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**PROCESS EVALUATION OF AN INTEGRATED
MODEL OF DISCHARGE PLANNING**

by

Chantale Marie LeClerc

**A thesis submitted in conformity with the requirements
for the degree of Master of Science
Graduate Department of Nursing Science
University of Toronto**

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Abstract

Process Evaluation of an Integrated Model of Discharge Planning

Master of Science 1998

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In this study, a new, theoretical model of discharge planning for the hospitalized elderly was evaluated to determine whether it could be implemented in a hospital setting and what facilitated or challenged the implementation. The process evaluation involved four case studies conducted on three in-patient units of two acute-care hospitals in Metropolitan Toronto. Data were analyzed using the strategies of explanation-building and case-comparison. Three main study results emerged. First, the integrated model had the potential to be implemented in a hospital setting when certain conditions were in place. Facilitators to the implementation included (a) a high level of commitment of the discharge managers (DMs); (b) patients having stable medical conditions; (c) DMs familiar with the integrated approach, having offices on the in-patient unit and, working extended hours; (d) substitute decision-makers being available; and (g) discharge planning forms being included in the patient's hospital chart. The second major study finding was that use of the integrated approach to discharge planning contributed to patient satisfaction. Thirdly, the materials developed as part of the discharge planning protocol required only minor formatting modifications in order to be rendered user-friendly. In the thesis, recommendations were made to facilitate future implementations of the integrated model in other settings and for ongoing and future process evaluations.

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Acknowledgments

"A good traveler has no fixed plans and is not intent on arriving."

Lao Tzu

(870-490 BC)

The road that led to the completion of this thesis has been by far one of the most challenging and difficult ones that I have traveled. It lead me up hills and mountains and down gorges and valleys. It was winding and tortuous and more than once I thought I had lost my way. The journey has proved to be much more than an academic accomplishment. It has been one of self-discovery and growth. I realize now that I have not come to the end of the road, but to a mere resting place from which I can view the distance I have covered and the paths that lie ahead. I most certainly would not have come to this place without the help and guidance of some very special individuals.

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Chapter One: Introduction, Background and Literature Review

This thesis represents the first attempt at implementing a new theoretical model of discharge planning for elderly patients in a hospital setting. This integrated model was developed by Wells, Martin, Moorhouse, Craig and Foley (1998) out of a concern for the many problems associated with current discharge planning practices. The goal is to help hospital professionals plan for patient discharges in a manner that achieves organizational objectives while ensuring ethical decision making. However, before these outcomes could be measured, it was necessary to determine if the empirically-derived model could be used in the hospital setting. Therefore, a process evaluation was conducted to determine what challenged or facilitated the implementation of the model. In this thesis, the results of the process evaluation of the integrated model of discharge planning are presented and recommendations are made for those wishing to implement the model in their settings and for future, ongoing evaluations.

Background: Discharge Planning in Today's Hospital Context

In recent years, medical advances, shifting demographics and altered public expectations and accountability have placed enormous pressure on hospitals to provide services differently (Axler, Donner, Underwood & Van de Bogart, 1997). The requirements for acute-care beds have been reduced substantially and there is a shift from inpatient acute-care services to more in-home and long-term care services. Furthermore, governmental funding to hospitals has decreased despite rising hospital costs (Baumann et

al., 1996).

These trends have resulted in massive restructuring of the hospital system. Hospitals in Canada are presently undergoing “the most extensive round of reform since the inception of Medicare twenty-five years ago” (Hurley, Lomas & Bhatia, 1994, p.491). The number of hospital beds in Canada has dropped 30% in the last decade and hospitals have either closed, merged, or converted to other uses leaving 978 as opposed to 1,224 hospitals in the country (Statistics Canada, 1994). In Metro Toronto alone, the number of acute-care beds has decreased by 3,500 between 1988 and 1994 (Axler et al., 1997). In addition to the restructuring, the remaining hospitals are developing other strategies to further control expenditure. One method relies on decreasing the length of time patients remain in hospital. Today, the average length of stay is 7 days. Ten years ago, it was 9 days (Statistics Canada, 1994).

Elderly patients who are sixty-five years of age or over are often targeted by early discharge programs. They have approximately twice as many hospital admissions and over twice as long an average length of stay than other age groups (McWilliam, 1992). Furthermore, elderly patients typically have an unpredictable clinical course and discharge outcomes (Wells, 1997). Although the rates of hospitalization are slowly moving downward for the elderly, especially those over 75 years of age, their numbers are rising rapidly as mortality rates fall among this age group (Evans, 1985). It is therefore becoming more critical to address the discharge-related challenges posed by this population.

The findings of research conducted during the last couple of decades have clearly demonstrated that the present approaches to discharge planning for the elderly in the acute-care hospital setting are problematic. Current in-hospital discharge planning

practices actually impinge on the hospital's heightened interests in managing resources effectively, providing quality patient care, and ensuring ethical decision making (Wells, 1997).

In order to learn about ways to provide more efficient and compassionate discharge planning for acutely-ill elderly patients, a 9-month qualitative study using focus group and telephone interviewing methods was recently completed (Wells et al., 1998). Based on the perceptions of the 130 participants in the study, which included hospital and community-based professionals, patients, and families, a new, integrated model of discharge planning was developed. The model consists of seven key elements or principles. These elements *together* constitute the integrated approach to the discharge of elderly patients. A protocol was developed to operationalize the model. It comprises 24 activities to be carried out by a discharge manager (see Appendix A). At this time, the integrated model requires evaluation to determine whether it can be implemented in a hospital setting. Subsequent to this evaluation, the model will also require an examination of its effect on patient and hospital outcomes.

Literature Review

The purpose of the literature review was twofold. First, the research literature was examined to learn what was known about the process of discharge planning for the hospitalized elderly. Second, the review was conducted to determine if any strategies had been developed to address the problems associated with current discharge planning practices identified in the literature and how these approaches were implemented and evaluated.

Extensive manual and computerized searches of databases for nursing and allied health, medicine, psychology, and the social sciences were conducted to uncover the literature related to discharge planning. This search produced a large quantity of material pertaining to various aspects of the discharge process. References were included in the literature review if they (a) were published in English or French, (b) were research-based, (c) were published within the last 15 years, and (d) included in the sample persons over 65 years of age. A final number of 32 research studies were included in the literature review.

In the literature review, the findings of 26 descriptive studies that outline the nature of discharge planning for elderly persons in today's hospital context are presented first. These studies are summarized to provide an understanding of the problems associated with current discharge planning practices. Next, the focus turns to six studies that describe formally evaluated approaches to discharge planning. These six studies are reviewed and critiqued. A summary and an identification of the gaps in the literature on discharge planning for the hospitalized elderly appear in the final section of the literature review. In this section, a seventh model of discharge planning developed to address the shortcomings of previous research of discharge planning approaches and, which is the focus of the current study, is also presented.

Discharge Planning Practices for the Hospitalized Elderly

The nature of discharge planning for elderly hospitalized persons has been examined in several studies. The conclusions of these descriptive studies were that current approaches used to plan for hospital discharges are not only inefficient regarding resource use but also present ethical concerns. The problems outlined in these studies are described in the following sections.

Discharge decisions not congruent with the patient's clinical trajectory. Wells

(1997) conducted a critical ethnography of the process of discharge decision making for elderly patients to examine the nature of the process over the total course of patients' hospital stays. The focus was on describing the timing and conditions of decision making, the related activities of professionals, professionals' perceptions of the process, and the effects of the process on those involved and the hospital organization.

The ethnography involved non-participant observation of professionals' activities related to discharge decision making, medical record analysis, and interviews with professionals, patients, and families. Data analysis of 31 patient cases demonstrated that in 27 of the cases, the process was not intricately linked with patients' clinical trajectories. Because decisions were made before the patients' actual clinical outcomes became clear, a subsequent change was required in the discharge plans from those made earlier in 26 of the 27 cases. The need to modify discharge plans had consequences on the efficient use of hospital resources and was distressing to patients and families.

McWilliam (1992) also found in a qualitative study that discharge planning was often inconsistent with the patient's progress. The study involved in-depth interviews with 12 patients, 12 caregivers, and 62 health professionals involved in the discharge planning process, as well as participant observation and review of pertinent documents. Data were collected in hospital and 10 days post-discharge. The findings of the study were that discharge planning was conducted on the basis of physicians' progress notes, written orders, or informal verbal communication, most frequently with the charge nurse. Such communication proved to be inadequate for planning. Often the patient's progress changed, written orders were modified by orders or directions of other physicians

participating in the patient's care, and verbalized intentions were modified for either of these reasons. Dill (1995) through participant observation and interviews with hospital staff and patients on three in-patient units of a large teaching hospital found similar results. One example of premature decision making outlined in Dill's study involved discharge planners initiating applications to several nursing homes as soon as a patient's condition seemed to indicate the potential for placement. Making decisions prematurely often restricted patients' choices and control over discharge-related decisions.

Lack of clarity around the discharge planner role and absence of cooperation and support from physicians. In a descriptive exploratory study, Feather (1993) illustrated the importance of organizational factors in explaining the discharge planner's perceptions of the effectiveness of the discharge planning process across 378 hospitals. Through questionnaires completed by discharge planners, Feather found that the single most important variable in perceived effectiveness of hospital discharge planning was the support and cooperation of the physician staff. The author concluded that if discharge planners had power and clarity, almost any model of discharge planning could be effective. McWilliam (1992) and McWilliam and Sangster (1994) also found that discharge planners only had the ability to ensure the quality of discharge planning if and when physicians chose to share their authority and responsibility for care.

Current approaches to discharge planning lack a clearly defined discharge planner. For example, McBride (1995) performed a review of 60 sets of nursing notes and found that in 43% of cases, patients had their discharges arranged by more than one nurse. Although the consequences of having several nurses involved in discharge planning were not discussed, the author recommended that a single person should be responsible for

coordinating the discharge planning process. The author did not discuss why a single discharge planner would be required or suggest who that person should be.

Lack of coordination, communication, and leadership in discharge planning.

Current approaches to hospital discharge planning lack coordination, communication and leadership, which have negative consequences for patients, such as (a) patients not receiving the services they require upon discharge (Jewell, 1993), (b) less than adequate discharge plans (McBride, 1995; Proctor & Morrow-Howell, 1990), (c) delays in discharges (Proctor & Morrow-Howell, 1990), and (d) patients not receiving the information or education they required to manage at home upon discharge (McBride, 1995). Armitage and Kavanagh (1997) found in a recent qualitative study that lack of coordination and communication resulted in poor discharge planning. The nurses interviewed in the study portrayed discharge planning as a random event and most nurses relied on just picking up problems from conversations with patients or relatives. They described the process as “hit and miss” (p. 18).

Patient needs inaccurately assessed while in hospital. A discrepancy is often found between the needs identified and planned for in hospital and the person’s actual needs once they return home (Jewell, 1993; Mamon et al., 1992; Mistiaen, Duijnhouwer, Wijkel, de Bont, & Veeger, 1997; Perlman Simon, Showers, Blumenfield, Holden, & Wu, 1995; Prescott, Soeken & Griggs, 1995; Proctor, Morrow-Howell, & Kaplan, 1996; Storer Brown, 1995). One of the explanations for this discrepancy was the health care professionals’ narrow focus on medically-related issues. Mamon et al. (1992) compared two discharge planning strategies with regard to the extent that home care needs of patients being discharge from hospital were being met. They contrasted the needs of

patients who received usual discharge planning (i.e., that provided by the attending physician and nurses on the in-patient unit) with those of patients receiving formal discharge planning (i.e., where a social worker or registered nurse was the formal case manager). The researchers found that even when a discharge planning case manager was involved, only unmet needs related to medical treatment were significantly reduced ($-.097, p < 0.001$). The presence of the case manager had no effect on needs related to activity limitation, self-sufficiency needs, or other overall needs. The results of Mamon et al.'s study indicated that formal discharge planners focus primarily on treatment or medically-related needs.

Another potential explanation for why patients' post-hospitalization needs are not well identified during hospitalization may be that health care professionals and patients themselves are not able to anticipate what their needs at home will be while still in hospital (Boyle, Nance, & Passau-Buck, 1992; Jopp, Carroll & Waters, 1993). Furthermore, Reiley et al. (1996) found that nurses and patients do not agree on what constitutes the needs of patients following discharge home from hospital.

Patients and families not systematically involved in discharge planning. Patients have little or no involvement in decisions pertaining to their care following discharge from hospital (Congdon, 1994; Coulton, Dunkle, Chow, Haug, & Vielhaber, 1988; Kadushin & Kulys, 1994; McWilliam, 1992; McWilliam & Sangster, 1994; Wells, 1997). In only one study did most (71%) patients participate in the discharge planning process and control the final decisions over discharge plans (Abramson, 1988). However, the perceptions of patient involvement in discharge planning of 57 social workers from 7 acute care hospitals

rather than the patients' perceptions of their own involvement were reflected in the study finding.

In semi-structured interviews with 80 social workers, Kadushin & Kulys (1994) found that 34% of patients had almost no involvement in discharge planning. Patient participation was linked to functional status ($r = -.22, p < 0.05$), and mental status ($r = -.53, p < 0.001$). Surprisingly, 23% of competent patients were not involved in planning for their discharges from hospital ($r = -.32, p < 0.05$). The social workers explained that time constraints prevented them from involving all patients in discharge planning. In other studies, not involving patients in discharge decision making posed ethical problems related to the patient's right to self-determination (Chadwick & Russell, 1989; Dill, 1995; Dubler, 1988; Jewell, 1993; Morrow-Howell, Proctor, & Mui, 1991; Proctor, Morrow-Howell, & Lott, 1993; Wells, 1997).

Conflict of loyalty for professionals. Proctor, Morrow-Howell, and Lott (1993) interviewed 16 hospital social workers at a large urban teaching hospital, reviewed the medical records of 395 older patients for whom the social workers had provided discharge planning and interviewed these patients upon their return home from hospital. The authors found that 6% of conflicts experienced by the social workers resulted from trying to meet the needs of the hospital while trying to maintain a commitment to meeting the needs of the patient. In a critical ethnography of discharge planning for hospitalized elderly, Wells (1997) found that discharge decisions were related to requirements of the hospital organization rather than the patients' clinical conditions. The professionals interviewed in Well's study acknowledged that institutional goals of maintaining economic viability sometimes took priority over patients' and families' interests. As a result, patients were

discharged home sicker and families were pressured to accept the first place that became available when the patient was being discharged to a long-term care institution, regardless of their preference.

Summary of Discharge Planning Practices for the Hospitalized Elderly

In the review of the 26 descriptive studies, several problems associated with current discharge planning practices for the hospitalized elderly were outlined. These were (a) discharge decisions made too early, that is, before the patient's condition was clear; (b) a lack of clarity around the discharge planner role and an absence of cooperation and support from physicians; (c) a lack of coordination, communication, and leadership in discharge planning; (d) patient needs inaccurately assessed while in hospital and therefore, community services needing to be modified after discharge; (e) patients and families not systematically involved in discharge decision making thus challenging ethical principles related to informed decision making and patient autonomy; and (f) a conflict of loyalty for professionals between their commitment to the hospital and the needs of patients and families. These problems impact on the efficient use of hospital and community resources as well as on the well-being of patients and families. Interventions that were designed to improve the manner in which discharge planning for the hospitalized elderly occur are examined in the following section.

Empirically-Tested Models of Discharge Planning

The literature was reviewed to determine if any models or programs aimed at improving the process or outcomes of discharge planning had been developed and evaluated. Only six such studies were found. Four of the studies were conducted in the United States (Evans & Hendricks, 1993; Haddock, 1994; Naughton, Moran, Feinglass,

Falconer & Williams, 1994; Naylor, 1994), one took place in Scandinavia (Styrborn, Larsson & Drettner, 1994), and the sixth occurred in Israel (Soskolne & Auslander, 1993). The six empirical studies are presented individually. For each, a description of the design, study purpose, sample, data collection procedures, analysis, results related to the study objectives, as well as potential threats to internal and external validity is provided. The studies are then critiqued in terms of (a) the underlying theoretical principles guiding the development of the models, programs or interventions; (b) the manner in which the models, programs or interventions were implemented; (c) the manner in which they were evaluated; and (d) the quality of the evaluations.

Evans and Hendricks (1993) tested the effect of an early discharge planning program for high risk patients on decreasing length of stay in hospital, readmissions and nursing home placement. A randomized clinical trial design was used. The 835 elderly patients ($M=67$ years) included in the study had been identified as high risk for frequent health care resource use according to a risk screening index developed and validated by the researchers. The presence of eight mutually exclusive variables was evaluated in the index. These were (a) two or more chronic conditions, (b) poor mental status, (c) psychiatric comorbidity, (d) previous admission, (e) age of 70 years or older, (f) living alone or in a nursing home, (g) dependent ambulation, and (h) being unmarried. Scores ranged from zero to eight depending on how many of the characteristics were true for each patient. Patients with a score of three or more were considered at risk.

The 417 patients in the treatment group received discharge planning by a social worker from day three of admission. The social worker assessed the patient's marital relationship, support systems, living situation, finances, and area of need for patient

discharge planning by reviewing the hospital chart, consulting the attending physician and nurse, and interviewing the patient and family. The 418 patients included in the control group received discharge planning by the social worker only if a written physician request was made. This referral was usually initiated around day nine of hospitalization.

The data collection strategies of the study were not described. The data were analyzed using chi-square tests and t-tests. The authors found that 79% of the patients who received early discharge planning by a social worker were discharged back to their homes as compared to 73% in the control group. The authors did not state if these differences were statistically or clinically significant. The experimental group subsequently spent fewer days in a nursing home during the study period (25.5 ± 7.8 versus 39.9 ± 11.2 , $p < 0.001$). Fewer patients in the experimental group were readmitted during the month post-discharge (24% versus 35%, $p < 0.001$). Also, the average number of days readmitted was significantly less for experimental subjects (10.1 ± 8.3 versus 12.1 ± 9.1 ; $t = 3.3$, $p < 0.001$). The groups did not differ on length of index hospital stay or in frequency of death in hospital. However, the groups differed in the amount of social services received. The patients in the treatment group received more social services (97% versus 30%; $\chi^2 = 42.9$, $p < 0.001$). The authors report a difference in the timing of initiation of discharge planning. For the treatment group the discharge planning was initiated around the third day of admission as compared to the ninth day for the patients in the control group (3.1 versus 9.4; $t = 21.3$, $p < 0.001$).

The discharge planning protocol evaluated in the Evans and Hendricks' (1993) study was not described. The authors did not state explicitly what the social worker did to plan for the discharge. They also did not report when during the course of the patient's

hospital stay the discharge planning activities were performed. A description of who else was involved in the discharge planning process and of the types and timing of decisions being made was not provided. The authors concluded that early discharge planning had a positive effect on patient outcomes. However, because the discharge planning protocol may not have been administered consistently across patients, indicating a potential threat to the study's internal validity, it is difficult to conclude with certainty whether it was the early initiation of the discharge planning or the nature of the discharge planning itself that created the effect. The study findings do not lend support for the authors' conclusions that targeting efforts to those most in need was more efficient than trying to provide comprehensive planning for all patients or that the study identified criteria that predict a need for early discharge planning.

Haddock (1994) developed a structured discharge planning program which relied on the collaboration of a clinical nurse specialist (CNS) and a social worker as discharge planners. The desired outcomes of the program were to (a) increase patient satisfaction with the discharge planning, (b) increase the number of services provided to patients, (c) decrease hospital length of stay, (d) decrease hospital readmission, and (e) increase the amount of documentation concerning discharge plans.

In the quasi-experimental study, 64 patients aged 65 and over ($M=72.7$ years) admitted to five medical-surgical units in one acute care hospital in Southeastern USA were included. The first 35 patients who agreed to participate in the study served as the controls. They received the usual discharge planning by staff nurses, a CNS and, a social worker. The following 29 patients enrolled in the study received discharge planning directed through a collaborative effort by a CNS and a social worker following a

structured protocol using the Long-Term Care Information System (LTCIS) to guide assessment, planning and implementation. The LTCIS is a standardized tool for the collection of assessment information, including health and functional status, sociodemographic data, current resource utilization, medical treatment and, drug therapy. The author reports that the tool had received prior testing for reliability and was found to be 90% reproducible (Falcone, 1979, as cited in Haddock, 1994). Although the author states that the tool had also been found valid, a description of how this conclusion was established was not provided. Information on the LTCIS is gathered through patient interviews and chart review.

Before the study, the CNS and social worker agreed upon which areas of the assessment form each would complete. Together they reviewed the data and planned for the patient's discharge using the Translation to Service Needs Form of the LTCIS. To coordinate discharge preparation and needed services, the collaborating CNS and social worker met daily to review progress of the plan and determine specific tasks to actualize the plan. Patients in both groups were interviewed at 2 and 4 weeks post-discharge and their charts were reviewed.

