MONTANA STATE UNIVERSITY

Getting fixed : perceptions of rural and urban patients who have experienced total knee or hip replacement surgery and their discharge planners in a Montana hospital
by Allison Marie McIntosh

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Nursing
Montana State University
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Abstract:
The. purpose of this study was to explore and describe the perceptions of rural and urban elderly patients and their discharge planners regarding actual available formal and informal assistance following hospitalization for an acute health care episode.

This study utilized a qualitative approach which was based on grounded theory. The sample was comprised of 17 patient informants, 7 men and 10 women. Definitions of rural and urban were provided. The patient sample was divided into comparative groups. Patient informants were hospitalized after surgery for a total knee or hip replacement. The discharge planning process was studied in the participating Montana hospital by observing discharge planning conferences and interviewing discharge planners. Data from patient informants and discharge planners were collected by conducting face-to-face interviews using interview guides developed by the researcher. The interviews were taped and transcribed. Two main analytic strategies in grounded theory, the constant comparative method and theoretical sampling, were utilized. An analytic skeleton emerged from the data for viewing patient perceptions of the experience of total joint replacement surgery. A description of the discharge planning process was provided including assessment criteria reported by discharge planners to identify patient needs and strengths as they related to the patient's ability to manage at home. Follow-up interviews with 10 patient informants were conducted approximately four weeks after hospital discharge to determine if their perceptions had changed.

The study indicated that although variability existed in patient perceptions, patterns were identified. The process which emerged from analysis described core concepts shared by all patients. Patient discharge needs related to gender, marital status, age, rural/urban considerations, and other variables were not uniformly reflected in the discharge planning conducted in the Montana hospital.

Indications for improvement of discharge planning were evident. Prehospitalization assessment and planning and individualized assessments during hospitalization which consider the patient's capacity to cope with returning home are needed. This study identified the need for further nursing research which describes discharge planning activities which exist in practice and their effectiveness in providing individualized care. Further refinement of discharge planning models is needed to meet the demands of a continually changing health care system.

GETTING FIXED: PERCEPTIONS OF RURAL AND URBAN PATIENTS WHO HAVE EXPERIENCED TOTAL KNEE OR HIP REPLACEMENT SURGERY AND THEIR DISCHARGE PLANNERS IN A MONTANA HOSPITAL

by

Allison Marie McIntosh

A thesis submitted in partial fulfillment
of the requirements for the degree

of

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APPROVAL

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This thesis has been read by each member of the graduate committee and has been found to be satisfactory regarding content, English usage, format, citations, bibliographic style, and consistency, and is ready for submission to the College of Graduate Studies.

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ABSTRACT

The purpose of this study was to explore and describe the perceptions of rural and urban elderly patients and their discharge planners regarding actual available formal and informal assistance following hospitalization for an acute health care episode.

This study utilized a qualitative approach which was based on grounded theory. The sample was comprised of 17 patient informants, 7 men and 10 women. Definitions of rural and urban were provided. The patient sample was divided into comparative groups. Patient informants were hospitalized after surgery for a total knee or hip replacement. The discharge planning process was studied in the participating Montana hospital by observing discharge planning conferences and interviewing discharge planners. Data from patient informants and discharge planners were collected by conducting face-to-face interviews using interview guides developed by the researcher. The interviews were taped and transcribed. Two main analytic strategies in grounded theory, the constant comparative method and theoretical sampling, were utilized. An analytic skeleton emerged from the data for viewing patient perceptions of the experience of total joint replacement surgery. A description of the discharge planning process was provided including assessment criteria reported by discharge planners to identify patient needs and strengths as they related to the patient's ability to manage at home. Follow-up interviews with 10 patient informants were conducted approximately four weeks after hospital discharge to determine if their perceptions had changed.

The study indicated that although variability existed in patient perceptions, patterns were identified. The process which emerged from analysis described core concepts shared by all patients. Patient discharge needs related to gender, marital status, age, rural/urban considerations, and other variables were not uniformly reflected in the discharge planning conducted in the Montana hospital.

Indications for improvement of discharge planning were evident. Pre-hospitalization assessment and planning and individualized assessments during hospitalization which consider the patient's capacity to cope with returning home are needed. This study identified the need for further nursing research which describes discharge planning activities which exist in practice and their effectiveness in providing individualized care. Further refinement of discharge planning models is needed to meet the demands of a continually changing health care system.

CHAPTER 1

INTRODUCTION

A complicated picture emerges when considering the elderly and the health care services available to them. Rapid changes in demographics, economics, public policy, health care delivery systems, and quality of care standards are realities in the current situation. Struggling to keep pace with these changes, health care professionals are seeking ways to more effectively arrange and monitor the care their patients receive after hospital discharge. These activities are generally referred to as discharge planning. One way to improve the effectiveness of discharge planning is to make accurate and individualized assessments of the perceptions of patients that relate to the event of hospital discharge.

This study focused on the assessment component of discharge planning using a sample of rural and urban elderly clients in Montana. The goal of this research was to accurately describe the perceptions of both the clients and the health care professionals who take part in this process. To better interpret the findings of this study, a discussion of the multi-faceted issues surrounding this research area was provided.

An increasingly aging population adds urgency to the current problems in the U.S. health care system. The number of people over 65 years of age in the United States is expected to increase from 29.2 million in 1986 to 64.6 million in 2030. Those over 85 years of age are the fastest growing group of people in the U.S. (American Association of Retired Persons, 1987). Further projections indicate that 33% of the United States population will be over 65 years of age and 5% will be over 85 years of age by 2050. Technology, cures for disease, new treatments, and a focus on wellness all have had an impact on lifespan (Waite, 1989). Chronic ailments and functional impairments that require long-term care often accompany this longevity (Newhouse & McAuley, 1987). Planning for the future will require many changes in today's health care delivery system, including long-range projections for how to deal with finite health care resources.

Health care expenditures have risen to 11.1% of the gross national product despite major efforts in cost containment. As health care spending is expected to continue to rise above the inflation rate, the aging population will compound the problem. In 1980, hospital care costs alone reflected that people over 65 years of age used over three times the health care dollars compared to those people under 65 years of age (Waite, 1989). This does not include costs for nursing home care or home health services. This gap between the health care costs for the older and younger populations will no doubt widen as the demographic projections become actualized in the future.

Medicare's Diagnostic Related Groups (DRGs), an outgrowth of the federal government's prospective payment system, have also had a great impact on the nation's health care system. This policy financially rewards institutions for early discharge of patients from the hospital (Iglehart, 1986). Shortened hospital stays often result in increased acuity at discharge and the potential for costly readmissions to the hospital for unresolved problems. It has not been established whether this system really saves money (Waite, 1989). Hospital patients, more acutely ill on discharge, often require assistance to return to their former living arrangements (Butler, 1984). Voluntary providers, such as family and informal community caregivers, have experienced the shift in costs from the formal health care sector. Lost work hours, loss of benefits from working part-time instead of full-time, and other out-of-pocket costs all impact the informal caregivers. Older working women are most likely to experience these hardships (Muurinen, 1986).

Current health care debates in Congress have centered around Medicare's differential funding of rural and urban hospitals. Since the enactment of DRGs in 1983, rural hospitals have been reimbursed at lower rates compared to urban hospitals for the same medical and surgical interventions. This has been an added hardship for small rural hospitals which suffer from chronically low occupancy and underutilization of expensive technology, such as is used in small intensive care units. The equipment costs are the same for all hospitals. Rural hospitals are also dependent on a higher proportion of Medicare reimbursements

(Hart, 1988). This is due to an older and poorer population living in rural areas (Glasgow & Beale, 1985). Furthermore, rural dwellers find third-party insurance coverage difficult to secure without the presence of large industries and the group plans that accompany them. Rural dwellers are both less likely to be covered by private insurance and more likely to be underinsured when they do obtain insurance (Rosenblatt & Moscovice, 1982).

Given the multiple challenges with which rural hospitals are faced, there is an increasing number of rural hospital closures (Mullner, Rydman, Whiteis, & Rich, 1988). When rural hospitals close, people requiring health care depend more heavily on referrals to city medical centers, which are often great distances from their homes. Glasgow and Beale (1985) stated:

> The proportion of elderly living in poverty is more than half again as great in rural areas as in cities. And, paradoxically, while the rural elderly require more hospitalization and medical care, they have become concentrated in many rural areas poorly equipped to serve their special medical and other needs. (p. 22)

In 1989, in response to the urgent needs in rural areas, Congress enacted various bills which will, over time, eliminate the discrepancy in Medicare reimbursements. According to Heidi Werling, Legislative Assistant for Montana's Congressman Max Baucus, the legislation should eliminate the differential within five years (H. Werling, personal communication, December 11, 1989). Werling also described other proposals which include bonuses for rural physicians and more federal funding for community hospitals which have fewer than 100 beds and are dependent on at least 60% of admissions from Medicare recipients. This

type of hospital characterizes approximately 80% of the hospitals in Montana. The problems in rural areas appear to be only partly solved, however. At present, community services such as home health nursing and physical therapy will continue to be funded as before (H. Werling, personal communication, December 11, 1989).

In response to an aging population, spiraling costs, limited community resources, and changes in delivery systems, many hospitals are being challenged to arrange and monitor the care their patients receive after discharge. This new task is difficult to assume because hospitals have traditionally focused on the episodic treatment of acute physical conditions rather than the long-term effects of such treatment (Butler, 1984). The concept of discharge planning has received greater attention in recent years and it has become a major means by which a hospital can work toward financial solvency (Rehr, 1986). Costly readmissions due to complications incurred from less than adequate discharge planning can be prevented. In turn, patients experience less expensive, shorter lengths of stay.

Discharge planners in rural referral hospitals are faced with several complex tasks. They are encouraged to work quickly and effectively during shortened hospital stays to send clients home safely with adequate supports. Typically, these hospitals serve both rural and urban populations. Discharge planners work with clients who are discharged to the same city in which the hospital is located. These clients are within minutes of medical and nursing services. They also work

with rural clients who are often discharged to their homes several hundred miles away in sparsely populated and sparsely serviced areas.

Besides the assessment of available resources, discharge planners must consider the preferences of their clients. Even if formal services are available to a rural elder, this does not mean that they will be utilized. Perhaps this is related to a past reliance on informal resources. Formal resources need to be acceptable, available, accessible, affordable, and known to a client (Coward & Rathbone-McCuan, 1985). Time is clearly needed to obtain detailed information from each client. Typically, rural clients and their families are given no more days of hospitalization during which discharge planning occurs than are their urban counterparts. An assessment of the client's available resources, both formal and informal, is a crucial step toward adequate discharge planning. If discharge planners understand who the client perceives as helpful and supportive to them, more effective discharge planning can occur.

Significance of the Study

This study was designed to describe perceptions of both hospitalized clients and discharge planners. It was anticipated that hospital and community health nurses could benefit from a clear understanding of these perceptions. With this information, all areas of the nursing process (assessment, diagnosis, planning, implementation, and evaluation) could become more effective for clients. To fulfill the role of client advocate, nurses need an awareness of the congruence and/or

incongruence between the perceptions of clients and the perceptions of human service professionals who serve those clients.

Purpose and Research Aims

A regional rural referral hospital provided a unique opportunity to study comparisons in the discharge planning of rural and urban clients. The purpose of this study was to explore and describe the perceptions of discharge planners and rural and urban elderly clients regarding actual available formal and informal assistance following hospitalization for an acute health care episode.

Specific aims of this research study were to: (a) explore the differences and similarities which may exist in discharge planning for rural and urban clients, (b) describe the perceptions of rural and urban clients regarding available supports at the time of hospital discharge, (c) describe the perceptions of discharge planners regarding available supports for rural and urban clients at the time of hospital discharge, (d) discover if perceptions change in rural and urban clients after they return home, and (e) describe the perceptions of rural and urban clients that relate to the effectiveness of their discharge planning once they have returned home.

Definition of Terms

1. Urban client. A client and family unit which has undergone hospitalization for an acute health care episode and lives in a Standard Metropolitan

Statistical Area (SMSA). An SMSA was defined as a metropolitan area of greater than 50,000 people in a city which exists in a county of over 100,000 people (Hassinger & Whiting, 1976). For the purposes of this study, urban clients resided in the same county as the rural referral hospital.

2. Rural client. A client and family unit which has undergone hospitalization for an acute health care episode and lives in a town or in the countryside near a town which lies in a non-SMSA designated county. These clients lived at least 30 miles driving distance from the hospital.

3. Informal assistance, help, support, or resource. These words have been used interchangeably to define assistance which was provided by family, friends, neighbors, church groups, and other community members which were not represented by a formal agency.

4. Formal assistance, help, support, or resource. These words have been used interchangeably to define assistance which was provided by professionals or employees who work within an official agency and provide services for a fee.

5. Discharge planner(s). The individual(s) most responsible for planning post-discharge care while the client was still hospitalized. The discharge planners who were employed in this position by the hospital were a registered nurse and a social worker. Other persons responsible for discharge planning were in charge nurse or nursing supervisor positions.

6. Regional rural referral hospital. A hospital which serves clients from a multi-state region with at least 25% of the admissions coming from rural clients.

7. Perceptions. Values, views, and beliefs that emerged from communications with clients, families, and discharge planners.

CHAPTER 2

REVIEW OF LITERATURE

A search of the literature indicated that the term "discharge planning" has appeared relatively recently in nursing and related research studies. Diagnostic Related Group (DRG) based reimbursement has made hospital administrators realize that financial survival depends on rapid turnover and accelerated care. The discharge of sicker patients places greater demands on family and community care (Rehr, 1986). The research to date seems to lag behind the rapid changes that are taking place in the health care system.

Discharge Planning

Nurses and social workers have identified that discharge from the acute care setting can represent a serious crisis for family members and the patient. The transition from the hospital to the home requires adaptation by the patient and his or her family. During this transition, the initial supports provided by the hospital are withdrawn and new supports or ways of coping have not yet been developed (Blazyk & Canavan, 1986; Reichelt, 1982).

Discharge planning teams have been developed by many hospitals to facilitate patients and families in adapting to post-hospital care. McKeehan

(1981) defined discharge planning as "the process of activities that involve the patient and a team of individuals from various disciplines working together to facilitate the transition of that patient from one environment to another" (p. 22). Simmons (1986) indicated that often discharge planning is viewed as a professional service rather than a collaboration among patients, their families, and professionals. Research which measures the effectiveness of this collaboration requires a focus on patients' perceptions. The real effectiveness of discharge planning as perceived by discharged patients is in need of study.

Outcomes of Hospitalization

Studies pertinent to discharge planning explore and predict the outcome of hospitalization for elderly persons. Wachtel, Derby, and Fulton (1984) compared 50 elderly persons discharged to nursing homes and 50 elderly persons discharged to their homes. The authors used discriminant function analysis to predict discharge status from patient characteristics at the time of admission. A main finding in the study was that men and women differ in relation to the effect a spouse at home has on their discharge status. A man with a spouse at home was less likely to be placed in a nursing home following discharge from a hospital. Married women, however, did not experience this protection. Having a child or relative in the home was another predictor of post-discharge placement; however, their influence was not as strong as having a spouse. Patients who had experienced multiple prior hospital admissions also were more likely to return

to their homes. Perhaps the crisis of discharge had been handled before with previous admissions and coping strategies were already in place for these patients and their families (Watchel et al., 1984).

A study by Dolinsky and Rosenwaite (1988) examined the role which demographic factors play in the placement of elderly persons into nursing homes. The researchers closely examined the role played by close kin in avoiding this type of institutionalization. A 5% population sample of the 1980 census for all persons aged 75 years and older was used. These findings, as determined through a logit regression model, indicated the importance of having a caregiving spouse or child at home to avoid placement into a nursing home. Advanced age and the presence of disability were the other significant factors related to nursing home placement. In agreement with Wachtel et al. (1984), this study found that marital status was a more significant factor for the men who were able to return to their own homes.

Prognostic factors for discharge to home have been identified in a three-month prospective study with elderly hip fracture patients (Broos, Stappaerts, Luiten, & Gruwez, 1988). The results again indicated that pre-operative functional status, ambulatory capacity at discharge, age, and presence of relatives in the home were significant factors related to the capacity to remain at home at least three months following discharge from the hospital.

Informal Caregivers

Clearly, elderly people rely on informal caregivers in the event of a discharge crisis. Kulys and Tobin (1980) found that most elderly persons recognize the need to have at least one "responsible other" to whom they can turn in the event of a crisis. Lurie, Robinson, and Barbaccia (1984) reported that two months after hospital discharge, 64% of their sample named a main helper from an informal support system, and 11% named a helper from a formal agency. Only 11% insisted they had no main helper. Both of these studies found that there is a clear order of preference for those named as a main caregiver. This is usually determined by the nature of the kin relationship. Spouses are selected before children, daughters are selected before sons, and sons are selected before other extended family. Those persons with no available relatives named friends and neighbors (Kulys & Tobin, 1980; Lurie et al., 1984).

Never-married elderly have also been studied, and results have shown that they tend to be socially active and may not be at high risk for placement into nursing homes compared to married, widowed, and divorced groups (Stull & Scarisbrick-Hauser, 1989). This study represents the conflicting nature of the importance of having a spouse in delaying institutionalization. As noted previously, being without a spouse in old age has been reported to greatly increase the chances of service utilization from the formal sector (Michels, 1988). Further study is needed in this area.

Rural and Urban Elders

Comparisons between rural and urban elders and their informal caregivers are both conflicting and sparse (Scott & Roberto, 1987). Several studies described unique characteristics of rural elderly as compared to urban elderly. Lee and Cassidy (1985) reported that rural elderly interact more often with their kin and are more likely to be married. Kivett (1985) reported that rural elderly spend more time with friends and neighbors. Scott and Roberto (1987) reported that rural elderly received more help during illness from children and friends when proximity, marital status, and gender were controlled in the rural and urban samples. The research also revealed that rural elderly parents reciprocate more than urban counterparts when caring for their ill adult children.

Interpreting findings in studies which make rural and urban comparisons is difficult if the sample characteristics are not clearly described. Scott and Roberto (1987) stressed the need to describe or control for socioeconomic status, marital status, region of the country, type of occupation, and whether the comparisons are farm/nonfarm or rural/small town. For example, the researchers discovered that elderly people experience higher morale if they live in open country versus small towns. Another study by Lee and Lassey (1980) reported that geographic proximity of kin greatly influences kin interactions. Scott and Roberto (1987) warned that when interpreting studies which measure only frequency of kin interaction, the findings may not indicate the level of support provided by these

networks. Clearly, any study which attempts to describe rural and urban comparisons must carefully examine the characteristics of the study samples and the characteristics of the helping relationships within the identified support systems.

