that period and two of them did not receive home help services until two weeks post-discharge. This is in direct contrast to the Canadians in this study, all of whom received home help services the day of or the day after discharge. The three Canadians who had home nursing services in their discharge plan all received this service within three days of being at home, whereas in Scotland one older man had been at home for a week before a home nursing referral was made.

The implementation delay in Scotland has two main sources. The first was to be found within the structure of the ward team itself, and ward discharge planning practice. Professional roles were less rigid in the Scottish ward, and this extended to referral practice. Referrals were divided amongst staff with some services - such as home helps, home nursing, day centres, and community alarms - regarded as 'grey areas'. These services could be accessed by the OT, ward nurses, the social worker and the health visitor. Although there were positive aspects to this less rigid division of responsibility, it did lead to crossed lines of communication between professionals and also the hospital and community services. It also resulted in duplication of referrals or conflicting information.

Secondly, the absence of a liaison nurse on the Scottish ward meant that professional referrals consisted merely of a request for services from the relevant community agency, rather than a decision about the amount and timing of services that could be provided. The fact that Scottish staff could not determine the amount of services had two implications. The first was that ward staff could not provide patients with full details of services prior to discharge. The second was a delay in starting services. This arose either because referral messages were not received or processed quickly enough, or because community services would only decide on the appropriate level of service after they had done their own assessment of the patient's needs. Home help services were the best example of this. For new clients, a referral from the hospital team initiated a visit by the home help organiser, who would determine the kind of support the older person needed and then arrange for services to start. For two Scottish patients, two weeks had passed before the home help organiser visited. The basic problem was the divide between hospital and community services in Scotland. Community health and social care agencies had to decide for themselves how much support they could offer to the recently

discharged older person. The hospital team could neither predict nor dictate the timing or level of services.

Domiciliary services were deployed more rapidly in British Columbia due to the liaison nurse model of discharge planning. The community liaison nurse was able to dictate precisely which services an older person could receive, what level of service would be offered and when this service would begin. This process brought the community into the discharge planning process, and eased the transition from hospital to home. However, the liaison determined what level of service would be required by each patient by way of assessment that was done in hospital. This meant that the needs met by the implemented discharge plan were those that the team had observed on the ward. Older people's needs changed when they went home. Although some required more support than the hospital team predicted, others in fact needed a lower level of service than anticipated. This meant that service levels, certainly with reference to home support/home help, were less appropriate in British Columbia than in Scotland. Professionals themselves, including the liaison nurses, were aware that they often tried to protect older people by providing a more frequent or more intensive level of homecare services than the older person wished. As a result, more Canadians had experienced a change in levels of domiciliary service than their Scottish counterparts when the researcher visited them at home four weeks after discharge. Whereas the five Scottish patients who received a higher level of home support following discharge retained that level of service, only two of the seven Canadians receiving a seven-day home help service were continuing to receive that level of support four weeks following discharge. The older people themselves had decided to reduce the service because it did not fit their needs. The reasons given for cancelling some hours of service related to a desire to remain independent. They felt capable of carrying out some of the tasks the home support worker was performing, and so reduced the service. Alternatively, they felt the tasks the worker had been sent to perform were not suited to their needs, such as providing bathing assistance. Altering the type and amount of service received was one way that the older Canadians in this study reasserted their independence at home.

Despite the initially generous level of home support provided to Canadians, there were serious deficiencies in other services that resulted in unmet needs for all the patients in this study. Three common causes for unmet needs were identified: inadequate assessment in hospital; lack of flexibility in community services; and lack of community resources. Inadequate assessment has been highlighted through

two case descriptions⁴: one man in Scotland whose home was inappropriately adapted and discharge unnecessarily delayed due to inadequate assessment by therapy staff, and one man in Canada who had no community services arranged for him following discharge. Inflexible community services in both countries resulted in unmet medication monitoring needs in British Columbia and Scotland and unmet bathing needs in Scotland. Both these needs fell between the boundaries of health and social care⁵. Finally, there was a shortage of some services in both countries. Unavailable or rationed community provision was a significant barrier to good discharge planning. Ward staff in both countries were aware that some services included in the discharge plan would be provided less frequently or for a shorter duration than needed. For some services, waiting lists prohibited any inclusion in the discharge plan. The researcher observed, as other studies have found, that there was a relationship between unmet needs post-discharge and poorer ability to cope at home. Even four weeks post-discharge, it was evident that the restriction of on-going therapy services, inappropriate aids/adaptations, inadequate follow-up services or even the absence of home help to provide a safe, clean home environment had limited the continued recovery of the older people in this study.

Despite the evidence of limited opportunities for patient participation and unmet needs following discharge from hospital, interviewees were satisfied both with their involvement in discharge planning and the amount of support they received at home. Nineteen of the twenty patients told the researcher that they were satisfied with the implemented discharge plan. Older people in both countries recognised that some of the services they needed had been delayed or not provided, but they did not attribute these deficiencies to a lack of discharge planning. Not one interviewee was willing to blame hospital staff for their unmet needs. Even community services were not criticised. Restrictions or new charges for services were met with acceptance. Five Canadians did choose to reduce the amount of home support they received following discharge, but no patients in this study formally complained about any aspect of their stay in hospital or the services they received at home. This was especially true for the Scottish patients, who were more accepting of the hierarchy of decision-making within the hospital ward and were

⁴ See Chapter 9 - 'Follow Up'

⁵ See Chapter 9

not willing to question the delays or deficiencies in the provision of community services following discharge.