Data were analyzed using chi-square tests and t-tests. The results showed that patients in the treatment group were significantly more satisfied with the discharge planning than were the controls as rated on a 10-point Likert scale ($M \pm SD$, 1.24 ± 0.23 versus 2.14 ± 0.52 , $p=0.001$). They also received a significantly higher number of required services upon discharge (0.99 ± 0.05 versus 0.86 ± 0.16 , $p=0.001$). No significant difference in length of hospital stay was found between the groups ($p=0.06$). The patients who received the discharge planning intervention had significantly lower rates of readmission

than the patients in the control group (10% versus 23%, $p=0.00$).

Haddock (1994) also wanted to determine if use of a structured protocol would increase the amount of documentation related to discharge planning in the patient's chart. Therefore, she reviewed the charts and considered five areas of documentation that she believed were important to discharge planning. These were (a) general patient status, (b) social support, (c) patient teaching, (d) referrals made, and (e) placement plans.

Documentation of the patient's general status and patient teaching were the only areas that revealed significant differences between groups ($p=0.02$, $p=0.001$) The experimental group had better documentation of baseline patient status, while the control group had better documentation of teaching to prepare the patient for discharge. The author did not describe how these judgments were made nor did she discuss these findings.

Haddock (1994) concluded that a structured format of discharge planning using collaboration between a CNS and a social worker in a direct patient contact model helped to identify needs post-discharge more clearly and gave discharge planners definitive information to communicate with the patient about specific services needed. However, the nature of this communication was not described. The author also indicated that the model gave patients a feeling that they had a personal part in planning with those who were directly responsible for the plan, which lead to a higher level of satisfaction. This conclusion is not supported by the study findings as the study did not describe how patients were involved in the discharge planning and no measure of the patients' involvement in planning was included. Furthermore, the author did not describe how other health professionals, for instance, the attending physician, were involved in discharge planning.

A randomized control trial was designed by Naughton, Moran, Feinglass, Falconer and Williams (1994) to test the impact of a geriatric evaluation and management model on the costs of acute hospital management of urgently admitted older adults. A total of 111 patients 70 years of age and over, admitted from the hospital emergency room to medical units, who did not have an internist on staff were enrolled in the study. Fifty one of those patients were randomly assigned to receive the treatment which consisted of care delivered by a Geriatric Evaluation and Management team (GEM) comprised of a doctor, a geriatrician and a social worker. A CNS and physical therapist were involved when needed. The GEM team evaluated the patient's mental status, psychosocial condition, functional status and medical condition to determine medical, rehabilitation and social needs. The team met two to three times per week. Responsibility for implementing the agreed upon care plan was apportioned among team members. The physician was responsible for managing the medical condition. The social worker arranged for community resources and a follow-up 2 weeks post-discharge, and the CNS arranged for transfer to home care when needed. The 60 patients comprising the control group received usual care, that is, treatment by the medical house staff and attending physician. The services of a social worker and discharge planner were available upon request.

The effect of the intervention by the GEM team on reducing hospital length of stay, total cost of hospital care and cost of lab, pharmacy and rehabilitation services was determined by a review of hospital case mix records and the patients' medical records. Data were analyzed using least square multiple regression analysis. For patients in the treatment group, the length of hospital stay was decreased by 2.1 days which was not significant ($p=0.085$). The total hospital costs as well as the lab and pharmacy costs were

significantly lower for the treatment group ($p=0.029$, $p=0.007$, $p=0.047$). The authors concluded that the intervention contributed to decreasing acute medical care costs. However, the authors did not examine if using a GEM team approach to discharge planning would have any effect on the adequacy of discharge plans at meeting patients' needs post-discharge and the patients' satisfaction with those plans. In other words, even if the model helped to reduce hospital costs, it would not be as valuable if patients did not also benefit from the intervention.

A formalized discharge planning protocol to be implemented by a gerontologic CNS in consultation with a multidisciplinary team was developed by Naylor et al. (1994). The authors hypothesized that the protocol would help decrease (a) hospital length of stay, (b) time between hospital readmission, (c) rehospitalization rates, and (d) charges for hospital care. The authors enrolled 276 patients over the age of 70 years and 125 caregivers into the randomized clinical trial. The patients were divided into medical and surgical diagnostic groups. Patients were randomly assigned to one of four groups. The medical treatment group was comprised of 72 patients and 20 caregivers. The medical control group included 70 patients and 18 caregivers. The surgical treatment group was made up of 68 patients and 48 caregivers and 66 patients and 33 caregivers were included in the surgical control group. The sampling procedure was not described.

The patients in both medical and surgical treatment groups received the hospital's routine plan and a comprehensive individualized discharge planning protocol implemented by the CNS from admission to 2 weeks post-discharge. Activities to be completed by the CNS according to pre-established guidelines were included in the discharge planning protocol. These activities were (a) an initial hospital visit with patients and contacts with

caregivers within 24 to 48 hours of admission; (b) patient and caregiver assessment using an instrument 24 to 48 hours after admission; (c) development of an initial plan in collaboration with the patient, caregiver, physician, primary nurse and, other health care team members; (d) interim hospital visits with the patient at least every 48 hours to further develop and implement the discharge plan; (e) a discharge visit with the patient and contact with the caregiver 24 hours prior to discharge in order to finalize discharge preparations; and (f) telephone outreach after discharge to monitor and modify the discharge plan when appropriate within 24 to 48 hours after discharge and again 7 to 10 days after discharge. Furthermore, the CNS was available for telephone contact with patients, caregivers or health team members for extended hours 7 days per week throughout the patient's hospitalization and for 2 weeks after discharge.

The patients in both control groups received the hospital's usual, routine discharge planning, that is, uncomplicated discharges were managed by the physician and primary nurse while complicated discharges were managed by the social worker and community nursing coordinators. The definition of complicated versus uncomplicated discharges was not described. Discharge planning services were provided in accordance with the medical plan of care.

Data were collected for all four groups at 2, 6, and 12 weeks post discharge. The data collection procedure was not described. The data analysis strategies included chi-square or Fisher exact tests and independent t-tests. The results showed differences between the medical treatment and medical control groups only. There was no significant differences in length of hospital stay between groups. The patients in the treatment group had fewer readmissions at 2 weeks post discharge (3% versus 16%, $p=0.02$), but no

significant differences were found during the 2 to 6 weeks and 6 to 12 weeks intervals. No significant differences were found in the number of days between discharge and rehospitalization ($p=0.12$). The treatment group had lower total charges for care at 2 weeks (-170 248\$, $p=0.001$) and lower rates between the 2 to 6 week interval (-137 508\$, $p=0.01$). No significant difference in charges for care was found between groups during the 6 to 12 week interval. No significant differences in any of the outcome measures were identified between the surgical intervention and control groups.

The major study finding was that the discharge planning protocol had its greatest effect in delaying or preventing rehospitalization of patients in the medical intervention group during the first 6 weeks after discharge. The authors concluded that post-hospitalization outcomes were improved as a result of the discharge planning protocol but these outcomes were not measured other than in terms of rehospitalization.

Styrborn, Larsson and Drettner (1994) evaluated the outcome of a geriatric discharge planning procedure on a geriatric rehabilitation ward in Scandinavia. The study design was descriptive and did not include a control group. Thirty six patients between the ages of 50 to 96 years ($M=80$) who were discharged home or to "old people's homes" ($p=168$) during a 4 month period were included in the study. The sampling procedure was not described. All of the 36 patients in the sample received the multidisciplinary team approach to discharge planning which included (a) patient assessment; (b) development of a discharge plan; (c) implementation of the discharge plan in the form of provision of services including patient and family education, service referrals, adequate technical aid, home visits, housing adaptation and home training; and (d) follow-up and evaluation. The team members included physicians, ward nurses and nursing staff, a physiotherapist, an

occupational therapist and a social worker. The role of each was not described. The outcome measures were also not well described. It appeared that the researchers believed that the discharge planning procedure would have an impact on patients' medical and functional status, the use of nursing services in the home, and patients' opinions about discharge expectations and discharge outcomes. The patient's functional status was assessed by the occupational therapist on the day of discharge and by the social worker 1 month post-discharge. The other data collection procedures were not described.

The authors examined the differences between the patient's condition at the time of discharge and 1 month post-discharge. The results are presented in percentages and statistical analysis were not conducted, therefore, it is not possible to determine if the observed differences were significant. For 86% of patients, the medical condition remained stable during the first month after discharge home from hospital. Seventy two percent of patients required nursing services for medication administration, 33% needed nursing management of wounds and injections, 36% had special nursing needs, and 8% did not require nursing services at one month post-discharge. Changes in the patients' functional status after discharge were also examined. Three percent of patients showed some improvement in their functional status after discharge, 83% remained the same, and 14% had some deterioration. Eleven percent of patients reported that they coped better than expected, 61% coped as expected, 25% did not cope as well as expected, and 3% coped much more poorly than expected.

Because a control group was not included in the study, no conclusions about the effectiveness of the discharge planning procedure at improving patient outcomes could be made. The researchers did not discuss the effectiveness of the discharge planning

procedure at improving patient outcomes, which was the original purpose of the study. The only conclusion drawn was that rehabilitation was of great benefit to the patients in the study as evidenced by the medical and functional conditions remaining stable for the majority of patients.

In Israel, Soskolne and Auslander (1993) studied the effectiveness of a formalized, early discharge planning model implemented by a social worker at (a) reducing emergency room visits, (b) decreasing hospital readmissions, and (c) increasing patients' satisfaction with health services and the discharge process. A comparative, descriptive design was used to examine patient outcomes prior to and after implementation of the discharge planning model. A total of 295 patients were included into the study. All patients who received social work services in the first 3 months of the study served as a control group. The average age of these 163 patients was 68 years. The control group received the usual social work interventions. Patients receiving social work services in a subsequent 3-month period were considered as the treatment group. These 132 patients also had an average age of 68 years.

In between the two 3-month periods, the social workers on the four units in the two hospitals included in the study received training in discharge planning. The social workers were trained to contact the patients within 48 hours of admission in order to screen for high risk cases. They were taught to use a psychosocial problem list for all summary reports, how to review post-hospitalization services, how to involve patients, families and staff in the discharge planning process and how to encourage family members to examine alternative post-hospital services. The researchers reviewed the social work records and conducted telephone interviews with patients at 3 weeks and 2 months post-

discharge in order to determine if patient outcomes were affected by the introduction of the discharge planning protocol. Data were analyzed using chi-square tests and t-tests.

The implementation of the discharge planning protocol did not achieve the desired effects. Use of the protocol did not reduce the number of visits to the emergency room. It produced to opposite effect, that is, the patients who received discharge planning according to the new protocol had higher emergency room visits at 2 weeks and 2 months post-discharge than did the patients in the control group. Only the percentages at the 2-month follow-up were statistically significant (32% versus 13%, $p < 0.001$). There were no significant differences in rates of readmission to hospital following the use of the new protocol. Patients in the treatment group were less satisfied with discharge planning and with post-hospital health services. However, the second measure is not necessarily a measure of the social workers' care as the reasons for dissatisfaction were not provided. For instance, if patients were dissatisfied because the wrong service was arranged, this would be a reflection of poor discharge planning on the social worker's part. However, if patients were dissatisfied because of the quality of the services being provided, this would not be an indication of the adequacy of the discharge plans.

The researchers could not accurately account for their findings. One explanation that they provided, but that they did not verify, was that social workers may not have changed their practice despite the training received. Furthermore, the data may have been biased in that caregivers sometimes answered for patients during follow-up telephone interviews. These two extraneous variables could present threats to the study's internal validity.

Critique of the Evaluated Models of Discharge Planning

The focus of the six studies previously reviewed was on models or programs aimed at improving the manner in which discharges occur for hospitalized elderly. Two approaches concerned primarily patient outcomes (Evans & Hendricks, 1993; Styrborn et al., 1994), two placed emphasis on hospital resource utilization (Naughton et al., 1994; Naylor et al., 1994) while in the remaining two, both patient and hospital outcomes were addressed (Haddock, 1994; Soskolne & Auslander, 1993). What was obvious from the models or programs described in these studies was their atheoretical nature. With the exception of the Haddock study which utilized the McKeehan and Coulton model for continuity of care as a conceptual framework for developing the discharge planning program, none of the other five programs had a theoretical foundation. The authors of these studies did not outline how their discharge planning approaches were developed and on what theoretical or conceptual basis. The authors appeared to select certain variables from the mostly descriptive literature on discharge planning and attempted to control these variables, hoping to achieve desired outcomes.

In the studies reviewed, a description of how the discharge planning programs were implemented on the hospital units was not provided. With the exception of Soskolne and Auslander (1993), the authors did not describe how the health professionals involved in discharge planning were trained to implement the new approaches or if they were allowed a practice phase to become familiar with the new methods of discharge planning.

All of the studies conducted outcome evaluations of the programs of discharge planning. However, this type of evaluation is considered the final step in a series of evaluations that are usually undertaken on new programs. Hawe, Degeling and Hall

(1990) describe three levels of evaluation that are to be completed in a predetermined order. The first type of evaluation is a process evaluation which measures whether the program is actually being implemented as planned. It is essential to complete this type of evaluation before judgments can be made about the effectiveness of the program in meeting both the objectives and goals of the program. Once it has been determined that a program is running as planned, an impact evaluation can be completed. In this type of evaluation, the immediate effects of the program are examined. Finally, an outcome evaluation is undertaken. It looks at the long-term effects of the program.

The six empirical studies reviewed all present shortcomings in that the outcomes of the discharge planning programs were evaluated prematurely, that is, before it could be established that the programs were being implemented consistently and as planned. Therefore, the studies could contain threats to internal validity if the programs were not implemented as they were designed.

Summary of the Literature Review and Gaps in the Literature

The literature concerning discharge planning is comprised mostly of descriptive studies in which the process of discharge planning is examined and a number of related problems are presented. Only six studies were found in which models or programs of discharge planning that could address the problems described in the literature were empirically evaluated. However, none of these models were developed in Canada, therefore, their applicability in a Canadian context is not known. Furthermore, these models were not based on any underlying theoretical or conceptual frameworks. The manner in which they were implemented was not described. Their ability to be implemented in hospital settings was not evaluated nor was their process examined. The

evaluations focused on the measurement of outcomes before it was established that the programs were in fact implemented as planned and before adjustments rendering the programs consistent with the settings in which they were being tested could be made.

The theoretical and methodological shortcomings of the existing discharge planning programs are addressed in a seventh model. The integrated model of discharge planning (Wells et al., 1998), is the outcome of a 9-month qualitative study aimed at developing a more efficient and compassionate discharge planning model for acutely-ill, elderly patients. The sample included 5 hospitals and 20 community advocacy and health and social service organizations in Metropolitan Toronto. Persons from the hospitals and community organizations that were directly involved in discharge planning as either practitioners, administrators or advocates were invited to participate in focus groups. A total of 99 persons attended. In all, 16 focus groups were conducted, which ranged in size from 3 to 14 participants. Furthermore, 25 patients recently discharged from hospital and 6 family members were interviewed either face-to-face or by telephone. The focus groups were centered around a broad question: "What are your perceptions of an ideal approach to discharge planning?" To help participants think about an ideal approach, the researchers asked them to speculate on (a) the most important goals to be achieved; (b) who should be involved, how, and why; (c) strategies to achieve the goals; and (d) what barriers might interfere with achieving an ideal approach and how these may be overcome. By conducting a content analysis of the data, seven key elements believed to be essential to efficient and effective discharge planning were identified. These seven key elements were represented in a theoretical model.

The model represents a more robust approach towards discharge planning than the six formally designed discharge planning programs previously discussed in the literature review. In addition to the features found by these studies to be key elements in planning, namely (a) the presence of a designated discharge manager, (b) the need for early and systematic communication about the discharge plan, and (c) an explicit discharge planning protocol, the integrated model incorporates other essential features. It is patient-centered, identifies a core team that includes a community person, stipulates a rationale for the involvement of other health professionals (versus the automatic commitment of a multidisciplinary team), describes a process of communication that is oriented towards mutual understanding between participants as well as goal setting, and links discharge planning with patients' clinical trajectories and a clear knowledge about their social circumstances. Furthermore, the model represents the perceptions of Canadians and therefore is more likely to be congruent with the requirements of the Canadian hospital system than discharge planning approaches developed in other countries.

The model developed by Wells et al. (1998) is the first of its kind to explicitly address considerations of both cost containment and the ethical treatment of persons. It is said to be integrated because all seven elements together constitute an ideal approach, that is, no one element on its own was thought to be sufficient to achieve the best process of discharge planning. The seven elements of the model are supported by principles from bioethical theory (Wells et al., 1997). Specifically, the principles of autonomy and justice provide moral justification for granting a central role to patients in discharge planning and requiring the efficient use of resources. As well, ideas from Habermas' theory of communicative action are applied to the discharge planning model. In the model,

discursive rules in the discharge planning of elderly patients include the consideration of the opinions of participants, engaging appropriate people at the right time, and ensuring the adequacy of information used in decision making. Finally, the definitions, assumptions, goals, target group, elements of the model, outcome objectives and indicators of the model are all linked intimately.

Use of the integrated model of discharge planning has the potential to achieve positive outcomes for patients and lead to the efficient use of hospital resources. At this stage, the model represents a theoretical conceptualization of an ideal approach to planning for discharges from hospital for elderly persons. An evaluation of the model in a hospital setting now needs to be completed to first determine whether it can be used to plan for hospital discharges and then to identify the outcomes of its use.

Purpose of the Study

The purpose of this study was to evaluate the feasibility of implementing the integrated model of discharge planning in the hospital context. The implementation process was evaluated in order to modify or adapt the operationalization of the model so that a summative or outcome evaluation of the model's overall effectiveness could be undertaken in a later study.

Chapter Two: Conceptual Approach, Objectives and, Methodology of the Process Evaluation of the Integrated Model of Discharge Planning

Conceptual Approach Guiding the Evaluation of the Integrated Model of Discharge Planning

To ultimately study the outcomes of the integrated model of discharge planning, that is, whether the model could contribute to improving patient outcomes and the efficient use of hospital resources, a process evaluation was undertaken as a necessary first step. Conducting a process evaluation ensures that a program, or in this case, the discharge planning protocol, is implemented as it was intended (Hawe, Degeling & Hall, 1990; Rossi & Freeman, 1993). In process evaluation, all aspects of the process of program delivery are examined and specific information which helps improve or modify the program is provided. For this reason, process evaluation has also been referred to as formative evaluation. Patton (1997) explains that the formative evaluation of a program is improvement oriented and tends to be open ended. A variety of data, such as a program's strengths and weakness, kinds of implementation problems that emerge, unexpected happenings, participants' perceptions of the program, and the effect of the external environment on the program are gathered.

Process evaluation seeks to answer four main questions: (a) Are all the activities of the program being implemented? (b) Are participants satisfied with the program? (c) Are all the materials and components of the program of good quality? and (d) Is the program reaching the target group and are all parts of the program reaching all parts of the target group? (Hawe, Degeling & Hall, 1990). In process or formative evaluations, the process

of the program is evaluated, adapted, and rendered operational so that summative judgments about the overall effectiveness or outcomes of the smooth-running program can ultimately be made.

Process or formative evaluations rely primarily on qualitative methods and small sample sizes (Patton, 1990). There is no attempt to generalize beyond the immediate context. Rather, “formative evaluation...is limited entirely to a focus on a specific context” (Patton, p. 156). The findings are key to the summative evaluation, which goes on to test the effectiveness of the program in controlled comparisons and relatively larger samples thereby permitting generalizability across settings. The results of a formative evaluation may also be used by persons at the specific setting to improve what they are doing.

Research Objectives and Related Questions

The research objectives and related questions of the current study were derived from the three main questions of process evaluation outlined in the previous section. The fourth question, which pertained to the program’s reach, was not addressed because the model was implemented for those patients agreeing to participate in the study and not for all elderly patients on the hospital units. The objectives and related questions of the process evaluation were:

- I. To identify if all the activities of the discharge planning protocol were implemented as planned.
 1. Are all activities of the discharge planning protocol implemented?
 2. Can the discharge planning activities be conducted and completed within a pre-determined timeframe?

3. What is the time involved in discharge planning activities?
 4. Do the discharge plans reflect the assessment data collected?
 5. What do participants identify as barriers or facilitators to the implementation of the model?
 6. What are the unanticipated effects of implementation of the model?
 7. What are the written guidelines that discharge managers require to accomplish the integrated approach to discharge planning?
- II. To describe participants' perceptions of the integrated model of discharge planning.
1. Are the participants satisfied with this approach to discharge planning and with the discharge plans?
 2. What do they like, dislike, want to change?
- III. To describe the appropriateness of materials used in conjunction with the discharge planning protocol.
1. Are the data collection forms adequate to collect all needed data for the study?
 2. Does the information contained in the completed data collection forms allow the discharge manager to formalize discharge plans?