Formal and Informal Assistance

Help from family and friends, as noted previously, figures prominently in home discharges for elderly people. The literature describing the relationship between service from formal and informal sources, however, was more difficult to analyze (Lurie et al., 1984). The hypothesis that formal services are simply substituted for available informal assistance is not well supported by the literature. The issue appears to be more complex. The prevailing theme of much of the past research indicates that the informal helping networks often draw little assistance from formal services. Only when physical or financial exhaustion is reached, social functioning is impaired, or the medical regimen becomes too complex does the informal network turn to formal services (Archbold, 1980; O'Brien & Wagner, 1980; Smyer, 1980; Wan & Odell, 1981). Attention also has been focused on research describing the effects, sometimes detrimental, of long-term caregiving on families (Archbold, 1980; Chenoweth & Spencer, 1986; Deimling & Bass, 1986; Miller, 1981; Mosher-Ashley, 1988; O'Brien & Wagner, 1980). These and more recent works by Johnson and Higgins (1987) and Payne (1988) have described effects on caregiving families which include: family role

disruption; mental, physical, and financial exhaustion; denial; anxiety; grief; guilt; low frustration tolerance; feelings of being overwhelmed; mistrust of professional caregivers; and helplessness. The studies which were cited focused on the effects of a variety of disease processes, but did not include rural and urban comparisons.

Importance of Perceptions

Pioneering work by Snyder (1981) has underlined the importance of exploring perceptions of rural subpopulations. This study described Montanans' views of distance and access to health care for kidney dialysis patients. The results indicated that average distances of over 400 miles from a home training center were not perceived as distant because of a reliance on mutual assistance between other kidney dialysis patients in the area. Weinert and Long (1987) and Taylor (1982) also reported that the rural subpopulation in Montana shares unique perceptions related to health, health care, and formal service providers. Members of this rural subpopulation generally see themselves as healthy, even if they have chronic disability and disease. Health is perceived as the ability to work and the self-help concept emerges as a main factor in forestalling the use of professionals, who are sometimes viewed as outsiders. These findings indicated that differences exist in perceptions among certain subpopulations in Montana relating to formal and informal support networks. The studies indicated the need for more research which describes rural and urban patients' perceptions

of an acute health care event and the types of support which are actualized during the recovery phase of the crisis.

Summary of Studies Examined in Review of Literature

The studies outlined in this review of literature all have implications for discharge planning. Generally, the research findings indicated the presence of formal and informal support systems in a variety of situations. In several studies the availability of informal support systems were considered along with other variables, such as age and marital status, to predict whether patients would return to their homes or be placed in nursing homes following the hospitalization period. Other studies have described the impact which caregiving has on family members who are increasingly called upon to assume responsibility for ill relatives. These studies are relevant to the current situation of shortened hospital stays, sicker patients returning home, limited financial resources, and rising costs.

Another group of studies described the perceptions shared by patients of various rural subpopulations which relate to health, health needs, and preferences for the types of assistance they receive with their needs. Gender, marital status, and the availability of family members to assume caregiving responsibilities emerged as major variables in the discussion of this work. Only a few studies have focused on rural and urban comparisons. Health concerns and the nature of informal caregiving relationships have been described from rural and urban perspectives.

It is asserted that all of these research contributions can be of value to discharge planners. What is greatly needed, however, is a clear understanding of the discharge planning process as it is currently applied in practice settings. In order to be effective in a clinical setting, discharge planners must first make accurate and individualized assessments of their client's situation. As this review of literature suggests, the assessment must focus on the perceptions of the client. Similarly, the researcher who studies the effectiveness of discharge planning in a particular setting must also focus on the perceptions of those persons involved in this collaborative process. Patterson, Germain, Brennan, and Memmott (1988) emphasized the need for a researcher to:

> . . . enter the environment and interpersonal relationships of natural helpers and attempt to understand and evaluate this world within its own context. Professional helpers and clients arrive at a common understanding of the effectiveness of the helping relation within the context of that relationship; the same is true of the natural helpers and help recipients. (p. 279)

This study explored and described the phenomenon of discharge from a hospital following an extensive orthopedic surgery. The need to enter the environment and interpersonal relationships of the study informants lent itself to a qualitative methodology. Perceptions of available resources or assistance were studied over time in a rural and an urban sample. Understanding the perceptions of the rural and urban clients, within the context of the perceptions of those who plan their care, will add to the growing knowledge base concerning the real health needs of elderly people.

Conceptual Framework

The purpose of this study was to explore and describe the perceptions of discharge planners and rural and urban elderly clients regarding the actual available formal and informal assistance following hospitalization for an acute health care episode. Specific research aims, which were described in Chapter 1, were derived from the overall goal to accurately describe these perceptions within a real-life context in a regional referral hospital in Montana.

After reviewing the literature, the researcher concluded that there were no existing models which could be appropriately applied to the study design. The discharge planning process has been simply defined in nursing and social work literature, but it has not been discussed theoretically or tested empirically. Descriptive studies which have been conducted have focused on related elements of discharge planning, but none have described the entire process. The researcher's professional work experience as a registered nurse also served to indicate that discharge planning activities vary among hospitals and that there are varying interpretations of what constitutes discharge planning among health care professionals. Therefore, it was not known prior to conducting the study what activities related to discharge planning would be observed in the Montana hospital which took part in the study. Given the level of knowledge concerning the phenomenon of discharge planning, an inductive approach based on grounded theory was employed in this study.

The grounded theory approach provided for the systematic collection and analysis of qualitative data for the purpose of generating theory (Chenitz & Swanson, 1986). Theory development occurs when substantive studies build on one another to contribute to an evolving conceptual framework. Since this study focused on issues largely unexplored in past research, it was the goal of the researcher to make a contribution to the cumulative literature regarding discharge planning. After analysis of the findings, an analytic skeleton emerged which represents a way of viewing patient perceptions of the phenomenon of discharge to home following hospitalization for an acute health care episode. The perceptions of the health care professionals involved in discharge planning and comparisons between rural and urban patients were also described within the context of this analytic skeleton. It was hoped that the development of an analytic skeleton which was based on one component of discharge planning, the assessment of perceptions, would provide the foundation for further explorations and descriptions of this clinically significant phenomenon. The findings of the study are discussed in Chapter 4.

CHAPTER 3

RESEARCH METHODOLOGY

Design

A qualitative approach based on grounded theory was used to explore and describe the perceptions of rural and urban clients regarding available assistance following hospitalization for an acute health care episode. A sample of adult recipients of total hip or knee replacement surgery was interviewed prior to hospital discharge. The registered nurse and social worker, who served as the discharge planners for the referral hospital, and members of the orthopedic nursing staff were also interviewed. They were asked questions relating to their perceptions of available assistance for the patient informants included in the sample. These data were compared and contrasted to the findings the researcher obtained from patients at follow-up interviews approximately four weeks after hospital discharge.

Grounded theory was developed by Glaser and Strauss (1967). Evolving out of the symbolic interactionist perspective (Blumer, 1969; Mead, 1934), grounded theory is a useful method to study the impact life events have on individuals. Describing human behavior as a process, symbolic interactionists maintain that life events produce different perceptions and meanings to people.

These various perceptions and meanings, then, guide actions (Chenitz & Swanson, 1986).

The grounded theory approach is becoming increasingly important to the nursing profession because it allows nurses "to capture the complexity of problems and the richness of everyday life" which are so much a part of nursing practice (Corbin, 1986, p. 91). Nurse researchers who employ the grounded theory approach study clinical phenomena as life events and view their subjects in their natural settings and within real-life contexts (Chenitz & Swanson, 1986). By being sensitive to various perceptions and personal meanings related to a clinical phenomenon, nurses can interpret the resulting behavior patterns. Conducting research in this manner illuminates potential nursing interventions which are individualized and therapeutic in practice settings.

Grounded theory is also a useful approach when the level of knowledge and research about a topic is in the exploratory or descriptive stage. Besides being a precursor for other research, grounded theory serves to develop theoretical concepts and propositions (Chenitz & Swanson, 1986). It creates rather than tests theory. It was the goal of the researcher to describe the complex role of discharge planning in a rural referral hospital while highlighting rural and urban differences and similarities. At the same time, attention was focused on the first-hand experiences and perceptions of both the patients who were experiencing this clinical phenomenon and the health care professionals who were planning their care. Furthermore, patient perceptions were described as they changed

over time. Given the current level of knowledge and the gaps in past research regarding this area of study, a grounded theory approach was most appropriate.

Setting

Two research settings were used in this study. The first was a regional rural referral hospital in a metropolitan area of approximately 100,000 people in the state of Montana. The second setting was in the patient informants' homes approximately four weeks following hospital discharge.

Study Population

The population originally consisted of all patients 65 years or older undergoing an uncomplicated total knee or total hip replacement surgery at a regional rural referral hospital. During the first week of data collection and initial analysis, however, the population was enlarged to include younger informants. Initial analysis revealed that patient informants differed in their perceptions relating to the personal meanings of being in the hospital and that discharge planners considered age when planning care for certain patients. Younger aged persons were included in the sample to serve as comparison groups to highlight these data. A listing of all patients scheduled for the surgeries was obtained by the researcher on a weekly basis for the six weeks of data collection.

Before the researcher approached any of the surgical patients for participation in the study, a member of the orthopedic unit's nursing staff was consulted

to be certain the patient was alert, conversant, and oriented to person, place, and time. Patients who had experienced complications from surgery, such as acute pulmonary distress, stroke, myocardial infarction, cardiac arrhythmias, or renal difficulties, were not approached to participate in the study. Patients who were transferred to the intensive care or the telemetry unit as a result of complications were also excluded from the sample. By eliminating the presence of post-surgical complications within the sample, more homogeneous groups were studied. This made comparisons between rural and urban informants more meaningful. The post-hospitalization course of total knee and total hip replacement surgical recipients was judged to be similar after consultations with orthopedic physicians, nurses, and physical therapists prior to the conduct of the study.

Sample

The sample was comprised of 17 patient informants who ranged in age from 37 to 86 years. The demographic characteristics of the patient informants included in the hospital interviews are provided in Appendix A. The sample was comprised of 10 women and 7 men who varied with respect to education, annual income, marital status, religion, and occupation. Table 1 (Appendix A) illustrates a comparison of rural and urban informants with respect to gender and marital status.

Using the definitions of urban client and rural client provided in Chapter 1, the 17 patient informants were designated accordingly. Ten of the informants lived outside the county in which the hospital was located and were designated as rural clients. This group listed residences which were in towns or in the countryside near a town which was outside of an SMSA. These subjects lived at least 30 miles driving distance from the referral hospital. The other seven informants lived within the county in which the hospital was located and were designated as urban clients. The cooperating hospital was located in a Montana county which is an SMSA. This metropolitan area includes more than 50,000 people in a city which is located in a county of over 100,000 people (Hassinger & Whiting, 1976). Of the seven urban clients, six lived in the city and one resided in a neighboring town which was within the SMSA designated county.

Table 2 (Appendix A) shows that 6 of the 17 patient informants had previously received a total joint replacement surgery on either the same or the opposite joint. Other data included in Table 2 are the size of the towns represented by the patient informants, the distance in miles from the subjects' residences to the hospital, and other variables such as income, occupation, age, and educational level.

The discharge planners consisted of the designated discharge planners (a registered nurse and a social worker) assigned to work on the orthopedic unit and the orthopedic unit nursing supervisor or charge nurse. These individuals were involved with their normal duties in planning care for patients included in the

sample. The researcher did not select them from a study population, but interviewed them based on their involvement with the patient informants in discharge planning activities as described by their job descriptions. Those individuals interviewed were most responsible for planning discharge care on the orthopedic nursing unit. Questions designed by the researcher elicited their perceptions of available assistance for patients included in the sample prior to their discharge from the hospital.

Data Collection

Patient Informants

When potential patient informants were first approached by the researcher, they were read the Introductory Statement (Appendix C). This statement included the purpose, benefits, risks, and the planned procedure to be used in the study. If the patient showed interest in participating in the study, a copy of the Consent Form (Appendix D) was given to the patient. If the patient agreed to participate in the study, they were asked to sign a second copy of the Consent Form for the researcher.

Following consent procedures, a semi-structured interview guide developed by the researcher was used to collect data pertinent to the rural and urban informants before their discharge from the hospital (Appendix E). The interview questions permitted the clarification of meanings by both the researcher and the informants. This method of data production proved useful to the

researcher because there was no way to have anticipated responses or provide a prescribed selection of answers from which informants could choose. Each informant provided unique responses based on his or her experiences and perceptions. The face-to-face interview also provided observational data that would have been lost with other methods. Informants were able to "talk through" ideas rather than present their thoughts in a rigid manner, which is characteristic of structured interview, survey, or questionnaire methods (Woods & Catanzaro, 1988). The face-to-face interview also produced a high participation rate. Of the 18 patients approached to participate in the study, 17 agreed to serve as informants.

Family members of several informants expressed an interest in participating in the interview. Their comments were recorded and analyzed as such, but the main focus of the interview was on the person who had undergone the surgery so that consistency was maintained for all of the interviews.

The first set of interviews was conducted within the last several days of each informant's hospital stay. The average length of hospital stay is 7 to 10 days for total knee or hip replacement surgeries. Consistent with the national trend to discharge patients as soon as possible, the majority of informants were discharged within seven days. The informants were interviewed between the fourth and eighth days of their hospitalization (see Table 2, Appendix A). This was an appropriate time to talk to the informants about discharge concerns, as their thoughts were naturally focused on going home. All of the informants appeared to have gained enough strength by this point to tolerate the interview,

which lasted approximately 45 minutes. All of the informants had Patient Controlled Analgesia (PCA) pumps removed by the time of the interview. Surgical recipients generally received this intravenous narcotic infusion for the first several days post-operatively. All of the informants had switched to oral pain control methods and none appeared sedated or drowsy. The informants were given an opportunity to set a mutually agreeable meeting time with the researcher if the timing of the first meeting was not satisfactory to them. All informants agreed to meet with the researcher at the time they were first approached.

Discharge Planners

Signed consent forms were obtained from the discharge planners and participating orthopedic unit nurses (Appendix F) prior to the conduct of the study. A semi-structured interview guide was developed by the researcher to elicit their perceptions of available assistance for patients included in the sample prior to their discharge from the hospital (Appendix G). These interviews were conducted within several days of each of the patient informant interviews and while the patient was still hospitalized. The researcher also attended the weekly discharge planning conferences held on the orthopedic unit. These meetings were attended by discharge planners and the charge nurse. The purpose of these meetings was to plan for patient care during admission and after hospital discharge. The researcher did not take part in the actual discharge planning for any of the patient informants.

Follow-up Patient Informant Interviews

After discharge from the hospital, 10 of the original 17 informants (5 rural clients and 5 urban clients) were called on the telephone to ask if they would participate in a follow-up interview. All informants who were contacted agreed to continue in the study. Participants not contacted to continue in the study were sent a letter thanking them for participating in the first interview.

The follow-up informants formed a convenience sample group. The rural informants were contacted if they lived within an approximate 200-mile radius of the hospital. The researcher did not interview those who lived at greater distances because of financial and time constraints. The urban clients were selected in the order in which they were interviewed in the hospital. Demographic data from the follow-up interview informants are provided in Appendix B. Table 3 (Appendix B) illustrates a comparison of rural and urban patient informants with respect to gender and marital status. Table 4 (Appendix B) displays other variables such as income, occupation, age, and the driving distances of the informants from their homes to the hospital.

Consenting informants were interviewed in their homes approximately four weeks after hospital discharge. The researcher developed a semi-structured interview guide (Appendix H) for this purpose prior to the follow-up interviews. The second interviews lasted approximately one hour. The purposes of the second interviews were to gain a general sense of how the patient informants were recovering and to establish whether perceptions of available assistance had

changed after participants returned home. Participants were also asked questions that related to the effectiveness of the planning which occurred in the hospital prior to their discharge. Following termination of data collection for the follow-up interviews, informants were sent a note thanking them for participating in the study.

Procedures for Recording Data

All patient interviews were tape recorded and then transcribed word-for-word onto paper by a professional transcriptionist. Field notes were written by the researcher after each interview to supplement the taped interview data. These notes included data on the client and family interaction, the level of comfort during the interviews, and the surroundings and home environments of the participants. Interviews with the discharge planners and the discharge planning conferences were also taped, but these were not transcribed. Field notes supplemented these meetings and highlighted pertinent information regarding patients included in the sample.

Protection of Human Subjects

The study was initiated after approval of the proposal from the Montana State University Human Subjects Review Committee in Bozeman, Montana (Appendix I). Next, the proposal was submitted to the participating hospital and approval was granted. A copy of the letter for approval is provided in Appendix

J. The letter was signed by the clinical nurse manager of the orthopedic unit. In order to assure confidentiality and anonymity to the patient informants, the discharge planners, and to the nursing staff, this letter and the signed consent forms were stored in locked files on the Bozeman campus of Montana State University and will be destroyed in five years.

The rights of the subjects were protected throughout the research study. Ongoing protection of confidentiality, the assurance of anonymity, and voluntary participation were stressed throughout the project. Subjects were given ongoing assurance of the right to withdraw from the study at any time. Identifying information concerning the participants and the hospital were not reported in this study and will remain confidential. All raw data (i.e., tapes, transcribed interviews, field notes) were stored at the researcher's locked residence and were kept confidential. The face sheets for the patient interviews which had identifying information such as name, address, type of surgery, and date of surgery were separated from all other data and locked in a drawer in the researcher's home. Tapes, field notes, and transcribed interviews were referenced only by a letter code, such as "Informant C." All tapes, including those of the discharge planning conferences and the interviews with discharge planners, were erased after transcription and analysis were completed. The field notes and typed transcriptions will be maintained under lock and key at the researcher's residence and will be kept confidential. The interviews for patient informants, discharge planners, and nursing staff participants proceeded with no noted untoward effects.

Data Analysis

The grounded theory approach jointly employs two main analytic strategies. Buehler (1982) identified these approaches as the constant comparative method and theoretical sampling. The method of constant comparative analysis allows the researcher to progressively focus on the research as the data become clearer (Artinian, 1986). Major methods used to clarify data were open coding, recoding, memo-writing, and the constant comparative process.

Wilson (1985) recommended that three copies be made of each transcribed interview. One copy was left intact and placed in storage and the other two copies were used in analysis. In total, 27 patient informant interviews were analyzed. Seventeen patient informant interviews were included in the first set of interviews, and 10 patient informant interviews were gathered at the follow-up meetings approximately four weeks after the hospital discharge of the subjects. Data analysis was initiated after the first interview and continued throughout and after the data collection process.

The data collected from the tape recorded interviews with discharge planners and the discharge planning conferences were analyzed along with the patient informant interviews. Field notes supplemented these tape recordings and were also analyzed. While carefully reviewing the tape recordings, the researcher wrote out direct quotes and other information which directly related to the patient informants included in the sample. These data and the data from

patient informant interviews which were transcribed verbatim made up the entire data set.

At the beginning of the study, open codes were written by the researcher in the margins of the transcribed interviews and field notes. The incident or fact was underlined and the code was given a label. Coding was considered open because the categories, concepts, properties of concepts, and relationships between concepts emerged from the data. The codes were as unique as the data they represented and were not preconceived by the researcher (Buehler, 1982).