The high levels of expressed satisfaction found in this study relate to the attitudes of older people regarding their own health and their role as patients within the health care system. The older people in this study regarded themselves as responsible for their own health, and accountable for any lack of ability to cope. They had low expectations of health and social care services in the community, and thus expressed high levels of satisfaction with any assistance offered. What they valued above all was their independence, no matter how limited. This independence centred around the ability to be able to return to their own homes, and to continue to live there. Admission to hospital involved surrendering that independence, if only temporarily. In order to regain it, the older people in this study were willing to put their trust in the knowledge of professionals, and surrender to them their decision-making rights. Compliance with discharge decisions made by these professionals was seen as the fastest and most effective route to returning home.

Findings from this study raise a series of further questions relating to patient participation and discharge planning. They also reveal how two different health-care systems can provide examples of good practice that could benefit patients in other similar settings. These questions and suggestions for health policy represent the implications for research and practice that arose from this study.

RESEARCH IMPLICATIONS

This study raises both methodological and substantive issues to be addressed by further comparative research in social policy and gerontology. In Chapter 3 ('Methods') several advantages of comparative research were described. These were that comparative research allows the researcher to: overcome some of the methodological implications of a study done in only one location; question established practices in the researcher's own country or setting; evaluate practices that exist in one setting but not the other; and focus on conceptual clarity and methodological precision.

All of these advantages are reflected in the findings from this study. However, the first three could have been maximised by changing aspects of the research design.

Firstly, this comparative study did overcome some of the methodological limitations of a study done in one location. This was achieved by drawing a distinction between findings which appeared specific to one setting only, and those which were more generalisable observations regarding, for instance, professional practices or the opinions of older patients regarding their health. The validity of these generalisations would have been expanded if the study had been conducted in two or more wards in *each* country. Two wards in British Columbia could have been selected, along with two Scottish wards. This type of approach to the comparative case study should be considered in future research⁶. It would allow researchers to determine more definitively which findings are specific to the organisation of the wards studied, and which can be generalised to comment on the discharge planning process in either country or region as a whole.

Secondly, this study did allow the researcher to question practices in each setting, such as the divide between health and social care in Scotland, or the role of GPs in British Columbia. Despite these observations however, the organisation of care for older people, and the attitudes of patients and staff in each country actually turned out to be more similar than the researcher had originally anticipated. Although the similarities between the two settings were an advantage with reference to reliability, comparative findings could have been enhanced if more dissimilar research settings had been chosen. A study comparing the United States and Scotland, for instance, would have produced very different results. This is especially relevant with reference to the concept of participation. Staff and patients' attitudes towards the concept would have undoubtedly been more contrasting and perhaps more revealing if one part of the fieldwork had been carried out in a more market-oriented health-care system.

Finally, the claim that comparative research permits evaluation of practices that exist in one setting but not the other, was supported by findings from this study. The impact of the liaison nurse model of discharge planning was assessed here. However, alternative models of discharge planning do exist within both Scotland and British Columbia. Although there were no direct examples of liaison discharge

⁶ At the research design stage, conducting the study in more than one ward in each country was considered by the researcher and her supervisors. The eventual decision to restrict the study to one ward in Canada and one in Scotland was taken in order to maximize the depth of findings. Two more wards would have restricted the time the researcher had to spend on each unit, to interview patients and staff, and may have necessitated follow-up interviews earlier than one month post-discharge. Studies involving more than one ward in each setting would have required a longer fieldwork period, or more than one researcher.

planning in the Scottish city where the research was conducted, other British studies have detailed examples of discharge planning co-ordinated by a representative from community services (Gatt and Taylor, 1973, Townsend, 1988, Challis et al, 1995). Despite this, no controlled comparative studies evaluating different models within geriatric assessment and rehabilitation were identified by the researcher (although many examples of such studies exist in the American literature)⁷. Rigorous comparison of different discharge planning structures *within* the UK and Canada is still required. This type of comparative research is extremely valuable, and could inform current practice.

This study has also raised further methodological questions with reference to the link between participation and outcomes. Evidence has demonstrated that excluding older patients from discharge decision-making can result in unmet needs, and thus poorer discharge outcomes. This was particularly the case for patients who were not consulted about their need for particular aids and adaptations, and thus provided with unsuitable ones. It is also true for those patients who had questions about their medication and the treatment they were receiving, but were not able to ask them in hospital. It is true for the Canadian man who requested a home help and meals on wheels, but did not have his requests passed on to the liaison nurse by other team members. Finally, it is true for those patients who staff *assumed* would get assistance from their families (for example with bathing) but, once at home, did not receive this support. Patient participation does matter, even if the involvement desired by the older patients in this study does not match the model of 'active patients' envisaged in the policy reforms of Scotland and British Columbia.

This study has not *measured* the benefits of participation in decision-making regarding health. Findings do not definitively demonstrate that, without patient involvement in discharge planning, the process itself will result in negative clinical outcomes. But this absence of definitive, identifiable proof of the links between participation and better health is a product of the research design adopted in this study. Qualitative methods cannot measure outcomes. No universal statements can

⁷ The Darlington Community Care Project (Challis et al, 1995) did apply a case management model to discharge planning, comparing one group of patients leaving long stay NHS wards whose discharge was planned using this approach, with two other groups of patients (one remaining in long stay wards, another already living in the community and attending day hospital). Although their findings revealed the advantages of a joint agency model of care planning, they did not specifically compare the discharge planning process with and without the case manager or liaison role. This is the type of comparison which needs to be attempted in future research.

be made from qualitative findings. Instead, they can comment on the substance and extent of phenomena observed and reported by respondents. Most importantly, they can describe a process and its impact on the individuals who consent to take part in the study.