Methodology of the Process Evaluation of the Integrated Model of Discharge Planning

Design

The case study design was used in the process evaluation of the integrated model of discharge planning. A case study is "an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries

between phenomenon and context are not clearly evident” (Yin, 1994, p. 13). Therefore, the case study method is useful when attention to contextual conditions is desired. It is an approach to research that seeks an in-depth and holistic understanding of a form of social behaviour through examination of an instance of that behaviour, or a set of instances, of that form of behaviour. Casing is a process of defining units to be examined in their totality, as instances of some broader set of units (Ragin, 1987). In the process evaluation, the unit of analysis or case to be studied was the discharge planning according to the protocol as performed by a discharge manager that occurred from the time the patient was admitted to the hospital in-patient unit to the time the patient was discharged home. Although this planning was not a naturally occurring phenomenon but one dictated by the research study, the objective was still to examine the context within which the integrated model was implemented. In other words, the case study method was used to determine the implementability of the integrated model in a real-life context.

Sample

Hospital sample. A purposive sample of two acute-care hospitals in Metropolitan Toronto participated in the evaluation of the integrated model of discharge planning. These were fully-affiliated university hospitals, one large and one moderately sized. The process evaluation occurred on three in-patient medical units: One from the first hospital and two from the second. Initial contacts were made respectively with a nursing director and a vice-president of nursing at the two hospitals, who agreed to participate in the process evaluation. The setting is described in more detail in the individual reports of the case studies in the third chapter of this thesis.

Patient and family sample. Patients meeting the following criteria were included in the process evaluation: (a) 65 years of age and over; (b) acutely ill, that is, *not* those elderly patients awaiting long stay or those designated Alternative Level of Care (ALC); (c) admitted to general medicine, general surgery, orthopaedics, or cardiology; (d) able to speak and read English; and (e) not cognitively impaired as judged by the primary nurse. A family member most directly involved in the patient's discharge was also asked to participate when available.

Originally, a total of ten patients and family members were to be included into the study. However, after 5 ½ months, only four patients and one family member agreed to participate in the study. The challenges of recruiting study participants are discussed in the final chapter of the thesis.

Sampling Procedure

The actual recruitment of study participants proceeded in the following manner:

1. A person was designated for each of the three in-patient units to assist in the recruitment of potential study participants (hereafter referred to as the designated hospital contact person or DHCP). The three DHCPs were not involved in the study other than to assist with the recruitment procedure.
2. The researcher met with the DHCPs individually to review the study, answer questions, outline the sampling criteria, and review the procedure for obtaining consent (see Appendix B).
3. The DHCPs identified elderly patients on their hospital units meeting the sampling criteria. Before asking the patient to participate in the study, they first met with the patient's attending physician to provide him or her with an explanation of the study

(see Appendix C). This was done to ensure that the physician would fully participate in the study as the literature had identified a lack of cooperation and support from doctors to be an obstacle to effective discharge planning (Feather, 1993).

4. The DHCP then approached the patient meeting the sampling criteria and a family member within 12 hours of the patient's admission to the hospital unit and explained the study by using a letter of introduction (see Appendix D). A copy of the letter of introduction was given to the patient and family member.
5. Because the research took place on three hospital units at two hospitals and because contact had to be made early in the hospital stay, it was not possible for the researcher to meet with each patient and family member to explain the study and obtain consent. Therefore, the DHCP sought the permission of the patient and the family member to be included in the study. If they agreed, the patient and family member were asked by the designated person to sign a consent form and were given a copy of the form (see Appendices E & F).
6. The DHCP gave the researcher the names of the patients and family members who provided written consent to participate in the study. At that time, the researcher assigned a code number to each patient and family member.
7. The researcher arranged to pick up the consent forms at a later time.

Data Collection Procedures

A discharge manager (DM) per in-patient unit involved in the study was appointed to conduct the implementation of the model of discharge planning. Three DMs were involved in the implementation. A description of the discharge managers in each site is provided in the results chapter. The researcher met with the three appointed DMs

individually to train them with regard to the implementation of the discharge planning protocol. The training proceeded according to a written procedure to ensure consistency. The historical development of the integrated model as well as its theoretical underpinnings and key elements were first presented. Then, the discharge planning protocol was reviewed step-by-step (see Appendix A). As well, the researcher provided training to the DMs with respect to completing the One Stop Access Client Assessment Form (OSCA) (see Appendix G), and the two discharge planning forms developed for the process evaluation which were (a) the record of meetings/contacts form; and (b) the initial, updated and final discharge plans forms (see Appendices H& I). The OSCA provided a comprehensive profile of the patient's status prior to hospitalization, and was used to flag any changes in that status to determine the patient's discharge needs. It had been previously tested on a sample of 194 community elderly and disabled clients and found to be reliable and valid (1991, Haliburton County Community Directional Plan).

The information gathered from the OSCA was used by the DMs to develop the initial, updated, and final discharge plans. The record of meetings/contacts form was used to document the timing and persons involved in discharge planning. The initial, updated and final discharge plans forms were used to document the content of the discharge plans that were made. These data collection forms were piloted in this study to determine their ease of use and their ability to capture all the necessary data for the process evaluation. They will require testing for reliability and validity subsequent to this initial piloting.

After their training, the DMs were instructed to approach the other core professionals involved in discharge planning that is, the attending physician and relevant community person in order to explain the study to them using the letter of explanation (see

Appendix C). They were also to describe the discharge planning practice protocol (see Appendix A). The DMs then implemented the protocol for the patients entered into the study and completed all related documents. During the implementation, the researcher had informal telephone contacts with the DMs to problem solve and answer questions as they arose. The researcher kept written fieldnotes of the content of these contacts to determine the kinds of experiences the DMs were having and how they were doing in relation to the protocol implementation.

Using a guide (see Appendix J), the researcher conducted a semi-structured interview with patients and families about their perceptions of the discharge planning process and the final discharge plan. The face-to-face interviews were to be undertaken in hospital 24-48 hours prior to the discharge of the patient, and after the final discharge plan had been written. However, in two of the case studies, the interviews with the patients were conducted via telephone after the patients had returned home. In the first case, this change in the data collection procedure was made because the patient was discharged without the discharge manager's prior knowledge. In the second case, the hospital stay was very short (3 days) and the patient was discharged home on a Saturday when the researcher was not available. The interviews with the four patients and one family member lasted between 30 minutes to one hour. The two face-to-face interviews were tape recorded. The two telephone interviews were transcribed as close to verbatim as possible.

Using a guide (see Appendix K), the researcher conducted a semi-structured interview with each individual discharge manager after they had implemented the discharge planning protocol on one patient. At the outset of the study, the intention was to also interview the other core participants involved in discharge planning, namely the

attending physician, the relevant community person and other relevant health professionals. The researcher later decided not to interview these participants because it was thought they would have little input regarding the integrated model having only been exposed to it for one patient. After a preliminary analysis of the research findings was completed, the researcher met with the three discharge managers as a group to share the results of the study, obtain comments regarding their impressions of the study findings and any other additional insights.

Ethical Considerations

Before data collection began, ethical approval to conduct the study was received from the Office of Research Services at the University of Toronto and the two hospitals. As well, written informed consent was obtained from patients and families who agreed to participate in the study. The obtaining of the consents followed the steps outlined in the sampling procedure. During the consent process, it was explained to potential study participants that (a) they would be asked to answer questions about their age, health status, ability to carry out personal care and other activities of daily living; (b) they would be interviewed by the researcher for approximately one hour about their ideas concerning the discharge planning process and the final discharge plans; (c) the interview would be tape recorded; (d) they could refuse to answer any questions and stop the interview at any time; (e) they could withdraw from the study at any time without their care being affected; (f) although they would not benefit directly from participating in the study, no harm would come to them as a result of their participation; and (g) any information obtained would be kept confidential and anonymous.

Steps to uphold the participants' right to confidentiality included ensuring that (a) all consent forms and data collection documents would be kept for up to 7 years and in a secure location, (b) only the researcher had access to the interview transcripts, and (c) all consent forms and data collection documents would be destroyed 7 years after completion of the study. In the study, anonymity was maintained by assigning a code number to the participants and ensuring that their names did figure on any document or in any report of the findings.

Data Analysis Strategies

The main data analysis strategy that was used in this study was explanation-building (Yin, 1994). This analytic strategy serves to explain a phenomenon or to stipulate a set of causal links about it. The explanation-building process is iterative in nature. The case study evidence is examined, theoretical positions are revised, and the evidence is examined once again from a new perspective. Because the approach was applied to four case studies, the result of the explanation-building process resulted in a cross-case analysis, not simply an analysis of each individual case.

In conjunction with the explanation-building approach, a second data analysis strategy was utilized. Drawing on the work of Charles Ragin (1987, 1992), Marshall (1997) describes a method that is useful for reasoning with case study data. By making an analytical judgment, one case is selected as the anchor point against which the other cases are compared. In this study, the anchor case was the case that most closely resembled the ideal type model. By examining similarities and differences between this best case and the other three cases, an explanation could be constructed that allowed the researcher to identify the factors that either facilitated or limited the successful implementation of the

integrated model of discharge planning in the hospital setting. These facilitators and barriers are presented in the results chapter.

As well, all data collected were content analyzed by the researcher in light of the research objectives and questions. Data from the OSCA were used to describe the patient and family samples. The OSCA and the initial, updated, and final discharge plans forms were read and analyzed to determine how the discharge plans reflected the assessment data. The record of meetings/contacts form was evaluated to determine patterns with regard to who had been involved in discharge planning and how, as well as the amount of time that they spent in discharge planning.

In preparation for the content analysis of the fieldnotes obtained during informal contacts with the DMs by the researcher and the semi-structured interviews, the data were first entered into a computer software program called The Ethnograph (Seidel, Kjolseth & Seymour, 1988). A numbered file was printed for hand coding by the researcher, which involved identifying distinct topics in the data and assigning them a code. The final step in organizing the data for content analysis was to assemble all the data material belonging to each code or topic into one place, which was done using the Ethnograph program. Next, the content or substance of the codes or topics were summarized by the researcher to identify the patterns of participants' experiences related to the implementation of the integrated model. The research questions were kept close at hand during pattern analysis in order to focus on the data most relevant to the research and to ensure that the study questions were answered.

Chapter Three: Results of the Process Evaluation of the Integrated Model of Discharge Planning

This chapter presents the results of the process evaluation of the integrated model of discharge planning. The process evaluation took place over the course of 5 1/2 months. The intention at the onset of the study was for the implementation of the integrated model to occur over an 8-week period beginning in late June or early July and finishing at the end of August. However, due to recruitment issues that will be discussed in the final chapter of the thesis, the data collection began in July and was completed in mid-December. Four case studies were conducted on three in-patient units of two hospitals in Metropolitan Toronto. One case study was conducted in the first hospital and two in the second.

The case studies illustrated four instances of discharge planning. They represented varying degrees of implementation of the discharge planning protocol. The case that most closely resembled the ideal model is presented first. This case served as the anchor case, that is, the case against which the three other cases were compared (Marshall, 1997). The worst case is presented next. It represents the case that least approximated the seven dimensions of the ideal model. These two extreme cases were compared and contrasted in order to identify elements that either facilitated or limited the implementation of the integrated model. The remaining two cases were also compared to both the anchor case and the worst case in order to confirm emerging hypothesis about the conditions within the hospital setting that facilitated or limited implementation of the protocol. Furthermore, the analysis of the last two cases helped identify additional elements that, if present, could

lead to a more successful implementation of the protocol. The chapter concludes with a summary of the major results of the process evaluation.

The Best Case

“Everything seemed efficient. It was well organized. There was nothing to dislike really except the wait for the ambulance”.

Ms. A. was a 92-year-old single woman living in her own self-contained apartment in a retirement home. Her meals were provided by the facility and she hired a cleaning person to assist her with housework. She was admitted to hospital for 3 days in order to treat an episode of pneumonia. The hospital was a medium-sized, university-affiliated, acute-care institution. Ms. A. was admitted to a 70-bed unit offering general and specialty medicine services. Of these 70 beds, 59 were for acute-care, 10 were designated as Alternative Level of Care (ALC) and 1 was an isolation room for patients receiving radioactive iodine treatments. The mode of delivery of nursing on the unit was primary nursing. The medical staff were divided into four teaching teams comprised of staff physicians, residents, interns and medical students. The staff physicians changed every month, the residents and interns every two months, and the medical students every three to four weeks.

Ms. A. met with the discharge manager on her second day of hospitalization. The discharge manager was a registered nurse whose usual occupation was that of Clinical Care Manager. Clinical Care Managers in this hospital were advanced practice nurses offering a variety of services including the coordination of patient care for individuals and

groups of patients, discharge planning, and resource utilization management and review. The discharge manager first met with Ms. A. for one hour in order to complete the initial assessment of the discharge situation using the One Stop Access Client Assessment form (OSCA). During that assessment, Ms. A. and the discharge manager identified that assistance with homemaking and medication administration were potential areas of concern. The discharge manager then spoke with the attending physician concerning the discharge date and the discharge plans. The discharge manager also telephoned a registered nurse at Ms. A's retirement home to discuss these same issues.

After these discussions with the core participants, the discharge manager wrote the initial discharge plan. She did not confirm the written plan with the core participants nor did she develop or write any updated plans. She stated in a subsequent interview with the researcher that this was because the initial plan did not change during the course of Ms. A's short length of stay in hospital. In fact, the discharge manager wrote the final discharge plan on the same day as the initial one (on day two of hospitalization). The final plan was for (a) prescriptions to be filled in the hospital pharmacy, (b) the nurse in the retirement home to administer Ms. A's two new medications, (c) existing supports for homemaking to continue as before, (d) transportation via ambulance to be booked, and (e) the physician in the retirement home to provide the medical follow-up. The final plan reflected and addressed the issues raised during the initial assessment which included the need for homemaking and assistance with medication administration. All of the core participants, that is, Ms. A., the attending physician and the retirement home nurse, agreed to the final plan. By the afternoon of the second day, the discharge manager met with Ms. A. to review her medications, to provide information about her follow-up care and to

assess her readiness for discharge. Ms. A. returned home the next morning, the third day of the hospital stay.

Ms. A. was interviewed by telephone by the researcher (CL) three days after her return home. Initially, she could not identify how she was involved with the discharge manager in planning for her return home. The following segment illustrates this point:

CL: "How were you involved in planning for your return back to the retirement home?"

Ms. A.: "It was pretty simple. I just phoned them and told them I would be released and to have things ready for me".

CL: "Were you involved in any decisions concerning your return home from hospital?"

Ms. A.: "No, not really. They just told me I could go home and that was it."

The researcher had to probe further to ask specifically if Ms. A. had met with the discharge manager and what they discussed. Ms. A. then indicated that the discharge manager asked her about how she would be able to manage once she returned home and about the things that she might need. She described how the discharge manager had helped her by stating: "She (the discharge manager) was mostly reassuring. A very nice person." When asked what she liked about the manner in which her discharge from hospital was planned, Ms. A. replied: "Everything seemed efficient. It was well organized. There was nothing to dislike really except the wait for the ambulance". Ms. A. was asked what she liked about the final plans that were made and her response was: "Well, the plan was pretty much there before I even went into hospital. I was only going because I was sick. I knew they would make me better then they could send me back home where I am

looked after.” From the analysis of the interview, it was determined that Ms. A. was satisfied with the discharge planning and the final plans that were made because (a) the discharge process was smooth, efficient and well organized; (b) the discharge manager was nice and reassuring; (c) there was nothing to dislike; and (d) the plan was in place at her time of discharge.

The discharge manager spent a total of 1 hour and 40 minutes to complete the activities of the discharge planning protocol over the course of Ms. A’s three-day stay in hospital. The 1 hour and 40 minutes reflected the time involved in implementing the activities that required consultation or discussions with participants. No provisions were made in the research to capture the time the discharge manager spent writing the initial, updated and final discharge plans. More than half the time was spent completing the initial assessment. The discharge manager indicated in a subsequent interview with the researcher, that the 1 hour and 40 minutes she spent involved in discharge related activities was too much time. She did not believe that she would be able to sustain this amount of involvement with several patients simultaneously. She also indicated that the OSCA was long to complete. She did not express any concerns regarding the other data collection forms, namely the initial, updated and final discharge plan forms and the record of meetings/contacts form. Overall, she was satisfied with the discharge planning protocol because the activities were straightforward and she was able to complete these activities close to the timeframes outlined in the protocol. She did not think that she required any additional written guidelines in order to be able to implement the activities of the protocol. She stated that the training received was sufficient.

This case was judged as being representative of the best case because it most closely resembled the integrated model. All the activities of the protocol that were relevant to Ms. A's situation were implemented as planned. The seven key elements of the integrated model of discharge planning were upheld. There was evidence to show that the patient was involved in the discharge planning process. The discharge manager coordinated the process and involved the other core participants in the planning. Communication seemed to be open and consensus oriented, that is, all core participants were consulted and provided their input. The planning followed the patient's clinical course and final plans were only made when the clinical trajectory became clear. The patient was satisfied with the discharge planning and the final plans that were made.

The Worst Case

"No one bothered to tell me anything...I don't like being treated like a horse in a stable. They at least have names".

Mrs. B. was a 71-year-old woman living with her husband. Mr. B. was 75 years of age and his spouse's primary caregiver. Mrs. B. was taken to hospital for the treatment of congestive heart failure. The hospital was a large-sized, university-affiliated, acute care facility. She was admitted on a Thursday to an in-patient unit comprised of 20 general medicine beds and 20 geriatric rehabilitation beds. She occupied a general medicine bed. The mode of delivery of nursing care on the unit was primary nursing. The medical staff was comprised of attending physicians who stayed on the unit for a six month period, and residents, interns and students who rotated off the unit every two months.

Mrs. B. first met with the discharge manager on the second of her five-day stay in hospital. Mr. B. was not present at the time of this initial meeting. The discharge manager in Mrs. B's case was a Masters prepared registered nurse. In her usual role, she worked as Coordinator of Discharge Planning. The functions of this position were to oversee and develop hospital policies, standards and procedures pertaining to discharge planning. In this position, she only became involved in discharge planning for a given patient on an advisory basis. The social workers who were responsible for discharge planning in this hospital, would consult with the coordinator regarding problematic or complex cases.

During the one-hour meeting with Mrs. B., the discharge manager assessed the initial discharge situation by completing the OSCA. From this assessment, the discharge manager identified the need for greater support to Mr. B. given his role of primary caregiver. Mrs. B. indicated that the couple was considering moving from their home to an apartment that would be suitable for full-time, live-in help.

After the initial meeting with Mrs. B., the discharge manager spoke with the unit's nurse manager concerning Mrs. B's possible discharge date. The nurse manager informed the discharge manager that Mrs. B's condition was stable and that she could potentially be discharged home on the week-end. The discharge manager did not complete any other activities of the discharge planning protocol and had no further contact with Mrs. B. or any of the other core participants before the week-end. At that time, no discharge plans had been established.

On Monday, the discharge manager was told by the charge nurse that Mrs. B. had not been sent home over the week-end because she was found to be confused. The discharge manager discussed this change in Mrs. B's condition with the medical resident.

The plan from the resident's point of view was still to discharge Mrs. B. later that day or the next. The discharge manager then telephoned the Home Care coordinator in the community who had been providing homemaking services to the couple prior to Mrs. B's admission to hospital. The discharge manager informed the Home Care coordinator of Mrs. B's admitting diagnosis and of her course in hospital. The discharge manager attempted to contact Mr. B. by telephone in order to discuss his spouse's condition and discharge needs and plans. However, Mr. B. was not home and the discharge manager left a message asking Mr. B. to contact her. The discharge manager wrote the initial plan that day. The discharge goals were for Mrs. B. to resume her lifestyle as before. Potential areas of concern included medication compliance and confusion. The initial plan did not reflect the need of support for Mr. B. identified during the initial assessment and it was not confirmed with any of the core participants. The discharge manager did not complete the updated or final discharge plans forms.

The discharge manager returned to the unit later that day to find that Mrs. B. had just been discharged home. No one had paged her, as she had requested, when Mr. B. arrived to pick-up his spouse. The discharge manager spoke with Mr. B. on the telephone at approximately 4:30 p.m., after the couple had returned home. She discussed home care services and provided him with numbers of agencies providing live-in help.

