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Factors influencing Western Australian clinical registered nurses in discharge planning

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FACTORS INFLUENCING WESTERN AUSTRALIAN CLINICAL REGISTERED NURSES IN DISCHARGE PLANNING

By

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Abstract

A descriptive quantitative study was conducted to determine what factors nurses considered when discharge planning, and how these factors compared with factors identified in the literature as being effective in planning for discharge.

This study was undertaken because with the intended Prospective Payment System (PPS) of funding to hospitals, it is essential that Western Australian Clinical Registered Nurses are able to prepare patients for discharge effectively to prevent the financial burden of cost outliers and re-admissions.

Anderson and Steinberg (1984) in their studies of factors that influence the cost of hospital care for the elderly, found that the results of inappropriate and premature discharges resulted in a 22% readmission rate within 60 days of discharge for all Medicare hospitalisations. Their (1988) study of readmission rates of Medicare beneficiaries between 1974 and 1977 showed that the added costs associated with readmissions cost the U.S. government more than US$2.5 billion per annum. It would seem probable that such a system introduced into the Australian health care system will have the potential to produce similar effects for Western Australian patients, nurses and nursing.

A questionnaire designed by the researcher was sent to 400 randomly selected Western Australian Clinical Registered Nurses employed in country, metropolitan, public and private hospitals to survey their discharge planning processes. The establishment of a list of factors which influence nurses' discharge planning, has made it possible to draw comparisons with accepted models of discharge planning to establish the efficacy of the discharge planning process in the local context. Data were analysed using descriptive statistics and *t*-tests to examine the relationships between the variables of nursing location, type of nursing education, length of clinical experience and the influence of their work context.

Findings showed that nurses considered a total of 62 factors when planning for discharge, with the number of factors considered by individual participants varying

from 0 factors to 16 factors. The findings also revealed that there were no significant differences between the independent variables, and that the factors currently considered by Western Australian Clinical nurses, whilst being similar to those found in the literature, were not as complete. The study identified only one nurse who identified factors in nine of eleven identified groups of factors with the majority of respondents considering between three and six groups.

Recommendations are directed towards cost implications, education and evaluation strategies.

Declaration

"I certify that this Thesis does not incorporate without acknowledgment any material previously submitted for a degree or diploma in any institution of higher education; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text."

Signature: 

Date: 10th October, 1995

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Chapter One

Introduction

This study was designed to look at how Western Australian nurses develop nursing discharge plans, in particular, what factors they consider when planning patient discharges. Discharge planning is a process which should be part of the everyday practice of nurses who provide bedside care for patients. In the past, discharge planning has not enjoyed a place of prominence or priority in the provision of patient care (Williams, 1991). However, this is likely to change as Australian health authorities prepare to follow the lead of American systems of hospital admission and discharge.

In the United States of America (U.S.A.) in 1983, discharge planning moved from being a minor facet of patient care to a position of prominence; a change which was attributed directly to the introduction of Prospective Payment Systems (PPS) based on Diagnosis Related Groups (DRG's) (Iglehart, 1990). In 1993, the Australian Government introduced a modified form of the U.S.A. developed DRG, Casemix and PPS into the health care system. Because of effects reported in the U.S.A., it would seem probable that such a system introduced into the Australian health care system will produce similar effects for Western Australian patients, nurses and nursing; that is, a reduction in the number of patients who exceed the mean length of stay, a reduction in admission rates and an increase in the need for discharge planning appropriate to client needs (Bull, 1988; Schlemmer, 1989). It is therefore envisaged that the prominence of the discharge planning process will increase, relative to other nursing activities.

Background to the Study

Rising health care costs, running at 8.4% of the Gross Domestic Product (GDP) in 1992 (Institute of Public Affairs) have placed financial pressure on the Australian government and hospitals. In response to this pressure, the Australian government is introducing Australian National Diagnosis Related Groups (AN-DRG's) as a Casemix system for acute care hospital funding. Casemix is the frequency of patients falling into case types according to some predetermined characteristic such as a DRG. Patients admitted to acute care hospitals will be allocated a length of stay (LOS) related to a DRG. A standard payment rate will be set for each DRG. This means that hospitals will be reimbursed according to the LOS allocated to a DRG. If the patient is discharged from hospital prior to their allocated LOS, the hospital will make a profit. If patients overrun their allocated LOS and incur a cost outlier, which exceeds the payment rate set for the DRG, the hospital will have to carry the additional cost (Trofino, 1989).

Cost outliers are defined as those cases in which hospital stay falls outside the 'trimpoints' or designated variance for that DRG. When this occurs, funding reverts to the per diem method until the patient is discharged or dies; that is, hospitals will be paid a previously set daily rate for the patient regardless of diagnosis or resources utilised (Joel, 1984; Cuthbert, 1986). As a consequence, hospitals may lose money because the outlier funding will be based on the per diem method rather than the PPS driven medical resource usage for the extra days the patient is hospitalised. Cost outliers will also prevent other patients from utilising beds, exacerbating the problems associated with bed shortages. There will be increased pressure on nurses who care for patients in acute care settings to plan discharges effectively, as lack of effective discharge planning will result in an increased number of cost outliers. A further problem relates to readmissions. Thompson (1985) and Rehr (1986) claim that when discharge planning has been inadequate, readmissions have been more frequent, resulting in a burden for both the patient and health care service.

Significance of the Study

Despite some Western Australian hospitals having Admission and Discharge policies, Williams (1991) reports that discharge planning usually occurs on an ad hoc basis, and some planning practices are largely ineffective. With the intended Prospective Payment System (PPS) of funding to acute care hospitals, it will no longer be acceptable for nursing discharge planning to continue on an ad hoc basis. It is essential that Western Australian nurses are able to prepare patients for discharge effectively to prevent the financial burden of cost outliers, and to maintain or improve quality of nursing care, including reducing the likelihood of readmission.

Establishing a list of factors that influence nurses' discharge planning, will make it possible to draw comparisons with accepted models of discharge planning to establish the efficacy of the discharge planning process of Western Australian nurses. The list will provide a framework on which to plan education needs to ensure the effectiveness of future discharge plans "... and to assure a comprehensive approach to easing the patient's transition from unit to unit within the hospital, from hospital to other care facility, or from hospital to home" (Thompson, 1985, p. 51). By identifying these factors it should be possible to prepare future nurses to develop discharge plans which are advantageous in reducing the cost of hospital stay, allowing more efficient utilisation of beds, and a more effective utilisation of hospital resources as well as improving patients' quality of life. The criteria for effectiveness is based on improved patient care and education, increased patient satisfaction, decreased length of inpatient stay, reduced avoidable readmission rates, increased hospital throughput decreasing waiting lists and reduced variance of inpatient day stay for patients with the same DRG (Williams, 1991).

This study is reported in the hope that it will encourage Western Australian nurses to examine their discharge planning practices, to develop nurses' professional role and to foster their collaborative role with other health professionals to better care for patients and their families.

Purpose of the Study

The purpose of this study was to investigate what factors Western Australian Clinical Registered Nurses working in acute care hospitals currently consider when planning patient discharges, in order to meet patients' needs and maintain or reduce hospital expenditure in preparation for the introduction of PPS and DRG's.

Research Questions

The research questions addressed in this study are:-

1. What are the factors influencing Western Australian Clinical Registered Nurses in discharge planning?
2. How do the factors influencing Western Australian Clinical Registered Nurses compare with factors identified in the literature as being effective in planning for discharge?
3. Is there a difference in the factors considered for planning patient discharges between:-
    (a) metropolitan and non metropolitan Registered Clinical Nurses?
    (b) tertiary and hospital educated Registered Clinical Nurses?
    (c) length of clinical experience?
    (d) work context?
4. What factors are considered to enhance the discharge planning process?
5. What factors are considered to impede the discharge planning process?

Definition of Terms

Western Australian Clinical Registered Nurse -

A Western Australian Clinical Registered Nurse is defined as any nurse who is currently registered with the Nurses Board of Western Australia and is employed as a Level 1 or Level 2 nurse under the terms of the State Career Structure, with the exception of Level 2 Area Managers. Level 1 and level 2 nurses have been selected for the study as they are most representative of direct care givers .

Discharge Planning -

"The part of the continuity of care process which is designed to prepare the patient for the next phase of care and to assist in making any necessary arrangements for that phase of care, whether it be self-care, care by family members or care by an organised health care provider" (American Nurses' Association, 1975, p. 10).

Diagnosis Related Groups -

DRG's are a classification system for medical diagnoses and procedures that group patients who are clinically and resource homogenous (Nelson, 1991). In other words, patients who are admitted to hospital for the same procedure, or with the same medical diagnosis, are allocated the same DRG. "The DRG classification system ... groups patients according to 23 major diagnostic categories (MDCs) ... organised by body systems and disease aetiology." (Cuthbert, 1987, p. 46). The AN-DRG grouping process generally involves four stages with the principal diagnosis (PDX) being used to assign the episode of care to one of the 23 major diagnostic categories. Then the episode is classified as being medical or surgical, followed by a sub grouping based on the precise surgical procedure performed or, for medical patients, the precise condition designated as the principal diagnosis. Age or the existence of a complicating diagnosis usually decides the final DRG allocation (South Australian

Health Commission, 1993, p. 2). The information required to allocate the DRG is usually obtained from each patient's records ... following the patient's discharge. " (Cuthbert, 1987, p. 46).

Prospective Payment Systems -

PPS is the total payment a hospital receives from the government for a specific DRG (Smeltzer & Flores, 1986A). A length of stay (LOS) is allocated to each DRG, and a payment rate set for that length of stay. For patients who remain in hospital for more than 20 days or 1.94 standard deviations from the mean, whichever is smaller, the hospital is reimbursed on an average daily rate for that DRG (Cuthbert, 1987). If the patient is discharged from hospital prior to their allocated LOS, the hospital makes a profit. If the patient overstays his/her allocated length of stay, the situation become a cost outlier, and the hospital has to carry the additional cost (Trofino, 1989).

Casemix -

Casemix refers to the frequency of patients falling into case types according to some predetermined characteristic, in this instance, DRG or the distribution of the hospital's inpatients among various DRG's (Williams, 1991; Nelson, 1991, p. 4).

Effective Discharge Planning -

Refers to constructing a plan for the patient's discharge which takes into account the following factors; patient care and education, patient satisfaction, length of inpatient stay, avoidable readmission rates, increased hospital throughput decreasing waiting lists and reduced variance of inpatient day stay for patients with the same DRG (Williams, 1991).

Cost Outlier -

Refers to those costs which exceed the payment rate set for the DRG, based on length of stay.

AN-DRG's -

A DRG system developed to more accurately reflect clinical practice in the Australian health care environment. AN-DRG Version 1 was released in July, 1992 and Version 2 in July, 1993 (South Australian Health Commission, 1993).

Organisation of the Thesis

The next chapter reviews the literature related to DRG's and discharge planning, and the role of discharge planning as a cost containment measure. The theoretical framework selected to guide this study is discussed and illustrated. The results of the data analysis are presented in Chapter 4. Chapter 5 discusses the findings of the study, and the thesis closes with the summary, recommendations for the future and limitations of the study in Chapter 6.

Theoretical Framework

Von Bertanlanffy's (1952) 'general systems' theory provides the conceptual framework for this study. As the theory is broad in scope it lends itself well to interpretation. Von Bertanlanffy based his 'general systems' theory on the assumption that a system is made up of a set of interrelated parts, (inputs, throughput, outputs, and feedback), which function together as a whole to achieve a common purpose. "The open system uses and effectively integrates the skills and contributions of all health care professionals, is responsive to change, is an open exchange of ideas and input is encouraged as is feedback" (Zarle, 1985, p. 12).

According to Zarle, (1987) general systems theory is an analytical framework that guides observations yet avoids observations based on only one component or element. Whatever is observed or studied is not a single entity but a collection of interacting components in operation at the same time. These components have to be

planned, arranged, maintained or managed and therefore, many techniques are needed to see the interrelationships that exist between all the elements (p. 11).

These interacting components can be equated to the nursing process of which planning is an essential component. These nursing inputs / stimuli based on a continuing nursing assessment of individual client needs, then become the input or stimulus that generates the actions or interventions (throughputs) required to achieve the desired outcomes for the patient. Feedback into the system provides a measure of the effectiveness of the discharge. Within the framework, communication between the input and the throughput stages is a two way process. However, between the throughput and the output stage, communication flows out of the system and only re-enters via feedback as a new input (see Figure 1).

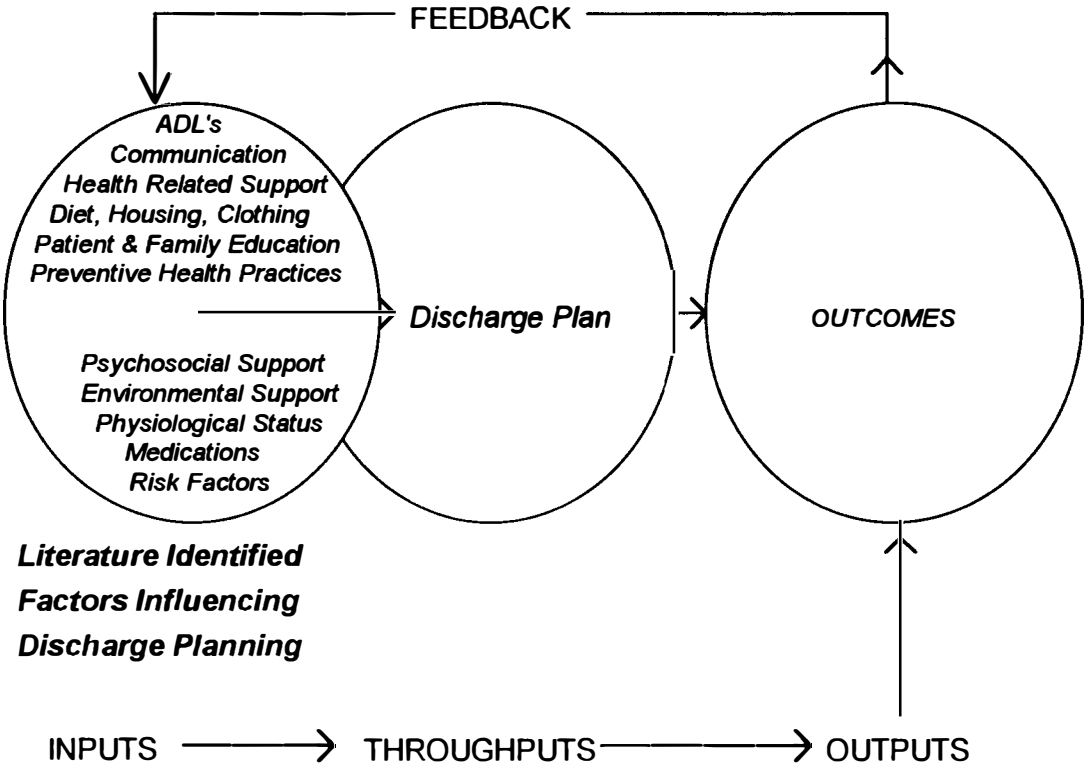

Figure 1. Discharge Planning Model.