The first codes written for each interview or field note were called initial codes. After initial coding of the first several field notes and interviews, memos were hand-written to describe ideas and to document recurring themes in the data as more data were collected. Memos served as written records for the researcher and evidenced evolution throughout the study. For example, one code which emerged from early patient informant interviews was "returning to normal." The patient informants were asked when they thought they would be back to normal to elicit their perceptions of the length of their recovery time. One informant stated, "I wouldn't have no idea. Three months, four months. I know the neighbors . . . some of them has been a year." Consider how this contrasts with the response of a second informant who stated, "I would say within two weeks I will be doing everything I did before, including the lawn, because the lawn mower is self-propelled." The "returning to normal" code was then

expanded with the use of memos. The researcher wrote about and analyzed these two statements regarding: the informant's time orientation for recovery, the informant's perception of recovery as the ability to do work, and the reliance on the experiences of others as compared to an internal motivation factor. Thus, the early code of "returning to normal" took on new meanings. These two patient informant interviews and subsequent patient interviews were then recoded to better describe the identified properties of "returning to normal."

As more coding was done, the memos became more abstract. Incidents were compared to incidents, concepts were compared to concepts, and coded data were examined within the same interview and between interviews. Patient informant trends related to gender, marital status, occupation, family configuration, and other variables were reflected in the written memos. Trends were also identified in memos of the discharge planning process which included the data obtained from interviews with the discharge planners, participating orthopedic unit nurses, and the discharge planning conferences.

As codes became more well defined through writing memos, they were expanded or collapsed to form descriptive categories (Chenitz & Swanson, 1986). Transcribed interviews and other written data were then recoded to describe the data more consistently with the identified categories. As descriptive categories began to evolve, the researcher commenced work on an analytic skeleton. This process involved placing descriptive categories on a map or diagram as they were related to each other. For example, the category of "returning to normal"

was placed according to its relationship to other categories. Patient informants related to the researcher that they did not think about returning to normal until after they saw how the surgery had gone. Thus, the analytic skeleton was organized according to a time line. The "returning to normal" category was placed later chronologically than another category called "trying it out." This latter category referred to the informants' experience of seeing how the new artificial joint was going to work. As the analytic skeleton evolved, the researcher discovered that the patients "try out" their new joint before they think about "returning to normal." They generally pass through these phases before they actively involve others in planning for their discharge to home.

As other descriptive categories emerged from the data they were compared, modified, expanded, and verified as data collection continued (Corbin, 1986). Thus, the constant comparative process was continued until no new information emerged from the data and the researcher sensed that the data were reaching saturation (Chenitz & Swanson, 1986; Wilson, 1985). Consistent with the grounded theory method, descriptive categories which focused on human behavior and interactions were generated as a clear description of the subjects' perceptions emerged from the data.

The second analytic strategy, theoretical sampling, was used jointly with the constant comparative method in this research. Glaser and Strauss (1967) described theoretical sampling as "the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyzes his data and

decides what data to collect next and where to find them, in order to develop his theory as it emerges" (p. 41).

The concept of theoretical sampling was applied in several ways throughout this study. The convenience sample identified prior to the conduct of the study was changed to include younger age groups, as mentioned earlier in this chapter. Initial data analysis revealed that age-related concerns may have been important in the experience of total hip or knee replacement recipients. This could only have been determined if analysis was started at the onset of data collection, and this method provided a flexible tool with which to make necessary adjustments.

The second way theoretical sampling was applied in this study was evidenced by the use of the interview guides developed by the researcher before the study was initiated. As data collection and analysis progressed, the questions asked by the researcher became more focused and were influenced by interviews conducted earlier. The researcher became sensitive to which questions needed further description and clarification and then used appropriate probes to elicit these data during the interviews. As new information was obtained, questions were expanded to reflect the ongoing analysis. This was especially apparent by the time the follow-up interviews were conducted with the patient informants.

CHAPTER 4

FINDINGS

Qualitative Analysis

The purpose of this study was to explore and describe the perceptions of rural and urban patients who have experienced total knee or hip replacement surgery and their discharge planners in a Montana hospital. Specific aims of this research were to: (a) explore the differences and similarities which may exist in discharge planning for rural and urban patients, (b) describe the perceptions of rural and urban patients regarding available informal and formal assistance at the time of hospital discharge, (c) describe the perceptions of discharge planners regarding available supports for rural and urban patients, (d) describe whether perceptions change in rural and urban patients after they return home, and (e) describe the perceptions of rural and urban patients that relate to the effectiveness of their discharge planning once they have returned home.

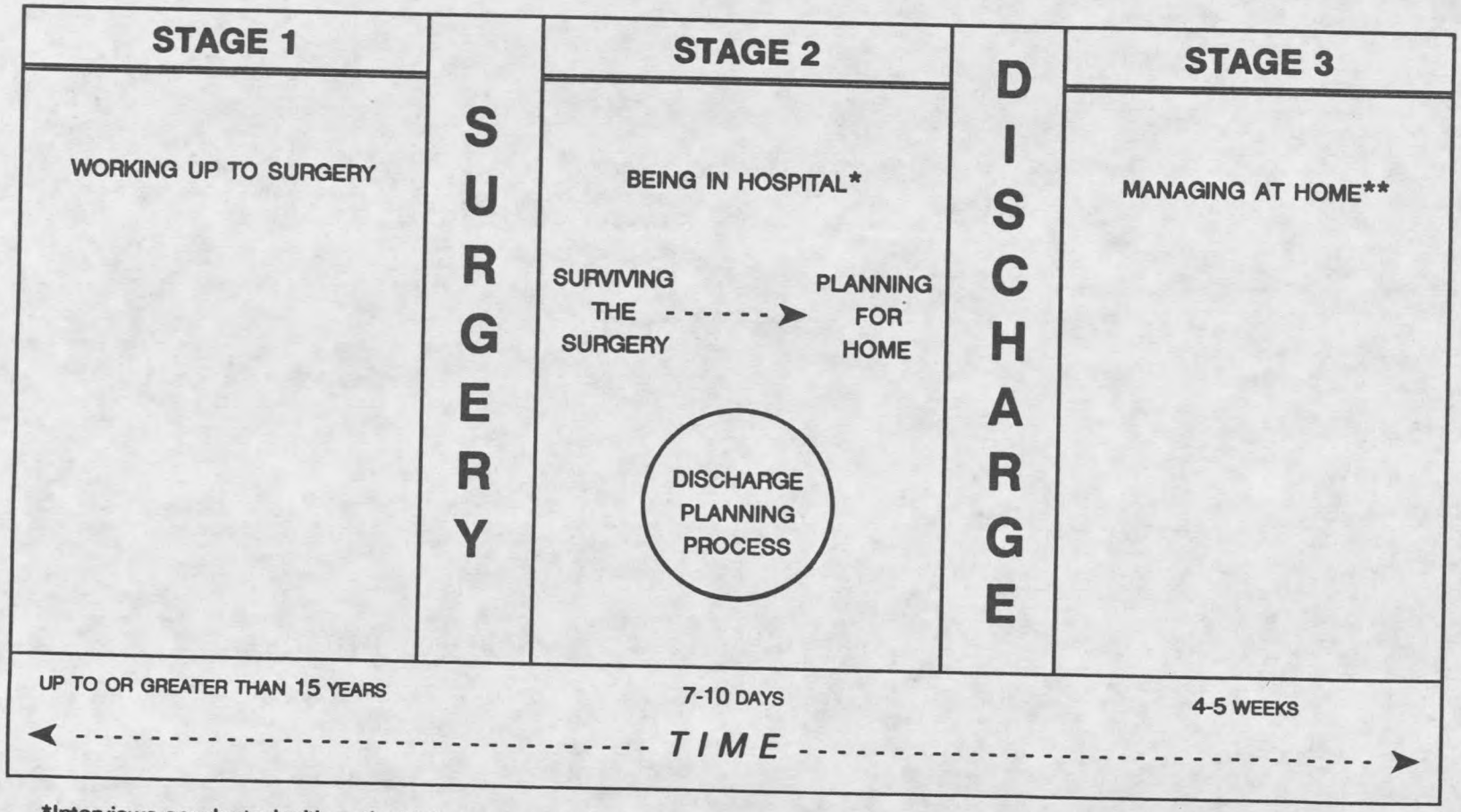
A qualitative approach which used grounded theory was selected to examine these issues. This approach was appropriate because it provided a way to examine and compare several social processes which were occurring simultaneously, and to generate theoretical concepts based on these processes. The main analytic technique in grounded theory, the constant comparative method,

allowed the researcher to identify concepts and processes and describe their properties and relationships as they emerged from the data. Coding, the constant comparative process, and theoretical sampling helped to bring meaning to the large amount of data generated from this research.

The research was designed to highlight rural and urban comparisons in both perceptions of informal and formal support systems and the discharge planning process for these two groups within a regional rural referral hospital. As data analysis progressed, core concepts emerged which were shared by both patient groups. The analytic skeleton presented in Figure 1 represents a way of viewing the experiences of total knee or hip replacement surgery as perceived by the patient informants and those responsible for their discharge planning. This process was entitled "getting fixed." The discussion provided in the following text will describe the concepts and their properties which emerged from the data. The discussion will proceed in a chronological manner from the perspective of the patient informants. Patient perceptions of the preparation or "working up to surgery" phase, the hospitalization phase, and the planning for surgery phase are discussed first, in that sequence. Next, the discharge planning process which is a part of the patients' hospitalization experiences will be described. Finally, the patient perceptions of "managing at home" will be reported as they were related by the patient informants who participated in follow-up interviews four to five weeks after they returned to their homes. In keeping with the purpose and aims of the study, rural and urban comparisons will be highlighted throughout the discussions of each phase of the research.

FIGURE 1.

Diagram depicting the process of "getting fixed":
Patient perceptions from preparation for total joint replacement surgery to recovery.



*Interviews conducted with patient informants and discharge planners during hospital days 4 through 8.
**Interviews conducted with follow-up patient informants 4 to 5 weeks after discharge to home.

Demographic Characteristics of the Sample

Data collection from patient informants occurred at two points in time. The first set of patient informant interviews were conducted four to eight days after the informants had experienced either a total knee or hip replacement surgery. The patients included in the sample were hospitalized at the time of the first interview. Demographic characteristics of the sample are provided in Appendix A. The sample was comprised of a group of 17 adults, 10 women and 7 men, who ranged in age from 37 to 86 years. Using the definitions of urban patient and rural patient previously defined in Chapter 1, individuals in the sample were assigned accordingly. The comparative groups consisted of 10 rural patients and 7 urban patients. The rural patients lived in or near towns which had 100 to 7,000 citizens. Driving distances for the rural informants from their homes to the hospital ranged from 48 to over 400 miles. Four of the 10 rural informants listed farming and ranching as their occupation. The entire sample included a wide range of occupational and educational backgrounds. Six were employed part-time, six were retired, and two were employed full-time. Two women stated they were homemakers and one man stated he was a full-time student. The men and women varied in marital status. Of the seven men who served as informants, all were married except one who had never married. Of the 10 women informants, two were married, three were divorced, and five were widowed.

The Process of "Getting Fixed"

Through analysis of the data, a process emerged and was entitled "getting fixed." This process best reflected the perceptions of the patient informants, it encompassed the three identified stages, and it was defined in terms of identified time periods.

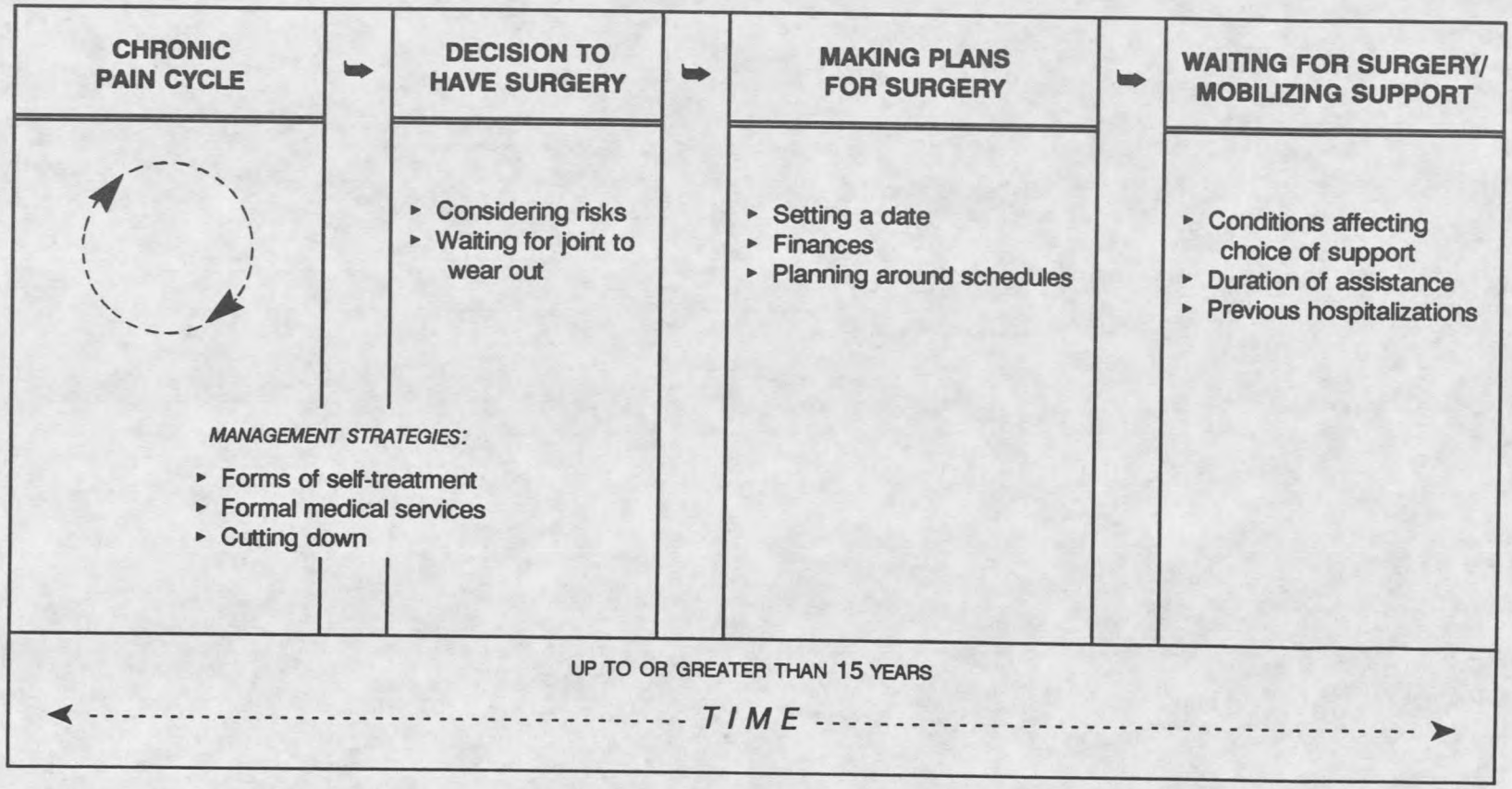
Stage 1: Working Up to Surgery

Stage 1, "working up to surgery," is presented in greater detail in Figure 2. The majority of informants were able to identify the month and year in which their symptoms began. Most persons in the sample suffered from degenerative osteoarthritis. The chief complaint associated with this condition was chronic pain. Patient informants stated that they had experienced pain for "several months" up to "over 15 years." The exception was a 37-year-old man who had been diagnosed with multiple sclerosis three years earlier. He sustained a severe hip fracture after losing his balance and falling in a shopping mall parking lot. He stated that "numbness, . . . loss of balance, . . . and inability for full movement" were his main symptoms prior to his total hip replacement.

Several other informants developed arthritis after traumatic injury. One 53-year-old man had experienced chronic pain since 1968, when he suffered a gun-shot wound to his leg. A 45-year-old woman had experienced a motor vehicle accident in 1975 which had severely damaged her hip. The other informants

FIGURE 2.

Stage 1: Working up to surgery.



experienced a gradual degeneration of the knee or hip joints. Several of the informants had pain in the joint opposite the one which received the surgery. Six of the 17 informants had already experienced at least one other total joint replacement on the same or opposite joint prior to the hospitalization.

Chronic Pain Cycle

The chronic pain cycle was identified as a property of the Stage 1 experience and is represented by the life changes experienced by the informants because of chronic pain. The informants generally described their pain as severe. Statements such as "the socket had eaten away," "bone against bone," "excruciating," and "unbearable" were common descriptions. Because of this pain, most informants identified a decline in mobility and "walking with a limp" as troublesome. The majority of informants stated they had difficulties in activities of daily living such as bathing, home maintenance, shopping, and housework. Some informants mentioned that the chronic pain they experienced had caused debilitating changes in terms of their "quality of life." Indeed, informants generally indicated that the pain they had experienced made a serious impact on their daily lives, and the pain had gradually increased to an intense level.

Management Strategies

Inherent in the chronic pain cycle were the various management strategies employed by the patient informants to control pain. These issues were explored in patient interviews because it was anticipated that past patterns of coping with

chronic pain could have implications for patient perceptions of needs and assistance following hospital discharge. Generally, the length of time the person had experienced chronic pain determined the extent to which he or she searched for self-treatment modalities.

Forms of self-treatment. A majority of the sample, both rural and urban patient informants, reported first using over-the-counter pain medications. These included non-narcotic agents and anti-inflammatory agents. Several informants stated that they had "been living on pain pills" up to the time of their surgery. In addition to medicines, informants experimented with heat treatments such as warm baths, whirlpools, heating pads, and application of analgesic creams to the affected joints. There were no clear rural/urban differences in either the use of medications or heat therapies. Two women who served as urban informants, however, reported that they used other self-treatment modalities that were not reported by any of the rural informants. For example, one 72-year-old urban informant reported that she had "tried acupuncture" to control her pain. Both this woman as well as an 86-year-old woman, also an urban informant, reported that they had "changed" their diets in an attempt to control their activities.

Formal medical services. The rural and urban samples varied in their reported use of formal medical services during the stage of "working up to surgery." The urban informants, both men and women, tended to use walk-in clinics and emergency room services for X-rays of the joint, cortisone injections, and to obtain narcotic prescriptions. The urban group, when compared to the

rural group, sought the services of an orthopedic surgeon earlier before their surgeries. The rural informants reported that they relied on the services of a local internist or family practice physician for a longer time before they contacted an orthopedic specialist. An explanation for this difference was greater accessibility to urban patients of formal medical services in the metropolitan area in which they resided. It was not clear if the rural informants would have used the services of an orthopedist if such a specialist had been more accessible, that is, located in the same town. The rural informants described the task of "picking a doctor" (orthopedic surgeon) as occurring much later in the "working up to surgery" stage than the urban informants.

Cutting down. The property of "cutting down" as a management strategy was described by all of the patient informants in the sample. Generally described as rest, this strategy was also described as "napping," "pacing," and putting their "feet up" daily. "Cutting down" on the total amount of work and activities in which they participated was widely reported. Important conditions surrounding the property of "cutting down" were age, financial position, the extent of disability, and the type of work activities in which the informants participated.