The couple was interviewed by telephone by the researcher one day after Mrs. B's return home. Mrs. B. still seemed somewhat confused. She could not remember having spoken to anyone in the hospital. When asked how she was involved in planning for her discharge home, she stated: "I don't think I was. I didn't talk to anyone. No one asked my opinion." Mr. B's description of the discharge planning was similar:

“I wasn’t (involved). I was simply told over the phone that my wife could go home today and to please come and pick her up. When I got to the hospital, there was nobody there. I waited at the nursing station for a long time. I wanted to speak to a doctor before taking my wife home, but there was none available. We had to wait around for the discharge documents. I thought I could have walked out of there with my wife and nobody would have cared”.

Mr. B. went on to state that he did not work with anyone to plan for his spouse’s discharge home. When asked if he had spoken with P., the discharge manager, he replied: “Oh yes. P. called me after we got home. I talked to her about permanent live-in help. She gave me the names of two agencies. She was really nice and helpful.” He indicated that in order to improve the manner in which his spouse’s discharge occurred:

“Somebody in the nursing section should have known the details of my wife’s leaving, should have arranged for me to meet the doctor and have a report for me about what happened in the hospital. No one bothered to tell me anything. We were like specimens, not humans. I don’t like being treated like a horse in a stable. They at least have names. I like it the old way better. You paid your bill and got your money’s worth. You got looked after. The doctor was responsible to you. Now the doctor has no human touch.”

Mr. and Mrs. B. were not satisfied with the discharge planning because they perceived that they did not communicate with anyone and because they did not know what the final discharge plans were. Mr. B. perceived that there was no planning at all and that no one in the hospital really cared. However, he was satisfied with the discharge manager because she was nice and provided him with useful information.

The discharge manager spent 1 hour and 36 minutes involved in discharge related activities. This time is an approximation only as the time she spent discussing with the Home Care coordinator was not recorded. One hour out of the total time of 1 hour and 36 minutes was required to complete the initial assessment. During an interview with the researcher, the discharge manager indicated that: "Everything happened too quickly. There was no real planning." She stated that she did not have time to implement the activities of the protocol as outlined because Mrs. B's length of stay was too short. Even though Mrs. B. stayed in hospital 5 days, her stay included a week-end and therefore there were only 3 days available to the discharge manager to plan for the discharge because she did not work on week-ends. As well, Mrs. B's condition changed. Her confusion prevented her from participating in the final planning and Mr. B. was not available to make decisions on her behalf.

This case was judged to be the worst case because it least resembled the ideal approach to discharge planning. None of the key elements of the model were upheld. The patient was only involved in the initial assessment of her needs. She was not central to the discharge planning process. The core participants were not involved in discharge planning. The attending physician was only consulted regarding Mrs. B's change in cognitive status. The relevant community person, a Home Care coordinator, was only informed by the

discharge manager of the Mrs. B's course in hospital. The coordinator was not involved in the discharge planning. Furthermore, the discharge manager involved the unit's charge nurse in discussing Mrs. B's discharge plans. However, the charge nurse was not a core participant as outlined in the ideal model. The discharge manager did not coordinate the discharge planning and the discharge occurred without her knowledge. Communication was inadequate because information was not shared between all the core participants. The discharge planning did not follow the patient's clinical trajectory and the discharge took place even though her medical condition deteriorated.

The discharge manager perceived several barriers to the implementation of the discharge planning protocol. She perceived that (a) other health care professionals failed to communicate with her because her usual role did not require her to routinely be involved in discharge planning and decision making, (b) she missed opportunities for communication because she was on the hospital unit only intermittently, (c) the patient could no longer be involved in decision making after her medical condition changed, (d) the patient's spouse was not available during her working hours to be involved in the discharge planning, (e) the time available to implement the protocol was limited because the patient's length of stay was short and included a week-end, (f) she did not have control over everything that happened to the patient while she was in hospital, (g) there were multiple demands placed on her and she had little time to be involved in discharge planning in addition to her usual duties, and (i) the research situation itself made it difficult to change all the health care professionals' practice for only one patient involved in the study.

The discharge manager indicated that she liked the OSCA. She stated that its questions were pertinent and useful. It helped her comprehensively assess the patient's

situation. However, she found the form very long and stated that overall, too much of her time was spent documenting. She indicated that the updated plans form was too repetitive and therefore she did not complete it. She disliked the record of meetings/contacts form because there was not enough space provided for recording interactions. The discharge manager indicated that the training she received was sufficient for her to implement the protocol. She did not require any additional written guidelines.

Comparison of Best and Worst Cases

The two case studies presented were compared and contrasted in order to gain an understanding of why the discharge planning protocol was successfully implemented in one instance, and not in the other. The similarities and differences between the best and worst cases were examined. By first examining the similarities, the researcher was able to explain away several potential reasons that could have accounted for the variation in the extent to which the model was implemented. Potential explanations became more evident after an examination of the differences between the two case studies. The factors that appeared to contribute to a successful implementation of the integrated model were (a) the patient's ability to remain involved in the discharge planning throughout the hospital stay, (b) a high level of commitment of the discharge manager, and (c) the discharge manager being involved in discharge planning as part of her usual role.

Similarities

The following factors were present in both case studies and therefore could not explain why one discharge manager was able to implement the integrated model as planned and why the other was not.

Social context. The social context was similar in both cases. The crisis in the health care system was affecting both hospitals which were faced with budgetary constraints and cut-backs. This meant that both discharge managers were faced with pressure from their organizations to do more with less. They were both extremely busy and had many demands placed on them.

Setting. Both hospital units were similar in staff composition and the delivery of nursing care. Both discharge managers had to contend with the artificiality of the research situation. It was a challenge in both settings to change the practice of all the health care professionals for only one patient involved in the study. Both discharge managers had offices located off the unit and therefore both would have had to visit the units frequently to communicate with core participants and share new information.

Training. Both discharge managers were trained by the same researcher and in the same manner concerning the procedure for implementing the model. Both were novices and were implementing the protocol for the first time. They both experienced similar delays between the time they received the training and their first attempt at implementing the protocol. The discharge manager in the worst case in fact experienced less of a delay in training than the one in the best case. She implemented the protocol 5 weeks after the training whereas the discharge manager in the best case did not implement the protocol until 9 weeks after having been trained.

Patient characteristics. Both patients had similar characteristics in terms of age and diagnosis, which were requirements of the sampling criteria for the study. They both experienced short lengths of stay in hospital. In fact, the patient in the best case had a shorter length of stay than the one in the worst case, that is, 3 versus 5 days.

Differences

As seen thus far, some of the barriers such as (a) the patient's short length of stay, (b) the discharge manager not having control over everything that happens to the patient while in hospital, (c) multiple demands placed on the discharge manager and, (d) the research situation, which were perceived by the discharge manager in the worst case, were common to both cases and therefore could not account for the observed differences in the level of implementation of the integrated model. The following section describes factors that were present in one case and not in the other. These differences between the best and the worst cases could potentially explain why one discharge manager was able to implement the integrated model as planned and why the other was not.

Patient's ability to remain involved in discharge planning throughout the hospital stay. One of the differences between the two cases was that the patient in the worst case suffered a change in medical condition which prevented her from being involved in planning for her discharge home, whereas the patient in the best case was able to remain involved throughout the hospital stay. The fact that Mrs. B. became confused and was no longer able to make decisions could help explain why she was not central to the discharge planning process. However, had the discharge manager been able to reach the spouse, the discharge planning could have continued with Mr. B. acting on his wife's behalf. Although the discharge manager did attempt to contact Mr. B. this was only later in the patient's stay. No attempt was made to involve him from the beginning.

Level of commitment of the discharge manager. The change in Mrs. B's medical condition could not explain, however, why (a) the discharge manager did not coordinate the discharge planning process, (b) she did not involve other core participants in the

planning, (c) communication was inadequate and, (d) why the discharge planning did not follow Mrs. B's clinical course. A potential explanation may be related to the discharge manager's level of commitment to implementing the protocol as it was intended. She did not seem to be able to distance herself from her usual role in order to embody the role of discharge manager as required by the study protocol. For instance, she perceived that the other health care professionals involved in Mrs. B's case failed to communicate with her but according to the protocol, it was up to her to communicate with them. Had she been frequently present on the hospital unit, she may have been able coordinate the discharge planning by not missing opportunities for communication and information sharing.

Involvement in discharge planning as part of usual role. A final reason that may help account for the observed differences in the success of implementation of the protocol lies in the fact that the discharge manager in the best case was usually involved in discharge planning whereas the discharge manager in the worst case was not. Therefore, in the best case, the discharge manager may have been able to communicate with other health professionals with greater ease because working relationships were already established. In the worst case, the discharge manager would have had to establish these relationships and orient the other health professionals to her change in role for the purpose of the study.

Additional Insights from the Remaining Two Cases:

The Case of Mrs. C.

"If it weren't for P. (the discharge manager) it would have been the same as every other time: 'We've done your tests and we're going to release you tomorrow' and I would have been out the front door. No question about that".

Mrs. C. was a 67-year-old divorced woman. She was retired and living on her own in an apartment. She did not have any close relatives involved in her care. She was admitted to hospital for 9 days for the treatment of a pulmonary embolism. She occupied one of the general medicine beds on the same unit as Mrs. B., described in the worst case study. The discharge manager was also the same person that had planned for Mrs. B's discharge.

The discharge manager met with Mrs. C. for 45 minutes on her second day of hospitalization in order to complete the initial assessment using the OSCA. Concerns that were identified at that time included the need for (a) assistance with housekeeping and activities of daily living, (b) Mrs. C. to find a new general practitioner, (c) monitoring of pain control and mobility in the home after discharge, and (d) increased social supports as Mrs. C. was socially isolated, that is, she did not have any friends, relatives or neighbors who could help with daily activities or provide emotional support and companionship. The discharge manager then spoke to the medical resident regarding Mrs. C's in-hospital treatment plan. There was some disagreement as to the course of treatment. The resident wanted Mrs. C. to have tests done as an out-patient and the discharge manager asked for

the tests to be done while Mrs. C. was in hospital. The discussion ended with the resident agreeing to reassess this situation. The discharge manager then spoke to a registered nurse on the unit concerning the nursing care plan. She also shared with the nurse her finding that Mrs. C. was having difficulty coping at home. The discharge manager then partially wrote the initial plan. She indicated that the discharge goals were to assist Mrs. C. with activities of daily living and pain control. The other potential areas of concern identified during the initial assessment were not documented in the initial plan.

The discharge manager met again with Mrs. C. in the morning of the next day, her third day of hospitalization. She shared with Mrs. C. her conversation with the resident the day before. She also discussed home care services that were available to assist Mrs. C. at home after her discharge. It was agreed that the discharge manager would make a referral to Home Care. That afternoon, the discharge manager informed a nurse on the unit that Mrs. C. was having severe back pain and would be going for x-rays. The nurse agreed to complete a home care assessment. The discharge manager then made the referral to Home Care. From the documentation on the meeting/contacts form and the initial plans form, it was not clear which Home Care services were being requested. The discharge manager met with Mrs. C. the following day, a Friday, in order to discuss the discharge plans. At that time, the discharge date was still not determined. Later that day, she wrote the final discharge plan. She documented that the discharge date was tentatively set for the Monday. The needs identified included pain control, homemaking activities and activities of daily living management. The measures implemented to meet the identified needs were not documented but the discharge order was for in-home nursing to assess pain control

and ongoing homemaking needs. The final plan was not confirmed with any of the core participants other than the patient.

The discharge manager met with Mrs. C. on the Monday, her seventh day of hospitalization. The discharge date was still not known and Mrs. C. was very concerned about the amount of back pain she was having. She told the discharge manager that she still did not have the CT scan that had been booked the previous week. The hospital's Home Care coordinator had been in to see her and arranged for homemaking, nursing, and occupational therapy visits upon Mrs. C's discharge. The discharge manager spoke to the resident concerning the CT scan. Due to an error, the test had not been booked and the resident agreed to keep Mrs. C. in hospital until the scan could be performed. The discharge manager then made a referral to a specialist asking him to see Mrs. C. before her discharge home. The discharge manager informed Mrs. C. of her actions. Mrs. C. told the discharge manager that she was unable to find a means of transportation home and the discharge manager agreed to arrange this prior to Mrs. C's discharge. The discharge manager went to the unit the next day to see Mrs. C. but she was gone for the CT scan. She told the unit clerk that she would visit Mrs. C. the following morning.

On Mrs. C's last day in hospital, the discharge manager spoke to the specialist. They discussed Mrs. C's medical condition as well as the discharge plans. At 11:00, the unit clerk informed the discharge manager that Mrs. C. would be discharged home that day and that Mrs. C. had asked to see the discharge manager before she left. The discharge manager saw Mrs. C. at 13:00. She gave Mrs. C. telephone numbers of transportation services for future medical appointments as well as a taxi chit for her return home. She reviewed Mrs. C's medications and the procedure for getting her prescriptions

filled. The discharge manager reviewed the Home Care paperwork and realized that the services were to begin that day and that in-home laboratory services for regular blood work had not been ordered. Next, the discharge manager informed the specialist's secretary of Mrs. C's imminent discharge. The secretary agreed to have the specialist see Mrs. C. in the clinic. The discharge manager then called the Home Care coordinator to have her delay the start date of services and arrange for laboratory services. She also contacted Mrs. C's pharmacy to arrange for her medications to be ready as Mrs. C. would be picking them up on her way home. She met one last time with Mrs. C. to review the final plans, the Home Care services, the procedure for obtaining her medications, and to instruct her to go to the specialist's clinic prior to taking a taxi cab home.

Mrs. C. was interviewed in hospital by the researcher 4 days prior to her discharge home, her sixth day of hospitalization. She indicated that she was satisfied with the discharge planning because (a) nursing services were arranged, (b) she believed the final plans were adequate, (c) the discharge manager was nice, reassuring and made her feel better, (d) the discharge manager kept her informed and acted as a link between the attending physician with whom she believed communication was difficult, (e) she had been involved in planning for her return home, and (f) although she was medically ready, her discharge would occur after she had the CT scan. In her words: "It's great that she (the discharge manager) came in, I was really happy about that. We discussed a lot of things...I'm extremely happy because I wouldn't have known I could have a nurse, you know. I'm just, just ecstatic that somebody will be there to help out or at least check on me...If it weren't for P. (the discharge manager), it would have been the same as every

other time: 'We've done your tests and we're going to release you tomorrow' and I would have been out the front door. No question about that."

The discharge manager spent 3 hours and 47 minutes involved in discharge planning activities during the course of Mrs. C's 9 days in hospital. She believed that this was too much time given that Mrs. C's case was straightforward. By straightforward, she meant that there were simple solutions to Mrs. C's problems such as arranging for home care services. She indicated that if she spent this much time with Mrs. C, then she would spend even more time with complex or problematic cases.

Comparison of the First Intermediate Case with the Best and Worse Cases

This intermediate case more closely approximated the dimensions of the integrated model than did the worst case but the protocol was still not as fully implemented as in the best case. This section compares the case of Mrs. C. with both the best and worse cases with regard to the seven elements of the integrated model.

Best Case

The implementation of the discharge planning protocol in the case of Mrs. C. was not as successful as in the best case because the following elements of the integrated model were not or only partly upheld: (a) the discharge manager coordinates the process, (b) core participants are involved in all aspects of discharge planning, (c) other health professionals are involved as needed and in a timely fashion, and (d) communication is open and information is shared between core participants.

In the case of Mrs. C. the discharge manager coordinated the process to a greater extent than in the worse case. She assessed Mrs. C's post-discharge needs and arranged

for appropriate services. She had input into Mrs. C's clinical care in hospital by discussing with the attending physician the need for tests to be done while Mrs. C. was still in hospital. However, the fact that she was not aware of the final discharge date, and that she did not notice that Home Care services were to start on the wrong day, indicated that she did not control the process to the same extent as the discharge manager in the best case.

The discharge manager in the case of Mrs. C. discussed the discharge plans with the attending physician and the Home Care coordinator. However, although some information was shared with these core participants, they were not systematically involved in the planning. This is to say that the core participants were not involved in making any decisions regarding final plans. The discharge manager did not consult with the specialist until the last day of hospitalization. Therefore, the discharge manager did not ensure timely referral to the specialist as required by the discharge planning protocol. Furthermore, the discharge manager communicated with a nurse on the unit and the charge nurse but these two individuals were not involved in discharge planning. Therefore, their involvement was not necessary and did not uphold one of the elements of the integrated model, which was to involve other health professionals only when required. Communication was improved in this case from the worst case study. The discharge manager did obtain the input of the patient and the physician. She acted as a link between Mrs. C. and the physician and information was shared between all three participants. However, communication was not consensus oriented, that is, the discharge manager did not confirm written plans with all core participants. The discharge date was not communicated to the discharge manager. As well the discharge manager did not consult with the Home Care coordinator after she had assessed the patient. The discharge

manager found out about the services that would be provided through Home Care from Mrs. C.

Worst Case

The discharge planning protocol in Mrs. C's case was judged to be more fully implemented than in the worst case because the following elements of the integrated model were upheld: (a) the patient is central to the discharge planning process, and (b) the discharge planning follows the clinical trajectory.

Mrs. C. was involved in the discharge planning throughout her hospital stay and did appear to play a central role. The documentation on the record of meetings/contacts form showed that the Mrs. C. had input into the assessment of her post-discharge needs and into the final plans that were made. Furthermore, the discharge manager shared information with Mrs. C. and kept her informed of plans as they progressed. The discharge planning followed Mrs. C's clinical trajectory and she was not discharged until all necessary tests and consultations had been performed.

Explanation Building and Hypothesis Confirming

The analysis of the case of Mrs. C. by using the comparative method allowed the researcher to explain why the protocol was not as successfully implemented as in the best case but upheld the elements of the integrated model to a greater extent than in the worst case. It also allowed the researcher to confirm the hypotheses that emerged after the analysis of the two extreme cases. The results of this case study supported the explanations that (a) the level of commitment of the discharge manager, and (b) the patient's ability to remain involved in discharge planning throughout the hospital stay influenced the implementation of the discharge planning protocol. The findings did not

lend support for the hypothesis that the discharge manager being previously involved in discharge planning facilitated implementation. Additional insights gained were that (a) all patients could benefit from the approach to discharge planning and (b) the discharge manager's ability to implement the protocol improved with practice. These explanations are presented in greater detail in the following section.

Level of commitment of the discharge manager. The discharge manager indicated in an interview with the researcher that she had been able to more successfully implement the discharge planning protocol in Mrs. C's case than she did in Mrs. B's because she made more frequent trips to the unit and took charge of the situation. This indicated that she expended a greater effort in this case. Although this does not necessarily mean that the discharge manager had a high level of commitment to the study or to the concepts of the integrated model of discharge planning, it does suggest that she was committed to implementing the protocol in this case.

Practice. A concurrent explanation as to why the discharge manager was able to more successfully implement the protocol in the case of Mrs. C. than in that of Mrs. B. could however be that she was more familiar with the protocol the second time and therefore was able to implement the activities with greater ease. This would seem to indicate that a practice phase would facilitate implementation of the protocol.

Patient's ability to be involved in discharge planning throughout the hospital stay. Mrs. C's condition remained stable throughout the hospitalization and she was able to remain involved in the discharge planning. This would seem to support the hypothesis that the inability of the patient to remain involved in discharge planning and decision making

because of poor medical status or a change in the medical condition renders implementation of the discharge planning protocol a challenge.

Discharge manager usually involved in discharge planning. The case study did not lend support for the hypothesis that the discharge manager being previously involved in discharge planning as part of her usual role fostered successful implementation of the model. The researcher hypothesized that if the discharge manager was already engaged in discharge planning in her usual occupation, working relationships with other health professionals would already have been established thus minimizing the need to develop these by building trust and orienting others to the role of discharge manager. However, the case study of Mrs. C. took place on the same unit as in the worst case and the discharge manager, the other health professionals involved, and the setting were the same. Therefore, it does not seem likely that the discharge manager would have been able to establish working relationships with the other health professionals on the unit after only one attempt at implementing the protocol in the worst case. What appears to be the more plausible explanation is that the discharge manager made a greater effort in this case than in the worse case to work with other health professionals by taking control and coordinating the discharge planning process.

Additional Insights

One interesting lesson learned from Mrs. C's case relates to who might benefit from the integrated approach to discharge planning. The discharge manager indicated during an interview with the researcher that according to the hospital's usual procedure, Mrs. C. would not have received any formalized discharge planning because she would not have been considered a high risk case according to usual screening criteria. However, the

discharge manager believed that Mrs. C. benefited from working with a discharge manager because there were issues that needed to be addressed. For example, Mrs. C. may not have received any home care services nor would she have seen the specialist prior to discharge had she not been part of this study. Mrs. C. noticed this difference and stated that she was much more satisfied with the discharge planning than during previous hospital admissions. Therefore, the findings suggest that all patients can benefit from the integrated approach to discharge planning, regardless of risk level.