This open system offers the patient a choice of services and supports from several health care disciplines. The system also permits professional contribution from many different health groups, all of them expected to assume responsibility and accountability for their services to the patient.

The influencing groups of factors which constitute the inputs in the above model are based on those factors identified as being considered by Western Australian Clinical Registered Nurses in the study sample when planning a patient discharge.

In summary, the open patient centred model is presented as a model to guide analysis.

Chapter Two

Review of Literature

This literature review has two purposes. The first is to establish current trends and opinions on Prospective Payment Systems, Diagnostic Related Groups, their impact on discharge planning and to identify the current state of knowledge on the subject. The second is to examine the role of nurses in discharge planning.

DRG's and Their Effect on Discharge Planning

On October 1st, 1983 the United States of America (U.S.A.) Congress legislated that all hospitals would be reimbursed prospectively for Medicare patients. Hospitals had previously been reimbursed by third party payers, by the per diem method (Trofino, 1989), whereby the hospital was paid a fixed daily rate for each patient regardless of diagnosis and resource intensity. This change in funding was an attempt to control and/or reduce the spiralling cost of health care by making hospitals more accountable for the services they provided (Bull, 1988; Mitty, 1987).

Nursing literature from the U.S.A. reports many changes affecting nursing, nursing practice, and nursing management, since the introduction of DRG's. Changes within the U.S.A. health care system have forced hospitals to address two objectives: reduction in the number of patients who exceed the mean length of stay, and reduction in readmission rates in order to reduce expenditure. Serious attention has been brought to bear on the process of discharge planning in response to federal pressure to reduce length of stay, whilst still providing continuity and appropriate levels of care (Schlemmer, 1989).

Bull's 1988 study on the influence of DRG's on discharge planning, professional practice, and patient care found that DRG's had a critical influence on discharge planning and that DRG's were expected to promote earlier discharge.

Since the inception of DRG's in the U.S.A., critics have questioned the consequences on quality of care and suggest that patients are being sent home prematurely without appropriate home care (Friedland, 1983). This criticism was supported by the Senate Special Committee on Aging, 1985B, (cited in Dobrof, 1991) which reported that many seriously ill patients are inappropriately and prematurely discharged. Anderson and Steinberg (1984) in their studies of factors that influence the cost of hospital care for the elderly, found that the results of inappropriate and premature discharges resulted in a 22% readmission rate within 60 days of discharge for all Medicare hospitalisations, with more than 5% occurring within five days of discharge. Their (1988) study of readmission rates for 270,266 randomly selected Medicare beneficiaries showed that between 1974 and 1977, 22% of Medicare hospitalisations were followed by a readmission within 60 days of discharge. This readmission rate accounted for more than U.S. $2.5 billion per annum in added costs or 24% of the total Medicare inpatient expenditure.

Whilst earlier discharges can be seen as a plus for hospitals and health funders there are many who believe that there will be negative effects created by patients being discharged from hospitals too early in order to meet lengths of stay allocated under DRG's. Sandra Friedland quoted in the New York Times (1985, p. 1) stated that "The agency that monitors the care of Medicare beneficiaries in New Jersey is concerned about the possibility that patients are being sent home too early."

According to one American Medical Examiner, "there has been an increase in the number of patients who have died or suffered relapses soon after release from a hospital. He said he suspected some cases were linked to early discharges or a lower quality of care under DRG" (Triebenbacher, 1985).

Study findings by Davis, Anderson, Renn, Rowland, Schramm and Steinberg (1985) which looked at Hospital Utilisation and Costs over the period 1981 - 1984 and based on national data from the American Hospital Association, indicate that the lengths of stay for Medicare patients decreased following the introduction of DRG's.

According to Schrager, Halman, Myers, Nichols and Rosenblum (1978), research findings on patients' length of stay in relation to the effect of discharge planning have been inconsistent. Cable and Mayers compared the annual median length of stay by diagnosis, at several hospitals, two years before and two years after the implementation of a discharge planning program. The results demonstrated that the effects of discharge planning on LOS were not consistent (Cable & Mayers, 1983). Interestingly, a 1986 study of 39 staff nurses and 39 nurse administrators conducted by Marchette and Holloman, which looked at variables affecting LOS found that when nurses were educated to perform discharge planning, the LOS was decreased by 0.8 days per patient.

Findings of a national American study conducted by Davis and Anderson et al (1985) based on data collected from the American Hospital Association indicate that the lengths of Medicare patients' hospital stays decreased following the implementation of DRG's. Given the decrease in hospital stay that DRG's are reported to have brought about, it may be anticipated that discharge planning will become of increasing importance to patients, care givers, care facilities and the providers of health care dollars.

In 1993, the Australian government introduced a modified form of the American system of DRG's into the Australian health care system under the title Australian National Diagnosis Related Groups (AN-DRG's). The introduction of AN-DRG's into the Australian health care system was for similar reasons that the U.S.A. introduced DRG's in 1983. According to Irurita, the introduction of the American DRG system into the Australian health care system was "an attempt to contain/decrease expenditure estimated at 7% of the Gross Domestic Product, maintain current health standards and improve outcomes" (1987, p. 154). In June, 1994, the Honourable Dr Carmen Lawrence, Australian Federal Minister for Health was reported in the Australian Financial Review as saying that "We've kept [health spending] around 8% [of gross domestic product] for about a decade and that is where I intend to keep it" (p. 5). However, according to the Institute of Public

Affairs, (1994) Australia's health spending already exceeds 8% of the GDP. "At 8.4% of GDP in 1992, Australia's expenditure on health was slightly above the [Organisation for Economic Cooperation and Development's] OECD average of 8.2%" (p. 1).

To this end, two of the critical problems which will face Australian health care services with the introduction of DRG's will be discharge planning and the continuity of patient care. Beale and Gulley claim that health care workers "should be concerned not only with maximum utilisation of hospital resources and follow up services in patient care, but also with ensuring the highest optimal functioning of the individual within his home and society" (1981, p. 713).

The Process of Discharge Planning

"Discharge planning is a current term for a concept that is a foundation of nursing: continuity of care" (Shine, 1983, p. 403). Kromminga and Ostwald, (1987) see discharge planning as a critical step in the nursing process which focuses on establishing a plan to meet the needs of patients who are moving from one stage of care to another. It is further defined as "a series of planned events that occur in order to prepare the patient for the orderly transition from one setting to another, whether it be institutional or community" (Povse & Keenan, 1981, p. 27). More importantly Hickey and McKenna see the goal of discharge planning as being able to move the patient smoothly from one level of care to another without losing or sacrificing the progress already made (1983). Iglehart (1990) contends that the discharge planning process is the same, regardless of the department or discipline in which it is located.

According to Barry (1983) there are six variables on which discharge planning is dependent; illness severity, expected health care outcome, anticipated duration of care, establishing actual and anticipated needs, availability of community resources, and the ability of significant others to be dependable. Keblusek (1989) suggests there are seven variables on which the discharge planning process is dependent. These are

physical, mental, financial, and psychosocial needs, the patient's current condition, anticipated status post hospital, and anticipated post hospital needs.

Kitto and Dale (1985) found little available literature with regard to utility, practicality or efficiency of discharge planning instruments. To this end, they developed their own discharge planning screen which was derived primarily from a list of 37 generally accepted nursing care problems. Their tool / inventory was based on Gordon's (1982) format of nursing diagnosis and on a psychosocial problem list from Spano's (1983) Staff Effort Accounting System used extensively by Social Workers. The discharge screen thus included item listings that encompassed all headings of both the nursing diagnosis and social work problem lists.

The discharge plan consisted of five broad categories which incorporated 27 areas of functional needs. These groups were headed Social Support, Psychosocial, Behavioural, Home Environment and Health. The screen lists groups to be assessed rather than specific problems and allows the discharge planner to review each group as superficially or extensively as considered necessary.

Slevin (1986) and Huey, Kiernan, Loomis, Madonna, Owen, Quaife, and Rosson (1981) suggest that the METHOD system (Medications, Environmental, Treatment, Outpatient referral and Diet) was sufficient to meet the requirements for developing an effective discharge plan. This suggestion was based on a study by Slevin of first semester senior student nurses at Bradley University in Illinois who used the METHOD system more frequently than any other developed discharge plan to demonstrate effective plans for discharge.

Criteria for assessing preparation for discharge have also been addressed by Steele and Sterling (1992) who see Acting and Doing for, Guiding, Supporting (physically and psychologically), Providing a developmental environment and Teaching as the broad groups which generate an effective discharge plan.

There is little published research on patients' discharge needs for information or referral, or their satisfaction with the discharge process. The consumer survey studies of Conger & Snider, (1982); Lindenberg & Coulton, (1980); Rosenthal &

Miller, (1979); Shamansky, Boase, & Horne, (1984) show little evidence to suggest that discharge planning programs are meeting the needs of consumers.

Inui, Stevenson, Plorde and Murphy (1981) claim that discharge planning is advantageous because it reduces the costs of hospital stay and facilitates more efficient bed utilisation. However, research findings in the U.S.A. regarding the effect of discharge planning on length of stay (LOS) have been inconsistent (Cable & Myers, 1983; Schuman, Osteld & Willard, 1976). The concept of discharge planning is not new to professionals and historically, nurses have been involved with organising appropriate discharge arrangements on behalf of patients. There is an abundance of literature on discharge planning studies mainly from the U.S.A. and the United Kingdom. These have emerged as a result of the DRG implementation and reflect the search for an ideal model for discharge planning that will meet both the needs of the patients and ensure effective resource utilisation. In order for a discharge plan to be considered effective, Schlemmer (1989) states it must demonstrate a reduction in the number of patient relapses, readmissions, and unnecessary visits; help families/patients understand aftercare; improve public relations; cut the cost of health care; and decrease the length of hospital stay.

In Australia, discharge planning is emerging as an integral and important component of overall patient management as a result of increasing health care costs, and the subsequent need to reduce long term acute hospital stays (Williams, 1991). A pilot study on Discharge Planning by Williams which involved 141 subjects, found that while there were some excellent examples of discharge planning, it was evident that there was room for overall improvement in discharge planning procedures from hospitals. Further, she states that education of health care professionals is a major area requiring attention in order to help them acquire the skills in implementing discharge planning that would achieve appropriate patient care outcomes in a timely manner (p. 4). Fritsch-deBruyn and Cunningham (1990) in their study of 78 American nurses' knowledge and sense of responsibility for discharge planning,

support this statement, reporting that nurses' knowledge and skills relative to discharge planning are under developed.

Discharge Planning - Whose Responsibility?

According to Rutkowski (1985) doctors control the admission of patients but nurses generally control the patient's discharge, as it is their nursing and coordinating skills which determine when a patient is ready to leave hospital. Much of the work carried out by nurses is influenced by the admitting policies of doctors and their prescribing practices, but both nurses and doctors must work co-operatively to ensure that patients are nursed using the most economical means and are discharged in the shortest possible time.

Beale and Gulley (1981) report that, historically, nurses and social workers have been identified as the key hospital personnel responsible for the implementation of discharge planning. According to Schlemmer (1989, p. 88B), "Nurses have been identified as the key coordinators for discharge planning." Schlemmer argues that nurses are members of a discipline that has 24 hour accessibility to patients, are experienced in working with patients and families, possess a knowledge of community dynamics, and they have a body of nursing knowledge. Cooke and Alley, (1992), in a study of 20 hospitals in Virginia, U.S.A. to determine responsibility for discharge planning, found that 70% of the respondents believed that the responsibility for referring discharge planning needs to appropriate sources, belonged to the staff nurse. In relation to patient pre discharge teaching, 25% believed the patient educator was responsible, 20% the primary nurse and 40% believed it was the responsibility of the staff nurse. The findings of this study indicate that nurses accept responsibility for identifying clients with discharge planning needs and referring them to the appropriate sources; however the system breaks down at this point with inconsistent teaching of nurses and follow up of discharge outcomes. Nurses as discharge planners need to be taught how to develop, implement and facilitate the discharge process, to be

knowledgeable about the continuum of services available in the community and how to follow up and analyse discharge outcomes.

From the published literature it would appear that there is some degree of competition between disciplines in relation to discharge planning, namely, between nurses with a focus orientated towards the individual patient and social workers with a bias towards families and systems (Rehr, 1986). Despite this rivalry, most researchers contend that nurses are best prepared for the role of discharge planning, although there is much support for a collaborative approach with the nurse acting as coordinator (Barry, 1983; Clausen, 1984; Cook & Alley, 1992; Schlemmer, 1989; Shine, 1983).

Regardless of who coordinates the discharge planning process, to be effective, the coordinator is required to demonstrate expertise in clinical practice, patient management, consulting, patient education and research (Schneider, 1992).

Fritsch-deBruyn and Cunningham (1990) suggest that the rising costs of health care services can be reduced significantly and patient outcomes improved with quality discharge planning by nurses. Bull (1988) agrees and claims that "nurses can be instrumental in maintaining quality of care and reshaping health policies in a direction that meets human needs and curtails costs" (p. 421).

Summary of Literature

From the review of literature there is evidence to support the fact that DRG's have had a major effect on the health care system in the U.S.A. In particular, the new system has placed major emphasis on decreasing length of patient stay whilst attempting to maintain or improve quality of care. It has also brought the discharge planning process to the fore as an attempt to control length of stay and therefore curb spiralling health costs (Schlemmer, 1989; Wolock, Schlesinger, Dinerman & Seaton, 1987).