A major difference which emerged from the data of rural and urban informants was the way "cutting down" was described. The rural informants involved in ranching or farming described it as "semi-retirement" or "early retirement." When asked to explain this to the researcher, one 66-year-old man stated that his "operation isn't full-time anymore." Although this informant had

reduced the production of his ranch, he stated he still works "hard during certain seasons." He jokingly said that he "began to slow down last week." This man worked "full-time" in cycles as evidenced by his statement, "I stacked all the hay this year . . . and we operate 10,000 acres." Another informant, a 71-year-old rancher, stated he considered himself "semi-retired" because several of his grown children and their families had "taken over" some of the physical aspects of the job.

Complete retirement from ranching was viewed by the rural informants as a significant life change. "Selling out" or "turning the ranch over" to persons outside of the family meant an end to a way of life or a move "into town." The rural informants involved in ranching, being self-employed, had apparently chosen to keep their operations within their control "for as long as they were able," as one informant stated. If their physical capacity had diminished, they were still able to remain in control by delegating responsibilities to people of their choice.

The other men surveyed stated that they had retired. The urban informants included a 53-year-old retired city worker and a 59-year-old retired oil refinery worker. The only rural informant who stated he was retired was a 58-year-old truck driver. These men, all in their 50s, used the term "early retirement" to describe their situations. They were recipients of Workman's Compensation insurance and had no paying jobs. A 37-year-old rural informant stated that since he "couldn't tolerate jobs which required manual labor," he had returned to college as a full-time student. This individual was a Medicaid recipient.

These latter informants all listed occupations which were dependent on an employer, rather than being self-employed. They apparently had fewer options available to them regarding "cutting down" than did the ranchers and farmers. Since they perceived they were no longer physically able to work full-time, they had retired. Their financial positions were viewed as stable because they were able to secure work-related disability insurance or Medicaid. These insurances were not available to the ranchers and farmers in the sample who may have been more inclined to "stay ranching," as one informant explained.

The women also varied in their descriptions of work and retirement as they related to "cutting down." Similar to the men, the conditions of age, disability, and financial positions figured prominently in the property of "cutting down" as a management strategy for chronic pain. A 72-year-old urban informant stated she worked "part-time as a real estate agent." Her pattern of work was similar to a "semi-retired" rancher because it was cyclical in nature. She stated her work weeks were "often greater than 40 hours, but this isn't every week." Another urban informant, a 67-year-old registered nurse, stated she worked "part-time," but when she worked it was for eight-hour shifts at a nursing home. Likewise, a 62-year-old urban informant stated she worked "part-time at a department store in a sales position." These women were divorced or widowed and were required to work full shifts which involved almost constant standing or walking. They indicated they worked out of financial need and that the physical requirements of their jobs were often a hardship. Several women who were urban informants

stated they had "not worked in years," and described themselves as "home-makers." They received no outside assistance with housework. A 66-year-old rural informant stated that she and her husband were "part-time ranchers," but she agreed with her husband who said, "a wife never really retires." The two oldest women in the sample had both worked full-time, one as a teacher and the other as a Forest Service employee, but each had retired with retirement benefits. The youngest woman in the sample, a 45-year-old divorced rural informant, was the only informant to state that she currently worked "full-time" at a paying job. She had undergone three total hip replacement surgeries in the past 15 years after suffering injuries from a motor vehicle accident. She worked at a local bank and maintained full-time employment by using her sick leave and vacation time to recover from her surgeries.

Clearly, the men and women who served as patient informants were affected by chronic pain to the point that their work patterns were disrupted. The management strategy of "cutting down" meant "semi-retirement" and "early retirement" to some people. Those who worked in part-time positions and "semi-retired" ranchers and farmers reported cyclical work patterns. Informants also indicated that chronic pain required them to reduce or eliminate certain recreational and social activities. Several men reported that they had "given up hunting," or "made smaller gardens." Women made statements that indicated they "missed square dancing," "missed walks," and "missed socializing" outside of their homes.

Decision to Have Surgery

The next property of Stage 1 which the patient informants described was the decision to have surgery. A major rural/urban difference which emerged within this property was the extent to which the decision to have surgery was determined by the individual or by sharing the decision with an orthopedic surgeon. Generally, this decision centered around weighing the risks of the surgery against the chronic pain and the relative success of the management strategies the informants were experiencing in their daily lives. Several informants stated that they had "worked up to" their decision. The informants tended to be well informed regarding the risks of surgery and reported their understanding that joint replacements generally "last around 10 years," as they were told by their physicians. Other informants expressed their understanding that further manipulation of the joint, such as repeat surgery, might require more cautious optimism once the natural bone and socket have been removed. In addressing this circumstance, one informant stated that repeat surgeries "don't do as good." Thus, informants stated they were encouraged "to wait as long as possible for the joint to wear out." Several informants in their 50s were told by their physicians that they were "too young for the surgery" and experienced several years of waiting. The 45-year-old woman who had experienced three total hip replacement surgeries explained that she was "too active and I wear them out quicker."

The majority of the informants who had already experienced a total joint replacement prior to this study were under 65 years of age. A 58-year-old rural informant stated that this surgery was his third total knee replacement in five years. He poignantly stated, "I figured it was going to be like a flat tire . . . get fixed and go like hell. But you don't do that. I am finally starting to realize that . . . but I was born and raised that way -- going like hell all the time." Thus, the process was repeated and after his surgeries he again experienced chronic pain, "waiting for the joint to wear out," all the time "working up to" another surgery.

Individuals who were experiencing the surgery for the first time related how they had come to their decision. One 66-year-old rural informant stated he "knew something had to be done. I had been dragging this leg around a long time." A 72-year-old woman stated, "I had been playing around with so many different things with my arthritis . . . thinking I could cure myself. But at the beginning of the year . . . New Year's resolution . . . I was going to get to the bottom of this." Informants who had not secured the services of an orthopedic surgeon, more typical of the rural informants, were more inclined to indicate that the decision to have surgery was their own. After their decision had been made, they selected a surgeon. The urban informants who had already seen a specialist by this time made statements that indicated shared decision making with their physicians. Several urban informants made statements such as: "We decided to go ahead with it," or "we went ahead and set a date." A 71-year-old rural informant stated

her main motivation for seeking out an orthopedic surgeon was her "family and friends." She revealed, "It was a matter of getting so ashamed to go downtown and have people say, 'haven't you had that taken care of yet?' So I just went ahead one day and picked a doctor."

Making Plans for Surgery

The third phase of "working up to surgery," after the phases of the chronic pain cycle and the decision to have surgery, was making plans for surgery. These plans centered around setting a date for surgery and arranging finances.

Selecting the date for the surgery was generally the informant's decision. Most of the informants stated that it took one to four months "to get scheduled." Several rural informants stated that "the weather" and "the roads" discouraged scheduling a date during the winter months. Ranchers and farmers in the sample mentioned that the early spring months were the most convenient time to schedule their surgeries.

A 71-year-old widowed rural informant stated that she had picked a doctor and planned her surgery at a hospital "where I could stay with a friend after the surgery." She travelled over 100 miles for her surgery. Her other option would have been to have her surgery at another hospital only 30 miles from her home.

A 72-year-old divorced urban informant stated she planned her surgery around the schedule of her daughter, who had to travel from southern Mexico. She stated, "I have to have the other hip replaced and a lot will depend on when my daughter can stay with me again." Another urban informant, an 86-year-old

widow, indicated that she had waited six months for her daughter to come from Germany before scheduling her surgery. A 45-year-old divorced rural informant explained that she planned her surgeries when she "had enough vacation time and sick leave" accumulated from her full-time job. Unmarried rural and urban women often indicated that they were "dependent" on other people or conditions when setting a date for surgery. Married women rarely mentioned this issue, probably because they already had assurances of support from their spouses. All of the married women, however, had spouses who were in fairly good health.

In addition to setting a date for surgery, all of the patient informants mentioned financing the surgery as a concern. For the majority of informants, this was a planned surgery and not an emergency. Pre-approval was a requirement of insurance companies and waiting for this approval directly influenced the choice of the surgery date.

Waiting for Surgery/Mobilizing Support

The last phase of the Stage 1 experience was "waiting for surgery/ mobilizing support." The general time frame for this phase was one to four months between the time the informant set the date for surgery and when he or she entered the hospital. Several major conditions emerged which affected the patient informants' choices for the support they would receive after they were discharged from the hospital.

In addition to the choice of support, other properties of "mobilizing support" were the duration of the assistance and previous experiences with hospitalization.

The "waiting for surgery" phase of Stage 1 occurred when the patient informants initially planned and mobilized their support systems for their recovery after discharge from the hospital. As will be explained in more detail later, the assessment of patient perceptions during this phase has great relevance to discharge planning.

Conditions affecting choice of support. During the time in which the patient informants were waiting for surgery, the informants also reported that they were selecting and mobilizing their support system. Conditions which affected their decision were best characterized by marital status, gender, and family configuration.

As stated in the discussion of the previous phase, "making plans for surgery," unmarried women tended to involve others in their plans early in the planning phase. All but one of the men in the sample were married. These men generally reported that they made no specific plans during this time period. The married men tended to list their wives as their main support. One 58-year-old married rural informant stated, "The wife is always the fail-back." The married men who were unemployed and who had wives who worked reported that their wives requested vacation time for "a week or so" after the hospitalization period. Several men stated that if planning was done, their wives "did it all" or "thought about it more than I did." The gentleman who had never been married lived on a large ranch with his brother who he stated was "as strong as an ox . . . so he can help if needed." One preparatory activity that several men reported was

"getting the bills paid up" prior to entering the hospital. This activity was reported by the rural informants involved in ranching.

The majority of the women informants stated that they were divorced or widowed. One rural informant and one urban informant stated they were married. The urban informant was the only woman with a husband employed full-time (as a long-distance truck driver), and he had requested two weeks off from work when she returned home.

The women who lived alone, including the informants who were widowed or divorced, were active in planning for their post-hospitalization recovery during the waiting for surgery and mobilizing support phase of Stage 1. The majority of women informants indicated that they had enlisted the support of their daughters, granddaughters, or daughters-in-law to care for them in their own homes. As mentioned earlier, several of the daughters lived out of the country, and several lived in distant states. The daughters arranged airline flights and their work schedules around the projected week to 10 days during which they expected their mothers to have first returned from the hospital. The daughters-in-law who provided assistance lived in the same town or within a 60-mile driving distance from the women informants. Generally, plans were made to stay with their mothers-in-law for "a couple of days" or to "check in as needed." Two unmarried rural informants stated that their daughters and/or granddaughters lived in the same town that they did and could "check in every day." These women stated they did not need to make special plans for this arrangement because they saw their daughters almost daily anyway.

Only one unmarried woman stated her main support person was her 30-year-old son who was single, unemployed, and lived with her. She indicated that no special planning was required with this arrangement, and that she had very supportive neighbors. One unmarried woman, an urban informant, had two daughters living in the city in which she resided. Her plans were to stay with both of them, "going back and forth." Her daughters were both working during the day, but would plan to call several times a day. This arrangement did not require a great deal of planning, but the woman indicated, "We all talked about it quite a bit." Atypical of the sample was a 72-year-old divorced urban informant who stated that her "ex-husband was planning to stay for a week" after she returned home. She related that they "discussed this arrangement at length" prior to when she entered the hospital.

Given the previous discussion, the conclusion might be drawn that men who were married and women who were divorced or widowed differed in their post-discharge planning activities before the surgery. When the data from the interviews were examined more closely, family configuration emerged as a major condition affecting the choice of support person. Several women informants explained that they would not consider "bothering" their sons because they "have their own families." What was most interesting for both the rural and urban informants was that in several cases the women had sons who lived closer than their daughters, even in the cases where the daughters travelled from out of the state or the country. Married fathers did not plan on receiving their daughters'

assistance, but unmarried mothers did. When daughters were not available, granddaughters or daughters-in-law were typically the next choice by the women informants. The married women also sought some assistance from daughters, but they did not plan on them to be main supports.

Duration of assistance. This property of "mobilizing support" relates to the amount and length of time immediate assistance was available to the informants. The situations where daughters lived in the same town as their mothers and communicated with them daily required little planning before surgery. The same was also true of the farmers and ranchers who had family "stopping in" every day "to check up and do chores," as one rural informant stated. Apparently this built-in support did not require patient informants to make extensive adjustments. The patient informants who relied on assistance that was provided for a limited time period, such as the women who were relying on their daughters to "come and stay for a week," required more planning and preparation. These women indicated they were concerned about their caregivers' schedules, transportation, finances, and rearrangement of living quarters.

Previous hospitalizations. Informants who had experienced previous hospitalizations and/or surgeries tended to compare their expectations for their discharge to what had occurred in the past. Based on their experiences, they more easily adjusted their plans for the next hospitalization. Statements such as, "I have been through a couple of these, so I know what to expect," appeared to indicate that having had past surgery of a similar nature was an asset. Several

informants had no such prior experiences and were required to actively plan for the recovery after discharge because they relied on assistance which was available for a limited period and/or they were without a spouse or nearby daughter. They related that they "could have used more information," and they "didn't know what to expect." These factors were not mentioned by any of the married informants, most of whom were men.

Summary, Stage 1

The previous discussion of Stage 1, "working up to surgery," has implications for discharge planning. Interview data from patient informants indicated that chronic pain, personal management strategies, the decisions to seek specialized medical care and to have surgery, and the waiting for surgery and mobilization of personal support systems all influence patient perceptions and expectations. Gender, marital status, work, age, financial resources, and family configuration are all conditions which figure into the preparatory stage of working up to the event of surgery. Most importantly, this stage was perceived by patients as a period during which they were required to function independently and without professional guidance. For those patients with limited informal support and/or those who were experiencing the surgery for the first time, many adjustments were anticipated. It is asserted that formal hospital based discharge planning would be more effective if it was initiated during the preparatory stage rather than in the last several days of the patient's hospitalization, as was the case in the hospital which participated in this study.

Stage 2: Being in the Hospital

The second main stage of the process of "getting fixed" is "being in the hospital." This stage was defined as the hospitalization period until the patients were discharged to their homes. Figure 3 illustrates the major concepts which are included in this stage. The approximate time period represented is the average 7 to 10 days the informants experienced being in the hospital. Stage 2, "being in the hospital," is divided into two phases: "surviving the surgery" and "planning for home." The related properties for each phase are also shown in Figure 3.

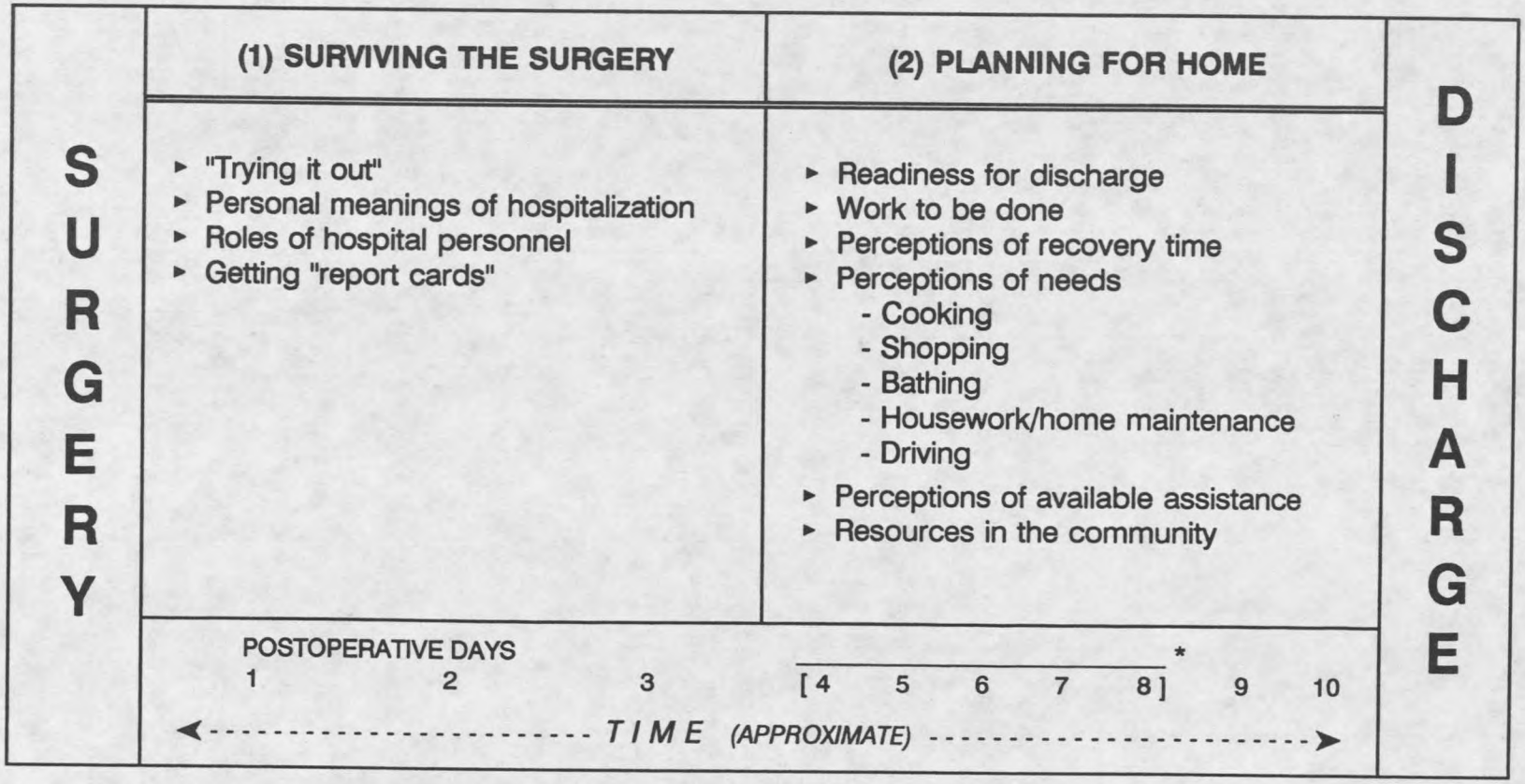
Surviving the Surgery

At the time of the first interview, patient informants were generally very talkative about what they had "gone through" in the previous several days of their hospitalization. Several of the informants stated that they had some "memory loss" and "blurriness" in the first one to two days immediately after their surgery. General anesthesia and narcotics were cited as the causes for these temporary conditions. All of the informants were alert and oriented, however, by the time of their interviews with the researcher.

Trying it out. The first "surviving the surgery" property to emerge in the Stage 2 experience was called "trying it out." This property is characterized by the informants' preoccupation with how their new joint "was going to work." "Awakening from general anesthetic" and having the surgery "over with" was

FIGURE 3.

Stage 2: Being in hospital.