The Case of Mrs. D.

“Z’s (the discharge manager’s) coming by made me think and get things in order. Because I was thinking of going home, but I wasn’t thinking of it in any way, well because you don’t when you’re sick. But by her coming in and discussing it all and everything, my mind started to pop, and got things into place, you know.”

Mrs. D. was 77 years of age. She was divorced and living on her own in an apartment. She had four children involved in her care, but the eldest daughter was the primary caregiver. However, this daughter suffered from rheumatoid arthritis and was not able to care for her mother during periods of acute flare-ups of the disease. Mrs. D’s children did not consent to be part of the study, although they visited their mother in hospital. The eldest daughter and a daughter-in-law were involved in the discharge planning.

Mrs. D. was admitted to hospital for the treatment of a myocardial infarction (MI). She was admitted to the same hospital as Ms. A. in the best case study, but to a different unit. It was a medical/cardiology unit comprised of 16 in-patient, acute-care beds and 4 beds for day procedures. Mrs. D. was admitted to one of the acute-care beds. The mode of delivery of nursing care on the unit was primary nursing. The medical team was comprised of attending physicians who changed every 2 weeks and clinical associates who were hired to work on the unit permanently. The unit was not a teaching one and therefore medical students were rarely present.

The discharge manager working with Mrs. D. was a registered nurse. Her usual occupation was that of Clinical Care Manager, the same position as the discharge manager involved with Ms. A. in the best case. The discharge manager first met with Mrs. D. on her third day of hospitalization. Mrs. D's daughter-in-law was also present. The discharge manager obtained initial information about Mrs. D. and her family's concerns regarding the discharge planning. The daughter-in-law expressed concerns that Mrs. D. did not have a realistic perspective of her ability to manage alone at home. She also indicated that family members were in disagreement about what were Mrs. D's needs and how best to address them. The discharge manager met with Mrs. D's daughter-in-law again later that day. The daughter-in-law reiterated her concerns regarding Mrs. D's ability to care for herself at home. The discharge manager explained how Mrs. D's needs would be assessed and that Mrs. D. would be the one to make the final decisions regarding her discharge plans. The daughter-in-law expressed concerns regarding potential difficulties for the family if Mrs. D. made a bad decision.

The discharge manager met briefly with Mrs. D. the next morning in order to set a convenient time to complete the initial assessment. At the agreed upon time, Mrs. D. informed the discharge manager that she was too tired to be interviewed and preferred to meet with the discharge manager after her angiogram which was scheduled for the next day. On the day after the angiogram, now Mrs. D's fifth day of admission, the discharge manager began the initial assessment using the OSCA. However, she was unable to complete the assessment because Mrs. D. was extremely tired. She had experienced a second acute MI following the angiogram and angioplasty the day before. The discharge manager spoke to the attending clinical associate regarding Mrs. D's medical treatment plan. The physician indicated that Mrs. D. would most likely be kept in hospital for a few more days in light of her second MI.

The discharge manager met with Mrs. D. the following Monday, the ninth day of hospitalization, in order to complete the initial assessment using the OSCA. The meeting lasted 2 hours and 20 minutes. The needs identified were for assistance with housecleaning, grocery shopping, meal preparation, laundry, personal care, as well as health and medication monitoring. During the assessment, the discharge manager began to question Mrs. D's mental status. Mrs. D. was often contradicting herself and expressed what the discharge manager interpreted as paranoid thoughts. For instance, Mrs. D. believed that people from a book company were breaking into her home in order to steal parts of a manuscript she was in the process of writing.

The discharge manager wrote the initial plan later that day. The initial plan reflected the data collected during the initial assessment. The discharge manager then spoke with an occupational therapist who had received a referral the previous Friday. The

source of the referral was not known but the occupational therapist agreed to communicate the findings of her assessment of Mrs. D's ability to engage in activities of daily living with the discharge manager. That evening, the discharge manager met with Mrs. D. and her eldest daughter. They discussed Mrs. D's ability to cope at home after her discharge. An argument between Mrs. D. and her daughter ensued. The daughter expressed that she could not provide the amount of assistance that Mrs. D. was expecting and that external supports should be explored. Mrs. D. insisted that she would not accept any strangers into her home other than a visiting nurse. The meeting ended with Mrs. D. making the final decision regarding the type of help she was willing to accept upon her discharge home.

The following day, the discharge manager spoke with the clinical associate about her concerns regarding Mrs. D's mental status. The physician told the discharge manager that Mrs. D. was judged capable of making decisions. However, he would write a letter to Mrs. D's family physician asking for further investigation of Mrs. D's behaviour in the event it represented a change in her mental status. The discharge manager then spoke to the hospital Home Care coordinator regarding the discharge plans and the need for nursing visits upon discharge. The coordinator agreed to meet with Mrs. D. in order to arrange services. The discharge manager then met briefly with Mrs. D. to review the final discharge plans which were for Mrs. D. to return home with nursing visits twice a week. Mrs. D. did not want any other services and expected her four children to each take turns looking after her. The final plan was not confirmed with any of the other core participants, that is, the physician, the Home Care Coordinator, or Mrs. D's daughter. Mrs. D. was discharged home the next day, after 11 days in hospital.

Mrs. D. was interviewed by the researcher in hospital on the evening before her discharge home. It was extremely difficult to obtain any meaningful data from her. Her answers to questions often consisted of stories containing incredible amounts of detail but were frequently off topic. At first she could not explain how the discharge manager had helped her as she stated that she had arranged for her discharge herself. She did however indicate that she was satisfied with the discharge planning because the discharge manager (a) assessed her ability to manage at home, (b) helped her problem solve and clarified her thinking, (c) kept her informed of plans and negotiated and shared responsibility with her regarding interventions and follow-up, and (d) was nice and helpful. As well, Mrs. D. indicated that she was extremely happy because her four children would take turns helping her therefore minimizing the burden placed on her eldest daughter. She described her satisfaction with the discharge planning in the following manner: "Z's (the discharge manager's) coming by made me think and get things in order. Because I was thinking of going home, but I wasn't thinking of it in any way, well because you don't when you're sick. But by her coming in and discussing it all and everything, my mind started to pop, and got things into place, you know."

The discharge manager spent 4 hours and 11 minutes implementing the discharge related activities of the protocol. Of these 4 hours and 11 minutes, 2 hours and 20 minutes were required to complete the OSCA. The discharge manager perceived that the initial assessment was long to complete and that overall she spent too much time planning for Mrs. D's discharge home. She believed that the final plan of sending Mrs. D. home with nursing visits could have been achieved by simply referring her to Home Care. She also

felt that this level of involvement would be difficult to sustain with several patients simultaneously.

Despite finding it long, the discharge manager stated in a subsequent interview with the researcher that the OSCA lead to a comprehensive assessment of the patient. However, she believed that it contained too much detail. For instance, she did not think that it was necessary to know if the patient could vacuum, dust, wash floors, clean the bathroom, et cetera. She believed that asking a broad question such as: "Can you do housework?" was sufficient. She found that it was difficult to write the initial and updated plans because these were always evolving until the final plan could be established. She found that completing the activities of the protocol within the pre-determined timeframes was a challenge given that Mrs. D. was too ill early in her hospitalization and her medical condition changed at the mid-point.

The discharge manager in this case study was able to offer some insights into her experience implementing the integrated model. She liked the approach to discharge planning advocated by the model. She believed that the conceptualization and underlying theories of the model lead to a humanistic way of performing discharges. She indicated that having the patient central to the discharge planning process had actually facilitated the discharge planning for Mrs. D. By respecting the patient's right to choose, the discharge manager avoided spending time and energy making plans that were not satisfactory to the patient. She believed that other health care professionals she worked with on the hospital unit had a poor understanding of what discharge planning entails. She indicated that having a written protocol helped her articulate to others what it is that discharge managers do. Furthermore, the discharge manager stated that although the hospital's mandate was

to ensure safe and well-planned discharges, hospital administrators and department heads offered little support to discharge planners. She indicated that because of the multiple demands placed on her by her superiors during the course of her everyday work, she actually had very little time to be involved in discharge planning. The discharge manager was also concerned that nurses did not appear to play a central role in discharge planning according to the integrated model. She believed that this devalued the role of the bedside nurse. Another critique was that in implementing the activities of the protocol, she felt like an “outsider” and “just another suit”. She believed that the discharge manager should be someone who had established a working relationship with the patient and was involved in the day-to-day care. She believed that ideally, the discharge manager should be the patient’s primary nurse. The discharge manager indicated that the lack of a central place to document discharge planning activities and required follow-up presented a barrier that made her work more difficult. It meant that she had to make efforts to communicate plans verbally to core participants which was not always possible given the availability of those involved.

Comparison of the Second Intermediate Case with the Best and Worst Cases

The case of Mrs. D. was compared with both the best and worst cases. The findings of the comparison are presented in the next sections.

Best Case

This attempt at implementing the protocol was not as successful as in the best case because the following elements of the integrated model were not or only partly upheld: (a) the core participants are involved in all aspects of planning, (b) other professionals are

involved as needed and in a timely fashion, and (c) communication is open and consensus oriented.

In this case, other than the patient, the other core participants were not consistently involved in all aspects of the planning. The attending physician was only involved in communications concerning the medical treatment plan and a relevant community person was not involved at all. Mrs. D's daughter was involved in the discharge planning although she did not agree with the final plan of having Mrs. D. return to her home. Other health professionals were not involved as outlined in the protocol. The discharge manager did not consult with the occupational therapist following her assessment of the patient although she was aware that a referral to the occupational therapist had been made. Communication in this case study was not consensus oriented, that is, the discharge manager did not obtain the input of all core participants and final plans were confirmed only with the patient.

Worst Case

The case of Mrs. D. was judged to be a more successful implementation of the protocol than in the worst case because the following elements of the integrated model were upheld: (a) The patient was central to the discharge planning process, (b) the discharge manager coordinated the process, and (c) the discharge planning followed the clinical trajectory.

Mrs. D. was central to the discharge planning process and she made the final decisions regarding the discharge plans even though her family disagreed. Furthermore, the discharge manager coordinated the process and the discharge planning followed Mrs. D's clinical trajectory. Plans were only made after her medical condition was stable.

Explanation Building and Hypothesis Confirming

The comparative method of analysis led the researcher to determine why the discharge planning protocol was more successfully implemented in the case of Mrs. D. than in the worst case and why the elements of the integrated model were not as fully upheld as in the best case.

The case study of Mrs. D. supported the hypothesis that the patient's medical condition could present a challenge to the implementation of the protocol. In this case, the discharge manager was able to implement the activities of the protocol, but the timeframes were not respected because Mrs. D. was too ill early in her stay and her medical condition changed after her second MI. She was therefore not able to be involved in the discharge planning process at all times during her hospital stay.

Summary of the Results Related to the Three Study Objectives

The process evaluation of the integrated model of discharge planning had three major objectives. These were to determine (a) if all the activities of the discharge planning protocol could be implemented as planned, (b) participant satisfaction with the discharge planning approach and the final plans that were made, and (c) the appropriateness of materials developed in conjunction with the discharge planning protocol. The results of the process evaluation as they relate to the three study objectives are presented in the following sections.

Can All Activities of the Discharge Planning Protocol be Implemented as Planned?

The first major result of the process evaluation of the integrated model of discharge planning was that the model has the potential to be implemented in a hospital

setting. The successful implementation of the discharge planning protocol in the best case study showed that the seven key elements of the model could be upheld. It was possible for the patient to be central to the discharge planning process. The discharge manager coordinated the process. She involved core participants in planning and decision making. Other health professionals were involved as required. Communication among core participants flowed freely and information was shared. The discharge planning followed the patient's clinical and social trajectories. The discharge manager used the action guides in the protocol to plan for the patient's discharge. In the two intermediate cases, discharge planning was patient-centered and it followed the patients' clinical and social trajectories. The five other elements of the integrated model were not upheld to the extent described in the model but were partly upheld. In the worst case, none of the seven key elements of the integrated model were upheld.

Comparison of the three less than best cases with the best case lead to the identification of facilitators and barriers to the implementation of the discharge planning protocol on the hospital units. The findings revealed that (a) the level of commitment of the discharge managers, (b) the medical status of the patient, and (c) the familiarity of the discharge manager with the integrated approach to discharge planning, could either facilitate or challenge implementation of the protocol and the upholding of the key elements of the integrated model. Additional elements within the hospital setting were also identified that could potentially facilitate implementation of the activities protocol. These were (a) the discharge manager having an office on the in-patient unit, (b) extended hours of work of discharge managers, (c) the availability of a substitute decision-maker, (d)

discharge planning forms being included in the patient's hospital chart. These facilitators and barriers will be discussed in the next chapter of the thesis.

The results of the process evaluation of the integrated model of discharge planning showed that not all the activities of the discharge planning protocol were implemented as planned. The initial assessment using the OSCA was the only activity that was consistently implemented in all four cases. Activities that were not implemented in any of the cases included (a) involving a relevant community person in discussing and providing information to the patient and family member about programs and services that could potentially meet their needs at discharge and determining the basis of their preferences, and (b) writing, negotiating, confirming, monitoring and modifying the updated discharge plans. The other activities of the protocol were implemented to varying degrees as described in the individual case studies.

Are Participants Satisfied with the Integrated Approach to Discharge Planning?

The second major result of the process evaluation was that use of the integrated approach to discharge planning lead to patient satisfaction. The patients in the best and two intermediate case studies were satisfied with the discharge planning and the final plans that were made. The patient and the family member in the worst case were not satisfied with the approach to discharge planning and were not aware of the discharge plans that had been made. Therefore, the findings suggest that patients and families were satisfied with the approach to discharge planning when the key elements of the integrated model of discharge planning were either fully or partly upheld. The findings also suggest that all patients can potentially benefit from the approach to discharge planning, not only those determined to be high risk by current screening methods.

The discharge managers did not express satisfaction with the approach to discharge planning due to their lack of familiarity with the model and protocol. They stated that they would need to implement the protocol a few more times in order to fully appreciate its advantages over their current practices of discharge planning. They did state however that they liked the initial assessment using the OSCA because it enabled them to obtain a holistic assessment of the patients' needs and helped them to elaborate discharge plans that were related to the needs assessed. They did not express any major dislikes with the protocol other than the OSCA was long to complete, that implementing the activities of the protocol required a lot of their time and that there was a large amount of documentation required for the purpose of the study.

Were Materials Used Appropriate?

In order to determine if the materials used in conjunction with the discharge planning protocol were appropriate, the researcher obtained the perceptions of the three discharge managers during interviews regarding the user-friendliness of the forms. The completed discharge planning forms were also reviewed by the researcher in order to determine (a) their ability to capture all the data necessary to answer the research questions, and (b) their usefulness in helping the discharge managers elaborate discharge plans.

The third result of the current study was that the forms would need minor formatting modifications in order to be more user-friendly and to capture all necessary data to answer all of the research questions as evident in the description of the forms below.

The One Stop Access Client Assessment form. The discharge managers found that the OSCA lead to a comprehensive and holistic assessment of the patient's initial discharge situation. Their main concern was that the form was long to complete. The time required to complete the assessment varied from 45 minutes to 2 hours and 40 minutes. However, despite this concern, the discharge managers stated that the information obtained from using the OSCA enabled them to identify patient needs and areas of concern. These assessment findings were reflected in the initial plans and later in the final discharge plans. Therefore, it appeared that the OSCA was helpful in elaborating discharge plans that were judged by the patients in the best and two intermediate cases as being satisfactory.

The initial, updated, and final discharge plans forms. The discharge managers indicated that the forms for the initial, updated and final plans were somewhat repetitive when there was not much change between the initial and the final plan. In fact, the form for the updated discharge plan was not completed for any of the patients in the study. The discharge managers stated that the three forms should somehow be combined into one, in order to simply highlight changes and not have to rewrite plans if there were no changes.

Furthermore, a review of the three completed discharge plans forms indicated that they were not able to consistently show if some activities of the discharge planning protocol were being implemented. From the data contained on these forms, it could not always be determined if the discharge manager was ensuring that (a) medications, treatments, supplies and services were in place at the time of the patient's discharge; (b) the discharge order was written; and (c) the patient and the family were ready for

discharge. Also, the forms did not require documentation of the time required to write the initial, updated and final plans.

Record of meetings/contacts form. The discharge managers' main concern with this form was that not enough room was provided for documentation. Also, a review of the completed forms indicated that they were not able to capture data pertaining to the timely referral to consultants. Although interactions with consultants were documented, it could not be determined if the referrals were made within 8 hours of an identified need as outlined in the protocol. As well, it could not be determined if discussion between the discharge manager and the consultant took place within the pre-determined timeframe of 24 hours of the consultant's completed assessment.

Chapter Four: Discussion of the Results of the Process Evaluation of the Integrated Model of Discharge Planning and Recommendations for Future Implementations and Ongoing Evaluations

In this chapter, the results of the process evaluation of the integrated model of discharge planning are discussed. The discussion will proceed as follows. First, the three major results of the process evaluation will be discussed as they relate to key elements of the theoretical model of discharge planning and findings of prior research. Second, the value of process evaluation will be examined. In this section of the chapter, the study findings will be discussed in light of what was learned about process evaluation. The limitations of the process evaluation of the integrated model of discharge planning will also be examined. The chapter concludes with recommendations for future implementations of the model and its ongoing evaluation.

Major Results of the Process Evaluation of the Integrated Model of Discharge Planning

The process evaluation of the integrated model of discharge planning lead to three major results. Based on the four case studies, the researcher concluded that (a) the integrated model has the potential to be implemented in a hospital setting when certain conditions are in place, (b) use of the integrated approach to discharge planning contributes to patient satisfaction, and (c) the materials developed as part of the discharge planning protocol require only minor formatting modifications in order to be rendered user-friendly. Each of these major results is discussed in the following sections.

The Integrated Model of Discharge Planning can be Implemented in a Hospital Setting

The process evaluation revealed that the discharge planning protocol has the potential to be implemented in a hospital setting and that it is possible to uphold the seven key elements of the theoretical model. In the best case study, although not all the activities of the discharge planning protocol were implemented, planning for the patient's discharge home from hospital proceeded in a manner that upheld each of the seven elements of the integrated model.

The formally-evaluated discharge planning protocols described in the literature have not conducted prior process evaluations of their approaches. Therefore, it cannot be concluded from these studies if the discharge planning approaches were implemented as planned and what facilitated or challenged implementation. Nevertheless, these studies indicated that it was possible to (a) designate persons with the explicit responsibility of coordinating the discharge planning process (Evans & Hendricks, 1993; Haddock, 1994; Naylor et al., 1994; Naughton et al., 1994; Soskolne & Auslander, 1993); (b) utilize a formalized discharge planning protocol that incorporated standardized assessments (Haddock, 1994; Naylor et al., 1994; Soskolne & Auslander, 1993); and (c) achieve frequent and early communication with patients and family members about discharge goals and expectations (Naylor et al., 1994). Therefore, the finding of the process evaluation that three of the seven elements of the integrated model could be upheld in hospital settings is supported by prior research. Furthermore, the process evaluation showed that the other four elements of the model could also be upheld. Also, the process evaluation revealed that there were conditions within the hospital context that could either facilitate or pose a challenge to the implementation of the discharge planning protocol. These

barriers and facilitators will be discussed as they relate to the key elements of the integrated model.

Discharge planning is patient-centered. The first element of the integrated model of discharge planning is that the patient is at the center of the discharge planning process. According to the model, the patient is actively and continuously involved in informed decision making. The case studies used in the process evaluation of the integrated model revealed that the patient's medical condition and cognitive status could either facilitate or challenge the first key element. The discharge planning was more likely to be patient-centered when the patients' medical condition remained stable and when they were cognitively intact. Conversely, it was a challenge for the discharge managers to involve the patients in discharge planning when they were either too ill or when their medical condition or cognition deteriorated, preventing them from continuous involvement in discharge planning throughout their hospital stay.

Other authors have also found that the patient's medical condition can render ongoing and meaningful involvement in discharge planning a challenge (Abramson, 1988; Coulton, Dunkle, Goode & MacKintosh, 1982; Proctor & Morrow-Howell, 1990; Proctor, Morrow-Howell, Albaz & Weir, 1992). These authors have indicated that involving a family member or a substitute decision maker would be necessary when patients are not able to make decisions on their own behalf. The integrated model of discharge planning also advocates this practice. However, this can be problematic at times as other authors have found that patients and families do not always agree regarding needs post-discharge, the appropriateness of the discharge plans, the timing of discharge, and the discharge destination (Bull, 1994; Congdon, 1994; Jones & Lester, 1994; McBride, 1995;

Proctor & Morrow-Howell, 1990; Rock et al., 1995). Furthermore, patients may not have a family member or a substitute decision maker to advocate on their behalf. As well, Proctor, Morrow-Howell & Lott (1993) have found that the patient's inability to be involved in discharge planning as a result of fluctuating cognitive status is often at the root of ethical dilemmas related to discharge planning.