The literature further suggests that an effective discharge planning process based on continuity of care will not only improve patient care and satisfaction with treatment and outcomes, but will also reduce the potential for litigation resulting from inadequate discharge planning (Cooke & Alley, 1992).

Many researchers believe that nurses are in the best position to coordinate discharge planning due to their constant interaction with patients. Whilst a majority of researchers see the nurse as the key person in discharge planning, there is consensus that this should be a collaborative process (Beale & Gulley, 1981; Cooke & Alley, 1992; Clausen, 1984). Further, it is generally accepted that nurses are the greatest contributors to the discharge planning process. It is a professional requirement of practice, and so it is imperative that they understand and implement the process effectively (Schlemmer, 1989).

Researchers are divided on the ability of effective discharge planning to reduce length of stay; however there is documentation to suggest that this has been adequately demonstrated (Davis et al, 1985; Schrager et al, 1978; Cable & Mayers, 1983; Marchette & Holloman, 1986). Therefore, a coordinated, planned process for discharge planning can improve quality of care, adequately prepare patients for discharge, and reduce the risks of cost outliers. Nurses as professionals have a responsibility to ensure that patients rights to effective discharge planning are protected, and have a financial responsibility to ensure that nursing services are efficient and cost effective.

The review of this literature indicates the need to establish a baseline of factors that currently influence discharge planning by Western Australian Clinical Registered Nurses in order to measure its effectiveness against current documented model discharge plans.

Chapter Three

Method of Investigation

Design

This descriptive, correlational study examined factors which influence discharge planning by nurses in a variety of clinical settings. A quantitative approach was used to compare groups and the effects of the independent variables of geographic location, basic nursing education, length of clinical experience and work context (clinical practice areas) with the dependent variable of factors considered when discharge planning. Quantitative data were supplemented by qualitative information from participants' responses to open ended questions which were then quantified. A study of the factors identified by respondents as influential in discharge planning provided data to compare with the identified factors of currently accepted models such as Barry (1983), Thompson (1985) and Pierangeli and Spencer (1987) and which would comprise an effective discharge plan. Further, the data provided information on the nurses' knowledge concerning discharge planning. These data will inform educational interventions to ensure that discharge planning in this State is adequate to meet the patients' needs, to reduce hospital expenditure and to effectively accommodate the introduction of Casemix, PPS and AN-DRG's. Factors identified from this study were compared to the stated criteria for effectiveness as defined by Williams (1991); ie. the construction of a plan for the patient's discharge which takes into account the following factors; patient care and education, patient satisfaction, length of inpatient stay, avoidable readmission rates, increased hospital throughput decreasing waiting lists and reduced variance of inpatient day stay for patients with the same DRG.

Data Analysis

Quantitative data were analysed using a statistical package (Statistical Package for the Social Sciences) to obtain general descriptive statistics of frequencies, means and medians. In order to compare differences between two or more means, *t*-tests for independent samples were utilised. Qualitative data were coded, categorised and quantified on a statement by statement basis from the questionnaire, and each statement was compared with every other statement to ensure mutual exclusivity for categorisation.

Assumptions

The independent variables were chosen because it was assumed that:

1. Country nurses may need to consider different factors than city nurses when planning patient discharge due to the degree of isolation and diminished local community resources.
2. Both tertiary and hospital based educational preparation should prepare nurses for effective discharge planning.
3. Length of clinical experience may be an influence on discharge planning ability.
4. All groups of Registered Nurses within a hospital should be able to discharge plan.

Subjects

400 practising nurses currently registered with the Nurses Board of Western Australia were randomly selected from the Nurses Board of Western Australia's database to participate in the survey. Of these 400 nurses, Registered and Clinical nurses were included in the study, as these categories of nurses best represent nurses at the bedside with the responsibility for coordinating patient discharge. Level 3 nurses were included only if they were employed as Staff Development nurses, as it is considered a part of their responsibility to teach discharge planning.

Data Collection Procedures

The Nurses Board of Western Australia was approached to assist with obtaining the names and addresses of 400 practising nurses currently on their register. Names and addresses were obtained from their database by clerical staff employed at the Nurses Board. The researcher placed 400 research packages into stamped envelopes, and the Nurses Board clerical staff addressed and posted the envelopes. Each envelope contained a letter of introduction and request for participation with the survey, a questionnaire, instructions on how to complete the questionnaire, a reply paid self addressed envelope for return of the questionnaire to the researcher, and a consent form. This method was chosen in order to maintain confidentiality for the nurses who are registered with the Nurses Board of Western Australia. Returned questionnaires were then sorted to exclude respondents who were not Registered Level 1 or 2 practising clinicians, or Level 3 Staff Development nurses.

Survey Instrument

A review of the literature failed to find a suitable measuring instrument, therefore a questionnaire was designed by the researcher. The questionnaire was set out in two sections. The first section contained the demographic variables of :-

1. Age
2. Gender
3. Initial nursing education
4. Highest nursing qualification obtained
5. Current position classification
6. Number of years practising as a Registered Nurse
7. Area of Employment
8. Employment facility
9. Usual work area

The second section of the questionnaire was designed to establish if :-

1. Nurses thought discharge planning was essential for continuity of patient care.
2. Nurses believed patients should be involved in planning their own discharge; and to determine :-
3. What factors nurses took into consideration when planning a patient discharge.
4. What influences made discharge planning easier or enhanced the process.
5. What influences made discharge planning difficult or impeded the process.
6. The final question was an invitation to make any comments on the process of discharge planning as it effects the role of the professional nurse.

The Pilot Survey

The questionnaire was tested for both content and consensual validity on five Western Australian Clinical Registered Nurses at a major Perth teaching hospital. Returned questionnaires identified two ambiguous questions which were modified and then the questionnaire was retested on seven Registered nurses and three Clinical nurses at another major Perth teaching hospital. The result of the retest identified one question which required splitting into two questions and several categories which needed to be added to the demographic question on area of work. The questionnaire was modified as necessary and retested until no further modifications were considered necessary. Subjects used in the pilot survey were excluded from the major study. The questionnaire was designed in three parts. The first part contained general demographics, the second contained questions on discharge planning to determine procedures and protocols currently being used in discharge planning. The third focused on factors nurses consider when planning for discharge (see Appendix E for a copy of the questionnaire).

The Major Survey

For the major survey, 400 stamped packages each containing a questionnaire, letter of explanation, a consent form and a reply paid, self addressed envelope were delivered to the Nurses Board of Western Australia.

The names of the nurses selected to participate were obtained from the General Register of the Nurses Board by Nurses Board staff members, using a computer programme to randomly select members from the register but excluding those 15 nurses who participated in the pilot surveys. Once selected, Nurses Board staff applied name and address stickers to the envelopes and organised postage.

The recipients were given written instructions on how to complete the questionnaire, advised of the required return date and asked not to identify themselves

on the questionnaire. Reminders for unreturned questionnaires were not forwarded due to the large target population and the costs involved.

Chapter Four

Findings

This study focussed on identifying factors which influence nurses in planning discharge and how the identified factors compared with those identified in the literature as being effective in planning discharge. Subsidiary questions were directed at identifying differences between geographical location, type of nursing education, length of clinical experience and practice area of participants. Therefore, the study findings will be presented in accordance with the research questions.

Research Respondents

Questionnaires were sent to 400 registered general nurses who were invited to participate in the study, as Figure 2 indicates one hundred and fourteen questionnaires were returned to the researcher, a response rate of 28.5%. Of the 144 questionnaires returned, ten were excluded as the respondents were currently employed as Level 3, 4 or 5 nurses, 34 were returned not completed and/or with a refusal to participate. One was returned 'address unknown'. The remaining 69 questionnaires which represent 17.25% of the total number of questionnaires formed the basis for data analysis.

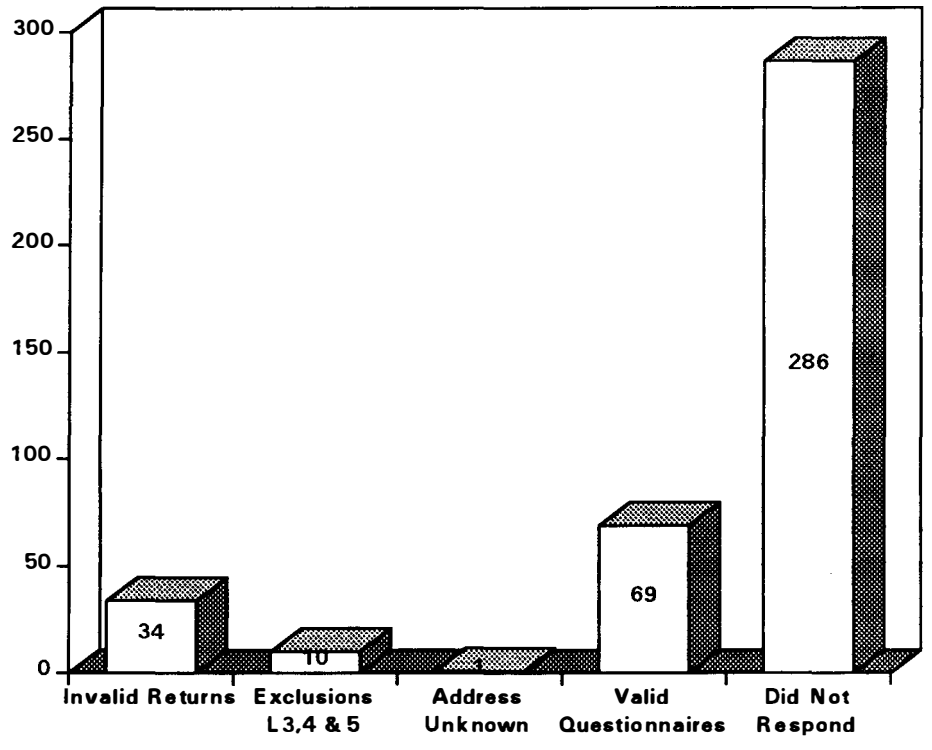

Figure 2. Summary of Questionnaire Returns.

Demographics

The age distribution of study subjects as illustrated in Table 1 shows that the majority of surveyed nurses were in the 30 - 39 year age bracket. Sixty one percent of the surveyed population were represented in the 30 - 49 year age bracket.

Table 1

Age Groups of Respondents (N = 69)

AGE GROUP	N	(%)
20 - 29 years	15	(22)
30 - 39 years	23	(33)
40 - 49 years	19	(28)
50 - 59 years	11	(16)
60 - 65 years	1	(1)
TOTAL	69	(100)

Four males and 65 females participated in the survey; 62(89.97%) of respondents were hospital and 7(10.3%) tertiary educated nurses.

Table 2 depicts the highest nursing qualification of the surveyed population.

Table 2.

Highest Nursing Qualification of Respondents (N = 69)

QUALIFICATION	N	(%)
Hospital graduate	45	(65)
Tertiary diploma	4	(6)
Tertiary degree	13	(19)
Post Graduate diploma	4	(6)
Masters	1	(1)
Missing data	2	(3)
TOTAL	69	(100)

Of the 69 respondents, 35 (51%) were currently employed as Level 1 nurses, 26 (38%) were employed as Level 2 nurses, 6 (9%)were employed as Level 3 nurses and the data were missing from 2 (3%).

Years of nursing practice ranged from three years to 32 years with a mean of 14.61 years, and a standard deviation of 8.8 years.

Forty nine nurses (71.01%) were employed in the metropolitan area, 19 (27.54%) were employed in the non-metropolitan area, and data were missing from 1 (1.45%) case.

Nurses who participated in the study worked either in the country or the city, in public or private hospitals, were tertiary or hospital educated, had varying lengths of clinical nursing experience and worked in a variety of nursing unit settings.

Figure 3 shows the type of employment facility of the participants.

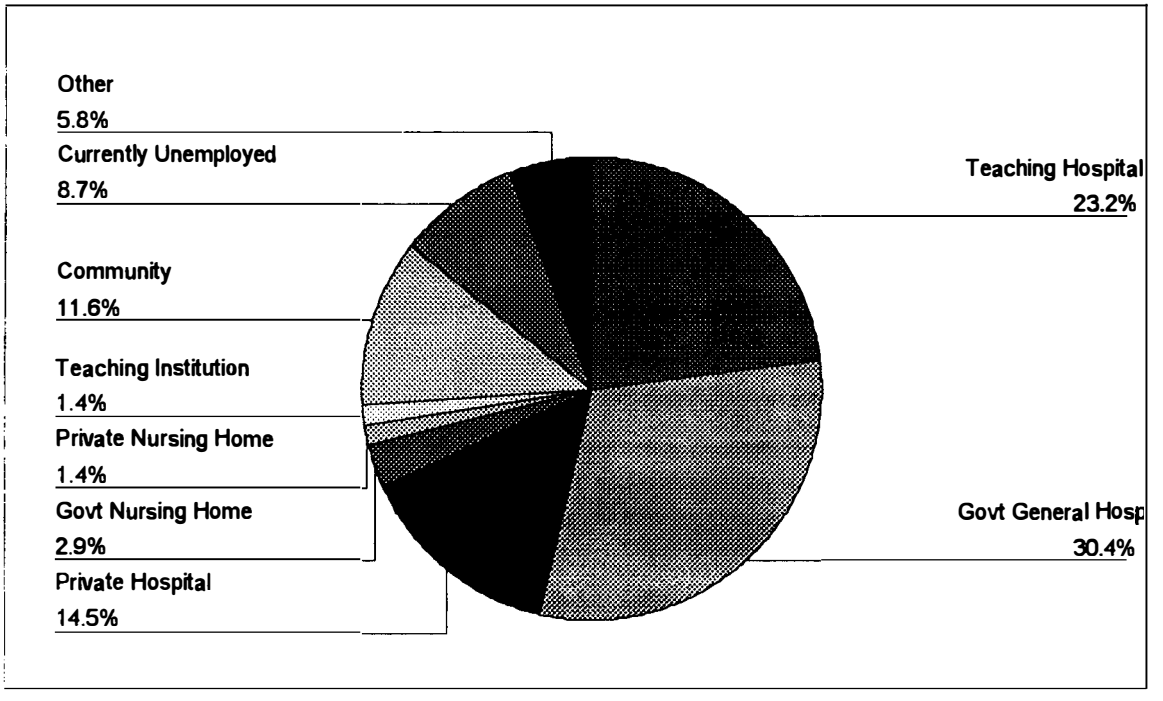

Figure 3. Participants By Type of Employment Facility (N = 69)

Figure 4 illustrates the percentage of nurses employed in various work areas, with Surgical/Surgical Specialties having the greatest number of nurses (27.5%) and Operating Room nurses the lowest (1.4%).