The need for rigorous research into the links between participation and better health remains⁸. This type of research needs to recognise that participation is not one concept, but is made up of a series of ingredients. Participation cannot occur without some knowledge, and this can only be obtained if the relevant information is provided. Participation does involve asking questions, but this can only be achieved if patients expect to be heard. Future studies need to identify and separate these component parts of participation, and measure their individual impact on health. Other studies (Schulman, 1979, Bird et al, 1988, Roter, in Brearley, 1990) have tried to do this, most commonly in a quasi-experimental design that measures the impact of information provision and/or specific opportunities to ask questions on one group of patients and then compares it with another who have not received this treatment. These types of studies are valuable, and should be attempted with older people engaged in discharge planning. Greater proof of the benefits of participation for different groups of older people in hospital is still required.

This evidence is most important because of findings from this study which indicate that policy makers' perceptions of participation (as evidenced by recent reforms reviewed in Chapter 1) deviate from those of patients themselves. It is clear from the evidence in this study that older people do not have high expectations for involvement in discharge planning, and believe that professionals are in a position to make decisions for them. These views do not negate the need for involvement in health care decision making, but rather indicate that health policy must accept the need for alternative patterns of practice within the geriatric assessment and rehabilitation setting. The kinds of reforms that will facilitate older patient participation are those that may not endorse the current push in both British Columbia and Scotland for faster through-put and lower staffing costs. Both systems need to provide older people with the opportunity to state their views, if

⁸ There were other unexplored avenues of investigation in this study which could be addressed by further qualitative work. For example, within the research design of this study two groups of respondents - carers and general practitioners - were excluded due to time limitations during fieldwork. Interviewing these individuals in each country would have provided a more holistic impression of patient participation, discharge planning and discharge outcomes in particular.

they wish. Providing the opportunity is the key. Two concrete policy suggestions are provided below.

FACILITATING PATIENT PARTICIPATION: IMPLICATIONS FOR PRACTICE

The two geriatric assessment and rehabilitation wards in this study have provided examples of good practice that could be implemented in other health-care settings. The advantages of the traditional ward round for patient participation have been identified. Family conferences in Canada, although excluding the patient, can benefit the discharge planning process. Two other examples of ward practice; the discharge checklist and the presence of the liaison nurse also had the potential to improve discharge planning. They serve as the starting point for two suggestions for practice: the client-held record, and the designated professional.

THE CLIENT-HELD RECORD

A discharge checklist had been used by both wards in this study⁹. The practice in British Columbia had been abandoned, but the Scottish ward still continued to use one. This document facilitated comprehensive discharge planning by providing a list of arrangements that had to be made before the older patient could return home. Nursing staff were responsible for the checklist and recorded tasks that had been completed. The checklist was described by staff as extremely valuable, as it ensured that no arrangements, particularly community service referrals, were forgotten. In addition to serving as a tool for staff, the checklist did have the potential to facilitate patient input. It contained a series of copies, one of which was designed to be given to patients just before leaving hospital. The different parts of the checklist were supposed to be explained by a member of staff, usually a nurse. Through the checklist, patients could learn precisely which services had been arranged for them as part of the discharge plan, and could raise any concerns they had.

The potential for patient input provided by the checklist was undermined by the actions of ward staff. Nurses often did not go through the checklist with patients,

⁹ See Chapter 8, 'Implementation'

and in at least two cases, the patient was not provided with their copy at all. In addition, Scottish staff did not see the patient's copy as an important component of the checklist. They assumed that older people would not understand it, that it would not be read and would be lost.

Other problems with the checklist in Scotland were that it did not provide any details about community services - when they would commence, and what the relevant contact numbers were. Predictions about timing and amount of service were difficult to make due to the division between hospital and community care, but there was no reason why names and numbers for the relevant agencies could not be included.

Staff in both Scotland and British Columbia agreed that discharge planning documentation could be improved. In Scotland, the discharge checklist was seen as too simple, not providing community staff or patients with enough details about the discharge plan and who would implement it. In Canada, there was no unified document that the staff could consult to make sure that all aspects of the plan had been implemented. Patients themselves could have benefited from one document that recorded the information they would need at home.

An alternative idea suggested by the health visitor and one of the occupational therapists in Scotland is that of a client-held record. This document would be drawn up for all older patients following their first hospitalisation or out-patient visit. The health visitor explained:

"I feel it would be very useful for the client to be given something [that] would have written on there all the services that you have planned, who the contact people are...And then I would like that record to go with them wherever they go, i.e.. to the out-patient clinic, It would be a good reference point to have and it would be good for the clients, because they are expected to remember an awful lot of stuff about services."

Staff in Canada agreed that more information could be provided to the patient and that a comprehensive document would be useful. As one practical nurse said:

"I feel it [info about discharge] should be almost ingrained in them beforehand and then reinforced on discharge. You have your medication calendar, you are having homemakers in on...you know two hours...they will be starting tomorrow, and here is a short list, very organised and walk them through it. Very direct, so that they know exactly what is going on."

Discharge checklists could be replaced with a more comprehensive document, such as the client-held record. During admission to hospital, this kind of record should be included in the main case notes on the ward, so that all staff could consult it. A comprehensive client-held record would also be of benefit to those providing formal or informal support to the older person at home. Home helps and other service providers could document their visits, informing others coming into the home when they had been there and what they were providing. This type of documentation would assist carers or the older person themselves in identifying any service gaps and contacting the necessary agencies.