The integrated model of discharge planning addresses these ethical issues by recommending that in addition to a family member or substitute decision maker, when available, a relevant community person should be involved in discharge planning as a core participant. This relevant community person could be the family physician, a home visiting nurse, a homemaker or another person involved in the patient's care at home. This assures that the patient's prior wishes and needs are communicated to the discharge manager. Prior research has not examined the involvement of a community person as a means of ensuring ethical decision making in discharge planning.

Discharge planning is directed by a discharge manager. The second key element of the discharge planning model is that a discharge manager is required to oversee and participate in the entire discharge planning process. The process evaluation showed that the level of commitment of the discharge manager could either facilitate or challenge this element. A commitment to implementing all the activities of the discharge planning protocol on the part of the discharge manager led to a successful implementation of the protocol in the hospital setting. However, when the discharge manager was not committed to implementing the activities as outlined in the protocol, the protocol was not completely implemented.

Patton (1997) has written that people problems are a commonly documented barrier to program implementation. He states that in implementing new programs and managing change, human obstacles are often present. These include staff who give up when they encounter trivial obstacles, people who hang onto obsolete ideas and outmoded ways of doing things, emotional outbursts when asked to perform new tasks, muddled communications, and delayed action when problems arise. With the exception of Soskolne and Auslander (1993), the empirically tested approaches to discharge planning described in the literature did not discuss whether such people problems occurred in trying to implement their approaches. Soskolne and Auslander concluded that their approach may not have achieved the desired outcomes because the social workers implementing the discharge planning program may not have changed their practice. Although the researcher in the current study did not observe these problems first hand, it is believed that the discharge managers in the process evaluation may have had difficulty changing their practice and may not have been fully committed to the new approach at the onset of trying to implement the discharge planning protocol.

Furthermore, the level of commitment of the discharge managers in the process evaluation may have been influenced by larger systemic issues. All three discharge managers stated during interviews that they were extremely busy during the course of their everyday work and they had to juggle multiple demands that were being placed on them. They stated that they did not have enough time to engage in discharge planning activities. As Shamian and Lightstone (1997) have documented, nurses working in today's hospital environment are increasingly feeling pressured as they try to provide quality patient care with shrinking resources. One discharge manager perceived that although hospital

administrators and department heads valued efficient and effective discharges, they offered little support to discharge planners. Cameron, Horsburgh and Armstrong-Stassen (cited in Baumann et al., 1996) found in a recent study that nurses in an Ontario city affected by hospital restructuring strategies were not satisfied with the supervision offered by their managers which in turn influenced their perceptions of the quality of their worklife. Therefore, the discharge managers in the process evaluation may have been committed to participating in the study by agreeing to implement the discharge planning protocol, but in reality, they could not make this their priority because they were attempting to meet the multiple demands of the work situation and lacked support for engaging in discharge planning activities.

Additionally, to effectively coordinate the discharge planning process, the discharge managers would require not only the support of their superiors but the power and authority to engage other professionals and lead the process. Feather (1993) has concluded that power, including discharge planner influence and the support of hospital administrators and physicians, is a most important predictor of discharge planning effectiveness.

The second key element of the integrated model may also have been challenged by the discharge managers' level of familiarity with the integrated approach to discharge planning. It is hypothesized that the discharge managers' ability to implement the protocol would have improved with practice. This hypothesis was supported when the discharge manager in the worst case study was more successful at implementing the protocol on her second attempt. It can be stipulated that the other discharge managers would have also

been able to improve their performance had they had the opportunity to implement the protocol on more than one patient.

The discharge managers' lack of familiarity with the integrated approach to discharge planning may have been aggravated by the lapse of time between the training and the actual implementation. All discharge managers were faced with having to wait before being able to actually put into practice what they had been taught by the researcher due to the participant recruitment problems previously discussed. The delay was 5 weeks for the discharge manager in the worst case and first intermediate case, 9 weeks for the one in the best case and 11 weeks in the second intermediate case. It is possible that the discharge managers forgot some of the content of the training during the interval of time between training and implementation.

Core participants are involved in discharge planning. The third key element of the integrated model is that in addition to the patient and the discharge manager, there are core participants involved in discharge planning. These are a family member or substitute decision maker, the attending physician, and a relevant community person. The findings of the process evaluation revealed that a number of issues could facilitate or challenge the involvement of these core participants in the discharge planning process.

First, the hours of work of the discharge managers could have challenged access to family members or substitute decision makers. The discharge managers in the process evaluation worked from 0800 to 1700 during week-days. They did not work on the weekend. Because family members often visit their hospitalized relatives in the evenings and on week-ends, they may not have been available to meet with the discharge managers during their regular hours of work. Some authors have recognized that the availability of

discharge planners can facilitate effective discharge planning. For example, Naylor et al. (1994) ensured that the clinical nurse specialist coordinating the patient's discharge was available for telephone contact with the patient, caregivers, and health team members for extended hours 7 days per week throughout the patient's hospitalization and for 2 weeks after discharge. Involving a substitute decision maker in discharge planning becomes critical when patients are not able to make decisions due to their medical or cognitive status. Discharge managers may therefore have to work extended hours in order to be more accessible to family members and substitute decision makers.

Secondly, the discharge managers may have missed opportunities to meet with family members, substitute decision makers and attending physicians because they had offices located off the hospital units and were not present on the units at all times. Although the discharge managers found strategies to minimize this barrier by making more frequent trips to the unit, for example, having an office located on the unit would make discharge managers more accessible to core participants. Other reports of empirically-tested discharge planning approaches have not discussed the need for the discharge planner to be physically located on the hospital unit.

According to the integrated model, involvement of a relevant community person is essential to the continuous flow of information between the hospital and community, and to a timely, well-planned discharge of the patient. Involving a relevant community person was a new concept for the discharge managers in the process evaluation. The only contact they had with the community setting in their usual practice was with the hospital's Home Care coordinator. Furthermore, the discharge managers' knowledge of community

resources and how they function may have also limited their ability to involve a relevant community person in planning for the patient's discharge home from hospital.

Descriptive studies of current hospital discharge planning approaches have concluded that liaison between hospital and community nursing staff was minimal (Jewell, 1993; McBride, 1995; McWilliam, 1992; McWilliam & Sangster, 1994). The description of the discharge planning process offered by Jewell's study showed that continuity with the community services that were already involved with patients prior to admission seemed to be poor. Communicating with community professionals was rarely seen by hospital staff as important to discharge planning. However, community service providers held the opposite view. They felt they had a vital role to play in providing information to facilitate discharge decisions. Therefore, the discharge managers in the current study may have required some additional training to understand who a relevant community person might be and how to work with that person, as this would not have been a function they had been performing previously.

Well-working communication systems are in place to support discharge planning.

In the integrated model of discharge planning, communication is open and flows freely between the patient, and the hospital and community professionals involved in the patient's care. The information that is gathered is shared equally among participants. The discharge manager is responsible for coordinating the information gathering and sharing.

Some of the barriers to effective communication among all core participants may have been partly related to the hours of work and physical location of the discharge managers, as well as, their commitment to implementing the activities of the discharge planning protocol. These barriers have been discussed in previous sections of this chapter.

An additional barrier to effective communication in this study may have been the lack of a central place to document discharge plans and required follow-up. The integrated model does not specify that communication between core participants need always be face-to-face. Communication could therefore have been enhanced with appropriate documentation. Furthermore, a common database used for information sharing could have facilitated communication with a relevant community person. The data collection forms developed in conjunction with the discharge planning protocol may facilitate adequate documentation and therefore efficient communication. The forms specify the content of important, relevant information concerning discharge planning that needs to be documented. Making these discharge planning forms part of the patient's hospital chart could facilitate information sharing with other health professionals involved in discharge planning.

The study by Haddock (1994) is the only one of the six empirically tested approaches to discharge planning described in the literature in which the need for documentation related to discharge planning is addressed. However, Haddock did not discuss why such documentation is required, only that it should be complete. Although the fact that poor communication as a barrier to effective discharge planning has been documented in descriptive studies of naturally occurring discharge planning practices (Congdon, 1989; Jewell, 1993; McWilliam & Sangster, 1994), the facilitators to effective communication have not been discussed in these studies.

The developments in computerized technology may offer a solution the communication problems identified with respect to discharge planning. In Kelowna, British Columbia, a continuous electronic health chart to facilitate the exchange of

information between hospital and community, thereby fostering more consistent discharge care across the health-care continuum, has been tested (Kelowna General Hospital, 1996; Zilm, 1996). Evaluation of the initiative showed that it could streamline the interface between acute and community health care and reduced time spent by staff on unproductive activities. The Medical Data Index developed in England is another example of a shared computerized database geared at assisting discharge planning (Pheby & Thorne, 1994).

Action guides facilitate discharge planning. The seventh element of the integrated model of discharge planning is that the planning process is guided by the action guides of a structured protocol. The process evaluation showed that not all the activities of the discharge planning protocol were implemented to the same extent. Some activities may therefore be easier to implement than others.

The only activity that was consistently implemented across all four case studies was the initial assessment of the patient's discharge situation using the One Stop Access Client Assessment. This may be related to nurses' familiarity with assessment. Assessment is central to the nursing process, and it may be that this a well developed skill in nurses. Furthermore, this initial assessment was an activity of the protocol that was clearly defined and the discharge managers were able to complete the OSCA.

Two activities were not implemented in any of the four case studies. These were (a) involving a relevant community person in discussing and providing information to the patient and family member about programs and services that could potentially meet their needs at discharge and determining the basis of their preferences; and (b) writing, negotiating, confirming, monitoring, and modifying the updated discharge plans. The discharge managers may not have involved a relevant community person in examining

discharge options with patients because, as discussed previously, they may not have understood how to go about doing this. The discharge managers appeared to have difficulty understanding the purpose of the updated discharge plans as exemplified by their failure to implement any protocol activities that pertained to these ongoing plans. One discharge manager stated that she found the updated discharge plans form too repetitive, and therefore she did not complete it. The nature of updated plans and the completion of the updated plans form may be an area of training that would need to be emphasized.

An interesting finding of the process evaluation relates to the time required to complete the activities of the discharge planning protocol. The discharge managers spent an average of 2 hours and 49 minutes implementing the activities of the protocol. The discharge managers all perceived that this was too much of their time because they stated that (a) the patients were straightforward, that is, they did not have complex discharge needs; (b) this much involvement would be difficult to sustain with several patients simultaneously; and (c) they could not easily spend that amount of time involved in discharge planning and perform all the other requirements of their positions as well. However, when one considers that the time required to plan for a patient's discharge according to the integrated approach would be spread-out over approximately 7 days, which is the typical length of hospital stay for elderly persons (Statistics Canada, 1994), it is difficult to comprehend the concerns of the discharge managers. Furthermore, it is hypothesized that the time to conduct the discharge related activities would decrease as discharge managers became more familiar with the protocol.

Use of the Integrated Approach to Discharge Planning Leads to Patient Satisfaction

The previous section has discussed the finding that the integrated model of discharge planning has the potential to be implemented in a hospital setting and that certain conditions within the setting can either facilitate or challenge its implementation. The second major finding of the process evaluation was that use of the integrated approach to discharge planning appeared to lead to patient satisfaction with the planning itself and with the final plans that were made when the seven key elements of the model were completely upheld. Patients were also satisfied when the elements were partly upheld, that is, when the discharge managers implemented at least part of the discharge planning activities that related to an element. In the three cases where patients expressed satisfaction, two key elements of the model were consistently upheld. These were that the patients were central to the discharge planning process and the planning followed the clinical trajectory. The research literature on discharge planning supports that these two factors are important contributors to patient satisfaction, as can be gleaned from the following discussion.

Several studies have examined patients' and families' perceptions of the discharge planning process. These studies found that patients and their family members were not satisfied with the discharge planning process when they were not consistently involved in decision making (Coulton, Dunkle, Chow, Haug & Vielhaber, 1988; Kadushin & Kulys, 1994; Jewell, 1993; McWilliam, 1992; McWilliam & Sangster, 1994; Morrow-Howell, Proctor & Mui, 1991; Proctor, Morrow-Howell, Albaz & Weir, 1992). Wells (1997) found that patients in hospital experienced distress when discharge decisions were made before a diagnosis was established or before the attending physician could accurately

predict the outcome of the illness. Therefore, coordinating the discharge planning process so that it is congruent with the patient's clinical trajectory may be another important element that contributes to patient satisfaction.

The patients in the process evaluation may also have been satisfied with the discharge planning approach because their situations were assessed using a comprehensive assessment tool. The discharge managers used the OSCA to assess the patient's situation prior to hospitalization and their discharge plans reflected the information obtained. Although the discharge planning approaches described in the literature included an initial assessment of the patient, only one approach used a structured instrument to collect data on the patient's health and functional status, sociodemographic data, current resource utilization, medical treatment, and drug therapy (Haddock, 1994). Haddock reports that the patients that were assessed using the LTCIS were significantly more satisfied than the control group that received the hospital's usual discharge planning, as indicated on a four-point Likert response scale ranging from 1 (very satisfied) to 4 (very dissatisfied) (2.14 ± 0.52 versus 1.24 ± 0.23 , $p=0.001$). Therefore, the result found in the current study that use of a structure instrument to assess the patient's initial discharge situation leads to patient satisfaction with the discharge planning process is supported by Haddock's study. The OSCA used in the process evaluation represents a more comprehensive assessment than the LTCIS. In addition to those areas assessed by the LTCIS, the OSCA also assesses the patient's living situation, ability to manage personal and instrumental activities of daily living and social supports.

In the process evaluation, any patient meeting the inclusion criteria could have received the new approach to discharge planning. The inclusion criteria did not include an

evaluation of the person's risk level. The discharge managers stated that according to their hospitals' usual screening procedures, three of the four patients in the study would not have been targeted to receive the services of a discharge planner because they were considered to be low risk. However, after working with the patients, both discharge managers expressed that they felt that there were issues that warranted the intervention of a discharge planner. Furthermore, the patients stated in interviews that they were satisfied with the discharge plans that had been made. The discharge planning strategies for the elderly in hospital settings described in the literature have focused primarily on those considered to be at risk. The decision to offer discharge planning services to only a certain segment of the elderly population is most likely driven by organizational factors, that is, the drive to cut costs by using resources sparingly. However, in the current study, patients considered low risk benefited from a structured approach to discharge planning.

The Materials used in Conjunction with the Discharge Planning Protocol Require Formatting Modifications

The third major result of the current study to be discussed in this section was that the discharge planning documents would require only minor formatting modification to improve their ease of use and to ensure that they could capture all the data required to achieve the objectives of the process evaluation.

Although the discharge managers found the OSCA (see Appendix G) long to complete, they stated that it helped them assess the patient's situation comprehensively and enabled them to elaborate the discharge plans. It is possible that as the discharge managers became more familiar with the assessment, the time required to complete it would decrease. In order to avoid repetition, the final page of the OSCA, the summary of

needs, should be removed in future implementations of the protocol. Instead, that summary page should be reflected in a modified discharge plans form (see Appendix L), which is an integration of the three original discharge plans forms, that is, the initial, updated and final plans forms (see Appendix I) into a single form. This new form could provide a clearer overall picture of the discharge plans as they evolve according to the patient's condition and decrease the need for repetition. The single form could be part of the patient's chart or nursing care plan and modifications to the plans could be made as required. A copy of the form could be given to the patient upon discharge to inform community professionals and the general practitioner of the plans and required follow-up. Also, the new form now includes a discharge check-list which was added because the existing discharge plan forms failed to capture certain activities of the discharge planning protocol.

The record of meetings/contacts form (see Appendix H) required only formatting modifications to allow more space for documentation. The modified form can be seen in Appendix M. Furthermore, a form that captures the timing of referrals and contacts with consultants would need to be added because the existing forms could not help determine if the referrals to consultants were being made within 8 hours of an identified need and whether the discharge managers were communicating with the consultants within 24 hours of their completed assessments (see Appendix N).

The Value of Process Evaluation

The second section of this chapter discusses what has been learned about process evaluation. One of the major lessons is that it is essential to evaluate a new program as it is

being implemented. The discharge planning protocol was not implemented consistently across all four cases despite the fact that the discharge managers received the same training and that the settings were similar. If the researcher had implemented the protocol on a large scale and evaluated patient and hospital outcomes without conducting a prior process evaluation, it would not be known what factors influenced the outcomes. This is one of the shortcomings of the empirically-tested models of discharge planning described in the literature. Because none of the studies reported doing a prior evaluation to determine whether the protocols were actually being implemented as intended or even implemented at all, there is a potential for threats to internal validity. Therefore, none of the results of those studies can be considered with great confidence because the reader has no means of knowing what accounted for the findings.

Second, the current study showed that conducting a process evaluation at the very onset of a new program can provide information about the program before re-invention can occur. Re-invention occurs when a program is modified or changed by its users in the course of its adoption and implementation (Brunk & Goepfinger, 1990). Although re-invention can be positive, resulting in the program being more suited to its target population and therefore more likely to be used, it can also be problematic. Re-invention can compromise carefully planned research because one can no longer be certain of what caused the observed effects, unless the re-invention is discovered.

Third, what is evident from this study is that process evaluation should be ongoing in the life of a program. Even after one is satisfied that a program is being implemented as intended and plans are made to evaluate the program's effects, monitoring of the process of program delivery is still required (Hawe, Degeling & Hall, 1990). This is done to ensure

that the quality of the program is maintained, that activities continue to be implemented as planned, and that the program is still congruent with the realities of the setting in which it is being used and of the users of the program. In the current study, the level of commitment of discharge managers was critical to a successful implementation of the integrated model of discharge planning. It is possible that their level of commitment could fluctuate as demands of the organization also varied. Therefore, ongoing process evaluation would ensure that the discharge planning approach continues to be implemented as planned.

Fourth, a point is made here for those wishing to implement the integrated model in their own settings. Although the process evaluation showed that the integrated model could be successfully implemented in the hospital setting as evidenced in the best case study, the results are intimately linked to that setting. This is to say that they are not directly transferable to a different site as there may be conditions in the new setting that pose different challenges to implementation. Although the insights gained in the current study should be taken into account in future implementations, the integrated approach to discharge planning would require an evaluation of its process in the new setting to enhance its implementation given the particular characteristics of that setting.

Study Limitations

The present study presents some limitations and these will be examined in this section of the thesis.

Sample Size

The first limitation is related to the study's sample size. Although a small sample size is appropriate for process evaluations (Patton, 1990), having only four cases meant that the explanations to account for what facilitated or challenged the implementation of the integrated model could not be verified. The findings of the process evaluation could have been rendered more credible had they been confirmed by additional cases. Furthermore, having a limited number of cases meant that the discharge managers in the process evaluation were not allowed a practice phase in order to become more familiar with the discharge planning protocol. It is difficult at this point to state with certainty whether the barriers to successful implementation would still be present after the discharge managers became more knowledgeable about the activities of the protocol.

Although few researchers readily point out weaknesses in their research, there is anecdotal evidence to indicate that recruitment problems are more commonplace than one might assume (Dowling & Wiener, 1997). These authors believe that the under-reporting of roadblocks encountered in subject recruitment is a disservice to the research community. In this spirit, this section examines some of the difficulties encountered by the researcher in recruiting participants into the study. The obstacles to the recruitment of participants are presented in terms of (a) population characteristics, (b) reluctance of patients to participate in research, (c) availability of designated hospital contacts and discharge managers, and (d) sampling criteria. Strategies used by the researcher to enhance the recruitment of participants into the study are also presented. These included (a) modifying the selection criteria, and (b) increasing the frequency of telephone contacts with DHCP and discharge managers.

The researcher had originally intended to recruit 10 patients into the process evaluation of the integrated model of discharge planning. A family member involved in the care of the patients recruited into the study, where applicable, was also to be asked to participate in the study. However, 5 1/2 months after the beginning of the study, only four patients and one family member were recruited into the study. A number of factors presented as obstacles to the recruitment of study participants and these are presented below.

Population characteristics. The process evaluation was conducted on three medical units. Elderly people are most frequently admitted to hospital for acute episodes of medical conditions (Statistics Canada, 1994) and, therefore, it was anticipated that the three medical units would have a high proportion of persons over 65 years of age. This belief was confirmed by the three DHCPs who all stated that the majority of patients admitted to the three units were elderly persons. However, during the course of the study, all three units had lower than usual numbers of elderly persons admitted as reported by the DHCPs. Therefore, the availability of potential study participants was less than expected. Furthermore, in one of the two hospitals, many of the patients admitted to the unit did not speak English or presented with cognitive impairment, both of which were exclusion criteria for being involved in the study.