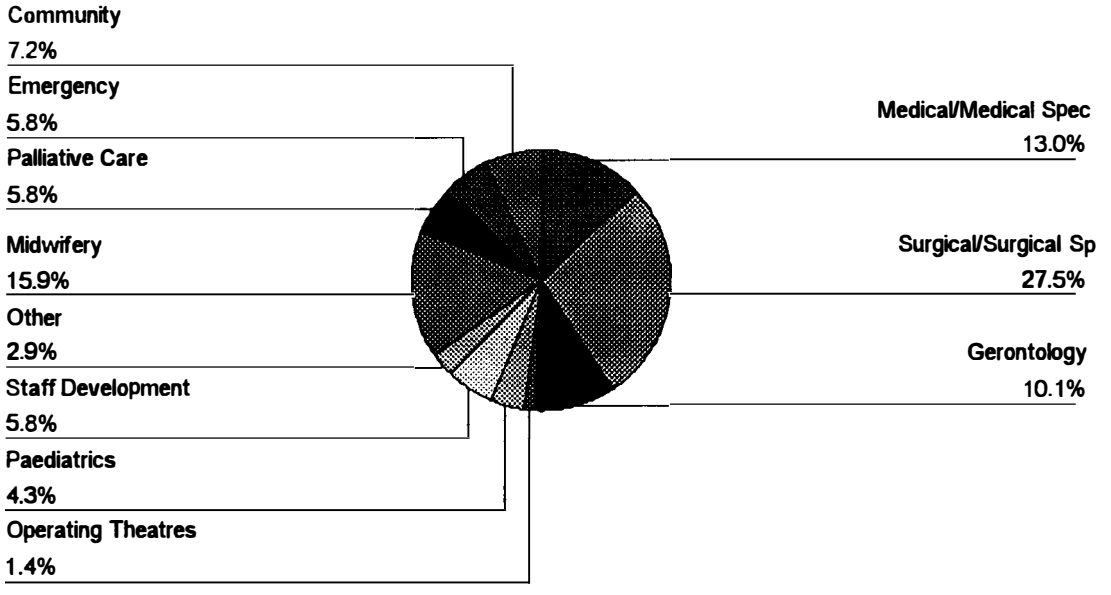

Figure 4. Participants By Area of Work (N = 69)

General Discharge Planning

The first question in Part B of the questionnaire was to establish whether nurses considered discharge planning as essential for the continuity of patient care. Fifty one nurses (73.9%) strongly agreed with the statement and 18 (26.1%) agreed. None disagreed.

The second question in Part B asked if nurses thought patients should be involved in planning their own discharge. The response was 100% in favour of patients contributing to their own discharge plan.

Identified Discharge Factors

Participants were asked to identify the factors they considered when developing a patient discharge plan. These responses address the first research question: "What are the factors influencing Western Australian Clinical Registered Nurses in discharge planning?" (See appendix A). Respondents identified 62 factors, with individual participants identifying between 0 and 16 factors. Table 3 lists the 10 most frequently identified factors in rank order. Almost three quarters of respondents mentioned that they considered family support when planning discharges, just over half considered community resources, and about one fifth considered such factors as the need to arrange for appointments, home environment, the patients' education, age, physical capabilities and the patients' ability to perform ADL's. Following the first 10 factors, the frequency of responses varied from 11 responses to 0 response (see appendix A for a full listing of the 62 identified factors).

Table 3

The Ten Most Frequent Factors Considered By Nurses When Discharge Planning

FACTOR No:	*FACTOR*	*FREQUENCY(%)*
1	Family Support	50(73)
2	Community Resources	39(57)
3	Follow Up Appointments	24(35)
4.	Home Environment	23(33)
5	Patient Education	20(29)
6	Age of Patient	20(29)
7	Physical Capabilities	19(27)
8	Ability to Perform Activities of Daily Living	18(26)
9	Medications	15(22)
10	Transport	14(20)

Research question 2 sought to determine how the factors influencing Western Australian Clinical Registered Nurses compared with factors identified in the literature as being effective in planning for discharge.

Barry (1983), Thompson (1985), and Pierangeli and Spencer (1987) identified varying numbers of broad group classifications which they considered as being effective for discharge planning. These broad groups were combined to form 11 groups which encompassed the areas identified by all three of the authors. In order to answer the second research question the 62 identified factors were categorised

according to the same 11 groups adapted from the above authors. These are illustrated in Table 4.

Table 4

Broad Group Categorisation of Identified Discharge Factors

Broad Group Number	Broad Group Classification
1	Physiological Status*
2	Activities of Daily Living*
3	Health Related Support*
4	Communications*
5	Nutrition, Housing & Clothing*
6	Medications*
7	Psychosocial Functioning*
8	Preventive Health Practices
9	Environmental Support*
10	Patient and Family Education (Health Related)*
11	Risk Factors

* Broad Groups identified by respondents in this study

Of the 11 broad groups of factors shown in Table 4, the Western Australian study sample identified nine of the groups. The two broad groups that the surveyed

population failed to identify were Preventive Health Practices and Risk Factors, both groups being representative of non obvious rather than obvious needs.

The surveyed nurses identified varying numbers of broad groups of factors they considered when discharge planning. The number of broad groups considered by individual nurses varied from none to nine.

Figure 5 shows the number of broad groups considered by individual participants.

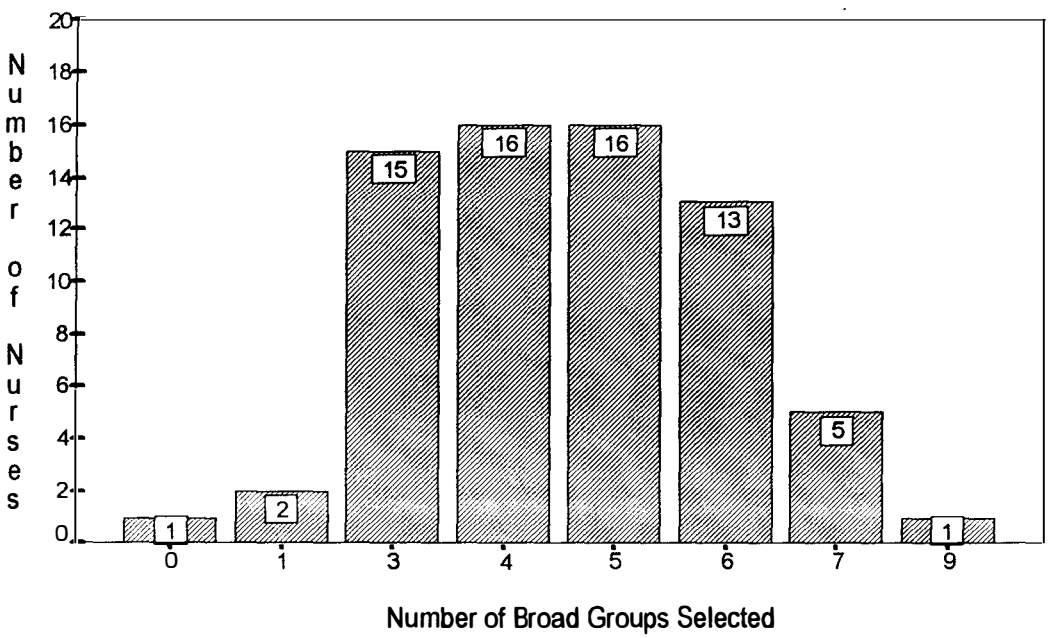

Figure 5. Number of Broad Groups Considered in Discharge Planning by Individual Nurses (N = 69).

Factors incorporated in each of the 11 broad groups are listed in the following tables. Table 5 covers broad groups 1 - 4; Table 6 broad groups 5 - 8 and Table 7 broad groups 9 - 11.

Table 5

Incorporated Factors for Broad Groups 1 to 4

1. Physiological Status.	2. Activities of Daily Living.	3. Health Related Support.	4. Communication.
Age of Patient	Physical Requirements of the patient	Availability of Follow Up Appointments	Ability of Patient/Carer to be Involved in Discharge Planning
Patients Physical Capabilities	Physical Supports Required by the Patient	Community Resources and Transport	Discharge Summary
Present Illness	Patient Dependency	Medical Liaison and General Practitioner Support	Anticipated Discharge Date
Previous Illnesses		Availability of Support Needs	
Degree of Recovery from Current Illness		Previous Exposure to Community Resources	
Admitting Diagnosis		Patient's Previous Need for Support	
Length of Hospital Stay		Closeness of Home to Follow Up Services	
Patient Mobility		Discharge Day of the Week	
		Other Facility Involvement	
		Accommodation for Rural Patients with City Follow Up Appointments	
		Provision of Post Discharge Carer	
		Occupational Therapy	

Table 6

Incorporated Factors for Broad Groups 5 to 8

5. Nutrition, Housing & Clothing	6. Medications	7. Psychosocial Functioning	8. Preventive Health Practices
Discharge Clothing	Drug Therapy	Family Support	
Discharge Home Environment	Medications	Social Situation of Patient	
Patients' Nutritional Needs		Capability of Carer	
Patients' Place of Residence		Psychological Capabilities of Patient/Carer	
		Patients' Feelings	
		Patients Ability to Understand Instructions	
		Patients' Social Capabilities	
		Family Feelings	
		Patients' Wishes & Expectations	
		Patients' Cultural Beliefs	
		Patients' Lifestyle & Religion	
		Number of Dependents	
		Patients' Behaviour Pattern	

Table 7

Incorporated Factors for Broad Groups 9 to 11

9. Environmental Support	10. Patient & Family Education (Health Related)	11. Risk Factors
Patients' Social Environment	Patient & Family Education	
Patients' Physical Environment	Patients' Understanding of their Health Disability	
Patients' Economic Status	Patients' Understanding of their Previous Health Illnesses	
Employment Status	Patient Compliance	
Hospital's Policy of Discharge	Return to Sexual Activity	
Medical Certificates		

Following the distribution of selected factors into broad groups, they were counted to determine how many respondents cited factors in each broad group. These are shown in Figure 5 and ranged from 0 to 9, with most respondents selecting between 3 to 6 broad groups, and one nurse selecting nine groups. At the other end of the scale one nurse failed to select any factors within any group and two nurses selected factors in only one broad group.

Nursing Location

The third research question examined a range of variables with respect to the number of factors considered. These are reported separately. A *t*-test was performed to compare the number of factors considered with whether the nurses worked in the metropolitan area or non metropolitan area.

The result of the *t*-test demonstrated no significant difference in the factors considered for planning patient discharges between nurses working in the metropolitan area (M = 4.7) and those working in non metropolitan areas (M = 4.2), $t(66) = 1.04$, $p > .05$.

Figure 6 shows the percentage of respondents who cited factors in each grouping by location.

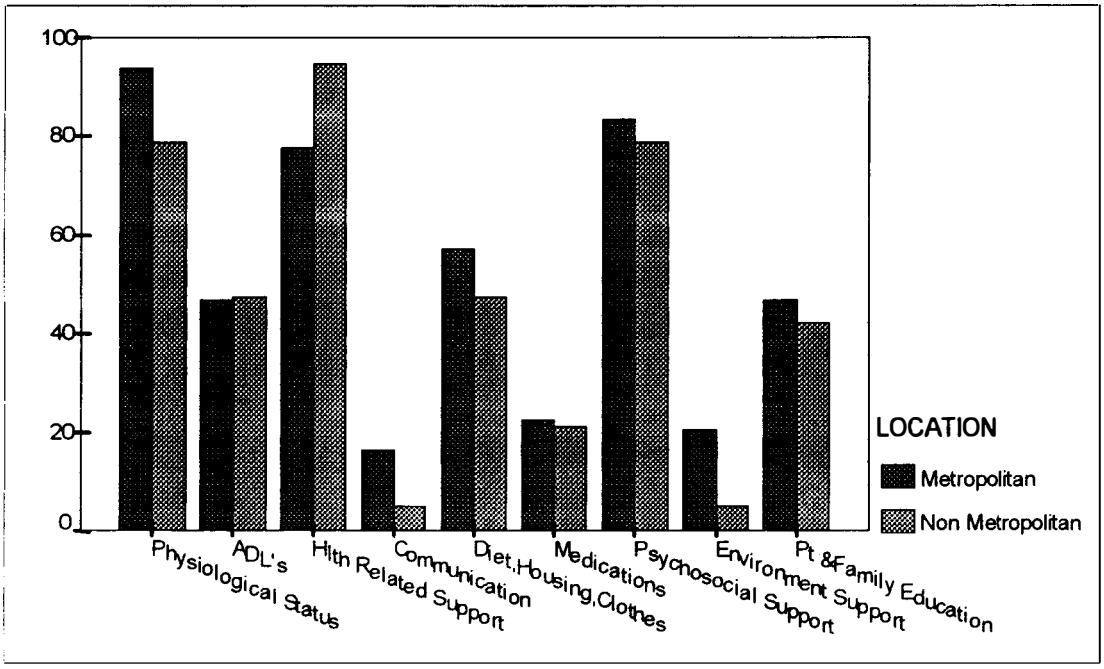

Figure 6. Percentage of Nurses Who Cited Factors in Each Grouping by Location. (N = 69).

Nursing Education

A *t*-test was again performed to determine if there was a difference in the number of factors considered by nurses with a hospital based diploma (M = 4.5) and nurses with a tertiary based education (M = 5.3.) $t(67) = 1.34$, $p > .05$.

As there were only seven participants in the tertiary educated group, the result of the *t*-test may be suspect. However, the means suggest that tertiary educated nurses may perhaps consider on average one more broad group than hospital nurses. Figure 7 illustrates that hospital educated nurses considered factors within all nine broad groups, whereas tertiary educated nurses considered factors in only eight of the broad groups, with Communication being the exclusion.