The successful implementation of this type of discharge planning document would still depend upon the actions of professionals. In order to be understood and referred to by the older patient, a ward team member would have to go through the document carefully with the patient prior to discharge. Family or carers should also have the record explained to them. Its utility following discharge would depend on the co-operation of community agencies and primary care providers, who would have to agree to document their services and refer to it themselves as a source of information about the patient and their needs. The main argument in favour of a client-held checklist is its potential to assist older people in retaining more control over decisions regarding their care. This study has identified information as one of the key components of participation. A client-held record could provide valuable information that would help the older person to make decisions about the type of support he/she would need. The record could assist older patients in recalling treatments and services they had in the past, and thus provide them with the necessary knowledge needed to contribute to decisions about care in the future.

THE DESIGNATED PROFESSIONAL

The advantages of the liaison nurse model of discharge planning have been well documented. Other studies have found that a gerontological nurse or case manager responsible for coordinating the discharge plan and making referrals has resulted in: reduced readmission rates (Gatt and Taylor, 1973, Naylor, 1990); fewer unmet needs following discharge (Krommiga and Ostwald, 1987, Mamon et al, 1992) and better information provision from the hospital to community agencies (Kelly and McClelland, 1985, Jowett and Armitage, 1988). Findings from this study suggest that the liaison nurse model of discharge planning resulted in earlier commencement of services following discharge and fewer unmet needs in the

immediate post-discharge period. Thus the benefits of the liaison nurse model are clear in terms of discharge outcomes. But does the liaison nurse facilitate patient participation?

Findings from this study suggest that the role of the liaison nurse in British Columbia did not improve patient participation in discharge planning. This was largely due to time pressures. Although the liaison nurses attended multi-disciplinary team meetings, their role in discharge planning relied more on verbal and written information from other team members than from patients themselves. One liaison nurse was responsible for several wards in the hospital, and thus met patients only once or twice prior to discharge, in order to carry out an assessment. This assessment aimed to identify the patients' post-discharge needs, based on what other team members had reported and what the liaison nurse recorded when she met with the patient. This meeting could have provided a valuable opportunity for patients to express any concerns or ask questions. In reality, the opportunity was often wasted. Patients did not have detailed knowledge of the roles and functions of different professionals, and were unaware that the liaison nurse was responsible for making discharge arrangements. Only one of the Canadians in this study could correctly identify the liaison nurse as the person to whom questions about discharge arrangements should be directed. The liaison nurse assessment usually did not take place until discharge plans had already been drawn up by the multi-disciplinary team, meaning that her meeting with the patient was merely an exercise in confirmation or obtaining consent. Little or no active decision-making by the patient could take place during this meeting.

What was required in both the Scottish and Canadian wards in this study was an alternative form of professional/patient interaction. As other studies of older people and their relationship with health and social care staff have shown (Eustis and Fisher, 1991, Neill and Williams, 1992, Edelbank et al, 1995), and findings from this study support, older people are more likely to express their concerns and opinions to one clearly-identifiable individual with whom they are familiar. The patient entering a geriatric assessment and rehabilitation ward should be able to identify one professional with whom they can discuss any issue relevant to treatment in hospital or discharge planning. This person should be the 'designated professional'. This concept is not new. It is closely related to primary nursing, 'named' nurse or 'key worker' schemes. It was advocated in the National Health Service guidelines for good practice in discharge planning (NHS, 1992). Yet Tierney and her colleagues, in their review of 319 wards in Scotland, found that the concept

was not being implemented at ward level (Tierney et al, 1994). Neither ward in this study used designated members of staff to act as a contact person for patients.

The designated professional is one member of the ward team, whom the patient meets shortly after admission. This individual is responsible for co-ordinating the discharge plan of that patient. This co-ordinating role consists of explanation, confirmation and monitoring: explanation in that the designated professional is responsible for explaining the process of discharge planning to the patient, describing the various options available, and providing the patient with written and verbal information about treatment and services; confirmation in that this professional is responsible for soliciting the views and preferences of the patient, and conveying these views within multi-disciplinary team meetings (confirmation of the progress of the discharge plan following meetings should also be communicated back to the patient); and monitoring in that this professional is responsible for identifying concerns the patient may have throughout their stay in hospital, rather than just prior to discharge.

One of the Canadian nurses explained to the researcher that she perceived a gap in the relationship between patients and professionals on the ward. Although not advocating a specific change, she highlighted several reasons why responsibility for involving each older person in discharge planning should be adopted by one team member. She said, with reference to the patients in the unit:

"They are not children, they are not pets, they are adults who have made decisions all their lives, and I think sometimes that is not our main focus. I think maybe it should be somebody's responsibility to say, today we had a meeting and this is what happened in the meetings and we see you here, where do you see yourself?"

Communication between the designated professional and the patient is the key to facilitating participation in discharge planning. Regular communication can ensure that adequate information is provided to assist patients in making decisions for themselves. The designated professional can act as a link between the patient and discharge decision-making done in team meetings and meeting with carers. The concept of the designated professional is a simple idea that deserves further development and evaluation in the geriatric in-patient setting. It is equally applicable in Scotland and British Columbia, and would complement rather than compromise current practice. This reform has the potential to expand patient involvement in discharge planning, without imposing inappropriate and unwanted behavioural expectations on older people in hospital.