*Interviews conducted with patient informants and discharge planners during hospital days 4 through 8.

reported by several informants as a relief. The next task which informants generally reported was to determine if the new replacement relieved their pain. The majority of informants compared their postoperative pain to the chronic pain they experienced prior to the surgery. Several informants stated that it took several days to ascertain whether their pain had diminished because of "all of the medication." Another informant stated, "I was all doped up and wasn't as active, so I didn't really know how it would come out." As less pain medication was needed and activities were increased, several informants reported that they felt "happy that it turned out" to be "worthwhile" and that this was "the best" they had felt "in a long time."

Personal meanings of hospitalization. After they had experienced "trying it out," the majority of informants made positive statements such as they had "gained energy" and were "motivated" to get stronger. Two informants, however, shared other concerns with the researcher which are important to emphasize. A 45-year-old divorced woman tearfully remarked, "I hope it isn't like this for the rest of my life." She went on to describe her past total hip replacements and other hip surgeries, and related the pain she experienced as having an impact on her past marriage. Her most immediate concern was, "I just hope my boyfriend is still around when I get home." Perhaps she had previously associated the event of surgery with other losses, such as an important intimate relationship.

A 37-year-old man shared that his total hip replacement brought more complications to his life as he was adjusting to the multiple sclerosis diagnosis he received several years ago. He was the only informant in the study who had not planned his surgery; he entered Stage 2, "being in the hospital," immediately after fracturing his hip. He stated, "The MS itself is pretty limiting, and I had to make a good number of adjustments for it. Now I will walk with crutches and not a cane. I have no idea what to expect." This informant indicated that the surgery "was yet another setback."

Both of these individuals, the two youngest in the sample, made statements that indicated they viewed their surgeries as having a negative impact on their lives. Thus, the personal meanings of the hospitalization they experienced were dramatically different from the majority of informants who viewed their surgery as a positive event which would improve their lives.

Patient perceptions of roles of hospital personnel. It was also during the early hospitalization period that the patient informants established who the main hospital caregivers were and what roles they assumed.

The orthopedic surgeon was generally viewed by the patient informant as the person responsible for the actual surgery and, to some extent, the outcome of the surgery. Visits by the physician were mentioned as important events and the majority of informants mentioned when and how often they were visited. Often family members timed their visits so that they "could be there when the doctor comes." Other informants mentioned the importance of having their baths

or physical therapy sessions at a time when it would not conflict with the physician's rounds on the orthopedic unit. Physicians gave recommendations which were perceived as "doctor's orders" and influenced several of the patient informants' expectations for recovery. For example, physicians frequently told the patients that in six weeks they "should be able to drive." When informants were asked when they thought they would walk without crutches or a walker, or when they would return to work, several framed their responses with "not until the doctor gives me orders."

Nurses, both licensed practical nurses (LPNs) and registered nurses (RNs), and nursing assistants were generally grouped together when discussed by the informants. They referred to persons in all of these positions "the nurses." One informant, a registered nurse, said she thought "the LPNs were the most helpful. They did the hands-on care." Another informant stated that the "fresh water" and "clean bed" were provided by the nursing assistants. Another informant mentioned that "nurses" were responsible for "giving out pain pills."

Physical therapists were viewed by several informants as having a very active role in preparing them for discharge. Informants indicated that physical therapists provided specific and detailed advice regarding exercises, ambulating, and the use of assistive devices. A 62-year-old woman commented, "I have a shower . . . the nurse said something about renting a stool or something to put in it . . . the doctor said I could rent a walker. Well, the therapists said not to get a walker, but to get a stool, so I thought I would ask the doctor's permission to

get a stool." This passage illustrated how some informants viewed nurses and physical therapists as supportive, offering advice and planning for their needs at home. Doctors were viewed as authoritative because they "gave permission" and "gave orders." The above quote might also have indicated a lack of collaboration among physicians and other professionals on the health care team. It also could have indicated this woman's need to rely on the advice of professionals. It should be noted that several informants made independent decisions regarding assistive devices to be used at home. They did not seek the advice of professionals or "get permission."

Getting report cards. The last property of "surviving the surgery" arose from a 71-year-old woman informant who stated, "The physical therapist gave me my report card and said I didn't need her anymore . . . so now I'm on my own." An 85-year-old woman also stated, "The doctor says I will not be discharged until I am well able to take care of myself." Several other informants who shared the same physician said, "The doctor told me I would be square dancing in a couple of months." These comments indicated that some informants received "bench marks" on their progress; that is, they felt their progress was being monitored and that the level of care they received would be dependent on their progress. Another informant, a 66-year-old woman, made a statement which also indicated that "getting report cards" could be either a facilitator or an obstacle in making plans after hospital discharge. When asked in the first interview if she had considered using the services of a home health agency upon her return home, she stated, "I will have to wait and see what the doctor says."

Planning for Home

The Stage 2 phase following "surviving the surgery" was called "planning for home." This phase occurred in the last several days of hospitalization, and is characterized by planning and preparing for discharge from the hospital and returning home. The related concepts in this phase were previously presented in Figure 3.

Readiness for discharge. The first property of "planning for home" reflects how prepared the patient informants stated they were to return home. As discussed in the "getting report cards" section, several informants indicated that they depended on "what the doctor would say" in regard to their plans for recovery. Analysis revealed that patient informants seemed to fall into two main groups. One group indicated dependence on the physician, illustrated by such comments as: "He said I could go Monday," and "He said I am getting ready." When informants answered in this manner, they usually did not provide any indication of how they personally felt about being discharged. Several of the unmarried women in the sample showed this characteristic. The men in the sample, most of whom were married, gave statements that indicated they were not as reliant on the opinion of their physician. Data to support this assertion included responses such as: "I'm ready," and "I think it will be just about right because I'm getting better and better." A 58-year-old man stated, "I talked him into letting me go tomorrow."

A related condition in the "planning for home" phase was the timing of the discharge. The most extreme example was provided by a 68-year-old unmarried

male rural informant. During the afternoon interview he had with the researcher, his surgeon entered his room and said, "I think you should be able to go tomorrow morning . . . before mid-morning so we don't get another day charged." The patient agreed, but then later shared with the researcher, "That is going to be tough. My nephew has to pick me up. We live 400 miles from here, so he will miss work and drive all night." The rural informants, who lived hundreds of miles away from the hospital, mentioned the short notice concerning discharge given by the physician was a hardship. The wife of a rural informant stated, "I wish he would let us know so we can make plans." None of the urban informants mentioned this issue.

Work to be done. The second property of the "planning for home" phase related to the perception of informants regarding the work they "had to do" when they returned home; that is, the general level of functioning their circumstances were going to require of them. A widowed 71-year-old rural informant stated that her daughter had traveled from out of state and was planning to stay with her "for a couple of weeks." She was concerned that "having visitors" was going to "tire her," as the daughter was bringing her infant with her. Apparently this woman perceived her role in this situation as that of a hostess rather than a recuperating patient needing assistance. A 45-year-old rural woman informant expected to return to work full-time and expressed concern that she "may not be ready." A 59-year-old urban man indicated that he was concerned about "keeping up the house and cooking" because his wife "works full-time" and these were his normal duties ever since he "took an early retirement." A widowed urban informant

stated she was relieved that she "didn't have to cook" for her husband, who had passed away, like she did with her last surgery. There was great variability in the perceptions of the work that would be required of the informants. However, none of the married rural men indicated concern about work, including the "semi-retired" ranchers. A 68-year-old man, who was single, operated a large ranch and expressed some concern by stating, "If you have a ranch, you work . . . you know?"

Perceptions of recovery time. This property of the "planning for home" phase concerns the informants' perceptions of the amount of time it would take before they would be "returning to normal." Some informants indicated that they thought this time would be a matter of weeks and others thought it would take several months to a year. Neither gender, marital status, nor place of residence suggested any patterns for the variability of this property. What is worthy of note, however, is that those informants who stated they expected shorter recovery times associated doing specific tasks or activities with when they would "return to normal." Being able to mow the lawn, drive, return to work, or garden were listed as activities which would indicate that their recuperation period was near the end. Those informants who stated the time would be many months and "up to a year" based their projections on either not knowing "what to expect" or on what others had told them, namely their friends and/or neighbors.

Perceptions of needs. The next property of the "planning for home" phase was the perceptions of needs. This property relates to the perceptions patient informants had of their capacity for and/or need for assistance with various

activities, primarily activities of daily living. This was an important area for patient informants to consider when "planning for home." Several of the informants reported that they had "thought about" what their capacity would be for specific activities, but these statements were characteristic of first-time surgical recipients. Several women, both rural and urban informants, further related that they "didn't know what to expect" or that they "had been trying to figure out" how they were going to do certain activities. The analysis provided in the following discussion relates to how informants perceived their needs concerning the primary activities of cooking, shopping, bathing, housework/home maintenance, and driving after they had experienced surgery. Where applicable, specific prehospitalization planning reported by the informants is also highlighted.

1. Cooking needs. As mentioned previously, one 59-year-old man, an urban informant, stated that he prepared the meals for himself and his wife because she worked full-time. The other married men who served as informants stated their wives were planning to cook for them as they had done prior to their hospitalizations. The unmarried man stated his brother would cook the meals as he had done previously. The married women stated that they were "going to open cans" or "get TV dinners." Both women stated their husbands could help "if needed," but that they were planning meals that were "quick" and "easy to prepare." Several of the unmarried women reported "cooking ahead" and freezing meals to be used when they returned home. One urban informant indicated that since she was staying with her daughter, cooking was not a concern. The informants who had their daughters and daughters-in-law staying

with them or "checking in" said that they were planning to receive help in meal preparation. Unmarried women who had daughters or daughters-in-law in the same town mentioned that they would bring them cooked meals or take them to their homes for some of the meals. Several of the women informants stated they read instructions "in the book" (provided to patients after their surgery on the orthopedic unit) to have someone help them "arrange the cooking utensils in the kitchen" so that they would not need to bend down to reach them. These informants indicated they had not thought of this hint before entering the hospital.

2. Shopping needs. Patient informants reported that grocery shopping followed the same patterns as cooking. Evidently, those who were planning to prepare the meals would do the shopping as well. Several unmarried women who had no one at home to help them stated their daughters, daughters-in-law, friends, and/or neighbors would bring them groceries or run short errands. Two women, both of whom had previous total joint replacement surgery, described in detail how they had learned to grocery shop while they were using their crutches. They used small plastic bags, and shopped often enough so that they would only fill one or two bags which they took from the check-out counter before they began shopping.

3. Bathing needs. Informants with showers which allowed them to stand up stated they thought they would be able to manage fairly independently. Patients, if they were married, stated that their spouses could assist them. Several married men stated that their sons could also help if needed. Tubs presented some projected problems for informants, as "getting their leg over the

side" was anticipated as being difficult. Women who had someone staying with them for one to two weeks thought they could learn how to bathe with help during that time and then function independently. Other informants mentioned that they were planning to buy hand-held shower heads and stools to be placed in the tub area. The 61-year-old woman who lived with her son was planning to ask a woman neighbor to assist her "for awhile." The nursing staff was viewed by several informants as the most helpful in demonstrating and suggesting hints to make bathing less cumbersome.

4. Housework/home maintenance needs. The married men in the sample stated that their wives were planning to do the housework as they had before the hospitalization. The exception was a 59-year-old husband who had been doing most of the household chores because his wife worked full-time. He stated that they might "hire a cleaning lady once a week for awhile," but that he would "pick up and dust." Several unmarried women stated that they "don't worry about housework." One said, "Dust can stay there for as long as it wants until I get in the mood to move it." These women stated they were mostly concerned with "keeping things picked up" and "keeping the dishes washed." They were planning to hire help if they found it difficult to vacuum or do heavier tasks. Unmarried women with close support from a daughter or daughter-in-law were planning to ask them to help until they felt strong enough. Several unmarried women stated they had planned ahead and left their homes "in good condition" prior to coming to the hospital. In terms of home maintenance or larger outdoor tasks, several unmarried women had already hired a "handyman" and could call

him if needed. Sons of both married men and unmarried women were cited as the main support person for these activities. Several men without sons related that they "preferred" to do these tasks independently. These men made statements such as: "I prefer to do everything myself, even if it takes three times as long," and "I can do just about all of it if I take breaks or work while sitting down." Three unmarried women lived in trailer courts and indicated there were people to hire or close neighbors to help if needed with watering the lawn or other maintenance projects, as they had called on these people to help before hospitalization.

5. Driving needs. There was a dramatic difference related to gender as to when informants indicated they were planning to drive their cars. All of the informants mentioned driving or a means of transportation as very important to their functioning. What is most interesting about driving is that the vast majority of the informants stated the doctor had given them orders not to drive for six weeks. When interviewed in the hospital, various informants indicated they were not planning to follow this medical advice. Without exception, the men in the sample stated they were planning to drive before the end of the six-week period. They all mentioned that they had pick-up trucks, some of them with "extended cabs." The majority of these informants indicated they thought they "could swing their leg around" into the truck with relatively few problems. One male informant stated he was planning to drive home from the hospital, a distance of 60 miles. The other informants said they were expecting to drive in "a couple of days" to "a week or so." The women informants presented a different pattern. Without

exception, the widowed women indicated they "had doctor's orders not to drive" or they "had to wait until the doctor released" them to drive. One married rural informant stated that her husband could drive her until she was "given the OK," but confided that he "usually drove anyway." The divorced women indicated they were planning to drive within "a couple of weeks." These women, employed part-time or full-time, mentioned that they had automatic shift cars. The other married woman, who worked part-time, stated she was trading her "shift" car for her son's "automatic" for "the next month or so." Two widowed urban informants stated they were planning to use "senior transport" services or relatives for transportation. The widowed rural women informants stated relatives or neighbors could drive them as needed. The ability to drive, perhaps more than any other activity of daily living, was clearly perceived as different by men and women.

Perceptions of available assistance. When informants were interviewed about their specific plans for managing at home, they generally mentioned those people who would assist them if they needed help. These forms of support have been highlighted as they related to specific activities. Informants were also asked to share with the researcher the types of help they were planning to receive from family, friends, neighbors, and formal community services. The following discussion summarizes these findings in a more general manner as they relate to comparison groups. Variables such as gender, marital status, family configuration, employment status, and other characteristics divided the informants into groups so that differences and/or similarities emerged from the data through the use of the constant comparative process.

The sources of informal care and support reported by the patient informants were analyzed by the researcher for duration and proximity of assistance. The majority of married informants named their spouses as their main supports. These people provided assistance of a long or unlimited duration and shared a close physical proximity with the informants; that is, they lived in the same household. To a lesser extent, married men reported that they could expect help from their sons. This was reported by the men who were involved in ranching or farming. Without exception, these men reported that their sons and their families did some amount of work on the farm or ranch at least every day or several times a week. One rancher explained, "He is here every morning to feed and he always eats lunch with us." An unmarried rancher stated that his main support was his brother with whom he lived, and a nephew who lived nearby and "was at the ranch often."

The married women also experienced assistance of a long duration and close proximity. They also expected their husbands to be their main support person. Married women reported that they could expect occasional help from daughters and daughters-in-law, generally of a short duration. Proximity of help from these women depended on how far they lived from the informants.

The unmarried women varied from the married men and women in regard to duration and proximity of assistance. Several widowed women planned to have their daughters from out of state or out of the country stay with them. These women received short duration and distant forms of assistance. These

women also demonstrated the most preplanning in the first stage, "working up to surgery." The other widowed and divorced women stated they planned to have assistance from daughters, daughters-in-law, and occasionally sons, who lived in the same town or within driving distance to their homes. They had planned for a limited duration of assistance that had varying but mostly close proximity of assistance.

Friends and neighbors were listed as main sources of support for unmarried women for such things as driving and home maintenance. This form of assistance was of limited duration but of a relatively close proximity. The three women who lived in trailer courts mentioned they could call on neighbors and/or friends who lived within the same trailer court.

An interesting pattern emerged in the data from the interviews with ranchers and farmers concerning assistance from friends and neighbors. These men, who stated they were "semi-retired," related that they felt uncomfortable asking for much assistance from nearby friends and neighbors. One man stated, "I only have 1,000 acres . . . a hobby ranch. How can I ask my neighbor to help? He has 27 sections." Another "semi-retired" rancher, who operated 10,000 acres with the help of his sons, said, "I don't do that . . . ask for help. I'm semi-retired. The neighbors are all running full-time." These men indicated that neighbors and friends would be available if needed, but they hesitated to ask them for assistance. Another rural informant stated he would ask his neighbors for assistance "if there was a real need. We don't have a telephone." The men who

were urban informants generally seemed less hesitant to ask neighbors for assistance. They indicated that "they check in sometimes anyway" and they "could help with heavier tasks" if needed. Friends and neighbors provided close proximity assistance of a limited duration, depending on the particular informant's willingness to ask for help.

Related to the preceding discussion are the data which reflect the informants' perceptions of who they would call in an unexpected medical emergency. The rural informants, without exception, listed family, friends, and neighbors, in that order. Urban informants listed family, friends, and neighbors as well, but several of the urban women informants mentioned that they would call their physicians after calling their family if they were able to. The rural informants seemed more concerned with transportation and would call their listed support persons to get them "to the doctor" before they would call the doctor.

Resources in the community. The majority of informants stated they were not planning to use any community resources such as Meals-on-Wheels, home health nursing, or senior transportation services. None of the men who were rural informants stated they had any desire for "extra help." One man stated, "If I ever decide I need extra help, I would [get help]." Several of the rural informants indicated that their wives would "know who to call." This may have reflected the lack of meal and transportation services in the areas where they resided. The only service that may have been considered was home health nursing. The men, the majority of whom were married, consistently did not mention they were planning to use this option.

Again, the women showed a wider variety in their responses in this area. None of the married women said they were planning to use home health nursing. One married urban informant indicated she knew meal services and transportation services existed, but she was not planning to use them. The married rural informant stated that she "wasn't sure" if those services existed, but was not planning to use them.

The unmarried women, both rural and urban informants, were generally knowledgeable regarding the services in their communities. The divorced women indicated they were not planning to use meal services, special transportation services, or home health nursing. Two widowed women, however, did state they planned to use home health nursing. A 75-year-old widowed rural informant stated, "The nurses said I needed it and they set it up." The 86-year-old widowed urban informant stated that she thought she "needed it" to get through "the transition period" after her daughter left. Both of these women stated they planned to use Meals-on-Wheels. The urban informant indicated that she would also use Senior Transportation. This was not available to the rural informant. Another widowed urban informant requested information on home health nursing services from the nurses on the orthopedic unit. This woman stated her main support person was her "daughter-in-law who lived 50 miles away on a ranch" and "has three little children at home."

The Discharge Planning Process

This nursing research study focused on describing the perceptions of people who were experiencing a total knee or hip replacement surgery in a rural referral hospital in Montana. Part of this experience is the hospitalization period. Professional nurses and a social worker served in the role of discharge planners for patients during this time. The discharge planning process was studied during the six weeks of data collection for the first set of patient interviews. The goals of this part of the research study was to describe the components of the discharge planning process that were evident in the hospital and to identify patient assessment criteria that were used by persons responsible for discharge planning for patients included in the sample. The perceptions of those persons responsible for discharge planning were compared to the perceptions of patient informants who participated in a follow-up interview four to five weeks after they had returned home.