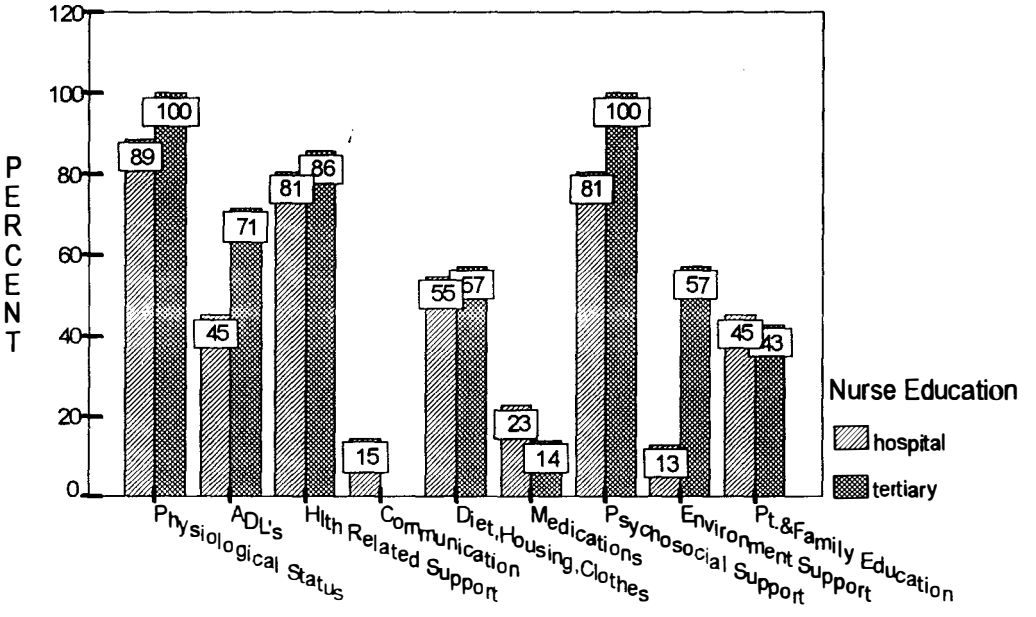

Figure 7. Percentage of Nurses Who Cited Factors in Each Grouping by Type of Nursing Education; Hospital (N = 62) and Tertiary (N = 7)

Years of Nursing Experience

This aspect of the research question aimed to determine if length of clinical experience had any bearing on the selection of discharge planning factors. In order to graph the data for years of nursing experience, a mean of 12 was determined then a quartile split was performed with groups being divided into those with 1 to 7 years of experience, those with 8 to 12 years, those with 13 to 21 years and those with 22 to 32 years of clinical experience.

Figure 8 identifies factor group selection and frequency by length of nursing experience.

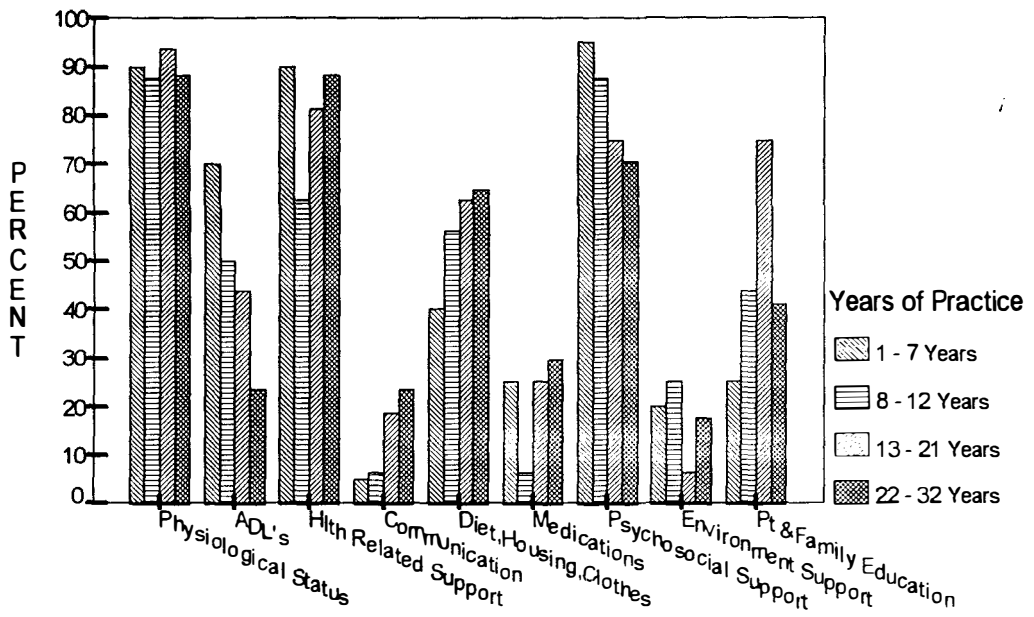

Figure 8. Percentage of Nurses Who Cited Factors in Each Grouping by Years of Clinical Nursing Experience.

Figure 8 demonstrates that the surveyed nurses considered Activities of Daily Living and Psychosocial Support less frequently when discharge planning with increasing years of practice; and Nutrition, Housing and Clothing and Communication more frequently with increasing years of clinical practice.

The results of the correlation between years of experience and number of broad groups cited, $r(67) = -.02$, $p>.05$ shows that there is no relationship between the number of years of nursing practice and how many broad groups of discharge factors the nurses considered.

Area of Work

To determine the answer to the next part of this research question related to specific work areas the responses to the 11 identified work areas illustrated in Figure 4 were regrouped into two areas, those of acute and non acute care. Areas incorporated in the acute care category were Surgica / Surgical Specialties, Medical / Medical Specialties, Midwifery, Emergency, Paediatrics and Operating Theatres. Non acute category consisted of Palliative Care, Gerontology, Staff Development, Community and Other areas. This was necessary in order to be able to present the findings with more clarity (see Fig 9).

A *t*-test was then performed to see if the observed differences were statistically significant between acute ($\underline{M} = 4.7$) and non acute work areas ($M = 4.3$) $t(67) = .87$, $p>.05$.

The *t*-test showed no significant difference in the selection of factors between nurses working in acute care areas and those working in non acute areas.

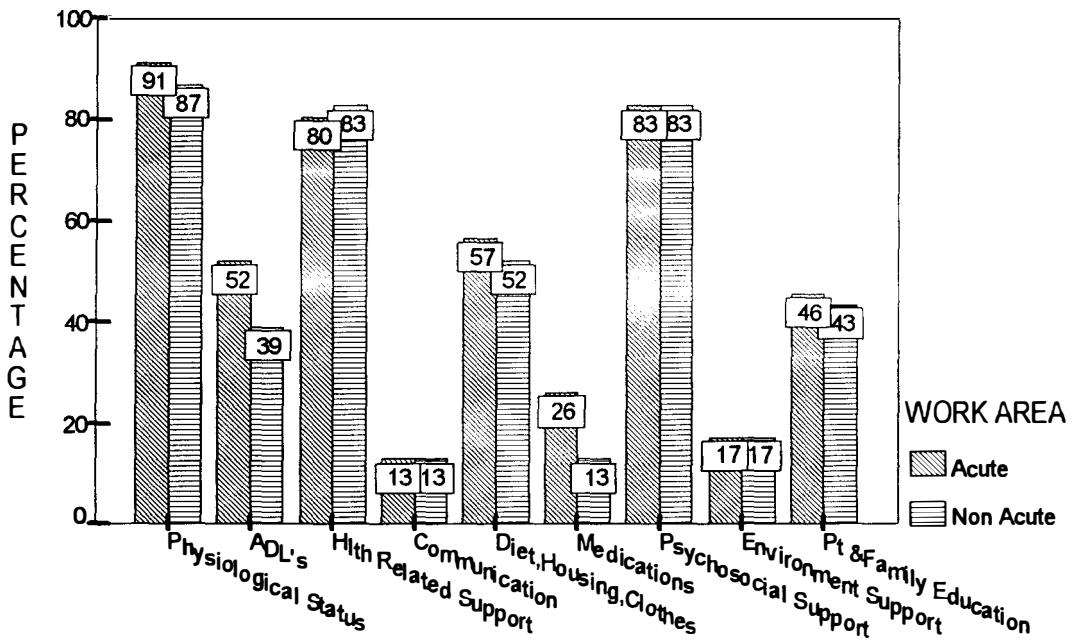

Figure 9. Percentage of Nurses Who Cited Factors in Each Grouping by Areas of Acute and Non Acute Settings.

Figure 9 illustrates that acute care nurses consider Medications twice as often as nurses working in non acute areas. Activities of Daily Living (ADL's) are considered by over half of nurses in the acute care areas whilst only 39% of nurses in the non acute area consider this factor. In all other groups the results were relatively equal.

Factors Which Enhance Discharge Planning

Question 4 in Part B of the questionnaire sought a response to the question: "What influences do you believe enhance your discharge planning (if any)?" Fifty five factors were identified. The 10 most frequent responses are listed in Table 8 by rank order with Community Resources being the most cited factor (32%). Subsequent responses ranged from 5(7.2%) to 1(1.4%). Interestingly no factor was mentioned by more than half of the surveyed nurses. Appendix B presents a full listing of factors that enhance discharge planning.

Table 8

The Ten Most Frequently Identified Factors Which Enhance Discharge Planning As Reported by Respondents.

FACTOR NUMBER	*FACTOR*	*FREQUENCY(%)*
1	Community Resources	22 (31.9)
2	Detailed knowledge of patient's particulars/home situation	17 (24.6)
3	Patient and family involvement in discharge plan	17 (24.6)
4	Effective communication between care giver	17 (24.6)
5	Patient education re discharge plan and expectations	16 (23.2)
6	Co-operative medical staff	13 (18.8)
7	Good family support network	12 (17.4)
8	Liaison with medical and para medical staff	11 (15.9)
9	Sufficient nursing hours to complete a discharge plan	10 (14.5)
10	Commencing discharge planning on admission	8 (11.6)

The 55 factors that were identified as enhancing discharge planning were treated similarly to the previously identified discharge factors; that is, they were grouped according to the same broad group headings used to describe the discharge factors (see Table 4).

In addition to these 11 broad groups, a further three groups were added to allow for those factors identified which were not directly related to either the patient or the family. These three added groups were Institutional Constraints, Medical / Nursing Knowledge and Medical / Nursing Practice Style.

Four broad groups which were not identified as enhancing discharge planning were excluded from the broad group list. These were Activities of Daily Living, Medications, Preventive Health Practices and Risk Factors.

Table 9 illustrates the broad groups into which all factors identified as enhancing discharge planning were incorporated, the number of incorporated factors in each group and the frequencies and percentages of each. It shows that Medical / Nursing Practice Style incorporating 13 factors, was the most frequently cited broad group (83% of the surveyed population). Medical / Nursing Knowledge incorporating 3 factors was the least frequently cited broad group being selected by only 9% of the surveyed population.

Table 9

Broad Group Categorisation, Incorporated Factors and Frequency (%) of Identified Factors Which Enhance Discharge Planning Ranked According to Frequency.

Broad Group Number and Classification.	No of Incorporated Factors	Frequency of Factors	%
1. Medical/Nursing Practice Style*	13	57	82.61
2. Health Related Support	9	50	72.46
3. Communication	7	37	53.62
4. Patient & Family Education	4	37	53.62
5. Institutional Influences*	9	29	42.03
6. Psychosocial Functioning	6	18	26.09
7. Nutrition, Housing & Clothing	1	17	24.64
8. Physiological Status	2	9	13.04
9. Environmental Support	1	6	8.70
10. Medical/Nursing Knowledge*	3	4	5.80

* Added Broad Group

Table 9 shows that over 80% of the surveyed nurses considered Medical / Nursing Practice Style as being the greatest contribution to enhancing discharge planning, with Health Related Support accounting for over 72%. Surprisingly, the patients' Physiological Status was only considered by 13% of the

surveyed nurses as enhancing the discharge planning process, and Environmental Support by only 8.7%.

Factors Which Impede Discharge Planning

The response to the question: "What influences do you believe impede your discharge planning (if any)?", also yielded 55 factors. The first 10 factors are listed in descending order in Table 10 and shows that the first two identified factors of Poor/inadequate communication/liaison and Busy workload/lack of time accounts for over half of the surveyed population responses as being the major impediments to discharge planning. Limited Community Resources were considered an impediment to discharge planning by only 17% of the subjects and ranked third by frequency of response. The frequency of the remainder of responses varied in number from 11(15.9%) to 1(1.4%). See Appendix C for a full list of factors that impede discharge planning.

Table 10

The Ten Most Frequently Identified Factors Which Impede Discharge Planning.

FACTOR NUMBER	*FACTOR*	*FREQUENCY (%)*
1	Poor/inadequate communication/liaison	19 (27.5)
2	Busy workload/lack of time	19 (27.5)
3	Limited community resources	12 (17.4)
4	Lack of assistance/support by family/friends/carers	11 (15.9)
5	Poor multidisciplinary documentation of discharge plans	8 (11.6)
6	Short notice of discharge by medical officer	8 (11.6)
7	Patient's ability or willingness to comply	7 (10.1)
8	Lack of information given to patient to make informed decisions	6 (8.7)
9	Lack of patient/family education	6 (8.7)
10	Unco-operative colleagues/patients/relatives/medical staff	6 (8.7)

In order to retain a degree of consistency these 55 factors were reclassified where possible, into the same broad groups that were used to reclassify identified discharge factors and factors that were identified as enhancing discharge planning. There were no identified impeding factors that fitted into the broad group headings of Activities of Daily Living, Preventive Health Practices and Risk Factors, therefore these three broad groups were omitted from the following list. Three broad groups were added to the remaining list of eight to encompass factors which were not directly related to patient or family interaction. These were the same three broad groups that

were added to the groups covering factors which enhanced discharge planning (Institutional Influences, Doctor / Nurse Knowledge and Medical / Nursing Practice Style). Table 11 shows the frequencies and percentages of all identified impeding factors and the broad groups into which all factors were incorporated.

Table 11

Broad Group Categorisation, Incorporated Factors and Frequency (%) of Identified Factors Which Impede Discharge Planning.