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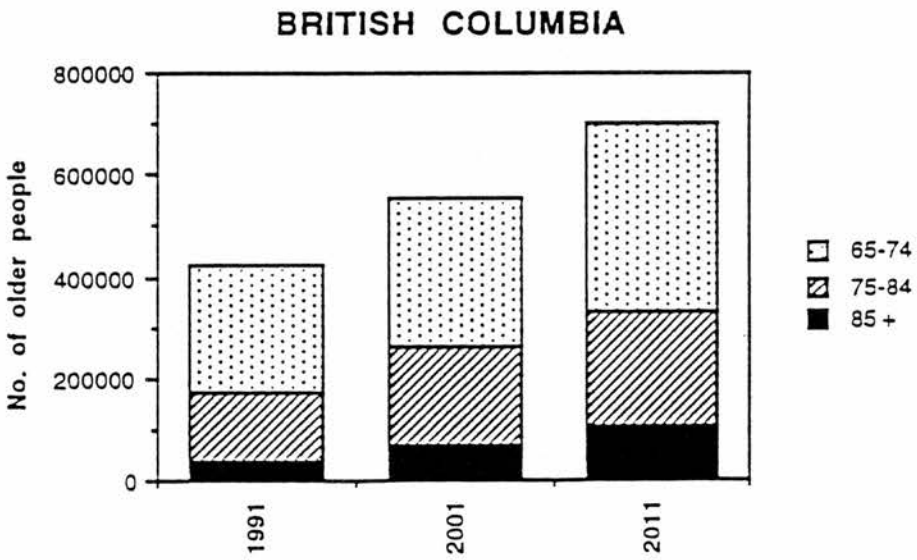
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APPENDIX 1: POPULATION FIGURES



APPENDIX 2: INTERVIEW SCHEDULES

OLDER PATIENT PARTICIPATION IN DISCHARGE PLANNING

FIRST PATIENT INTERVIEW

N.B. This interview schedule is to be used only after patients have been given the information sheet about the study, had the study explained verbally to them, been given the opportunity to ask any questions and signed the consent form.

TERMS USED ONLY IN BRITISH COLUMBIA APPEAR IN *ITALICS*

Begin the interview by emphasising that all information will remain confidential.

1. Previous experience of hospitalisation

1.1 Before you were admitted to the Eastern General/*Victoria General* this time, had you been in hospital at all in the last three years ?

(If this information is obvious from case records, begin the question - "I see you were in hospital in...")

1.2 If so, when?

1.3 Why?

1.4 Where? (geriatric unit?)

1.5 For how long?

2. Previous experience of discharge planning

2.1 Last time you were in hospital, can you recall being asked about the kind of help you might need at home after you were released from the ward? (if necessary, explain to interviewee what I mean by 'help at home')

2.2 If yes: Do you remember who asked you?(prompt: a consultant geriatrician, a nurse)

2.3 Did you feel you should have a say? Why?

2.4 When you were consulted, did you feel you had enough information to ask the doctors/nurses/others questions?

2.5 If no: Did you expect to be consulted?

2.6. Did you feel you should have had a say? Why? (or why not?)

3. Previous experience of aftercare

3.1 When you got home from hospital last time, did you receive help with any of the following?

	Yes	No
Dressing		
Bathing		
Managing pads (if incontinent)		
Taking medication		
Preparing meals		
Cooking		
Shopping		
Hoovering		

3.2 What kind and from whom?

	Tasks	Was it enough help?
Home Help		
Daughter/in-law		
Son/in-law		
Spouse		
Other relative		
Friend/neighbour		
Community nurse		
GP		
O.T		
Other		

3.3 Did you get any help that you didn't want or expect?

3.4 Did you feel your need for help changed after a few weeks at home? Was the help you were getting adjusted to this change?

3.5 In retrospect, do you think you should have asked for more or different help while you were still in hospital?

5. Outcome Expectation

5.1 Do you think your _____ (admitting diagnosis) has improved during this visit to the Eastern General/Victoria General? (tailor question to condition(s))

5.2 Why/Why not?

5.3 You must be wondering how things are going to be at home. Can I ask you, how well do you expect to cope? (if necessary prompt: The same as before you were admitted, Better than before you were admitted, Not as well as before you were admitted)

5.4 Do you feel anxious about coping at home? (if necessary prompt: Very anxious, Somewhat anxious, Not at all anxious, Anxious about one particular aspect of life at home)

5.5 Why?

5.6 If things do not go well at home and you have to be readmitted to hospital in the next few months, whose fault do you think it would be?

- a. Noone's - god's will/fate
- b. My own - have'nt taken good care of myself/take unnecessary risks
- c. The professionals - I was not given enough help in my home
- d. I don't get enough help from my family/friends
- e. I'm isolated - noone 'round about comes to check on me
- f. My house is inconvenient (I am anxious about the stairs and the bathroom)
- g. Other

5.7 How important is it to you that you have a say in planning the kinds of help you will need after your release from hospital?

5.8 Do you think being involved in planning will make a difference to your ability to cope at home?

5.9 Why/Why not?

6. Perception of staff attitudes to participation

Now I'd like to ask you some questions about talking to the staff here at the Eastern General/*Victoria General*.

6.1 During your stay in this ward, have you ever felt the need to ask any member of staff a question?

6.2. If yes, did you ask that question?

6.3 Who did you ask?

6.4 Is there any particular member of staff you feel is the easiest to talk to?

6.5 Why?

6.6 If you felt you were worried about anything while a patient here, who would you talk to?

6.7 While you are a patient here, if you had a question about help which you might need after you've gone home, would you know which member of staff to ask?