Components of the Discharge Planning Process

The discharge planning process discussion is organized according to the various components identified in the process as they were evidenced in a Montana hospital. First, the admission nursing assessment, hospital staff involved in discharge planning, and discharge planning conferences will be discussed. Next, the data obtained from interviews with discharge planners and

orthopedic nurses will be summarized into the patient assessment criteria which emerged through analysis.

Admission Nursing Assessment

When the patient was first admitted to the hospital, a nursing assessment was completed by a registered nurse. This assessment was recorded on a form which became a permanent part of the patient's record. The registered nurse reported current physical findings and past medical history in his or her assessment. Patients were also asked a series of questions which related to nutritional habits, weight gain or loss, health aids used, and cultural/spiritual issues. The educational needs of the patient were also identified such as orientation to the orthopedic unit and preoperative teaching. Questions pertinent to discharge planning related to: the admitting diagnosis, the patient's home town, whether the patient could discuss his/her own discharge plan, the anticipated living arrangements after discharge, and whether the patient was receiving home nursing services and if these services would be anticipated after discharge.

The answers to these questions were obtained on the first day of admission before the patient went to surgery. The information was recorded on a form which became available to any nurse on the orthopedic unit, the physician(s), and the discharge planning team responsible for discharge planning on the orthopedic unit.

Hospital Staff Involved in Discharge Planning

The nurses primarily responsible for discharge planning were the clinical nurse manager and the day shift supervisor. There was also a registered nurse and a social worker who were employed by the hospital as discharge planners and assigned to the orthopedic unit. The patient's surgeon was also involved in discharge planning, and was the individual who wrote the physician order to discharge the patient. A physician order was also needed for referrals to home health nursing, to nursing homes, and to the hospital based rehabilitation unit.

The day shift supervisor was responsible for conferring with the patient's physician regarding the overall plan for discharge. The discharge planners also met with the physician. Physicians varied on their involvement in discharge planning activities. Some depended on the nursing supervisor to tell them if there was a patient in need of further follow-up or one who might require a referral for professional nursing care. Other physicians tended to make referrals to the discharge planners, who then made an assessment and wrote a recommendation in the patient's chart for the physician to read. Sometimes it was the patient and his/her family who expressed a concern to a nursing staff member who, in turn, communicated this to the supervisor. The supervisor then spoke with the surgeon and/or made a suggestion during the discharge planning rounds that "someone needed to follow-up with the patient."

Discharge Planning Conferences

The researcher attended the discharge planning meetings which occurred once a week on the orthopedic unit and observed and wrote field notes relating to the discharge planning activities pertinent to the patient informants involved in the study. The meetings were 20 to 30 minutes in duration. The nursing supervisor or, in her absence, the clinical nurse manager, would discuss briefly every patient on the orthopedic unit on that particular day. The discharge planners, a registered nurse and a social worker, were also in attendance. The nursing supervisor typically would read each patient's name, room number, doctor, type of surgery, date of admission, and any unusual medical complications being experienced. A short statement was then given regarding the discharge plan for each patient. Typical quotes from these meetings included: ". . . has a wife to assist at home," and ". . . plans to go to her daughter's."

Through this procedure, certain patients were identified as having "questionable" or "shaky" discharge plans. Patients identified in this manner were singled out as needing further assessment. In some cases, the discharge planners did not know the patient's family situation. In other cases, the family situation was known but the discharge planners did not view the available support as being adequate. In either case, the nursing supervisor or a member of the discharge planning team would meet with the patient and/or family. The purpose of this meeting was to gather more information regarding the availability of family support and to identify whether formal follow-up services, such as home health

nursing, would be needed. If a discharge planner felt that formal services might be needed, she attempted to obtain a physician's order for these services by relating her assessment to the patient's physician.

Interviews with Discharge Planners

Close to the time patient informants were interviewed, the researcher met briefly with either the nursing supervisor or one of the discharge planners. Using the interview guide (Appendix G) developed before the conduct of the study, the researcher asked the participants specific questions related to discharge needs and forms of formal and informal assistance that would be available to each particular patient informant.

Data obtained from the discharge planning conferences and the discharge planner interviews were combined during analysis. Patterns were identified that described the types of assessments conducted in this system of discharge planning.

Patient Assessment Criteria

Assessments of patient informants were based on the clinical experiences of the nurses and the social worker involved in the discharge planning process. The researcher was interested in describing the informal assessment criteria which were evident in discharge planning activities. There was no written or formalized set of criteria currently in use on the orthopedic unit. However, the data from the interviews and discharge planning conferences suggested that the

particular planners involved in the process did follow a pattern in making assessments. This pattern will be discussed in the following text. The term "discharge planners" will refer to the combined efforts of the nurses and social worker.

Is the Patient Known?

As noted previously, repeat total joint replacement surgeries are fairly common in the patient population which was studied. Several of the patient informants had been patients on the orthopedic unit during past hospitalizations for either a total joint replacement surgery or other types of orthopedic surgery. Because of relatively long employee tenure, discharge planners tended to remember repeat patients and their families and mentioned this during the conferences. More discharge planning was devoted to "new" patients. Often at the discharge conferences, a discharge planner would state, "We don't know him very well," or "I don't know the family." This would indicate to the discharge planners that further assessment was necessary.

Family Involvement.

Discharge planners indicated that they assessed family involvement, family configuration, and the quality of the support provided by the main caregivers. Family involvement was generally measured by the number of people who visited the patient in the hospital and how they were related to the patient. Frequent visits by wives, daughters, and daughters-in-law were viewed as supportive.

Discharge planners were likely to follow-up on patients receiving only visits from a husband, son, or boyfriend. The quality of the assistance that could be provided by the main support person was also assessed. Typical statements made by discharge planners included: "He only has his wife, but their marriage appears very supportive"; and "His daughter has been here and is real involved."

Pain Control

The effectiveness of pain management and the level at which pain was controlled postoperatively were sometimes mentioned in discharge planning assessments. Patients who exhibited behaviors that indicated poorly managed pain were occasionally identified as needing further follow-up.

Level of Independence

The patient's level of independence was primarily mentioned as it related to activities of daily living and physical therapy. Level of independence appeared to be measured by both motivation and physical ability. One patient was described in the following terms: "She doesn't do much for herself right now." Another patient was described as "strong and motivated."

Activities of Daily Living

Discharge planners rarely mentioned specific activities, such as cooking, shopping, housework, or driving, in their assessments of patients. These and other activities were discussed in terms of "managing at home," or "getting along." Bathing was occasionally mentioned specifically by the discharge

planners. Statements such as "she may need help at home, especially for a bath" indicated an assessment of this need.

Recent Setbacks

Discharge planners referred to recent widowhood or divorce as "setbacks" in interviews and conferences. The discharge planners indicated that further assessment might be needed to determine how well the patient was adjusting emotionally or whether adequate supports were in place.

Past History

Discharge planners, primarily the nursing supervisor, occasionally mentioned that an assessment had been made of the patient's past emotional and medical history. Statements such as "she has no history of emotional problems," or "he has a long history of chronic problems and many surgeries" indicated that this assessment was viewed as relevant for discharge planning.

Patient Compliance Behavior

Statements such as "he follows instructions well," "she asks questions and listens well," or "she needs frequent reminders" indicated that certain compliance behaviors exhibited by patients postoperatively were noted by the nurses who served as discharge planners.

Community Resources

Discharge planners occasionally made statements such as "he doesn't need community services, and if he did he probably wouldn't be open to them," or "she knows the nurses [in her home town] and would call them." The discharge planners appeared informed about what services were available in certain rural areas and on some level assessed their assumptions of patients' willingness to use the services or their ability to contact the appropriate person to secure services if they were needed.

Informal Classification of Patient Characteristics

Often statements were made by the discharge planners which indicated to the researcher that they had developed an informal, in-group classification system. This classification system included shorthand labels or descriptors of patient characteristics which the discharge planners believed were predictive in identifying discharge planning needs and/or strengths. Statements such as "she is a fuss-budget type lady," "she is a worry wart," and "she is a TLC type woman" were examples of patient descriptors. Other examples were "he is independent" and "he is a rancher type." Patients were also classified as being particularly "demanding" or "quiet."

Overview of Discharge Planning Process Analysis

In this study, the researcher did not take part in actual discharge planning for patients. The statements made by the discharge planners were recorded and analyzed from an observer's viewpoint. Since the researcher was an outsider in relation to the discharge planning team and was not a member of the work group, the descriptors of patients provided in the discharge planning interviews and conferences were not clearly understood by the researcher. The researcher did not interrupt the flow of communication during the interviews or conferences to seek clarification of these patient descriptors. It remains unclear as to what the implied meanings were of certain patient characteristics, and what patient characteristics received additional assessment by the discharge planners.

It was the goal of this study to explore and describe the perceptions of rural and urban patients who have experienced total knee or hip replacement surgery and their discharge planners in a Montana hospital. It was hoped that this study would provide practicing nurses with a beginning awareness of the congruence and/or incongruence between the perceptions of patients and the perceptions of human service professionals who serve those patients.

This study explored and described the assessment phase of the discharge planning process that was evident in a Montana hospital and identified specific patient assessment criteria that were used by discharge planners to plan for patient discharge needs. However, a need for further research is indicated in

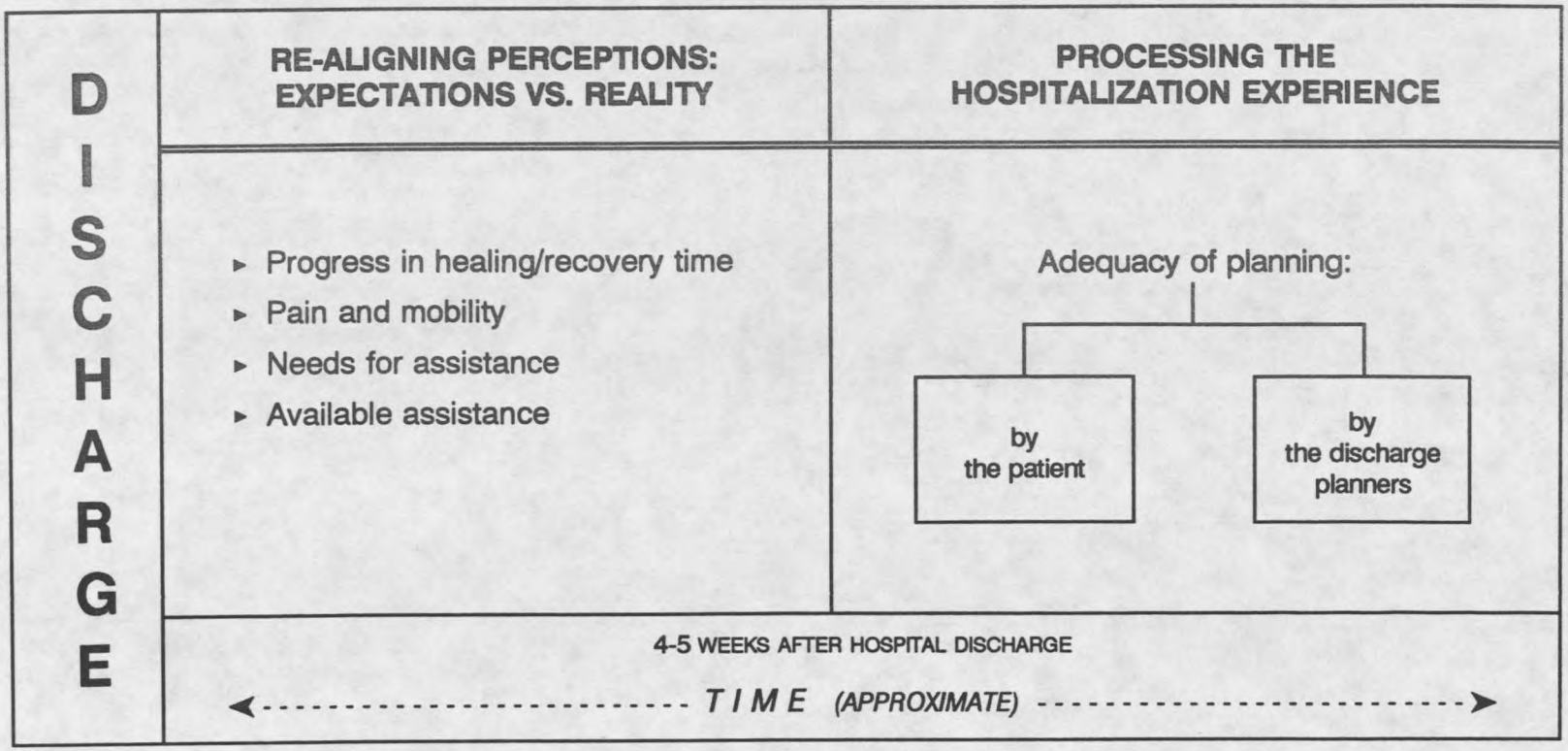
several areas that were beyond the scope of this study. A better understanding is needed of the shared informal communication system among discharge planners as it relates to the care provided to patients who are described by the various patient classifications. It appears that this informal communication system plays a significant, but not well-defined, role in the discharge planning process. Further research is also needed to explore if and how discharge planners validate their informal assessments and what activities define "follow-up" assessments by the discharge planning team. As more becomes known about how existing discharge planning models operate within natural settings, more effective nursing interventions can be implemented that take into account a variety of patient situations.

Stage 3: Managing at Home

The third main stage of the "getting fixed" process represents the time period that begins when the patient informants return home from the hospital and continues indefinitely. To examine this third stage, a selected group of patients was interviewed a second time four to five weeks after they returned home. Data were analyzed as they relate to this time frame. Demographic data for the patient informants who participated in the follow-up interviews are presented in Appendix B. The experiences and perceptions reflected in the following discussion serve to define the concepts presented in Figure 4.

FIGURE 4.

Stage 3: Managing at home.



Realigning Perceptions: Expectations vs. Reality

Patient informants shared with the researcher many of the perceptions they had regarding their first four to five weeks at home. Data were analyzed as they related to perceptions of progress in healing/recovery time, pain level, mobility and activity level, needs, and available assistance. Informant responses relevant to perceptions of progress in these areas are discussed below.

Progress in healing/recovery time. The majority of informants mentioned that they thought they were "progressing" and "healing." However, different patterns emerged related to the course of this progress. Two of the married men, who were rural informants, had both experienced one or more total joint replacement surgeries in the past on either the same or the opposite joint. These two men indicated that the other surgeries had "gone better." The first married informant stated, "I thought I would move faster with this one because I already have had one [a surgery] done." He later added, "Maybe I have progressed the same, but I just expected more of myself this time." The second married informant stated, "I forgot what it was like. I expected too much . . . thought I would bounce right back." Both informants indicated they were not disappointed with their progress, but had expected "too much" with this surgery. Several men who had surgery for the first time also indicated different perceptions of healing time. A married rural informant stated, "They told me in the hospital that I should take it easy for the first month, but I thought that was the average. I guess I was hoping I would go faster." An urban male informant related, "Sometimes I think

I'm not going as fast as everyone else . . . you know, recuperating . . . but I guess I'm doing all right."

The women also had varying perceptions regarding their progress in healing. The divorced women indicated they were pleased with their progress. They made statements such as "it was been easier than I thought," and "I'm right on course." One married woman indicated she was "having no problems." The widowed women, two urban informants and one rural informant, indicated they had made slow progress. A 67-year-old urban widow stated, "I really haven't felt good . . . I just felt blah." A 75-year-old rural informant stated that she "didn't really know" how she was doing. An 86-year-old widowed urban informant was sent back to the hospital for eight days "for treatment of a blood clot." She stated, "That set me back quite a bit." The eldest two informants, both women, stated that their progress had been slower than expected, indicating age may have been a factor in healing time.

Pain and mobility. Closely related to progress in healing and recovery time were the perceptions of pain and the level of mobility and activity. Rural married male informants varied in this regard. One man stated, "After I do my exercises I ache, ache, ache. I had to get more pain pills." This man added, though, that he was out working on his ranch and driving, and was "up and going" despite his pain. Similarly, a second married rancher stated that he was "in more pain than the last time around," but he was "forcing" himself "not to sit down . . . and to keep up with the chores." A third married male rural informant stated, "I don't get

slowed up just 'cause it aches a little." A married urban informant stated, "I have been pretty active, but every night I sit in my hot tub." Generally, the men in the sample tended to be active despite their pain and realigned their perceptions of recovery time by "forcing" themselves to progress in their daily activities. All of the men agreed that they were in less pain than before the surgery.

The divorced women tended to indicate that their pain was also less after surgery. Both of these women worked, one full-time and the other part-time. The woman employed part-time said she started back to work "after a week" and that she "took short naps" because she felt "a little tired after being in the hospital." The woman employed full-time stated, "I feel so bored . . . I re-did my bathroom," and that she was "anxious to start back to work." A married woman who worked part-time also said, "I have too much time on my hands."

The widowed women, all of whom were unemployed, indicated that the pain they experienced postoperatively was not dramatically less than before their surgeries. Their reported activity level was the lowest compared to the rest of the inform-ants. Again, age was a factor, as these two women were the oldest participants in the sample.

Needs for assistance. The third component of realigning perceptions was the area of needs for assistance. Comparing informants' expectations and their plans for activities of daily living at the first interview and at the follow-up interview also revealed certain patterns.

In both the first and second patient interviews, the married men consistently identified their needs as being "handled by the wife," as one informant explained. A married urban informant who took on household responsibilities while his wife worked full-time stated, "We worked together for the first couple of weeks. Now I am on my own."

The women generally showed a consistency of perceptions regarding needs for assistance in the two interviews, except in the cases of the widowed informants. Married and divorced women revealed that they had accurately identified which of their activities would require assistance. The widowed women, two urban informants and one rural informant, reported that they needed more help than they had anticipated. An 86-year-old widowed urban informant stated, "I wasn't anticipating that blood clot. I am sure glad I have the nurses [home health care] coming." She had planned for home health services, but did not expect to need so much help "with the bath and everything else." She added, "My neighbors in the trailer court have been more helpful . . . more than I could have imagined."

Another widowed urban informant, who went to her two daughters' homes to stay, said, "I thought I would be home by now, but I just haven't gone back yet [to her trailer]. Maybe I'm just lonely." The third widowed rural informant provided the response: "I wasn't so sure I needed the nurses [home health] before I came home, but I don't know how I could have done it alone now."

Available assistance. The last component of realigning perceptions was the area of available assistance. The married men who participated in the follow-up interviews were consistent in their perceptions of what support they would receive. Without exception, they listed their main supports as their wives, and this support was perceived as being adequate. None of the men reported needing support from other sources such as friends, neighbors, or other family members.