Broad Group Number and Classification.	**No of Incorporated Factors.**	**Frequency of Factors.**	**%.**
Health Related Support	12	49	70.7
Institutional Influences*	10	41	59.42
Communication	8	51	73.83
Patient & Family Education	6	22	31.88
Psychosocial Support	6	19	27.54
Medical/Nursing Knowledge*	4	8	11.59
Medical/Nursing Practice Style*	3	11	15.9
Nutrition, Housing & Clothing	2	6	10.7
Physiological Status	2	5	7.25
Environmental Support	1	2	2.9
Medications	1	1	1.4

* Added Broad Group

The questionnaire was designed to determine in the first instance, how importantly nurses rated discharge planning. Respondents agreed that discharge planning was essential to the continuity of patient care, however there was no way of measuring the intent of their commitment to the process. According to Clausen (1984, p. 58), "As essential as it is to the well being of every patient, discharge planning stands in jeopardy of being left to everyone's discretion, and therefore, to no one's accountability." However, Clausen suggests that the number of nurses who genuinely value discharge planning as an integral part of their practice is steadily growing. However, as there were no base line data from the present study with which to compare the extent to which they valued discharge planning, no conclusions can be drawn in that respect. The findings also indicate that the respondents agreed (100%) with the conclusions of Corkery, (1989); Gutierrez, (1985); and Hickey & McKenna, (1984) that patients should be permitted to be involved in the process of planning for their own discharge.

Demographic Data

Subjects comprised 65 females and four males, therefore no attempt is made to draw conclusions in relation to gender. This representation corresponds with the local gender distribution of nurses in Western Australia. The number of respondents who were hospital trained graduates compared to those who were tertiary educated graduates showed a wide variation. This was not unexpected, as tertiary nursing programmes have been operating for less than two decades in Western Australia.

Data indicated that the greatest number of nurses in the survey were in the 30 - 39 year age group. The most frequent highest nursing qualification was a hospital based diploma with the majority of nurses being employed in the metropolitan area. Government general hospitals were the largest employers of the surveyed population with the majority of the population working in the areas of surgery and surgical specialties.

Identified Discharge Factors

The surveyed population identified 62 discharge factors which they considered when planning for patient discharge. Individual responses to the number of factors considered when planning for discharge varied from 0 to 16 with 6.85 factors representing the mean. The one respondent who failed to list any factors when considering plans for patient discharge completed the rest of the questionnaire as requested, so it is assumed that the omission of considered discharge factors was an oversight on the respondent's part. Obviously the effectiveness of the discharge plan when no factors are considered must surely be in doubt.

Of interest from the ten most frequently considered factors was that Physical Capabilities and Ability to Perform Activities of Daily Living (ADLs) were rated quite low in their frequency of selection (seven and eight). It had been expected on the basis of the researcher's clinical experience, that these two factors should be the key in deciding what other factors may or may not need to be considered for planning discharge. That is, the individual physical / psychological capabilities of the client could be expected to generate the other needs / resources required for the discharge to be effective. For example, for the client with physical limitations following spinal fusion the need for assistance in performing activities of daily living is obvious and should generate the initial needs in planning for the discharge. These physical limitations should provide the "core" or primary base on which subsequent needs are determined. Likewise, if psychological limitations are the "core" problem then these should generate linked needs / resources.

In short, there is very little point in making education the primary concern in planning *this* patient's discharge - the "core" generator of needs / services should be the "core" problem; in this case, physical limitations with education becoming an important and consistent but secondary concern. Therefore, for the same reasons, Family Support (most frequently selected factor), Community Resources, Follow Up Appointments, Home Environment and Patient Education, all of which rated higher

than Physical Capabilities and the Ability to Perform ADL's, should primarily depend on the physical / psychological capabilities, and the ability of the patient to perform ADL's. This assumption can be equated to Maslow's Hierarchy which claims that basic needs must be met before more complex needs are able to be met.

The fact that surveyed nurses rated Physical Capabilities and the Ability to Perform ADL's so low on the selection scale may be an indication that nurses, whilst being able to randomly identify the factors considered essential in planning an effective discharge, are not necessarily basing the discharge factors on patients' individual needs, nor in any order of priority.

The researcher would suggest, from personal experience, that employing institutions are supplying nurses with a list of discharge factors to be considered when planning patient discharges, in the form of a Discharge Plan. Therefore, hospitals are supplying nurses with the means to identify discharge factors (from a checklist), but without priority, and not based on critical analysis of individual patient needs.

It would appear that the "standardised" check list for planning patient discharges may have produced a check list mentality amongst nurses. The data suggest that the advent of the "Discharge Check List" may have played a definitive role in diminishing and removing the motivating (assessment) skills which should generate the discharge process. However, this mentality may be addressed with the introduction of Casemix and DRG's. The advent of DRG's in the U.S.A. according to Bull, (1988) had a critical influence on discharge planning, with discharge planning becoming so institutionalised that nurses were recognised for their cognitive functions in planning patient care.

Broad Group Categorisation of Identified Discharge Factors

Broad group categories identified to accommodate expected discharge factors listed by the respondents were based on the literature of Barry (1983), Thompson (1985) and Pierangeli & Spencer (1987). These broad groups were identified by the researcher as they are commonly referred to on check lists for discharge planning and are therefore accepted for standardised planning for patient discharge.

Eleven broad groups were identified from the works of the above authors. All factors identified by the research participants were classified into the broad groups. The surveyed population identified factors which corresponded with nine of the eleven groups; ie there were two groups for which participants failed to select any factors; Preventive Health Practices and Risk Factors. It could be concluded from this that nurses are more able to identify factors if they are visible and obvious, although not necessarily by priority. On the other hand, the two broad groups that were not identified represent the obscure and not so obvious components of health care and therefore may be overlooked by nurses when planning for patient discharge. Another possible reason for these factors being overlooked may be that current available "Discharge Plans" in use by various agencies have not yet been adapted to capture the current focus and importance being placed on these less obvious factors.

This finding is a cause for concern for nursing, particularly in the current health climate where State and Federal Governments and health professions in general are spending vast sums of money to educate the public on the necessity of reducing health risk factors and on preventive health practices.

The findings showed that only one nurse from the surveyed population considered all nine broad groups when planning for patient discharge, with the majority of nurses selecting between three and six broad groups.

A conclusion to be drawn from the above findings and based on current literature suggests that the surveyed population do not always consider the most appropriate or sufficient factors when planning patient discharges.

Nursing Location in Relation to Broad Groups Identified

The findings of *t*-tests to compare if nurses working in the metropolitan area considered more or less broad groups than nurses in non metropolitan areas showed no significant difference. However, Figure 6 shows that metropolitan nurses considered slightly more factors related to Physiological Status and non metropolitan nurses citing slightly more Health Related Support factors.

It was expected that there would have been a greater difference in factors considered under the broad group Health Related Support between these two groups based on isolation and physical resources available. It was assumed that nurses working in non metropolitan areas would not consider factors related to Health Support if the required supports were not available within the community. That is, should the discharger consider nursing home placement if there is no nursing home in the community, or should the discharger consider Occupational Therapy in a community that doesn't have the resources to provide this service? The findings suggest that even though there may be differences in community resources, the surveyed population tended to consider the same factors.

It would appear from the above that in their approach to planning patient discharges, this group of nurses tend to utilise pre designed discharge plans incorporating standardised identified discharge criteria regardless of individual client needs and local community resources. This supports the author's assumption that Western Australian nurses in general, opt to use a check list facility rather than developing a unique plan based on individual client needs. The evidence would suggest that nurses utilise the discharge check list regardless of its appropriateness and to the detriment of their own assessment and planning skills. In other words, there is no evidence to support a critical thinking, problem solving approach to the discharge plan.

Nursing Education in Relation to Broad Groups Identified

Hospital educated nurses identified nine of the eleven broad groups, whereas tertiary educated nurses only identified eight of the eleven broad groups, with communication being the exception.

These results would indicate that despite the emphasis placed on communication in universities, communication does not appear to be a key factor in the planning of patient discharges for the tertiary educated nurses surveyed.

Individual factors which made up the broad group "Communication" included written and oral communication, listening and the two way transfer of information and knowledge to and from the appropriate sources through the appropriate channels and within time frames. It may be that tertiary educated nurses considered communication as such a basic component of any procedure, that purely by familiarity of practice it was not obviously considered in planning for patient discharge by this group of nurses. Alternatively, it may be that whilst this group of nurses have the theoretical knowledge of the art of communication, their practice time may have been insufficient to allow these theoretical skills to become automatic practice skills.

A *t*-test performed to compare if nursing education was a factor in determining discharge factors failed to show any significant difference however, the result of this *t*-test may be suspect and not significant as there were only seven participants in the tertiary educated group. Whilst it is interesting to note that all seven nurses in the tertiary educated group failed to identify education as a factor in planning for effective discharge, this cannot be taken to be representative of the tertiary educated nursing population.

Years of Nursing Experience in Relation to Broad Groups Identified

Data related to years of nursing practice failed to identify any relationship between length of experience and broad discharge groups identified. This in itself was a surprise as one would have assumed that like anything else, frequency of practice would improve the skill. This study showed that the frequency of identifying Nutrition, Housing & Clothing and Communication demonstrated a steady increase in relation to years of clinical practice whereas Activities of Daily Living and Psychosocial Support decreased steadily with length of clinical experience. These findings may bear some relation to the general concept of the life cycle and where the individual nurse currently fits, chronologically, within that cycle. That is, within the normal life cycle there is an expectation that as humans get older there is a greater need for security in relation to nutrition, housing and clothing, and that social interaction (communication) becomes very important in order to maintain feelings of need and self worth. On the other hand there is an expectation that activities of daily living will become increasingly difficult and that the perceived needs for the psychosocial aspects of life will gradually diminish with increasing age. It could therefore be assumed that nurses' perceptions of discharge needs may change in keeping with their own chronological status within the life cycle; that is, nurses appear to more readily identify with their own age groups. In other words, the power of experience due to life or circumstances is one of the greatest factors in achieving understanding and compassion. If a nurse has personally experienced a hysterectomy, her ability to identify and determine specific needs and discharge criteria are greatly enhanced. To this end, the nurse may be able to relate the life cycle experience to the physical condition that is a common occurrence within this particular age group. Therefore, the assumption that has been drawn is that nurses are better able to relate to, and understand patients' needs when there is compatibility either through age group or life experiences.

With the exception of the two broad groups, Communication and Nutrition, Housing & Clothing, the above findings appear to support the previous suggestion that nurses utilise a check list mentality in preparing patients for discharge using the same broad groups regardless of years of clinical experience. This is indicative of stereotyped discharge planning rather than a problem solving approach based on critical analysis of individual client needs. This finding contravenes one of the basic tenets of the nursing process which is the predominant methodology used in the delivery of nursing care in this State in which care is based on individual assessment. If this is the case then there is an obvious need for assessment of this educational aspect in relation to content and methodologies that are currently being used to educate nurses, particularly in relation to effective discharge planning.

Area of Work in Relation to Broad Groups Selected

Despite an expectation that significant differences would be identified, *t*-test results showed no significant difference in the selection of discharge factors between nurses working in acute care areas and those working in non acute areas. This expectation was based on the diversity of work areas and the areas to which each of these areas discharged their patients. The questionnaire only sought information on discharges and did not mention the word transfer as transfers were assumed by the researcher to be included in the broader definition of discharge. As there were no differences identified between work areas in factors considered for discharge, it can be concluded that all surveyed nurses took discharge to mean a discharge external to the nursing establishment. If this was the case then it is not in keeping with the literature which describes discharge planning as "the part of continuity of care process which is designed to prepare the patient for the next phase of care and to assist in making any necessary arrangements for that phase of care..." (American Nurses' Association, 1975, p. 10).

The next phase of care may not necessarily be back in the community but may well be a discharge from the Intensive Care Unit back to a general ward within the same establishment. In fact, it would be very rare for any patient from an Intensive Care Unit or Operating Theatre to be discharged to anywhere other than a ward within the same establishment. Therefore, one would expect that nurses discharging from these areas would consider different factors to those nurses discharging back into the community. These findings may well suggest that Australian nurses need to develop a definition of discharge planning in order to obtain some degree of consistency of content in formulating discharge plans.

Of the nine broad groups identified by nurses in both acute and non acute areas only Activities of Daily Living and Medications showed any real difference in frequency of selection. Nurses in the non acute areas considered Activities of Daily Living less frequently than nurses in the acute areas. This may be attributed to nurses in the non acute areas, for example, extended care, taking ADLs for granted in planning for discharge. As ADLs play such a major part in the day to day management of these patients it may well be that nurses automatically assume the need for this consideration in discharge planning, but fail to identify it because of its obviousness.

This may be in keeping with Benner's description of the expert performer who no longer relies on an analytical principle to connect understanding of the situation to an appropriate action, and has an intuitive grasp of the situation and is able to zero in on the accurate region of the problem without wasting consideration on a range of alternative diagnoses and solutions (Benner cited by Alexander in Marriner-Tomey, 1989, p. 191).

On the other hand, Medications were considered twice as often by nurses in the acute areas as opposed to nurses in non acute areas. This difference may be attributed to the importance in acute areas of medications in stabilising many acute conditions including pain. Failure to provide the medication may have deleterious effects for the patient and cause discomfort, therefore nurses in the acute care areas

are very conscious of the importance of medications in the care and welfare of their patients.

Similarly, one would have thought that nurses in the non acute areas would be equally considerate of medications in discharge planning as medications often represent an ongoing maintenance programme for patients from these areas. That is, if the patients' needs for chemical maintenance is not recognised by the nurse then the possibility of deleterious effects again become a major issue for the patient.

Factors Which Nurses Considered as Enhancing Discharge Planning

The 55 factors grouped into 10 broad groups identified by the research participants as having the ability to enhance discharge planning were predictable. Eighty three percent of respondents felt that medical and nursing practice styles that incorporated co-operative collaborative practices were the greatest contributors to enhancing the discharge process. This finding is in keeping with any multi-faceted procedure which involves more than one person. For it to be effective there must be a degree of expertise, collaboration and commitment to the action. It was interesting to note that some nurses perceived their colleagues as being not committed to the process of discharge planning and others as having insufficient knowledge of their patients' needs to be able to effectively plan for discharge.