6.8 If Yes: Who would that be?
If no: Why not?

6.9 Do you think all members of staff here at the Eastern/*Victoria General* (prompt: list possibilities) are equally willing to listen to any questions you might have?

THANK INTERVIEWEE. CONFIRM THAT THEY HAVE THE INFORMATION SHEET.
CONFIRM THAT THEY KNOW THEY WILL BE INTERVIEWED ONCE MORE IN HOSPITAL
JUST BEFORE THEY ARE DISCHARGED.

SECOND PATIENT INTERVIEW

N.B. The following questions should be posed to patients as near to the discharge date as possible, the day before or on the day of discharge. Slightly different terminology is used in this interview schedule for patients in each ward. Word changes for B.C are in *italics*.

Begin by thanking the person for agreeing to the second interview. Explain that this is the last interview in hospital. Explain that the aim of this interview is to discuss what kinds of help they will need at home after they are released from hospital. Stress that the information remains confidential.

1. Activities of Daily Living

Could we start by discussing some of the everyday activities you do for yourself at home?

1.1 Think back to the period just before you went into hospital. Two weeks before you were admitted (or before you had your fall/illness began/you began to feel poorly), which of the following activities could you do alone, without assistance?

ACTIVITIES	no difficulty	some difficulty	considerable difficulty	unable
Eat your meals				
Have a bath/shower				
Move from the bed to a chair				
Move from the bed to the toilet				
Climb the stairs				
Managing pads (if incontinent)				
Get dressed				
Cut vegetables				
Do basic cooking				
Hoover / <i>Vaccum</i> the floor				
Go shopping				

1.1.0 Which of these activities did you have difficulty with after you became ill/had your fall?

1.2 During your first three days at home following release from hospital, which of the following activities do you think you will be able to do alone, without assistance?

ACTIVITIES	no difficulty	some difficulty	considerable difficulty	unable
Eat your meals				
Have a bath/shower				
Move from the bed to a chair				
Move from the bed to the toilet				
Climb the stairs				
Managing pads (if incontinent)				
Get dressed				
Cut vegetables				
Do basic cooking				
Hoover / <i>Vaccum</i> the floor				
Go shopping				

1.3 Now I would ask you to imagine how you will feel about one month after you have been released from hospital. Try and imagine what your health will be like and whether you think you will be able to do all the activities you could do before you were admitted to hospital.

Which of the following activities do you think you will be able to do alone, without assistance, one month after you have been released from hospital?

ACTIVITIES	no difficulty	some difficulty	considerable difficulty	unable
Eat your meals				
Have a bath/shower				
Move from the bed to a chair				
Move from the bed to the toilet				
Climb the stairs				
Managing pads (if incontinent)				
Get dressed				
Cut vegetables				
Do basic cooking				
Hoover / <i>Vaccum</i> the floor				
Go shopping				

1.4 Have you discussed any of the above activities with staff here at the Eastern General/Victoria General ?

Yes	
No	

1.5 If so, which activities?

Eating	
Bathing	
Getting out of bed	
Getting to a chair	
Getting to the toilet	
Climbing the stairs	
Getting dressed	
Cutting vegetables	
Doing basic cooking	
Hoovering/ <i>Vacuuming</i>	
Going shopping	

1.6 With which member of staff? [Note member of staff beside activity above].

2. Services in the Community

2.1 At home at any time during the first month following your release from hospital, do you think you will need any of the following?

	Yes	No	
Visits from your GP			If so, why?
Visits from a District nurse/ <i>community nurse</i>			
Visits from another professional (ie. PT/OT)			
Meals on Wheels			If not, why not?
Aids such as a stick or railings in your home			
Services to help you meet other people (ie. lunch club)			Which, if any?

If you answered 'no' to any of the above community services, has anyone mentioned that you might get one or more of these services anyway? if so, who mentioned this?

2.2 Do you think you will need a home help/*home support worker*?

Yes	
No	

If yes, what types of tasks would you like the home help/*home support worker* to perform?

2.3. Have you discussed any of the above needs with staff here at the Eastern General/*Victoria General* ?

Yes	
No	

2.4 If so, which needs?

GP visits	
Nursing visits	
OT/PT	
Meals on Wheels	
Aids	
Day centres/clubs	
Home help/ <i>worker</i>	

2.5 With which member of staff? [Note member of staff beside form of assistance above].

3. Instructions

3.1 Do you think you will need any advice or instructions to take home with you concerning:

	Yes	No
Nutrition		
Medication		
Activity		

3.2 If yes to activity, which type of activity?

Movement/exercise	
Personal care	
Social activity	
Housework	
Other (specify)	

3.3 Have you discussed this need for information with any of the staff here at the Eastern General/*Victoria General*?

Yes	
No	

3.4 If so, with which member of staff? [note staff member next to need for instruction above]

3.5 If the need has been discussed, have you received any literature or written instructions of any kind?

Yes	
No	

If yes:

What kind of instructions?	
Has anyone gone through them with you?	

If no:

Have you received any clear verbal instructions?	
--	--

4. Recognition of Professionals

4.1 If I asked you to identify the following members of staff on the ward, would you be able to do so?

- A. The physiotherapist?
- B. A nurse?
- C. The occupational therapist?
- D. An auxiliary/nursing aid? (*not applicable in B.C*)
- E. The social worker?
- F. The consultant/*ward doctor/geriatrician*?
- G. A junior doctor? (*not applicable in B.C*)
- H. *The nutritionist?*

THANK THE INTERVIEWEE.