Patients declining to participate. The three DHCPs indicated that the majority of the patients that were approached to participate in the study simply declined. The patients told the DHCPs that they were too ill to participate or were not interested in being involved in a research study.

Availability of designated hospital contact persons and of discharge managers. The recruitment of study participants was dependent on the availability of both the designated hospital contact persons and the discharge managers. The DHCPs had to be present on the unit in order to explain the study to potential participants and obtain consent. The discharge managers had to be available in order to implement the protocol and collect the data once patients agreed to be part of the study. The three DHCPs and the three DMs were frequently not available throughout the course of the study due to vacation time, off-site meetings, conferences, courses, and illness. The recruitment of participants was often delayed for weeks at a time for these reasons.

Sampling criteria. According to the study's sampling criteria, patients had to be recruited into the study within 12 hours of their admission to the hospital unit. This was done to ensure sufficient time for the discharge managers to implement all the activities of the discharge planning protocol given that lengths of acute hospital stays average 7 days for elderly patients (Statistics Canada, 1994). The discharge managers stated that they often did not identify potential study participants until 48 to 72 hours after admission. This was the case if patients were admitted when the discharge managers were absent due to previously mentioned reasons or when patients were admitted over the week-end. Therefore, these patients were not asked to participate in the study.

Strategies to enhance the recruitment of study participants. Approximately 3 months after the start of the research study, two patients and one family member had been recruited from the first hospital and none from the second hospital. In an effort to enhance the recruitment of participants, the researcher made the following modifications to the recruitment procedure and to the sampling criteria.

1. The DHCPs were instructed to accept patients who could not speak English into the study if an interpreter was available. As well, patients could be accepted into the study up to 72 hours following their admission to the hospital unit.
2. The researcher began calling DHCPs every two days in order to remind them to search for potential study participants.

Despite these modifications, the recruitment of study participants was still difficult. It is this researcher's belief, as Dowling and Wiener (1997) also found in their study, that interest and willingness on the part of hospital personnel to participate in research did not necessarily translate into committed participation in the research study.

Participant Observation

The process evaluation could also have been strengthened had the researcher included participant observation as an additional data collection strategy. "The value of observational data in evaluation research is that evaluation users can come to understand program activities and impacts through detailed descriptive information about what has occurred in a program and how the people in the program have reacted to what has occurred" (Patton, 1990, p.202-203). The findings of the process evaluation were based on discharge managers' and patients' accounts of what occurred. The researcher could have corroborated those accounts with observations of what actually occurred in order to enhance the credibility of the findings.

Commitment to the Evaluation

Patton (1997) has written that one of the first challenges of program evaluation is engendering the commitment of intended users of the program for both the evaluation itself and its use. For this reason, he has stated that it is essential to involve stakeholders in

determining the purpose of the evaluation, the criteria for judging success, the methods of evaluation and the timeline for completing the evaluation. The process evaluation of the integrated model showed that the level of commitment of the discharge managers and support from hospital heads could facilitate successful implementation of the model in the hospital setting. Therefore, involvement of the main stakeholders in the process evaluation could have fostered a greater commitment to implementing the integrated approach to discharge planning.

The process evaluation provided useful information about how to modify the conditions within which the discharge planning protocol was implemented in order to foster a successful implementation. These adaptations are presented in the following sections of this chapter.

Recommendations

The final section of the thesis presents two types of recommendations. First, recommendations are made to facilitate future implementations of the integrated model of discharge planning in other settings. Second, recommendations are suggested for future process evaluations of the integrated model. Each of the two sections presents major recommendations. For each major recommendation, sub-recommendations are also listed.

Recommendations for Future Implementations of the Integrated Model of Discharge Planning in Other Settings.

The following recommendations are made to enhance future implementations of the integrated model of discharge planning in other settings. The recommendations are aimed at maximizing facilitators and minimizing barriers to implementation within the

hospital context. The major recommendations are (a) select appropriate discharge managers, (b) emphasize training of discharge managers and allow a practice phase, and (c) enhance communication between core participants. Each of these major recommendations along with related sub-recommendations are presented in the following sections.

Select appropriate discharge managers. The process evaluation showed that the discharge manager is critical to a successful implementation of the integrated model. Therefore, the following recommendations should be taken into account when selecting a discharge manager:

1. The discharge manager should be a highly skilled practitioner with advanced knowledge of the needs and care of elderly patients as well as community organizations and resources.
2. The discharge manager should have credibility within the hospital organization and the power and authority to lead the discharge planning process.
3. The discharge manager should be physically located on the hospital unit and well integrated into the functioning to the unit.
4. The discharge manager should have good working relationships with other health professionals on the units.
5. The discharge manager should be available for extended hours in order to meet with family members and substitute decision makers.

Emphasize content areas of training to discharge managers and allow a practice phase. The following recommendations are made to ensure the discharge managers are

fully trained on all aspects of the integrated model and its related protocol and become familiar with the new approach to planning:

1. The training should emphasize the need to involve a relevant community person in discharge planning. That is, examples of who the relevant community person may be should be provided. How to involve the relevant person should also be discussed.
2. The training should include specific information regarding the nature of the updated plans and the completion of those plans.
3. The discharge managers should be provided with examples of completed discharge related documents to serve as guidelines throughout implementation of the new approach.
4. The delay between training and actual implementation of the discharge planning protocol should be no longer than one week. If a longer delay occurs, the training should be reinforced.
5. Discharge planners should be allowed a practice phase in order to become more familiar with the activities of the discharge planning protocol and the related discharge forms.
6. During the practice phase, the evaluator should be available to answer questions, problem-solve and provide ongoing feedback to the discharge managers.
7. During the practice phase, the evaluator should review the completed data collection forms to ensure that the discharge managers are completing them correctly and to clarify any questions.

Facilitate communication between core participants. In order to facilitate the sharing of information related to discharge planning between core participants, the following recommendations are made:

1. Include the initial assessment and the discharge planning forms in the patient's hospital chart.
2. Provide the patient with a copy of the discharge planning form upon his or her return home to facilitate communication with community professionals and ensure that final discharge plans are implemented.

Recommendations for Future Process Evaluations of the Integrated Model of Discharge Planning

As discussed previously, the process evaluation of the integrated model of discharge planning presented some limitations. These were (a) the small number of cases, and (b) the absence of participant observation. To address these limitations and enhance the credibility and use of the findings of future and ongoing process evaluations of the integrated model it is recommended that (a) the integrated model be implemented for all patients on a hospital unit, (b) major stakeholders be involved, and (c) the evaluator conduct participant observation in the hospital setting as the model is being implemented.

Implement the integrated model of discharge planning throughout the hospital unit.

The manner in which the process evaluation was conducted presented certain problems. Because the discharge planning protocol was implemented only for a few patients on the hospital unit, participant recruitment issues ensued and discharge managers reported that the research situations felt artificial. Furthermore, participation of other core professionals was limited. To address these issues, the following recommendations are made:

1. The integrated model of discharge planning should be implemented for all patients on a hospital unit. In this manner, discharge planning according to the integrated model could be adopted by all unit staff as a new way of performing hospital discharges.
2. Patients on the unit would not have to consent to receive discharge planning according to the integrated model because it would constitute the only option for discharge planning offered on the unit. Patients would only have to consent to be interviewed for the purposes of evaluating both process and outcomes. Participant recruitment issues would therefore be minimized.

Involve stakeholders. In order to ensure a high level of commitment to implementing the integrated model of discharge planning in the hospital setting, minimize human obstacles and foster a change in practice, it is recommended that the main stakeholders be involved in the process evaluation. These stakeholders would be the hospital directors and administrators, the discharge managers, the other health professionals on the unit, and the patients and their family members. In order to involve stakeholders, the following suggestions are made:

1. The evaluator should meet with hospital heads and administrators before the start of the implementation to ensure that the organization is committed to supporting staff in changing their discharge planning practices.
2. The evaluator should provide hospital heads with regular updates regarding the progress of the implementation in order to ensure their continued support.
3. The evaluator should train the other health professionals on the unit with regard to the integrated model of discharge planning and the related protocol. In this manner, the evaluator could be made aware early on of concerns of other health professionals as

well as ideas and firmly held beliefs. Being aware of these beliefs, the evaluator could find strategies to work with these.

4. The training of other health professionals should be reinforced at regular intervals to ensure that staff remain committed to changing their practice.

Conduct participant observation. According to Posavac & Carey (1992), the credibility of the findings of program evaluations can be enhanced by prolonged presence at the program site, by the use of a variety of sources of information, and by checking interpretations with other evaluators and participants of the setting being evaluated.

Therefore, the following recommended are made:

1. The evaluator should be present on the hospital unit to observe the interactions between the discharge managers and the other core participants. In this manner, data collected through interviews with core participants and a review of the completed discharge planning forms could be corroborated with the participant observations.
2. The evaluator should be present on the hospital unit regularly to meet with core participants in order to obtain ongoing feedback about the discharge planning protocol, problem solve around issues that arise, and reinforce training. This could also ensure ongoing commitment to implementation of the integrated approach to discharge planning.

Conclusions

This study has evaluated a new, theoretical model of discharge planning for the hospitalized elderly. The model addresses the many problems associated with current discharge planning practices and is more robust than other approaches described in the

literature. The results of the evaluation have shown that the integrated model has the potential to be used in hospitals. Although there were conditions within the setting that challenged its implementation, and despite the fact that the discharge planning activities were not all fully implemented as planned, patients that received the new approach to planning for discharges home were satisfied with the planning itself and with the final plans that were made. Two elements of the model in particular appeared to contribute to patient satisfaction. These were, patients being central to the process, and decision making following the patients' clinical and social trajectories. Furthermore, the findings of the evaluation suggest that an initial, comprehensive assessment using a structured instrument also impacts on patient satisfaction. It therefore appears that use of the integrated approach to discharge planning could contribute to the quality of care of elderly persons in hospital.

The study has shown that despite organizational factors that are a reality in today's hospital system, it is possible to plan for hospital discharges in a manner that is attentive to patients' rights to autonomy and self-determination, as well as, the careful use of scarce hospital resources. It appears likely that the use of the integrated model would lead to positive outcomes for patients and families while also addressing organizational objectives when all key elements of the model are upheld. The study has also determined that process evaluation is critical when implementing new programs in practice settings. The translation of theory into practice is not always straightforward and even the most well designed program may need to be adapted to be rendered congruent with the particularities of the setting in which it is being used and to the needs of its users.

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Appendix A

The Discharge Planning Practice Protocol:

Protocol Elements, Sequence of Activities, & Timing of Activities

<u>Protocol Element</u>	<u>Sequence of Activities</u>	<u>Timing of Activities</u>
1. Assessing the discharge situation (initial)	A. Conduct pre-admission and/or admission assessment of the patient & family (use: "One Stop Access Client Assessment Form")	Within 3 days of admission
	B. Through personal communication, discuss & determine the initial expectations of the following persons about the patient's discharge needs & goals: i) the patient & family member ii) the attending doctor iii) the relevant community person iv) other health professional(s) directly involved in the care of the patient	Within 3 days of admission
	C. With the community person, discuss & provide information to the patient & family member about programs & services that can potentially meet their needs at discharge & determine the basis	Within 3 days of admission

<u>Protocol Element</u>	<u>Sequence of Activities</u>	<u>Timing of Activities</u>
	of their preferences	
II. Developing & writing the initial discharge plan	<p>A. Ensure that the patient, family, attending doctor, relevant community person, other professional(s) directly involved in the patient's care have the opportunity to provide input into the writing & discussion of the initial discharge plan</p> <p>B. Write the initial discharge plan (use: "Initial Plan" form)</p> <p>C. Negotiate & confirm initial plan with participants involved in the patient's care (see II.A.)</p> <p>D. Record all meetings/contacts with participants (use: "Discharge Planning Meetings/Contacts" form)</p>	<p>Within 3 days of admission</p> <p>Within 3 days of admission</p> <p>Within 3 days of admission</p> <p>At time of meeting/ contact</p>

<u>Protocol Element</u>	<u>Sequence of Activities</u>	<u>Timing of Activities</u>
III. Involving consultants in the patient's care & discharge planning	A. Ensure timely referral to consultants identified as important to the patient's care by those directly involved in that care (see II.A.)	Within 8 hours of identified need
	B. Through personal communication, discuss & determine the consultant's expectations re: the patient's discharge needs & goals	Within 24 hours of the consultant's completed assessment
	C. Record all meetings/contacts with consultants (use: "Discharge Planning Meetings/Contacts" form).	At time of meeting/contact
IV. Developing, writing, & modifying the updated discharge plan	A. Ensure that the patient, family, attending doctor, relevant community person, other professional(s) directly involved in the patient's care & consultants have the opportunity to provide input into the development, writing, & modification of the initial discharge plan	PRN as new information is obtained (re: patient's clinical, functional, or social situation)

<u>Protocol Element</u>	<u>Sequence of Activities</u>	<u>Timing of Activities</u>
	B. Write the updated discharge plan (use: "Updated Plans" form)	Within 24 hours of receiving new information
	C. Negotiate & confirm updated discharge plan with all participants (see V. A.)	Within 48hours of writing updated plan
	D. Record all meetings/contacts with participants (use: "Discharge Planning Meetings/Contacts" form)	At time of meeting/ contact
	E. Monitor updated discharge plan. so that it is congruent with knowledge about the patient's evolving clinical. social & functional condition	As knowledge about the patient's clinical. social, & functional condition emerges
	F. Modify the discharge plan as new information is obtained in collaboration with participants immediately involved in the patient's care (use: "Updated Plans" form)	Within 24 hours of receiving new information

<u>Protocol Element</u>	<u>Sequence of Activities</u>	<u>Timing of Activities</u>
V. Developing & writing the final discharge plan	A. Coordinate the involvement of patient, family, attending doctor, relevant community person & other professional(s) directly involved in the patient's care in negotiating & writing the final discharge plan	48 hours prior to discharge
	B. Write the final discharge plan (use: "Final Discharge Plan" form)	48 hours prior to discharge
	C. Negotiate & confirm the final discharge plan with participants	48 hours prior to discharge
	D. Record all meetings/contacts with participants (use: "Discharge Planning Meetings/Contacts" form)	At time of meeting/contact
	E. Ensure that medications, treatments, & supplies & other services are available & will be in place at patient's discharge	48 hours prior to discharge
	F. Ensure discharge order is written	24 hrs. Pre-discharge

<u>Protocol Element</u>	<u>Sequence of Activities</u>	<u>Timing of</u>
<u>Activities</u>		
	G. Determine readiness of the patient & family for discharge re: understanding of their medical condition & related treatments, & of the programs & services to be provided at discharge	48 hours prior to discharge
VI. Implementing & monitoring the discharge plan post-discharge	A. Tel. follow up with patient & family (initiated by discharge director &/or by patient &/or family) to: (a) monitor patient's progress & appropriateness of the final discharge plan, (b) modify plan with involved community-based professional, & (c) record patient & family & incidences post discharge	Tel. contacts at least once in 1st week & at 2 & 6 weeks post discharge

Appendix B

Letter of Explanation to Designated Hospital Contact Person

(Name of Hospital) has agreed to participate in a research study entitled:

“Process Evaluation of An Integrated Model of Discharge Planning”. Approval to conduct this study has been granted by the Office of Research Services at University of Toronto as well as the ethical review committee of *(Name of Hospital)*. This research is being conducted by co-principal investigators, Dr. Donna Wells, Assistant Professor at the Faculty of Nursing at University of Toronto, and Dorothy Craig, Professor at the Faculty of Nursing at University of Toronto. Chantale LeClerc, is the research assistant on the project and a Master of Science student at University of Toronto working under the supervision of Dr. Donna Wells.

The purpose of this study is to conduct a formative evaluation of an integrated model of discharge planning in order to examine the feasibility of implementing it in the hospital context. The formative evaluation seeks to gather information about a program's strengths and weaknesses, kinds of implementation problems that emerge, unexpected happenings, participants' perceptions of the program, and the effect of the external environment on the program. In the formative evaluation, the process of the program is evaluated, adapted, and rendered operational so that summative judgments about the overall effectiveness or outcomes of the smooth-running program can ultimately be made.

You are being asked to participate in this research study by assisting with the recruitment of potential study participants, which meet the following selection criteria:

1. 65 years of age and over.
2. Acutely ill (i.e., *not* those elderly patients awaiting long stay or those designated Alternative Level of Care-ALC).
3. Admitted to general medicine, general surgery, orthopedics, and cardiology.
4. Speak and read English.
5. Not cognitively impaired.

Once you have identified a person meeting the inclusion criteria for the study, you are asked to inform the attending physician of the study by providing the letter of explanation which you have been given (*Appendix C*). You are then asked to approach patients and a family member where possible, within 12 hours of admission to the hospital unit in order to explain the study using a second letter of explanation (*Appendix D*) and to obtain written informed consent (*Appendix E and F*). You are then asked to provide the research assistant and the discharge manager with the names of the patients and family members who have agreed in writing to participate in the study.

The patients may not benefit directly and there will be no harm as a result of participating in this study. We feel our research will contribute to improving the discharge planning process and ultimately the discharge plans for elderly persons in acute-care hospitals.

We thank you for your invaluable contribution to this research project. Chantale LeClerc, the research assistant, is available to answer any questions about the study you may have and can be reached at: (*phone number*)

Sincerely,

Signature of researcher

Appendix C

Letter of Explanation of the Study to Core Professionals Involved in Discharge Planning

(Name of Hospital) has agreed to participate in a research study entitled: “Process Evaluation of An Integrated Model of Discharge Planning”. Approval to conduct this study has been granted by the Office of Research Services at University of Toronto as well as the ethical review committee of *(Name of Hospital)*. This research is being conducted by co-principal investigators, Dr. Donna Wells, Assistant Professor at the Faculty of Nursing at University of Toronto, and Dorothy Craig, Professor at the Faculty of Nursing at University of Toronto. Chantale LeClerc, is the research assistant on the project and a Master of Science student at University of Toronto working under the supervision of Dr. Donna Wells.

The purpose of this study is to conduct a formative evaluation of an integrated model of discharge planning in order to examine the feasibility of implementing it in the hospital context. The formative evaluation seeks to gather information about a program’s strengths and weaknesses, kinds of implementation problems that emerge, unexpected happenings, participants’ perceptions of the program, and the effect of the external environment on the program. In the formative evaluation, the process of the program is evaluated, adapted, and rendered operational so that summative judgments about the overall effectiveness or outcomes of the smooth-running program can ultimately be made.

You are being asked to participate in the study by performing discharge-related activities according to a protocol developed by the investigators, for three patients and their families. These activities will be coordinated by a discharge manager designated by your hospital.

You will be in contact through informal interviews, with the research assistant and/or co-principal investigators during the course of the study. The purpose of these contacts will be to problem solve and make adjustments to the discharge planning protocol. As well, you will be asked to participate in a tape-recorded semi-structured interview lasting approximately one 30 minutes to one hour intended to assess your perceptions of the discharge planning process.

The patients may not benefit directly and there will be no harm as a result of participating in this study. We feel our research will contribute to improving the discharge planning process and ultimately the discharge plans for elderly persons in acute-care hospitals.

We thank you for your invaluable contribution to this research project. Chantale LeClerc, the research assistant is available to answer any questions about the study you may have and can be reached at: (*phone number*).

Sincerely,

Signature of researcher

Appendix D

Letter of Explanation to Patients and Families

You and a family member are being asked to participate in a research study entitled: "Process Evaluation of An Integrated Model of Discharge Planning". This research is being conducted by co-principal investigators Dr. Donna Wells, Assistant Professor at the Faculty of Nursing at University of Toronto and, Dorothy Craig, Professor at the Faculty of Nursing at University of Toronto. Chantale LeClerc is the research assistant on the project and is a Master of Science student at University of Toronto working under the supervision of Dr. Donna Wells.

The purpose of the study is to evaluate a new model of discharge planning. Our goal is to improve the way discharge from hospital happens for elderly people and the kind of discharge plans that are made. You may choose to participate in this new process to help us evaluate it or choose to be involved in the usual hospital discharge planning process.

If you choose to be involved in this study, a discharge manager will be working with you and your family to plan your discharge over the course of your hospital stay. You will be asked questions about your age, health problems, and your ability to carry out personal care and activities of daily living. If you agree to participate in the study, you and a member of your family will also be interviewed by the research assistant concerning your thoughts about how your discharge was planned and the actual plans that have been made. The interview will be approximately 30 minutes to one hour, and it will be tape recorded with your permission.