Factors in relation to Health Related Support were mentioned by 72% of the respondents making them the second greatest contributor towards enhancing the discharge process. These factors mainly addressed community resources and their availability on discharge; therefore, the day of the week of discharge was a factor which enhanced discharge planning for some nurses. That is, discharge on a week day when community resources were open and available was better than a discharge on a weekend when the facilities were closed or unavailable. However, it is recognised that in many cases the day of discharge is beyond the control of the nurse and in most instances the day of discharge is left to the discretion of the medical officer in charge.

This factor needs to be seriously addressed if discharge planning is to become an efficient process based on input from a multidisciplinary team.

Communication and Patient and Family Education were other broad groups which rated highly in enhancing discharge planning whereas areas such as Environmental Support, Physiological Status, Psychosocial Functioning and Nutrition, Housing and Clothing rated at the lower end of the scale. It is interesting to note that Physiological status rated at the lower end of the scale (13.04% or 7 responses) when it is, or should be, the catalyst that generates the association for individual clients' discharge dependency / needs. One possible reason for this finding may be that the surveyed nurses only listed those physical factors in which they believed they had control over, or could actively intervene in.

In summary, co-operation, communication and the availability of support services were the major areas which nurses saw as contributing to enhancing the discharge process.

Factors Which Nurses Considered Impeded Discharge Planning

Fifty five factors were identified by respondents as impeding the process of discharge planning. The two most frequently cited factors in impeding the process related to poor or inadequate communication and / or liaison (27.5%) and busy workload and lack of time (27.5%). Poor documentation accounted for (11.6%), too much paper work (4.3%), changes in patient health status (5.8%) and inadequate staffing (7.2%). These figures compare quite favourably with the results of Schlemmer's (1989) study which surveyed 70 critical care head nurses throughout the state of Washington. Her findings showed that the greatest impact in delaying discharge planning was increased working loads (21.2%) followed by increased patient acuities (18.2%), increased paperwork (10.6%) nurse / patient ratios (9.1%)

and inadequate staffing (6.1%). This would suggest that Western Australian nurses encounter similar problems to those of their counterparts in the state of Washington when it comes to effective discharge planning.

These 55 factors were then similarly grouped into broad groups in keeping with those used to group factors which enhanced discharge planning. Again, the broad groups identified by the research participants were predictable with poor / inadequate communication in all its forms being cited by almost three quarters of the sampled population as the biggest factor impeding effective discharge planning. This is to be expected where a multidisciplinary team is required to produce common outcomes and demonstrates the surveyed nurses' awareness of the importance of communication in all its forms in planning for patient discharge; that is, written and oral, listening and the two way transfer of information / knowledge to and from the appropriate sources, and through the appropriate channels within given time frames.

This finding lends further support to the assumption that nurses, and in particular, tertiary educated nurses, may consider communication as such a basic component of any procedure, that familiarity of practice was a reason it may have produced such a poor response as a factor for consideration in discharge planning. The findings also give support to the argument that tertiary educated nurses may have failed to identify communication as a broad group because of the minimal sample population. Health Related Support was the second most frequently cited group of factors which impeded discharge planning and accounted for 70.7% of the responses with Institutional Influences accounting for 59.42% of responses. The remainder of broad groups identified as impeding the discharge process all rated responses of less

than 50% and included Nutrition, Housing & Clothing, Physiological Status, Environmental Support with Medications at the lowest end of the scale (1.4%).

In summary, the data suggest that Communication, Health Related Support and Institutional Constraints are the three major areas which impede the effectiveness of preparing for patient discharges.

The surveyed nurses were very focussed in identifying those broad groups which impeded, and those broad groups which enhanced the discharge process. Furthermore, the frequency of selection for each broad group were similar within the enhancement group and the impeding group. This implies that regardless of the nurses' age, education, experience or work context they were consistent in identifying those factors which enhanced the discharge process and those factors which impeded the process.

Implications of Findings in Relation to P.P.S, Casemix and D.R.G's.

According to Bristow, Stickney and Thompson, (1976) effective discharge planning depends on six variables :-

1. Severity of illness
2. Expected health care outcome
3. Anticipated duration of care
4. Determination of actual and anticipated needs
5. Availability of community resources
6. Dependability of significant others

A review of current literature suggests that in the U.S.A. the advent of DRG's has encouraged nurses and social workers to consider all of these variables when admitting patients to ensure that an effective discharge occurs (Barry, 1993). In the

U.S.A. findings suggest that DRG's have had a critical influence on discharge planning, with increased routinisation, communication and collaboration (Bull, 1986). These factors have been instrumental in decreasing readmission rates from inappropriate or poorly planned discharges.

Stuen's (1987) on the study of prospective payment on discharge planners indicates that discharge planners have a different view of the possible strengthening effect DRG's can have on the nurses position in the hospital. In general, the literature suggests that the introduction of DRG's into the U.S.A. health care system has improved the quality of discharge planning.

The major findings from this study highlight deficiencies in utilising a problem solving approach in planning patient discharges, failure to demonstrate priorities in planning discharges, and lack of understanding of the term discharge. These findings either in isolation or together have the potential to prevent effective discharge practices and therefore, to increase costs to hospitals through either delayed or inappropriate discharges or readmissions.

These findings would suggest that the surveyed Western Australian Clinical Registered Nurses are not yet sufficiently educated or skilled in developing effective discharge plans that are based on individual patient needs, offer continuity of care and ensure quality care. Williams (1991) claims that discharge planning currently occurs on an ad hoc basis with some planning practices being largely ineffective.

With the introduction of casemix funding into the Western Australian healthcare system later this year (1995) it would appear essential that local nurses develop better skills in discharge planning in order to meet the challenge of cost containment under the new funding system. Effective discharge planning that reduces length of stay and decreases readmission rates will probably be the biggest contribution clinical nurses can make towards cost containment, and therefore, they should endeavour to perfect this process. Western Australian nurses are now confronted with the challenge to further develop their discharge planning skills and

have the opportunity to learn from the experience of their counterparts in Victoria who have been using casemix as a retrospective payment system since 1993.

According to the Honourable Dr Carmen Lawrence, Minister for Human Services and Health, the recently completed independent assessment of Victoria's casemix funding system should assist other states as they plan the move to casemix funding by highlighting areas and issues that still require addressing. Dr Lawrence said that while the assessment had shown casemix to be an effective administrative tool, it revealed several areas of concern. She said that the consultation process, surveys and data analysis conducted as part of the assessment were particularly useful in identifying many areas of concern in the way Victoria has introduced casemix based funding. These include the impacts on post discharge planning and continuity of care, the training of medical and nursing staff, and research (Lawrence, 1995).

In support of Dr Lawrence, Dr Michael Walsh says that "From a clinical perspective, we've seen changes in ward areas and the way they do business with the clinical departments. They are far more aware now of patients' requirements from both a clinical perspective and resource perspective" (Walsh, 1995. p.5). He reported that there was increasing attention being paid to preadmission planning and discharge planning. "Even though it is often associated with earlier discharge, we're seeing evidence that nursing and medical staff are working together to ensure the discharge option is an appropriate one" (Walsh, 1995, p. 6).

According to Professor Peter Phelan (1995, p. 20) casemix has "focussed the mind" on discharge planning. "I believe this problem was there before, but now, everyone has become so aware of the importance of proper discharge. Proper discharge is right and proper for the patient. The sooner the patient is back in their home the better ..." He says that "we clearly need to ensure that if the patients are going to be discharged early, that's planned, the community facilities are informed, it's negotiated. We need to involve general practitioners and community services. If casemix has achieved better discharge planning and earlier discharge I think that is a very positive thing."

The results from this study would indicate that whilst Western Australian Clinical Registered Nurses contribute to the discharge planning process, they do so as a collaborative component of a system that is both open and multifactorial. Furthermore, by nature of their role and position they are limited in the amount of input they can have into discharge planning. In order for Western Australian Clinical Registered Nurses to be able to improve discharge outcomes they need to be given greater powers to co-ordinate the process. It would seem that currently the process of discharge planning is disjointed or lacking specificity in terms of inputs. If the inputs lack clarity or content, then the effectiveness of the input in its translation as a throughput is jeopardised and will therefore affect the effectiveness of the output. If feedback from the output does not produce the desired outcome then the cycle has to be repeated. In discharge planning terms this means that if the inputs are inadequate to be actioned or interpreted and translated to an effective discharge outcome, the discharge may result in a readmission or added cost burden in the form of further treatment / resources. The findings suggest that currently nurses do not select discharge factors on analysis of individual needs, but on a prescribed list of factors; medical officers are most often not amenable to empowering nurses to make the discharge process efficient, and that often the facility itself does not provide adequate resources in the form of staff and time to effect satisfactory discharges. These individual inputs lack interaction which prohibits the components from being planned, arranged, maintained and managed so as to provide effective inputs to the process, in order to generate the interventions (throughputs) to achieve the desired outcomes.

Unsatisfactory outcomes are not only frustrating for the client, but place added costs and strain on the discharging facility by increasing readmission rates and therefore bed occupancy and overheads. Readmission rates are one measurement of the effectiveness of the discharge process and are readily relatable to the feedback component of Von Bertanlanffy's open system theory.

Chapter Six

Summary and Recommendations, Implications for Nursing, and Recommendations for Future Research

This chapter discusses the conclusions that have been drawn from the study, the implications for nursing and makes recommendations for further research.

Summary

In summary, the findings of this study show that Western Australian Clinical Registered Nurses believe that discharge planning is an essential component of continuity of patient care, and that patients should be involved in the planning of their own discharge; however the findings did not measure the nurses' commitment to these beliefs.

The surveyed population identified 62 individual factors which they identified as being considered when planning for patient discharge. These factors were similar in selection to those cited by Barry (1983), Thompson (1985) and Pierangeli & Spencer (1987) as being necessary to consider in planning for an effective discharge. The most frequently identified factors related strongly to support services / facilities such as Family Support and Community Resources followed by physical limitations / restrictions.

Following the reclassification of the individual factors into broad groups, comparison between metropolitan and non metropolitan nurses failed to demonstrate any significant differences in factors considered by these groups. Likewise, there were no statistically significant differences in discharge factors considered between nurses who undertook hospital based training and those who were tertiary educated. Findings related to length of nursing experience failed to identify any relationship

between length of experience and discharge factors identified. The areas (ward / unit) in which nurses worked also showed no significant differences in the factors considered when discharge planning.

Respondents were able to identify 55 factors which they considered enhanced the discharge process and 55 factors which they believed impeded the process. The factors which were identified as enhancing the process were conversely seen as impeding the process if they were not considered or deleted. The factors which were identified as impeding the process showed similarities with the results of a Washington, U.S.A. study by Schlemmer in 1989.

Overall, the findings suggest that the studied population do not have a clear understanding of the definition of "discharge". There is no evidence in the collected data to suggest that any of the respondents identified discharge as to include "transfer" or to assimilate the "next phase of care" whether it be in the same institution or another, with "discharge". The general consensus would appear to be that "discharge" and "transfer" are two totally different procedures, whereas the current literature indicates that discharge means any movement from one area of continuing care to another.

The findings also suggest that Western Australian Clinical Registered Nurses, regardless of type of education, length of clinical experience, area of work or location basically consider the same discharge factors when discharge planning. This suggests that the respondents are not seeing patients as unique beings with unique needs in a unique environment, but as beings that have to be moulded to fit a preconceived formula. If this is the case it begs the question of whether nurses really believe that patients should have direct input into their discharge plan and whether nurses really perceive discharge planning as being essential to the continuity of patient care.

Recommendations

In an attempt to improve the quality of discharge planning in order to better meet the demands of casemix, prospective payment systems and diagnostic related groups the following recommendations are suggested by the researcher :-

1. Nurse educators in all health domains be charged with the responsibility for ensuring that all nurses are conversant with, and understand the definition of patient discharge in its fullest sense, and in keeping with the definition laid down by the American Nurses' Association and supported by the Health Department of Western Australia and current experts in the field of discharge planning.

2. Care facilities develop discharge planning policy and protocols as an in-service program for nursing, medical, and allied health staff. Such in-service training will encourage staff ownership of the concept in conjunction with the concept of continuity of care.

3. Care facilities prioritise discharge planning training within the staff development curriculum to ensure that nurses are capable of preparing patients for discharges that are timely and in keeping with individual patient needs.

4. Determine that the resource personnel available to assist others to develop skills in discharge planning are evaluated regularly for competence.

5. The development of education programs for health professionals regarding patients' rights to be involved in planning to meet their own health care needs whether it be in or out of the hospital environment. Allowing patients to assume a greater role in planning their own health care needs will ensure a programme that is individually tailored to meet the patients' perceived needs, and not the needs of the nurse or the establishment.

6. A collaborative approach by a committee, representative of all health care workers to develop a single discharge planning tool suitable for all types of patient discharges regardless of specific environment. A tool be developed which is not definitive in its format, but encourages the discharge planner in conjunction with the patient, to work through broad parameters based on an individual assessment of the patients' obvious and perceived needs rather than the current system of working through set criteria regardless of need. These parameters should include :-

Proposed length of stay

Rehabilitative needs of the patient

Plan of action for education of the patient / family / significant others

Organisation of the services required to meet the identified needs of the patient prior to, and following discharge.

Expected health outcomes.

7. The development of a Performance Indicator of Quality Assurance activity to measure the effectiveness of discharge planning, particularly in relation to length of stay and readmission rates.

8. The development of an education package for patients providing information on their rights and responsibilities in relation to discharge planning.

9. The final recommendation pertains to the introduction of an educational programme for nurses on the importance of assessing individual patient needs in relation to preventive health practices when planning discharges. A programme of this nature will not only help to reduce complications and relapses but should have the ability to reduce readmissions and therefore a reduction in hospital expenditure. The findings of this study found that all surveyed nurses failed to consider this factor when planning patient discharges.

Implications for Nursing

The study findings have implications for nursing, particularly in the areas of nurse education and nurse practice.

Nurse educators must accept responsibility for ensuring that beginning nurses are fully conversant with, and capable of providing the knowledge and skills required on entry into the care facility to meet the needs of their clients. The findings of this study suggest that this may not be happening in relation to the discharge planning process. There is no demonstrated evidence that the surveyed nurses were able to conceptualise discharge in its broadest accepted context as defined by the American Nurses' Association, and the Health Department of Western Australia. That is, the subjects only saw discharge as being the transfer of the patient from the care facility to home or another care facility. No consideration was given to discharge from one area of care to another area of care within the same care facility.