MAKE TENTATIVE ARRANGEMENTS FOR THIRD INTERVIEW IN THE INFORMANT'S HOME ONE MONTH POST-DISCHARGE.

THIRD PATIENT INTERVIEW

Questions/words/phrases to be used only in British Columbia appear in *italics*.

N.B. The aim of this final interview is to determine to what extent the needs identified by the patient in hospital have been met by the implemented discharge plan. The patient will be visited in their own home or alternative setting if the discharge has not proceeded as planned. Retrospective opinions will also be sought concerning participation in planning and to what extent the patient believes it was adequate.

1.0 Immediate Discharge Arrangements

1.1 Do you think you were discharged too early/at the right time/too late? Why?

1.2 Thinking back to the day you were discharged from the Eastern General/*Victoria General*:

1.2.0 How did you come home from hospital (prompt: by ambulance, by taxi, with a friend/family member)

1.2.1 Was anyone in the house when you came home?

1.2.2 Did you receive a visit from anyone (else) the day you came home?

If no: who was your first visitor and when did they visit you?

1.2.3 Did someone prepare food for you the day you came home from hospital?

1.2.4 Had the heating been turned on in the house/flat when you came home? (*not applicable in B.C*)

2.0 Realisation of Discharge Referrals

2.1 From the discharge checklist/*list of services complied from case records*, ASK if the promised services have appeared. These services will vary from patient to patient.

2.2 Ask: When the service appeared

2.3 How often the service (Home Help, Community nurse etc.) has come since then.

2.4 What tasks the service is carrying out for the older person

2.5. If these are the tasks that the older person wanted done for them

2.6 If the service is what the older person expected (if not, why not)

2.7 Has the service that has been provided been entirely adequate, fairly adequate or inadequate?

2.8 Has any service that hospital staff discussed with you not appeared as planned? Have you received any service you didn't expect?

2.9 Has your GP been to see you? (should have been if hospital alerted him/her of discharge)

3.0 Satisfaction with the discharge plan

3.1 All in all, how satisfied are you with the arrangements the hospital has made for you at home? (not at all satisfied, somewhat satisfied, satisfied, very satisfied)

(explore satisfaction with individual services if not covered by questions in 2.0 above)

4.0 Predicted ability to cope

4.1 When you were in hospital one month ago and I interviewed you, you may recall that I asked you how well you thought you'd be able to do certain activities at home. Can I just ask how you are coping with these?

[at this point refer to filled in table from second interview which asked the interviewee to predict how well they envisaged they would be able to do certain activities four weeks following discharge]

From second interview: Which of the following activities do you think you will be able to do alone, without assistance, one month after you have been released from hospital?

ACTIVITIES	no difficulty	some difficulty	considerable difficulty	unable
Eat your meals				
Have a bath/shower				
Move from the bed to a chair				
Move from the bed to the toilet				
Climb the stairs				
Managing pads (if incontinent)				
Get dressed				
Cut vegetables				
Do basic cooking				
Hoover /Vaccum the floor				
Go shopping				

Addition to table: How is your mood?
How are you managing your medication?

4.2 In your opinion, are you coping better/worse/much the same as you expected one month after your hospitalisation?

4.1 These activities you are still having difficulty with (see table above), can you imagine any way that they could be made easier?

4.2 Of the activities that you still have difficulty with, did you mention any of them to staff while in hospital?

If no. are there any problems that have cropped up at home that you didn't expect?

4.3 How were your first three days after coming home, any problems of any kind right away?

5.0 Information and Choice

5.1 Do you still think that home is the best place for you to be?

5.2 Do you remember anyone discussing any other alternatives with you while you were in hospital?

5.3 Is there anything you wish you'd been given more information about by hospital staff?

5.4 Is there anything you wish *you'd* asked the hospital staff while a patient? If so what?

6.0 Family/Carer involvement

6.1 Do your family/friends agree with the Home Help/District Nurse/Day Hospital/*PT visits*/other service that you are now receiving?

6.2 Have any of your family/friends indicated to you that they think the hospital should have arranged anything else?

6.3 Do you think your family/friends are unhappy or worried about anything at all to do with you since you have returned home? (if so what, if no, why not)

6.4 Are your family/friends doing any extra jobs/tasks for you now that they did not do for you before you went into hospital? If so, what?

7.0 Degree of Hope

7.0 When you were in hospital, how hopeful would you say you were for the future at home?

7.1 How hopeful are you now?

THANK THE INTERVIEWEE. REMIND THEM THAT ALL INFORMATION THEY HAVE PROVIDED IS CONFIDENTIAL. INFORM THEM THEY WILL BE WELCOME TO SEE COPIES OF INTERVIEW TRANSCRIPTS.

THEMES FOR STAFF INTERVIEWS

Begin interview by explaining that many of these questions ask the respondent to make generalisations, which may at times be difficult to do. Also explain that some questions refer to elements of wards routine/practice that the researcher already knows about /is aware of but would like on tape for the sake of comparison with patterns of practice in the alternative research setting. Emphasise that all information is confidential and that they will not be identified by name in the final thesis.

All terms used only in British Columbia are in *italics*

1. Background

Begin by asking staff about details of their professional background. Also obtain a brief job description of their activities in the ward.