The study may not benefit you directly at this time, but we feel that our research will contribute to improving hospital discharge planning for elderly people in the future.

The research assistant, Chantale LeClerc, is available to answer any questions you may have about the study. She can be reached at: (*phone number*).

If you decide to participate in this study, you will be asked to sign a consent form.

We thank you for your interest in this project.

Sincerely,

Signature of researcher

Appendix E

Patient Consent Form

I _____ agree to take part in the study entitled “Process Evaluation of an Integrative Model of Discharge Planning”.

I have read and understand the letter of explanation that has been given to me. I understand that the purpose of the study is to evaluate an approach that can improve the way discharges will occur in hospitals.

I understand that the study will be occurring over the course of my hospital stay. A discharge manager will be working with my family and me to plan my discharge from hospital. I understand that during the discharge planning process, I will be asked questions about my age, my health problems and my ability to carry out personal care and activities of daily living. Furthermore, I understand that I and one of my family members will be interviewed by a research assistant one to two days before my discharge from hospital. I understand that the interview will be tape recorded and will last approximately 30 minutes to one hour. It will be held in a location of my choice. I will be asked questions about my satisfaction with the discharge planning and the final discharge plan.

I understand that participation in this study is completely voluntary. I have the right to refuse to answer any questions asked by the research assistant. I can stop the interview at

any time. I can also ask to be withdrawn from the study at any time without my care in hospital being affected.

I understand that any information which I provide will be kept confidential and that my name will not appear on any written reports of the study.

I understand that I may not benefit directly, and that there will be no harm as a result of participating in this study. I also understand that participating in this study will not affect the care that I receive in hospital in any way.

(Date)

(Signature of participant)

I have explained the nature of the study to the participant and I believe that he/she has understood it.

(Date)

(Signature of designated hospital contact)

Appendix F

Family Member Consent Form

I _____ agree to participate in the research study entitled:
“Process Evaluation of an Integrated Model of Discharge Planning”.

I have read and understand the letter of explanation that has been given to me. I understand that the purpose of the study is to evaluate an approach that can improve the way discharges will occur in hospitals for elderly patients.

I understand that the study will take place over the course of my relative's hospital stay. I understand that my relative and I will be working with a discharge manager to plan for my relative's discharge from hospital. I understand that during this discharge planning process, I will be asked questions about my age, my health status and, my ability to assist my relative with personal care and activities of daily living. Furthermore, I understand that my relative and I will be interviewed by a research assistant one to two days before my relative's discharge from hospital. I understand that the interview will be tape recorded and will last approximately 30 minutes to one hour. It will be held in a location of my choice. I will be asked questions about my satisfaction with the discharge planning and the final discharge plan.

I understand that participation in this study is completely voluntary. I have the right to refuse to answer any questions asked by the research assistant. I can stop the interview at

any time. I can also ask to be withdrawn from the study at any time without my relative's care in hospital being affected.

I understand that any information which I provide will be kept confidential and that my name will not appear on any written reports of the study.

I understand that I may not benefit directly, and there will be no harm as a result of participating in this study.

(Date)

(Signature of participant)

I have explained the nature of the study to the participant and I believe that he/she has understood it.

(Date)

(Signature of designated hospital contact)

One Stop Access Client Assessment Form (OSCA)

SECTION 1 Identifying Data

Identification number for purpose of research study: _____

Date of Admission: _____

Date Initial Assessment Completed: _____

1. Living arrangements:

- (d) ☐ House ☐ Apt. ☐ Sr. Apt.
☐ Rooming ☐ Supportive ☐ Other
☐ Congregate ☐ Nursing Home/Home for the Aged
- _____
- _____

2. Demographics

- a) ☐ Male ☐ Female
b) Date of Birth Day _____ Month _____ Year _____
c) Languages (circle preferred)

☐ English ☐ French ☐ Other (specify) _____
☐ Translation Required

d) Marital Status:

☐ Single ☐ Divorced ☐ Separated ☐ Unknown
☐ Widowed ☐ Married ☐ Common Law ☐ Other

e) Occupation (current or previous)

f) School

3. Contact Information

a) Physician (attending):

Name _____ Address _____ Phone No. _____

Physician (referring):

Name _____ Address _____ Phone No. _____

b) Family Contact

Sex (M or F) _____ Age _____ Relationship _____ Phone No. _____

Sex (M or F) _____ Age _____ Relationship _____ Phone No. _____

ID#:

SECTION 2**Client Living Situation****1. Household Composition** (✓ those for whom client is responsible)Lives alone: Yes ☐ No ☐

Relationship

Age

Occupation/School

Dependent

- a) _____ ☐
- b) _____ ☐
- c) _____ ☐
- d) _____ ☐

2. Are there persons outside of the home for whom client is responsible?

Age

Reason

- a) _____
- b) _____

3. Informal Care Providers: List those currently providing assistance and potential providers (family members, neighbours, friends, or other volunteers providing social involvement and/or support for ADL, transportation and friendship)

Relationship

Tasks

Person Most Involved

- a) _____ ☐
- b) _____ ☐
- c) _____ ☐
- d) _____ ☐

4. Family Members

Address

Relationship

- a) _____
- b) _____
- c) _____
- d) _____

5. Formal Services in Household or on Waiting List

Provider

Days of Week

Service

Service Frequency

How Long?

- a) _____
- b) _____
- c) _____
- d) _____

Assessment Notes

I.D.#:

SECTION 3 Health

1. Describe client's general appearance:

2. Do you have any medical conditions/health problems ?

3. Medical Diagnoses/Surgical Procedures

Primary

Secondary

Surgical

Diagnosis/es known to:

	Yes	No
Family	☐	☐
Client	☐	☐

4. I would like to ask you some specific questions about your health. Do you have problems with: (✓ if assessed, X if problem)

Condition

Describe problem and aids used/required:

☐	a) Headaches
☐	b) Dizziness/Balance
☐	c) Breathing
☐	d) Heart Trouble
☐	e) Blood Pressure
☐	f) Circulation
☐	g) Digestion
☐	h) Chewing/Swallowing
☐	i) Weight Change
☐	j) Skin
☐	k) Pain
☐	l) Joint and Muscle
☐	m) Bowel
☐	n) Bladder
☐	o) Sexual Function (optional)
☐	p) Sight
☐	q) Hearing
☐	r) Speech
☐	s) Endocrine (e.g. Diabetes)
☐	t) Neurological (e.g. Parkinsons)
☐	u) Sleeping
☐	v) Other

4.1. Describe impact of health status on functional status:

4.2. Do you feel that you need any other help for your health problems?

☐ Yes ☐ No If yes, describe:

I.D.#:

SECTION 3 Health (cont'd)

5. Can you show me the medications you are taking? (List both Rx and over the counter. If more than 10, record at bottom of page.)

	Medication	Dosage	Frequency	Timing	Route	Physician	Require Assistance from:
(a)							
(b)							
(c)							
(d)							
(e)							
(f)							
(g)							
(h)							
(i)							
(j)							

5.4. Do you have any allergies? ☐ Drug ☐ Food ☐ Other
Describe:

6. Nutrition

a) Do you have a good appetite? ☐ Yes ☐ No

c) If you don't eat regularly from these groups, is there a reason?

b) Do you eat foods

from the following groups?

Daily 4 - 6 x/wk 1 - 3 x/wk Never

Bread & cereals

Milk & dairy

Meat & alternates

Fruit & vegetables

d) Are you on a special diet? ☐ Yes ☐ No
If yes, describe:e) Do you understand your diet? ☐ Yes ☐ Nof) Is your diet difficult to follow? ☐ Yes ☐ No
If yes, describe:

7. Lifestyle

a) Do you have any regular exercise? ☐ Yes ☐ No

Times per week _____

Describe:

b) How often do you drink alcoholic beverages?

Drinks per day _____

Describe if problem:

c) Do you smoke? ☐ Yes ☐ No _____ Cigarettes per day
Describe if problem:

Additional Health Information

I.D.#:

SECTION 4

Daily Living

1. Personal Activities of Daily Living

Can you tell me how you manage the following?

Personal/Self Care

[illegible]

Describe:

[illegible]

2. Instrumental Activities of Daily Living

Can you tell me how you manage the following?

Housework

	N/A	Independent	Some Help	Total Help	NEEDS MET BY	UNMET NEEDS
Housework					All / Device Family Assistance Agencies	
a) Vacuuming	☐	☐	☐	☐	☐ ☐ ☐	☐
b) Dishes	☐	☐	☐	☐	☐ ☐ ☐	☐
c) Floors/Wet Map	☐	☐	☐	☐	☐ ☐ ☐	☐
d) Bathroom	☐	☐	☐	☐	☐ ☐ ☐	☐
e) Bed change/make	☐	☐	☐	☐	☐ ☐ ☐	☐
f) Polishing/Dusting	☐	☐	☐	☐	☐ ☐ ☐	☐

Describe:

Laundry

a) Personal Laundry	☐	☐	☐	☐	☐	☐	☐	☐
b) Household Laundry	☐	☐	☐	☐	☐	☐	☐	☐
c) Ironing	☐	☐	☐	☐	☐	☐	☐	☐
d) Mending	☐	☐	☐	☐	☐	☐	☐	☐

Heavy Cleaning

a) Stove	☐	☐	☐	☐	☐	☐	☐	☐
b) Fridge	☐	☐	☐	☐	☐	☐	☐	☐
c) Wax floors	☐	☐	☐	☐	☐	☐	☐	☐
d) Carpets	☐	☐	☐	☐	☐	☐	☐	☐
e) Windows	☐	☐	☐	☐	☐	☐	☐	☐
f) Curtains	☐	☐	☐	☐	☐	☐	☐	☐
g) Wash Walls	☐	☐	☐	☐	☐	☐	☐	☐
h) Cupboards/Closets	☐	☐	☐	☐	☐	☐	☐	☐
i) Garbage	☐	☐	☐	☐	☐	☐	☐	☐

Meal Preparation

a) Breakfast ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

b) Lunch ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

c) Dinner ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

1.D.#:

SECTION 4**Daily Living (cont'd)****2. Instrumental Activities of Daily Living (cont'd)**

Can you tell me how you manage the following?

	N/A	Independent	Some Help	Total Help	NEEDS MET BY			UNMET NEEDS	Describe:
					ADL / Device	Family Assistance	Agency		
Shopping									
a) Groceries	☐	☐	☐	☐	☐	☐	☐	☐	
b) General	☐	☐	☐	☐	☐	☐	☐	☐	
c) Clothing	☐	☐	☐	☐	☐	☐	☐	☐	
Transportation									
a) Drive car	☐	☐	☐	☐	☐	☐	☐	☐	
b) Can Travel in Car	☐	☐	☐	☐	☐	☐	☐	☐	
c) Use Public Transit	☐	☐	☐	☐	☐	☐	☐	☐	
d) Special Transit	☐	☐	☐	☐	☐	☐	☐	☐	
Telephone/ Emergency Aid									
a) Can Use Phone Independently	☐	☐	☐	☐	☐	☐	☐	☐	
b) Special Phone/Aids	☐	☐	☐	☐	☐	☐	☐	☐	
Minor Home Maintenance									
a) Lightbulbs	☐	☐	☐	☐	☐	☐	☐	☐	
b) Washers	☐	☐	☐	☐	☐	☐	☐	☐	
c) Smoke Detectors	☐	☐	☐	☐	☐	☐	☐	☐	
d) Cutting Wood	☐	☐	☐	☐	☐	☐	☐	☐	
e) Other	☐	☐	☐	☐	☐	☐	☐	☐	
Yard Work									
a) Snow Shovelling	☐	☐	☐	☐	☐	☐	☐	☐	
b) Leaves	☐	☐	☐	☐	☐	☐	☐	☐	
c) Lawn Care	☐	☐	☐	☐	☐	☐	☐	☐	

2.1. Home Support Resources
☐ Autowasher
☐ Winger
☐ Dryer
☐ Laundromat

☐ Dishwasher
☐ Stove
☐ Toaster Oven
☐ Microwave
☐ Refrigerator

☐ Vacuum
☐ Adequate Cleaning Equipment
 (mop, bucket, broom)

☐ Lawnmower
☐ Snowblower
☐ Rakes/Shovels
☐ Car**3. Home Environment (As Rated by Interviewer)**

	Yes	No	Describe:
a) Structural Damage	☐	☐	
b) Barriers to Access	☐	☐	
c) Electrical Hazards	☐	☐	
d) Signs of Careless Smoking	☐	☐	
e) Other Fire Hazards	☐	☐	
f) Dangerous Floors & Scatter Mats	☐	☐	
g) Unsanitary Conditions or Odors	☐	☐	
h) Inconvenient Toilet Facilities	☐	☐	
i) Insects or Other Pests	☐	☐	
j) Poor Air Circulation (windows and screens)	☐	☐	
k) Poor Lighting	☐	☐	
l) Pets	☐	☐	
m) Bath Hazards	☐	☐	
n) Inadequate Heating	☐	☐	
o) Inadequate Water Supply	☐	☐	

4. Community**Characteristics of Community**

	Yes	No	Describe:
a) Neighbourhood Safe, Secure	☐	☐	
b) Access to Shops, Delivery, Transportation	☐	☐	
c) Living Arrangement Satisfactory to the Client	☐	☐	
d) Accessible to Service Worker	☐	☐	

I.D.#:

SECTION 5**Social Supports**

1. What do you do in a typical day?

2. Do you participate in any social activities in your home? ☐ Yes ☐ No Frequency Describe:3. Do you participate in any social activities outside your home? ☐ Yes ☐ No Frequency Describe:4. Would you like to have more opportunities to be with friends or other people? ☐ Yes ☐ No Describe:5. Do you have any special interests or hobbies? ☐ Yes ☐ No Describe:6. Do you feel content with your life? ☐ Yes ☐ No Describe:7. Do you feel your spiritual needs are being met? ☐ Yes ☐ No Describe:8. Are you satisfied with care provided by family, friends or services? ☐ Yes ☐ No Describe:9. Have there been major changes in your life in the last year? ☐ Yes ☐ No Describe:**SECTION 6****Vocational**1. Are you currently employed? ☐ Yes ☐ No What:2. Are you satisfied with employment? ☐ Yes ☐ No If no, why not:3. Are there any factors that may interfere with your employment? ☐ Yes ☐ No Describe:4. Would you like further assistance regarding employment? ☐ Yes ☐ No What:

5. Education (note highest level attained)

SECTION 7**Mental Status**

1. Mental Status (interviewer's perception and/or caregiver's report)

From previous responses, do you feel that the client has problems with:

	Yes	No	Describe Problem & Impact:
a) Orientation	☐	☐	
(Person)			
(Place)			
(Time)			
b) Memory	☐	☐	
c) Concentration Span	☐	☐	
d) Wandering	☐	☐	
e) Impaired Judgement	☐	☐	
f) Inappropriate Behaviour	☐	☐	
g) Mood	☐	☐	
Discontent	☐	☐	
Seems concerned about specific problems	☐	☐	
Seems somewhat tense and anxious	☐	☐	
Seems depressed	☐	☐	

Assessment Notes

I.D.#:

SECTION 8**Finances**

1. Do you receive any of the following assistance plans?

☐ a) OAS	☐ e) GAINS-A	☐ i) CPP	Describe:
☐ b) GIS	☐ f) WCB	☐ j) WSA	
☐ c) FBA	☐ g) GWA	☐ k) Private Income	
☐ d) GAINS-D	☐ h) DVA	☐ l) Private Pension	
	☐ m) Other _____		

2. Is your income adequate to meet your needs for:

	Yes	No		Yes	No	Describe:
a) housing	☐	☐	d) recreation	☐	☐	
b) food	☐	☐	e) transportation	☐	☐	
c) clothing	☐	☐	f) extras	☐	☐	

SECTION 9**Primary Caregiver(s)**

1. Primary Caregiver (to be completed with primary caregiver)

a) How do you think (client) _____ is managing?

b) How are you involved? (probe)

c) How are you managing?

d) Do you need help to manage better? (probe) "How?" "What?"

e) Are you able to continue to be involved? ☐ Yes ☐ No Describe:**Assessment Notes**

I.D.#:

Section 10 Summary of Needs

☐	Initial plan
☐	Update
☐	Reassessment

Specify how client/caregivers were involved in plan:

Unmet Needs	Description of Needs (Number each need)	Goals
Client Living Situation		
Health		
Daily Living (PADL, IADL)		
Social Support		
Vocational		
Mental Status		
Finances		
Caregivers		

Appendix H

Record of Meetings/Contacts Form

Meeting/Contact # _____

Meeting/Contact # _____

Date, time and
day of hospitalizationPersons present and
reasons for
attendance

Items for discussion

Information provided

Decisions and
decision makers

Disagreements

Subsequent action
and
person who will
performTotal length of time
of meeting/contact

Appendix I

Initial, Updated, and Final Discharge Plans Forms

INITIAL DISCHARGE PLAN

Date of initial plan: _____

Proposed discharge date and time: _____

Proposed discharge destination: _____

Discharge goals: _____

Potential areas _____

of concerns: _____

UPDATED DISCHARGE PLAN

Please note any changes in the patient's condition and required changes to the initial plan:

Changes in patient's condition:

Changes to initial plan:

Date:

[illegible]

FINAL DISCHARGE PLAN

Date final discharge plan written: _____

Discharge date and time: _____

Discharge location: _____

Discharge orders: _____

Needs identified at time _____
of discharge and measures
implemented to meet _____
identified needs: _____

Plan agreed to by: _____

Planned follow-up: _____

Appendix J

Semi-Structured Interview Guide for Patients and Families

1. How were you involved in planning for your discharge from hospital?
2. When were you involved in planning for your discharge from hospital?
3. Who were you involved with in planning your discharge from hospital?
4. How satisfied are you about the way your discharge from hospital was planned?
5. What did you like about the way your discharge from hospital was planned?
6. What did you dislike about the way your discharge from hospital was planned?
7. What would you like to change about the way your discharge from hospital was planned?
8. What would you like to change about the way you were involved in planning for your discharge from hospital?
9. What do you like about the final discharge plans that have been made?
10. What do you see any potential problems with the final discharge plans that have been made?
11. What would you change about the final discharge plans that have been made?
12. How satisfied are you about the final discharge plans that have been made?

Appendix K

Semi-Structured Interview Guide for Discharge Managers

1. How easy was it to conduct and complete the discharge planning activities within the time frames outlined in the discharge planning protocol?
2. What were some of the barriers to the implementation of discharge planning activities within the pre-determined time frame?
3. How much of your time do you feel was spent on discharge planning activities? (Too much, too little, just right)
4. How easy was it for you to integrate the discharge planning activities into your role and daily practice?
5. What were some of the barriers to the integration of discharge planning activities into your role and daily practice?
6. What were some of the unanticipated events that occurred during the implementation of the discharge planning protocol?
7. What do you feel are some of the model's strengths?
8. What do you feel are some of the model's weaknesses?
9. What do you feel were some of the barriers or facilitators to the implementation of the discharge planning model?
10. Overall, what do you like/dislike about the model?
11. How do you think the model could be changed, adapted or improved
12. What additional guidelines would you have liked to have been given in order to facilitate your implementation of the discharge planning model? (written documentation, additional instruction, etc.)

Appendix L

Integrated Discharge Plans Form

Unmet Needs	Description of Needs	Discharge Goals	Changes in Patient's Condition	Changes to Initial Plan (date of change)	Needs at time of discharge	Interventions to Meet Needs	Follow-up
Living Situation							
Health							
Daily Living (PADL, IADL)							
Social Support							
Vocational							
Mental Status							
Finances							
Caregivers							
Time Required to Write Plan	Time:			Time: Time:			Time:

Proposed discharge
date and time: _____
Proposed discharge
destination: _____

Discharge location: _____
Discharge orders: _____
Plan agreed to by: _____

Discharge Check-List

	Yes	No	Reason
1. Discharge order written	_____	_____	_____
2. Prescriptions given	_____	_____	_____
3. Medications available	_____	_____	_____
4. Treatments ordered	_____	_____	_____
5. Supplies/equipment in place	_____	_____	_____
6. Services in place (e.g. homemaking nursing, physiotherapy, occupational therapy)	_____	_____	_____
7. Patient and family taught re:			
• medical condition	_____	_____	_____
• related treatment	_____	_____	_____
• medications	_____	_____	_____
• programs and services at discharge	_____	_____	_____

Appendix M

Modified Record of Meetings/Contacts Form

Meeting/Contact # _____

Date, time and
day of hospitalization

Persons present and
reasons for
attendance

Items for discussion

Information provided

Decisions and
decision makers

Disagreements

Subsequent action
and
person who will
perform

Total length of time
of meeting/contact