The women informants again showed varying patterns in their perceptions of available assistance. A 62-year-old married urban informant reported that she received assistance from her husband as she had planned. The divorced women were also accurate in their perceptions regarding the forms of support which they would receive. They indicated that this support was adequate and that no other forms of support were mobilized. However, the widowed women, one rural and two urban informants, varied from the other informants in terms of their perceptions. An example was a 67-year-old widowed urban informant who stated she did not expect to still be staying at her daughter's home. In this case, she accurately predicted her sources of support, but did not predict the extent to which she would rely on them. Another example was the 75-year-old widowed informant who received home health nursing services and did not expect them to be as helpful as she later felt they were.

Processing the Hospitalization Experience

In general, patient informants who participated in the follow-up interviews stated that their needs for assistance with activities of daily living were adequately met with the identified forms of available support. The married men showed a tendency to underestimate their level of pain, but they reported greater physical activity than the rest of the sample. Several of these informants indicated they had expected to have less pain with a second or third surgery and realized that this was not the reality. One man who had surgery for the first time also indicated that he had expected more from himself than the "average" person. This might have been based on his perception that he was more active than others in his age group. The married men named their main support as their wives, and could not identify anything for which they needed extra help. They generally felt they had planned appropriately for their needs and that their support was adequate. These informants also indicated, without exception, that they received adequate care in the hospital. They did not specifically identify discharge planning activities which occurred in the hospital. Discharge planners had identified members of this group as being "independent," "with adequate support," and "with strong support" from their wives.

The divorced women who participated in the follow-up interviews likewise indicated that their needs for assistance with daily living tasks were met. They asserted that their perceptions of their pain level, activity and mobility level, and their needs for activities of daily living were aligned with their perceptions of

reality once they returned home. According to these women, the preplanning which they did prior to hospitalization to mobilize their support systems was adequate. When compared to the other women in the sample, the divorced women reported a fairly high activity level.

One divorced informant indicated she thought her care at the hospital "went exceptionally well." She did not identify specific discharge planning activities which occurred in the hospital. The discharge planners indicated they thought this woman would receive "adequate support from her ex-husband." One nurse also said of this patient, "She is a real go-getter . . . seems independent . . . still works at [age] 72."

A 45-year-old divorced woman mentioned that a physical therapist had asked her about managing at home, but she did not recall specifically any discharge planning activities by the nurse or discharge planners. She commented, "They never tell you enough . . . like the doctor tells me to put only 10 to 20 pounds of weight on my leg, but what is 10 or 20 pounds? That's the kind of stuff that I don't think doctors and nurses tell you as much as they should." Generally, this woman indicated that she could have used more discharge teaching before her release from the hospital. She stated, "I hated to ask the nurses too many questions because I didn't want them to think I was being a baby." Discharge planners, however, identified this woman as adequately prepared in terms of support. They said, "She has a daughter nearby in town to help. This is her third surgery, so she should be OK."

A 62-year-old married woman who participated in a follow-up interview indicated that she thought her needs for assistance were met. She identified her husband as her main support and stated that he provided for her needs. Her perceptions of going home regarding pain, activity, mobility, and her needs in activities of daily living were in alignment with the reality she experienced at home. She was employed part-time and stated she "was bored" with "too much time" on her hands while not working. She thought her hospital caregivers responded to her needs. This informant maintained that the nurses in the hospital gave her adequate discharge teaching, specifically citing "not bending the hip too far in and using pillows for support." She also reported, "A nurse asked me, 'How are you going to be able to take care of yourself, or is there somebody at home to help you?' . . . 'cause I know if there wasn't somebody home, they wouldn't let me go home as soon as I did." The discharge planners described this woman as "independent" and commented that "she has a husband at home to help, so she should have no problems."

The widowed women in the sample of follow-up informants generally agreed that their needs for assistance were met. However, their perceptions of the extent of their needs and their reliance on support were not as well aligned as the other informants. In the first interview, they were less clear in describing their expectations for pain, activity and mobility, and their needs for activities of daily living. This group of women showed the lowest level of activity at the follow-up interviews. The women recalled certain discharge planning activities which

occurred in the hospital. They provided such examples as "they asked if I had help," "they said that I needed help at home and set it up," and "they were just wonderful to help you with going home . . . they made arrangements for the nurses to come as I had hoped they would." Two of these women, an 86-year-old and a 75-year-old, were referred to a home health nursing agency, and one 67-year-old stayed at her daughter's home. The discharge planners had identified these women as "needing follow-up." They indicated that the woman who was planning to stay with her daughter "would have support there."

The Profile of the Well-Insulated Patient

The perceptions of patients who had experienced a total knee or hip replacement surgery were highlighted in this study. After reviewing all three stages of the process of "getting fixed" ("working up to surgery," "being in the hospital," and "managing at home"), further analysis was undertaken. The characteristics which patients have that insulate them from having to make a large number of adjustments to their condition, the surgery, and the recovery time were of interest to the researcher. These characteristics were described in terms of the "well-insulated patient." This profile describes the perceptions of apparently well-insulated patients relative to needs, planning for needs, support, and expectations for recovery.

Perceptions of Needs

Patient informants who appeared well-insulated tended to provide only brief descriptions of their needs for assistance with daily living tasks, or they appeared at ease in talking about their needs and the assistance which was readily available to them. In either case, they generally mentioned themselves or their main support person as being able to handle any situation. These patients also were less inclined to "check with the doctor" regarding their care and seemed to have fewer questions. They did not wait for others to give them advice before they made their plans.

Perceptions of Support

Well-insulated patients shared the characteristic of having unlimited and nearby assistance. Being married was consistent with this characteristic. Generally, a smaller number of people providing continuous support was more insulating for the patient. Men appeared to be well-insulated by their wives who "were always the fallback," as one rural informant stated. Women appeared somewhat well-insulated by their husbands, but they were responsible for more daily living tasks which caused them concern and required a greater number of adjustments. Well-insulated patients tended to report that their support person would cook, shop, and clean as they had done before the hospitalization.

Planning for Needs

Well-insulated patients tended to report little or no preplanning in the "working up to surgery" stage. These patients reported that they "did not plan particularly" and they did not have to make adjustments in mobilizing support. When asked about their planning for going home, they again either stated they had few needs for assistance or were not concerned because they had consistent support for their needs.

Expectations for Recovery

Well-insulated patients tended to describe their recovery period as much shorter in duration. They defined "returning to normal" as a measurable outcome that they planned to achieve. An example provided by a male rural informant was, "In a couple of weeks I should be back . . . should be able to walk out to my shop . . . 300 yards." Within six months, this man had also planned "to be fishing on Vancouver Island with my wife and my daughter." Well-insulated patients, again the men, simply refused to make certain adjustments, such as not driving. They tended to report that they were "going to drive anyway," against medical advice. The same held true for the use of assistive devices such as crutches or a walker. The well-insulated patients tended to use them for shorter lengths of time.

Well-Insulated Patient Profile Overview

Follow-up interview data revealed that well-insulated patients shared perceptions during the hospitalization experience which were in alignment with their perceptions after they had returned home. Their expectations for healing and recovery time, pain and mobility, and needs for assistance and available support were congruent with the reality they experienced once they returned home. The personal meaning of the hospitalization and the surgery was generally viewed as a positive event and not "a setback." It was viewed as a time "to get fixed" and to "get rid of the pain."

Summary

This qualitative study employed a grounded theory methodology. Through data collection and analysis, a process entitled "getting fixed" emerged and represented the perceptions of rural and urban patients who have experienced total knee or hip replacement surgery and their discharge planners in a Montana hospital. Patient informants showed variability in their perceptions throughout the three main stages of the "getting fixed" process. These stages were "working up to surgery," "being in the hospital," and "managing at home." Marital status, gender, family configuration, available informal assistance, previous experience with hospitalization, age, and financial position were the main elements associated with this variability among patient informants. In addition, rural and urban comparisons were highlighted.

The discharge planning process was also explored at the participating Montana hospital. The discharge planning process was described, including the informal system of conducting patient assessment for discharge planning needs. Discharge planning assessment criteria were identified through interviews with discharge planners and observations of discharge planning conferences that related to the patient informants included in the sample.

Follow-up patient interview data allowed comparisons to be made regarding expectations during the hospitalization period and the experiences and perceptions of the participants approximately four weeks after their return home. Specific discharge planning needs were identified by the patient informants after they had lived through and "processed" the experience. Further analysis of the data yielded a description of "well-insulated" patients, or those who had apparently made the fewest adjustments while in the process of "getting fixed."

CHAPTER 5

CONCLUSIONS

Discussion

The findings of this study indicated that patients varied in their perceptions of the experience of total knee or hip replacement surgery. The process which emerged from analysis, entitled "getting fixed," described core concepts shared by all patients. The process occurred in three distinct stages and within identified time periods. The stages were defined as "working up to surgery," "being in the hospital," and "managing at home."

Hospital staff responsible for discharge planning, the nurses and a social worker, also shared their perceptions related to the after-discharge needs and available assistance of the patients who participated in the study. Observation of discharge planning conferences and interviews with discharge planners provided data which were analyzed in terms of assessment criteria. These criteria were consistently mentioned by the discharge planners as being predictive in identifying discharge planning needs and/or strengths. In addition, the discharge planning process was described as it is applied in the participating Montana hospital.

The constant comparative method, an important analytic strategy characterizing grounded theory, allowed the researcher to view and document several social processes which were occurring simultaneously. Continual comparison of data within and between patient interviews combined with concurrent examination of data from discharge planner interviews and conferences facilitated the identification of patterns. The findings support the assertion that variables such as gender, marital status, age, rural/urban considerations, occupation, family configuration, available informal assistance, and past experience with hospitalization were not uniformly represented in the identified discharge planning assessment criteria.

The findings of this study are significant for the nursing profession because they provide a beginning awareness of the congruence and/or incongruence between the perceptions of patients and the perceptions of the health care professionals who plan their care. As discussed in Chapter 4, there were no written or consistently applied set of discharge assessment criteria or screening tools being utilized at the participating hospital. This study was exploratory in nature and attempted to define what assessment activities do exist within the realm of discharge planning. Further nursing research is needed to validate if and how the assessment findings of discharge planners are incorporated into actual planning, implementation, and evaluation. The findings, based on the analysis of perceptions alone, do indicate that there are areas of congruence and

incongruence between patients and the discharge planners responsible for planning their post-hospital care.

For example, consider the identified assessment criteria of pain control. The effectiveness of pain management and the level at which pain was controlled postoperatively was mentioned in discharge planning assessments. Interviews with patient informants, however, revealed that incongruencies exist in this area. The men generally reported that they had not anticipated having as much pain as they were experiencing at the time of the follow-up interviews, four weeks after hospital discharge. Their reported activity level was higher than that of the women informants, and they continued their activities despite their pain and against the recommendations of their physicians. In the hospital, the discharge planners reported that these men had managed their pain postoperatively and they predicted that pain management would not be problematic after hospital discharge.

Another area of incongruence in patient and discharge planner perceptions was that of patient compliance behavior. Raw data from discharge planner interviews in this assessment area included such comments as: "He follows instructions well," "she asks questions and listens well," and "she needs frequent reminders." The follow-up patient interview data revealed that a major area of noncompliance, in addition to strenuous activity, was driving a vehicle before the recommended waiting period. Men especially were found to be noncompliant in

this regard, and yet they were identified in the hospital as being compliant with their postoperative care.

A third area of incongruence was the assessment criteria concerning activities of daily living. Discharge planners rarely assessed specifically the patient's capacity to perform cooking, shopping, and housework tasks. These activities were mentioned in a general sense, as exemplified by the statement, "She should be able to manage." However, hospital and follow-up patient interview data revealed that these areas were of concern to informants in the sample, especially for the unmarried women and one married man who was responsible for these tasks because his wife worked full-time. Some of the informants had planned ahead in this regard, but several mentioned they "could have used more information on what to expect."

The assessment criteria which showed the most congruence in perceptions between patient informants and discharge planners was that of family involvement. Discharge planners were accurate in identifying the main caregivers for patients. The most consistency was seen for married informants who listed their spouses as their main support. Although the discharge planners assessed to some extent the level of support provided by family care, several unique issues arose during patient interviews. One example was a widowed woman who was identified as having adequate support from her daughter-in-law. When interviewed by the researcher, the patient informant expressed distress because she did not want to "infringe" on her daughter-in-law who lived on a ranch "over

an hour away" with three small children. The patient subsequently asked for information regarding home health nursing.

The findings relating to patient informants concur with the findings of other researchers (Kulys & Tobin, 1980; Lurie et al., 1984) who found that most elderly people rely on informal caregivers in the event of discharge from a hospital. The oldest informants in the sample, who were widowed women, relied on formal caregivers in addition to some limited informal assistance. The findings also concur with the works of Kivett (1985), Lee and Cassidy (1985), and Scott and Roberto (1987) who stressed that rural and urban people have different informal assistance patterns relating to health events. The rural patient informants who were involved in farming or ranching were clearly unique in this regard. It appears that farming/ranching families are characterized by close-proximity family support as a function of their working together. Daily visits "while doing chores or feeding [animals]," especially from grown children who lived nearby, were widely reported. Rural informants who were not involved in farming or ranching occasionally reported being "out here alone," as one retired married male informant stated. He and his wife had moved "out of town" when he retired.

Additional studies (Archbold, 1980; O'Brien & Wagner, 1980; and others) have reported that informal helping networks often draw little assistance from formal services, which was certainly the case in this study. Indeed, the only informants to receive formal services, such as home health nursing, were the oldest widowed women who had no close relatives living in their town. There

were no cases of formal services being used by married, divorced, or widowed informants who had available and able family assistance.

Coward and Rathbone-McCuan (1985) indicated that formal services, even if they are available to rural elders, are not utilized unless they are acceptable, accessible, affordable, or known to the person. The present study showed that the rural comparative group in the sample sought specialized care later in the preparatory stage prior to their surgery. Further research is indicated to isolate the variables which relate to this pattern. The findings of this study indicated that occasionally the unique needs and perceptions of patients are not considered by health care professionals involved with discharge planning. The current system of discharging patients to return home sooner often is complicated by a shorter preparatory period. Patients await the physician to write the order for their release, but often this occurs sooner than the patients expect. Rural patient informants in this study frequently mentioned the long distances to return home as a stressor, especially if they relied on someone other than their spouse to drive them home.

The most distinct variables identified in the "getting fixed" process were age, gender, and marital status. When patients were compared with each other in regard to these variables, the greatest differences arose. For example, elderly widowed women had vastly different prehospitalization planning and help-seeking patterns than did younger married men. That is, the widowed women reported they were very active in preparing for their surgeries, arranging transportation for

relatives who were to stay with them, cooking, and other activities. The married men all made statements that indicated they did little preplanning because they relied on their wives to "take care of things." Age, gender, and marital status also were discussed in terms of the number of adjustments with which particular patient groups were confronted. Married men were the most insulated from having to make a large number of adjustments.

The findings in this study also indicated the need for prehospitalization discharge planning. The data presented in Chapter 4 support the assertion that the process of discharge planning should be extended beyond the last several days of hospitalization for the patients, and should include prehospitalization planning. This time period, defined in Stage 1 of the "getting fixed" process, was when patient informants reported they were "waiting for surgery" and mobilizing their support networks. During this time, patients reported they were quite active in planning for their own recovery period. Several of the patient informants who were without extensive informal support systems indicated they were making decisions without needed information. Effective prehospitalization planning would need to include individualized patient teaching. If the discharge planning process were extended to include the prehospitalization phase, then the days that the patients were in the hospital could be used to provide more individualized discharge teaching related to coping in the patient's particular home environment with the already identified sources of support. Specific planning for activities of daily living and setting realistic recovery goals could be emphasized. Perhaps

this would reduce post-discharge complications and increase patient compliance. Providing direct support to the patient and sharing in collaborative decision making are major contributions of the nurse to those patients who are moving from the acute care setting to another environment. Through individualized planning with the patient, nurses are in pivotal positions to enable patients to realize their full potential.

Other findings from this study indicated that more collaboration by the discharge planning team is needed to avoid giving the patients conflicting information. The fact that many patients wait until they "hear from the doctor" before they begin planning indicates that discharge teaching should be initiated as soon as possible after the surgery. This would also help patients who experience a very short forewarning of the actual discharge time. Patient informants also related that the first several days of hospitalization are not conducive to patient teaching or planning because they are either under the influence of narcotics or they are preoccupied with "trying out" their new artificial joints. Given these findings, the actual available time which is appropriate to teach patients is relatively limited. With such limited time, it might be effective to involve the health care providers who work at the bedside. Involving licensed practical nurses and nursing assistants in a collaborative team approach with the professional nurse to assist in discharge planning is one possible solution. For example, the health care providers who assist patients with their baths are probably in the best position to assess the patients' ability to perform this activity

after discharge. If these providers are given the opportunity to regularly report their findings to the professional nurse and the discharge planning team, then more individualized planning could take place. This finding should be considered when implementing alternative discharge planning models.

In conclusion, the value of qualitative research for generating theory relative to actual clinical phenomena and social processes was reinforced through this study. The assertion is made that no other single research method could have captured the dynamic process that emerged from the data collection and analysis. The data were rich in description. Hopefully, this research will provide the foundation for the development of hypotheses and further explorations and descriptions of other clinically significant issues.

Limitations

The limitations of this study are delineated as follows:

1. The non-representative and convenience sample precludes the generalization of the identified process to other patients without further research. However, the rich description of the sample does provide important clues concerning the needs for further research.

2. The research setting was limited to one hospital in Montana and generalizations cannot be made about other hospitals or rural referral facilities.

3. The use of semi-structured interview guides allowed for a wide variance in responses. Identified trends were shared by a small number of individuals.

This further discourages generalization to other patient groups. The wide variance in responses, however, added to the depth of the identified concepts and stages of the process. Indeed, it was the intent of the researcher to describe perceptions. The more descriptive the findings, the more they have implications for providing individualized interventions in a clinical setting.

4. This study focused only on the assessment phase of the discharge planning process and made no attempt to evaluate the efficacy of various models. The research goal was to describe the process as it is currently practiced in a Montana rural referral hospital.

Implications and Recommendations

The findings of this study have implications for nursing in a variety of settings, specifically in hospitals and community health agencies. The findings suggest further research is needed concerning alternative nursing models for delivering care.

The first implication of this study underscores the importance of assessing patient and health care provider perceptions and determining the relative congruence and/or incongruence of those perceptions. The research clearly showed that in the rural referral hospital which participated in this study there was a wide variance in the perceptions related to one clinical experience, a total knee or hip replacement surgery.

The second implication of this study relates to the verification of the conceptual issues which emerged from analysis. Further research is needed to expand, modify, verify, or refute the concepts presented in the analytic skeleton. As further research continues, it is hoped that a conceptual framework will be developed that would account for a wide variety of clinical phenomena that are related to the hospitalization experience. Research conducted with an inductive approach could use this study design for patients who have experienced other clinically relevant events, such as open-heart bypass surgery or an uncomplicated childbirth. Other patient populations then could be described in terms of their perceptions of these experiences. It is asserted that this research activity is most consistent with the mission of professional nursing to provide individualized care for a variety of patient groups.