2. The Discharge Planning Process

2.1 What do you see as *your* primary responsibilities in the discharge planning process?

2.2 What do you see as the patient's role if any?

2.3 What would you describe as some of the most common causes of delayed discharge?

3. The Discharge Checklist (Scotland only)

3.1 Could you tell me bit about the history of the discharge checklist used in this Ward ?

3.2 What do you see as the purpose(s) of the protocol?

3.3 Do you think it serves its purpose?

3.4 What is your opinion of the protocol? Can you think of any way that it can be improved?

3.5 Is there anything missing from it ?(like a box for a pharmacist)

3.6 Do you think patients always get their copy of the protocol? Do you think it is useful/valuable/important that they do? Do you ever think that providing the patient with their copy might confuse/upset them/add to stress of discharge?

3.7 Do you think that services written on the protocol always materialise when the patient is at home? [prompt with specific examples of this not happening if necessary] If not why not?

4. Teamwork

- 4.1 Do you think the staff in this ward work well as a team?
- 4.2 What do you see as the purpose of the weekly/*bi-weekly* team meetings?
- 4.3 Do they serve that purpose?
- 4.4 What is your opinion of the way the meetings are conducted, do you think everyone's opinions are heard equally? Are you comfortable with the routine of decision-making? Do you always feel free to express your point of view?
- 4.5 Do you think the way they are conducted is an effective method of discharge planning?
- 4.5 Do you think the patient's views are represented in the team meeting? If so, by which professional Why/How?
- 4.6 Do you think carers views are represented at the case conference? If so, by whom?
- 4.7 Would you describe the team meeting as the forum for discharge planning, or do you think discharge decisions are made elsewhere/at another time? If so, when and by whom?
- 4.8 In general, can you think of any ways that team meetings could be improved?

5. Other Professionals

- 5.1 Would you describe any one professional as more involved/responsible for discharge planning than others?
- 5.2 You have described your discharge planning responsibilities. Do you think other staff would agree that these are your responsibilities? Do you think all other staff are clear about what their role is in the process? How clear are you about what other staff do?
- 5.3 Can you give me any examples of instances where crossed lines of communication have resulted in necessary discharge arrangements not being made?
- 5.4 If patients had a question about anything to do with their continuing care at home, who do you think they would ask?
- 5.5 Do you think patients can differentiate between different types of professionals on the ward? Who might they have problems identifying and why?
- 5.6 Of all the staff, whose responsibility is it to determine, to the best of their ability, what the patients wishes are?

6. Community Services

6.1 Do you have any direct contact with professionals in the community? Please respond yes or not to the following professionals:

- a. GP
- b. Community Pharmacist
- c. District Nurse/*community nurses*
- d. Health Visitor (Scotland only)
- e. Home Care Organiser (Scotland only) *Community Long Term Care Managers?*
- f. Community Social Worker
- g. Community OT
- f. Community Physio
- g. Voluntary Organisations

Concerning those professionals you said yes to, how is this contact **formally** organised and what form is it supposed to take/consist of?

What form does this contact take/consist of **in practice**?

How often would you have contact with this professional in one week on average?

6.2 How would you describe hospital/community contact in general in this area?

6.3 Can you give me any examples of a communication breakdown that has led to a delayed discharge?

6.4 (question for medical staff only if not answered by questions above) Can you describe how contact with General Practitioners is conducted? How are GPs informed of discharge/when is letter sent/is letter ever given simply to the patient?

7. Information

7.1 How valuable do you think written information is to elderly patients in general?

7.2 Do you think patients benefit from access to written instructions about:

- a) nutrition
- b) activity/exercise/mobility
- c) medication
- d) community services, such as home care/*home support* leaflets?

(if so , why - if not, why not)

7.3 Do you think verbal instructions are as valuable/more valuable /less valuable than written instructions? Why?

7.4 Have you ever felt that patients have been afraid to ask questions because of fear of appearing ignorant?

7.5 Do you ever feel that patients might have asked questions if they had more information?

8. The Concept of Participation

8.1 In general, how willing do you think patients are on this ward to ask questions?

8.2 What types of circumstances might prevent them from asking questions?

8.3 What factors in your opinion might make elderly patients less willing to participate than their younger counterparts?

8.4 Do you ever feel that you are coercing reluctant patients into involvement in planning when they would rather someone else made the decisions for them?

8.5 In your professional experience, do you think patients in general are now more actively involved in dealing with their problems and planning for solutions than they were in the past?

8.6 Do you think there is a formal policy in this ward of involving patients in decision-making? Can you tell me about that policy? What do you think of it? Is it too ambitious? Do you think you do more or less than the formal policy as far as involving patients in decision-making is concerned?

8.7 We hear the phrase "patient participation" thrown around a lot these days. For the sake of definition, what do you think that phrase means in this ward?

9. The Older Patient

9.1 In your experience, how realistic do you think most patients are about their rehabilitation prospects at home?

9.2 If you had two patients with exactly the same condition, do you think in general, that a more verbal, proactive and involved patient has a better chance of coping well at home than one reluctant to make decisions for him/herself? Or do you think it makes no difference?

9.3 Do you ever find it necessary to calm patient anxiety about coping at home? What techniques do you use?

9.4 If you have the impression that a patient is lonely and isolated at home, what course of action do you take?

9.5 Are there patients that you find it more difficult to work with than others? What would you say were some of the characteristics of a patient who is difficult to work with? In general are many patients difficult?

9.6 If you wanted to convince a difficult patient of something, and were making no progress yourself, who would you call to do it?

Finish Interview by asking any specific questions related to the professional's specific role on the ward (ie. Scottish consultant and description of carers' evenings). Finish by thanking the respondent. Repeat that all information is confidential. Inform them that they have a right to review a transcript of the interview. Take a note of their home address. Make sure they have the University of Edinburgh Department of Social Policy sheet with researcher's address on it.