To this extent it may be advisable that the Australian Nursing Federation develop and communicate a position paper similar to its American counterpart, defining discharge planning and the associated responsibilities of Australian nurses.

Recommendations for Further Research

Findings from this study indicate that further studies should be conducted to :-

1. determine nurses' commitment to the discharge planning process. The determined level of commitment will ultimately determine the level of effectiveness in discharge planning.

2. specifically measure nurses' knowledge of the discharge planning process. This is essential to provide base line data from which to formulate educational requirements.

3. ascertain nurses' knowledge of the benefits of effective discharge planning in cost containment, particularly in relation to DRG's and prospective payment systems.

4. identify appropriate discharge plans which meet the needs of effective discharge planning in terms of individual patient needs, length of stay and reduction in readmission rates.

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APPENDIX A - FACTORS CONSIDERED WHEN PLANNING FOR DISCHARGE

FACTOR No:	*FACTOR*	*FREQUENCY %*
1	Family Support	50(72.5)
2	Community Resources	39(56.5)
3	Follow Up Appointments	24(34.8)
4.	Home Environment	23(33.3)
5	Patient Education	20(29)
6	Age of Patient	20(29)
7	Physical Capabilities	19(27.5)
8	Ability to Perform Activities of Daily Living	18(26.1)
9	Medications	15(21.7)
10	Transport	14(20.3)
11	Mobility	11(15.9)
12	Patient's Economic Status	10(14.5)
13	Patient's Understanding of Health Disability	10(14.5)
14	Psychological Capabilities	10(14.5)
15	Degree of Recovery from Current Illness	9(13)
16	Patient's Social Situation	9(13)
17	Place of Residence	9(13)
18	Family Education	9(13)
19	Physical Requirements of Patient	9(13)
20	Patient's Present Illness	9(13)
21	Availability of Support Needs	8(11.6)

22	Capability of Carer	8(11.6)
23	Physical Supports Required by Patient	7(10.1)
24	Diet	6(8.7)
25	Patient's Feelings	6(8.7)
26	Transfer Centre	6(8.7)
27	Length of Hospital Stay	5(7.2)
28	Patient's Ability to Understand Instructions	5(7.2)
29	Previous Exposure to Community Resources	5(7.2)
30	Communication	5(7.2)
31	Patient Compliance	5(7.2)
32	Social Capabilities	5(7.2)
33	Admitting Diagnosis	4(5.8)
34	Closeness of Home to Follow Up Facilities	4(5.8)
35	Return to Work	4(5.8)
36	Day of Discharge	3(4.3)
37	Families Feelings	3(4.3)
38	General Practitioner Support	3(4.3)
39	Medical Liaison	3(4.3)
40	Other Facility Involvement	3(4.3)
41	Patient's Previous Illness	3(4.3)
42	Patient's Wishes and Expectations	3(4.3)
43	Return to Sexual Activity	3(4.3)
44	Cultural Beliefs	3(4.3)
45	Ability of Patient \ Carer to be Involved in Discharge Plan	3(4.3)
46	Previous Needs for Support	3(4.3)

47	Patient Dependency	2(2.9)
48	Patient's Lifestyle	2(2.9)
49	Patient's Religion	2(2.9)
50	Patient's Employment Status	2(2.9)
51	City Accommodation for Rural Patients	1(1.4)
52	Clothes	1(1.4)
53	Hospital Policy of Discharge Time	1(1.4)
54	Medical Certificates	1(1.4)
55	Patient's Understanding of Previous Illness	1(1.4)
56	Provision of Post Discharge Carer	1(1.4)
57	Occupational Therapy	1(1.4)
58	Number of Dependents	1(1.4)
59	Discharge Summary	1(1.4)
60	Patient's State of Continence	1(1.4)
61	Patient's Behaviour Pattern	1(1.4)
62	Anticipated Discharge Date	1(1.4)

APPENDIX B - FACTORS WHICH ENHANCE DISCHARGE PLANNING

FACTOR NUMBER:	*FACTOR*	*FREQUENCY(%)*
1	Community Resources	22(31.9)
2	Detailed knowledge of patient's particulars/home situation	17(24.6)
3	Patient and family involvement in discharge plan	17(24.6)
4	Effective communication between care givers	17(24.6)
5	Patient education re discharge plan and expectations	16(23.2)
6	Co-operative medical staff	13(18.8)
7	Good family support network	12(17.4)
8	Liaison with medical and para medical staff	11(15.9)
9	Sufficient nursing hours to complete a discharge plan	10(14.5)
10	Commencing discharge planning on admission	8(11.6)
11	Continual assessment of patients' discharge needs	8(11.6)
12	Expected discharge date set by medical officer on admission	8(11.6)
13	Knowledge of patients' capabilities	7(10.1)
14	Nurses familiarity with local area/resources	6(8.7)
15	Ability of patients to co-operate and be responsible for their own health	6(8.7)
16	Standardised discharge plan form	6(8.7)
17	Knowing patients' diagnosis/operation	6(8.7)
18	Patients awareness of condition	6(8.7)
19	Accurate and thorough patient history	5(7.2)

20	Continuity of care	4(5.8)
21	Receiving agencies satisfaction	4(5.8)
22	Discharge plan summary in notes	4(5.8)
23	Patient's awareness of discharge policy on admission	3(4.3)
24	Nursing commitment to discharge planning	3(4.3)
25	Availability of transport	3(4.3)
26	Availability of follow up services	2(2.9)
27	Availability of satisfactory placement facility	2(2.9)
28	Degree of patient wellness	2(2.9)
29	Feedback of patient's needs	2(2.9)
30	Hospital's Discharge Co-ordinator	2(2.9)
31	Specialised resources available within the care facility	2(2.9)
32	Patient satisfaction	2(2.9)
33	Patient and family motivation	2(2.9)
34	Hospital's discharge planning policy	2(2.9)
35	Case conferences	2(2.9)
36	Correct attitudes towards discharge planning	2(2.9)
37	Families satisfaction	2(2.9)
38	Common sense	1(1.4)
39	Hospital Accreditation process	1(1.4)
40	If discharge is done by admitting nurse	1(1.4)
41	Non pressure by hospital for early discharge	1(1.4)
42	Nurse's experience in a variety of work settings	1(1.4)
43	Patient compliance	1(1.4)
44	Patient's willingness to leave hospital	1(1.4)

45	Patient's wishes	1(1.4)
46	Standardised information at point of entry to health care agency	1(1.4)
47	Sufficient notice of discharge by medical officer	1(1.4)
48	Supportive primary care giver	1(1.4)
49	Use of interpreters	1(1.4)
50	Availability of follow up phone contact	1(1.4)
51	Well educated nurses	1(1.4)
52	Nursing knowledge of discharge planning	1(1.4)
53	Hospital management support	1(1.4)
54	Prior knowledge of patient	1(1.4)
55	Good documentation	1(1.4)

APPENDIX C - IDENTIFIED FACTORS WHICH IMPEDE DISCHARGE PLANNING

FACTOR NUMBER:	*FACTOR*	*FREQUENCY(%)*
1	Poor/inadequate communication/liaison	19(27.5)
2	Busy workload/lack of time	19(27.5)
3	Limited community resources	12(17.4)
4	Lack of assistance/support by family/friends/carers	11(15.9)
5	Poor multidisciplinary documentation of discharge plans	8(11.6)
6	Short notice of discharge by medical officer	8(11.6)
7	Patient's ability or willingness to comply	7(10.1)
8	Lack of information given to patient to make informed decisions	6(8.7)
9	Lack of patient/family education	6(8.7)
10	Unco-operative colleagues/patients/relatives/medical staff	6(8.7)
11	Lack of planning by medical staff	5(7.2)
12	Lack of suitable accommodation	5(7.2)
13	Unrealistic family expectations	5(7.2)
14	Unrealistic patient workload/staff shortages	5(7.2)
15	Discharge plans being done just prior to discharge	5(7.2)
16	Poor nursing documentation on discharge plans	5(7.2)
17	Change of health status of patient	4(5.8)
18	Lack of follow up care	4(5.8)
19	Nurses apathy towards discharge planning	4(5.8)

20	Rushed discharges due to bed shortages	4(5.8)
21	Patients' expectations	4(5.8)
22	Cultural influences	3(4.3)
23	Foreign language difficulties	3(4.3)
24	Inaccurate assessments	3(4.3)
25	Lack of suitable transport	3(4.3)
26	Reluctance of patient to leave safe hospital environment	3(4.3)
27	The system	3(4.3)
28	Too much paper work	3(4.3)
29	Lack of finance for full follow up	3(4.3)
30	Nurses knowledge deficits in discharge planning	3(4.3)
31	Bed shortages	2(2.9)
32	Having to complete a discharge plan on a patient you don't know	2(2.9)
33	Inadequate planning	2(2.9)
34	Overbooked resources	2(2.9)
35	Pre set ideas by medical staff	2(2.9)
36	Too much information required on discharge plan	2(2.9)
37	Isolation of rural communities	2(2.9)
38	Family expectations	2(2.9)
39	Doctors' attitudes	2(2.9)
40	Community expectations	2(2.9)
41	Lack of knowledge in resourcing community backup	2(2.9)
42	Discharge medications not ready	1(1.4)
43	Fragmentation of services	1(1.4)

44	Frequent ward staff changes	1(1.4)
45	Inadequate In-Service education of discharge planning	1(1.4)
46	No consideration of trial discharge eg weekend leave	1(1.4)
47	Other health professionals	1(1.4)
48	Patients' resistance to use of other resources	1(1.4)
49	Requiring doctors approval to initiate aspects of discharge plan	1(1.4)
50	Short stay patients	1(1.4)
51	Patients' haste for discharge	1(1.4)
52	Patients' financial status/constraints	1(1.4)
53	Inadequate assessment of home environment	1(1.4)
54	Discharge date uncertain	1(1.4)
55	Unsupportive General Practitioner	1(1.4)

APPENDIX D - CONSENT FORM

[redacted]

6th September, 1993

Dear Colleague,

I am a Registered Nurse enrolled in the Masters in Nursing program at Edith Cowan University. As part of the course requirements, I am conducting a survey on discharge planning. I wish to establish a data base on the factors that nurses use to guide in planning patient discharges. By completing the enclosed questionnaire you will contribute to findings of the survey.

You have been randomly selected from the General Register of the Nurses' Board of W.A. by **Nurses' Board staff** to maintain anonymity, and there is no need to identify yourself on the questionnaire. If you agree to participate in this survey, you will be at liberty to withdraw from the survey at any time and for any reason and without penalty.

I know that your time is valuable, but the questionnaire is easy to complete, and should only take about 15 minutes of your time. Please place the completed questionnaire in the enclosed self addressed, reply paid envelope, and return by the 20th September, 1993.

If you have any queries about the survey itself, or any of the questions, you can contact me by phone or mail at the above address. I will also be happy to provide you with a copy of the results of the survey if requested.

CONSENT TO BE A RESEARCH SUBJECT:

I _____, agree to participate in the proposed study. I understand that by participating in the study my confidentiality will be maintained and that findings from this study will have no name identified data published.

I further understand that I may withdraw my consent to participate in this study at any time and for any reason without penalty.

I realise that there will be no personal benefit for me in agreeing to participate in this study and that I will not be paid for my participation.

Signature: _____ **Date:** _____

Thank you for your participation.

_____

Stan Suiter.

APPENDIX E - SAMPLE QUESTIONNAIRE

QUESTIONNAIRE

Part 'A'

Demographic Data: **Office Use Only**

1.	**AGE:**	20 - 29	( )	(01)
		30 - 39	( )	(02)
		40 - 40	( )	(03)
		50 - 59	( )	(04)
		60 - 65	( )	(05)
2.	**SEX:**	Male	( )	(01)
		Female	( )	(02)
3.	**INITIAL NURSING EDUCATION:**			
		Hospital	( )	(01)
		Tertiary	( )	(02)
4.	**HIGHEST NURSING QUALIFICATION:**			
		Hospital Graduate	( )	(01)
		Tertiary Undergraduate		
		Diploma	( )	(02)
		Degree	( )	(03)
		Tertiary Postgraduate		
		Post Graduate Diploma	( )	(04)
		Masters	( )	(05)
		Ph.D	( )	(06)

5. **CURRENT POSITION CLASSIFICATION**

Level 1	( )	(01)
Level 2	( )	(02)
Level 3	( )	(03)
Level 4	( )	(04)
Level 5	( )	(05)

6. **NUMBER OF YEARS <u>PRACTICING</u> AS A REGISTERED NURSE**

_____ years

7. **AREA OF EMPLOYMENT**

Metropolitan	( )	(01)
Non Metropolitan	( )	(02)

8. **EMPLOYMENT FACILITY**

Teaching Hospital	( )	(01)
Government General Hospital	( )	(02)
Private Hospital	( )	(03)
Government Nursing Home	( )	(04)
Private Nursing Home	( )	(05)
Teaching Institution	( )	(06)
Community	( )	(07)
Currently Unemployed	( )	(08)
Other _____ Please Specify	( )	(09)

9. **USUAL WORK AREA. (Tick one only).**

Medical/Medical Specialties	( )	(01)
Surgical/Surgical Specialties	( )	(02)
Gerontology	( )	(03)
Intensive/Coronary Care	( )	(04)
Operating Theatres	( )	(05)
Paediatrics	( )	(06)
Nursing Management	( )	(07)
Staff Development	( )	(08)
Nursing Research	( )	(09)
Other _____		(10)

Part 'B'

General Discharge Planning:

Please respond to the following by **ticking** the appropriate response.

1. **Do YOU think discharge planning is essential for continuity of patient care?**

Strongly Agree	( )	(01)
Agree	( )	(02)
Disagree	( )	(03)
Strongly Disagree	( )	(04)

2. **Do YOU believe patients should be involved in the planning of their discharge?**

Yes ( ) (01) No ( ) (02)

3. **What factors do you consider when developing patient discharge plan?**

4. **What influences do you believe ENHANCE your discharge planning (if any).**

5. **What influences do you believe IMPEDE your discharge planning (if any)?**

6. **Please feel free to make any further comments (either positive or negative) on the process of discharge planning in relation to your role as a professional nurse.**

Thank you for your cooperation in completing this questionnaire.