The third implication of this study is the recognition of the need to focus attention on the differential impact which hospitalization for an acute health care episode has on the men and women, married or divorced or widowed, who become patients. Gender, marital status, and age were shown to be significant variables in the experience of total knee or hip replacement surgery. Further study of these variables within the context of an actual clinical experience is greatly needed.

The fourth implication of this study relates to the need to develop alternative models of discharge planning so that patients receive needed information at a time when it is most useful to them. Furthermore, the information should be

presented by those professionals who are in a position to make individualized assessments of patient perceptions and plan for their needs in a collaborative manner with the patient, family members, and other persons who provide informal support, as well as the other members of the discharge planning team, including the physician.

The fifth implication of the study is the recognition that quality of care issues are of growing importance as the length of stay in the hospital declines and patients are discharged with greater dependency and instability in their conditions. Research has found that family caregivers have experienced the effects of this change in health care policy which now advocates home care. The challenge to professional nursing is to protect the patient and his or her family from the negative incentives of the current system and to contribute to research that monitors the quality of life for both patients and their families. The consequences for family caregivers must be clearly determined through further research which includes rural and urban comparisons.

The sixth implication of this study relates to the need to develop discharge screening tools and to formalize assessment criteria in the discharge planning process. It is predicted that hospitals which approach the task of discharge planning without utilizing a formal system are at risk for conducting incomplete assessments. Furthermore, there is no mechanism in place for validating the effectiveness of planning and interventions. The assertion is made that the consequences of such nursing care directly affect patients and their families.

These effects should be given immediate attention within the profession of nursing.

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APPENDICES

APPENDIX A

DEMOGRAPHIC CHARACTERISTICS OF THE SAMPLE OF PATIENT INFORMANTS

Table 1. Demographic characteristics of patient informants in hospital interviews: Urban and rural comparison groups by gender and marital status (N=17).

	MEN		WOMEN		
	Married	Single	Married	Divorced	Widowed
Rural	4	1	1	2	2
Urban	2	--	1	1	3

COMPARATIVE GROUPS:		***GENDER:***		***MARITAL STATUS:***	
Rural	10	Men	7	Married	8
Urban	7	Women	10	Widowed	5
				Divorced	3
				Never Married	1

Table 2. Demographic characteristics of the sample of patient informants in hospital interviews (N=17).

AGE:		***LIVING SITUATION:***		***POST-OPERATIVE DAY OF FIRST INTERVIEW:***			
35-44	1	Lives w/spouse	8	Day 4			3
45-54	2	Lives alone	7	Day 5			6
55-64	4	Lives w/adult son	1	Day 6			5
65-74	7	Lives w/brother	1	Day 7			2
75-84	2			Day 8			1
Over 84	1	***INSURANCE:***					
		Medicare only	4				
INCOME:		Medicare & supplement	7	***OCCUPATION/ EMPLOYMENT:***			
Under $10,000	4	Workmen's Comp	3	Employed part-time			6
$10,000 to 20,000	9	Spouse's insurance	1	Rancher/farmer	3		
$20,000 to 30,000	4			Real estate agent	1		
		SIZE OF TOWN/CITY:		Nurse	1		
EDUCATIONAL LEVEL:		1 - 999	3	Store clerk	1		
High school	10	1000 - 1999	2	Retired			6
Vocational	1	2000 - 2999	1	Forest Service	1		
College 2 years	2	3000 - 3999	1	Social worker	1		
College 4 years	2	4000 - 4999	0	Refining operator	1		
Post-graduate	2	5000 - 5999	*3	Truck driver	1		
		6000 - 6999	1	Teacher	1		
RACE:		> 50,000	6	City worker	1		
Caucasian	16			Homemaker			2
Native American	1	***MILES FROM HOME TO HOSPITAL:***		Employed full-time			2
		0 - 49	7	Rancher	1		
SURGERY TYPE:		50 - 99	4	Bank employee	1		
Knee	9	100 - 149	2	Full-time student			1
Hip	8	150 - 199	1				
		200 - 249	1	***RURAL INFORMANT OCCUPATION:***			
REPLACEMENT SURGERIES:		250 - 299	0				
		300 - 349	1	Farm/ranch			4
First time	11	> 400	1	Non-farm/ranch			6
Two or more	6						

*One town was located within a Standard Metropolitan Statistical Area (SMSA).

APPENDIX B

DEMOGRAPHIC CHARACTERISTICS OF PATIENT INFORMANTS IN FOLLOW-UP INTERVIEWS

Table 3. Demographic characteristics of patient informants in follow-up interviews: Urban and rural comparison groups by gender and marital status (N=10).

	MEN	WOMEN		
	Married	Married	Divorced	Widowed
Rural	3	--	1	1
Urban	1	1	1	2

COMPARATIVE GROUPS:		***GENDER:***		***MARITAL STATUS:***	
Rural	5	Men	4	Married	5
Urban	5	Women	6	Widowed	3
				Divorced	2

Table 4. Demographic characteristics of patient informants in follow-up interviews (N=10).

AGE:		***RACE:***		***LIVING SITUATION:***	
45-54	1	Caucasian	10	Lives w/spouse	5
55-64	3			Lives alone	5
65-74	4	***SURGERY TYPE:***			
75-84	1	Knee	7	***MILES FROM HOME TO HOSPITAL:***	
Over 84	1	Hip	3	0 - 49	5
INCOME:				50 - 99	2
Under $10,000	3	***REPLACEMENT SURGERIES:***		100 - 149	1
$10,000 to 20,000	6			150 - 199	1
$20,000 to 30,000	1	First time	6	200 - 249	1
EDUCATIONAL LEVEL:		Two or more	4	250 - 299	0
				300 - 349	0
High school	7	***SIZE OF TOWN/CITY:***		> 400	0
Vocational	1				
College 2 years	1	1 - 999	1	***OCCUPATION/ EMPLOYMENT:***	
Post-graduate	1	1000 - 1999	2		
		2000 - 2999	1		
INSURANCE:		3000 - 3999	1	Employed full-time	5
		4000 - 4999	0	Retired	3
Medicare only	3	5000 - 5999	*1	Employed part-time	1
Medicare & supplement	5	6000 - 6999	0	Homemaker	1
Workmen's Comp	2	> 50,000	4		

*One town was located within a Standard Metropolitan Statistical Area (SMSA).

APPENDIX C

INTRODUCTORY STATEMENT

INTRODUCTORY STATEMENT

Dear :

My name is Allison McIntosh. I am a registered nurse and a graduate student at Montana State University. I am interested in finding out what patients think about being discharged from the hospital after a hip or a knee surgery. My research study will focus on the types of needs you may have after your surgery and how you will get the assistance you need. There are no right or wrong answers. If nurses know more about what patients think when they have gone through a surgery like yours, they can be more effective.

I would like to talk to you sometime before you are discharged. This conversation will take about 45 minutes. You may also be asked to take part in a second interview about four weeks after you have been at home. I can come to your home or meet with you in a place of your choosing. This conversation will take about an hour and you can tell me how things are going for you after you have been at home for awhile.

Any information you give me is confidential and your name or town will not be used in any way in the study. Whether you participate or not will not affect the health care you receive now or in the future. This is voluntary on your part and you need not feel obligated to participate.

I would like to tape record our conversation because what you say is very valuable to this study. After the study is done, I will destroy the recording. Your name, town, and other identifying information will be stored in a locked file and kept separate from the information you give me. This will provide confidentiality, and your answers will not be traced to you individually.

If you agree to participate in the study, I have a consent form I would like you to sign. You can withdraw from the study at any time -- even after you sign the form. I will give the tape back to you or destroy it if you choose to withdraw from the study. Do you have any questions?

(The consent form was read if the patient showed interest in participating.)

APPENDIX D

CONSENT FORM FOR

PATIENT INFORMANTS

CONSENT FORM FOR PATIENT INFORMANTS

The purpose of this study is to explore the thoughts, perceptions, and feelings patients have about the source of assistance they receive after a hip or knee surgery.

You will be asked questions in one or at most two interviews. The first interview will take place before you are discharged from the hospital. This conversation will take about 45 minutes. You may also be asked to take part in a second interview about four weeks after you have been at home. This interview will take about one hour. I can travel to your home or meet with you in a place of your choosing.

There are no right or wrong answers in this study. I will not pass judgment on what you tell me. This is voluntary on your part and there is no risk in participating. If you do feel uncomfortable during the interview, you are free to not answer certain questions or end the interview at any time. Whether you participate or not will not affect the health care you receive now or in the future. You need not feel obligated to participate.

Your participation in this study will assist nurses in planning care for hip and knee surgery patients. The information you provide will add to the knowledge nurses have about patients in Montana.

All information that you provide will be kept confidential. This includes any information you share with me about your hospital stay or the care you have received.

The information will be used in a written report (thesis), but your answers will not be connected with your name, your town, or any other identifying information. The tape recording and other paperwork used in this research will not have your name, town, or other identifying information connected to it. After the study is completed, the tape recording and all other paperwork which has identifying information will be destroyed.

Your cooperation, time, and interest are greatly appreciated. By signing this form you indicate your voluntary consent to participate and agree you have been informed about the study.

_____

(Signature)

If you have questions regarding this study, feel free to contact me at any time. Thank you.

Allison McIntosh, R.N.
285-3769 -- Three Forks, residence (Call collect.)
994-3783 -- Bozeman, Montana State University, College of Nursing
(Leave message and I will return your call.)

APPENDIX E

FIRST INTERVIEW GUIDE FOR PATIENT INFORMANTS

FIRST INTERVIEW GUIDE FOR PATIENT INFORMANTS

INFORMANT	PHONE
NAME	SURGERY DATE
ADDRESS	SURGERY TYPE
	DATE OF INTERVIEW

I. DEMOGRAPHIC DATA

A. Age: _____

B. Sex: [ ] Male [ ] Female

C. Ethnicity/Race:

[ ] (1) Caucasian
[ ] (2) Black
[ ] (3) Asian
[ ] (4) Hispanic
[ ] (5) Native American
[ ] (6) Other: _____

D. Religion:

[ ] (1) Protestant
[ ] (2) Catholic
[ ] (3) Other Christian
[ ] (4) Jewish
[ ] (5) Islam
[ ] (6) Other: _____

E. Occupation:

[ ] (1) Retired How long?_____ Main work was_____
[ ] (2) Employed full time as_____
[ ] (3) Unemployed
[ ] (4) Employed part-time as_____

FIRST INTERVIEW GUIDE FOR PATIENT INFORMANTS (CONT'D.)

F. Annual Income:

[ ] (1) Under $10,000
[ ] (2) $10,000 - 20,000
[ ] (3) $20,000 - 30,000
[ ] (4) $30,000 - 40,000
[ ] (5) Over $40,000

G. Insurance:

[ ] (1) Medicare
[ ] (2) Supplemental to Medicare
[ ] (3) Other: _____

H. Education:

[ ] (1) No formal education
[ ] (2) Grades 1-8
[ ] (3) High School
[ ] (4) VoTech
[ ] (5) College No. Years_____
[ ] (6) Graduate School
[ ] (7) Other: _____

I. Marital Status:

[ ] (1) Never married
[ ] (2) Living w/spouse
[ ] (3) Widowed
[ ] (4) Separated
[ ] (5) Divorced

J. Home Situation (Who lives in the home):

[ ] (1) Spouse
[ ] (2) Child
[ ] (3) Sibling
[ ] (4) Other relative: _____
[ ] (5) Other person: _____
[ ] (6) Live alone

FIRST INTERVIEW GUIDE FOR PATIENT INFORMANTS (CONT'D.)

K. Number of Previous Hospital Admissions:

Number of times here: _____
Elsewhere: _____

L. Town:

Size: _____
Distance from home if not in town: _____
Distance of home from the hospital: _____

II. INTERVIEW QUESTIONS

A. Have you been hospitalized in the past?

When?

What was(were) this(these) hospitalization(s) for?

- Did you receive assistance from any community agencies (i.e., home health services, homemaker services, physical therapy)?
- Did you receive assistance from any friends or neighbors?
- Did you receive assistance from family?

Tell me about these.

B. What are your concerns about being discharged in the next several days?

Tell me about your plans for managing yourself at home.

- Will you receive assistance from professionals (i.e., nurses, physical therapists, etc.)? *Tell me about this.*
- What other assistance is available in your community (i.e., Meals on Wheels, Senior Transportation)?
- Will you receive assistance from friends or neighbors? *Tell me about this.*
- Will you receive assistance from your family? *Tell me about this.*

FIRST INTERVIEW GUIDE FOR PATIENT INFORMANTS (CONT'D.)

- Who do you think will help you the most?
- How often do you expect someone to be with you or check in on you?
- Do you expect to need assistance with (if "Yes," ask about details of who will provide):
  - Cooking
  - Shopping
  - Driving (social events, appointments, errands)
  - Bathing
  - After-surgery exercises
  - Housework
  - Home maintenance
  - Business/farm/ranch affairs (as appropriate)
  - Other
- If something unexpected comes up concerning your health, whom would you call?
- How long has this surgery been planned?
- Tell me what things you did to plan for your recovery time.
- Describe what you expect to be able to do in one month . . . , in six months . . . ?
- When do you think you will be able to resume all of your normal activities?
- Tell me about any other concerns you may have about returning home, the surgery, or the recovery period.

APPENDIX F

CONSENT FORM FOR

DISCHARGE PLANNERS

CONSENT FORM FOR DISCHARGE PLANNERS

The purpose of this study is to explore the thoughts, perceptions, and feelings patients have about the source of assistance they receive after a total hip or knee surgery. The study will focus on rural and urban comparisons in Montana. Since you as a discharge planner have clinical expertise in this area, I am seeking your consent to participate in this study. Your input will enrich the interpretation of my study findings.

Please review the list of 10 questions I have developed for discharge planners (a copy of Appendix G is provided). I plan to interview 16 post-surgical patients and would like to interview you briefly (3-10 minutes) about each patient included in the study using these questions. The study will be conducted in the hospital over a four to six week period. We can mutually agree on convenient meeting times. At no time will the researcher take part in actual discharge planning for patients.

These interviews will be tape recorded. Your name and the name of the patient will not be connected with this information. The data will be summarized in a thesis which will follow this study; however, your name and the names of the hospital and the patients will not be reported to protect your identity and ensure confidentiality.

There are no identified risks in participating and this is voluntary on your part. If you do feel uncomfortable answering certain questions, you may stop an interview at any time. You may also refuse to participate in future interviews. Whether you participate or not will be confidential and will not be reported to any of your supervisors or other hospital personnel.

You may review the entire thesis proposal prior to this study if you have further questions or concerns. Your cooperation, time, and interest are greatly appreciated. By signing this form you indicate your voluntary consent to participate and agree you have been informed about the study.

_____

(Signature)

If you have questions regarding this study, feel free to contact me at any time. Thank you.

Allison McIntosh, R.N.
285-3769 -- Three Forks, residence (Call collect.)
994-3783 -- Bozeman, Montana State University, College of Nursing
(Leave message and I will return your call.)

APPENDIX G

INTERVIEW GUIDE FOR

DISCHARGE PLANNERS

INTERVIEW GUIDE FOR DISCHARGE PLANNERS

INFORMANT_____

(1) What needs do you think client "X" will have on discharge?

(2) What community resources are available to client "X"?

(3) Do you think the client will utilize these resources?

(4) What family resources are available to client "X"?

(5) What assistance could be provided from neighbors and friends?

(6) How effective do you feel these informal resources will be?

(7) Does the client have strengths or weaknesses in his/her coping pattern that might influence how well they do after discharge?

(8) Compared to other clients you have worked with, has the discharge planning required more, less, or an average amount of time for client "X"?

(9) How well do you think this client will do after discharge?

(10) Is there anything else you can tell me about this client to make my follow-up visit (in 4 weeks) more meaningful?

APPENDIX H

FOLLOW-UP INTERVIEW GUIDE

FOR PATIENT INFORMANTS

FOLLOW-UP INTERVIEW GUIDE FOR PATIENT INFORMANTS

(1) Tell me how the last four weeks have been for you since your discharge from the hospital.

(2) Tell me about the kind of assistance you received from:

- Professionals
- Your community
- Friends and neighbors
- Family

(3) Is there anything you think you could have used more help with?

(4) What was the most helpful?

(5) How often did someone stay with you or check in on you?

(6) Has anything unexpected happened in the last month? Tell me about it.

(7) What assistance did you need with (ask about who provided it):

- Cooking
- Shopping
- Driving (social events, appointments, errands)
- Bathing
- After-surgery exercises
- Housework
- Home maintenance
- Business/farm/ranch affairs (as appropriate)
- Other

(8) In what ways was the hospital effective in planning for your recovery?

(9) Tell me about things you think would have been helpful to plan for your return home.

(10) Tell me about any other concerns you have had since you returned home.

APPENDIX I

APPROVAL FORM: HUMAN SUBJECTS REVIEW COMMITTEE

MONTANA STATE UNIVERSITY
COLLEGE OF NURSING

UNIVERSITY HUMAN SUBJECTS COMMITTEE SUMMARY

Name of Proposal: Perceptions of Available Assistance to Patients Following Total Hip and Knee Joint Surgery: A Rural-Urban Comparison in Montana

Name of Investigator(s): Allison M. McIntosh
Check one: [ ] undergraduate student(s) [✓] graduate student(s) [ ] faculty member(s)

Faculty Advisor (if student research): Jan Buehler (Chair)

Date of College of Nursing Review: March 14, 1990

Reviewed by:
(List all College of Nursing reviewers involved by names and type of committee, e.g., J. Doe, Great Falls Extended Campus Committee.)

APPROVED: M Prawdzienski — M. Prawdzienski, Bozeman Campus Committee

APPROVED: K Tkach — K. Tkach, Ed Director, Bozeman Campus

Brief Description of Subjects (age, sex, health status, etc.)
Subjects will be 16 hospitalized patients who have undergone an uncomplicated (see p. 17) total knee or hip joint surgery. Their ages will be 65 years and older. Subjects will be alert; oriented to person, place, and time; and will speak and understand the English language. The discharge planners (nurse and social worker) are also considered subjects.

Brief Description of Procedure (what is to be asked of or done to subjects)
Subjects are to be asked questions about sources of support/assistance following knee or hip surgery. Sixteen consenting hospital patients will have been read the Introductory Statement (Appendix A), signed the Consent Form (Appendix B), and then interviewed using an interview guide developed by the researcher (Appendix D) several days prior to their discharge to home. Some of the demographic data will be obtained from the patient chart. Discharge planners will be briefly interviewed prior to the involved subjects' discharge (Appendix E). All surgical participants will receive a follow-up letter (Appendix F). Ten consenting participants (of the original 16) will be interviewed approximately 4 weeks later in their homes or at a mutually agreed upon location. All identifying information will be kept separate from transcribed data.

UNIVERSITY HUMAN SUBJECTS COMMITTEE SUMMARY
Page 2

[✓] Exempt Under Federal Reg. 45 CFR 46

46.101(2)(b) (3)

(Insert number and letter as appropriate)

[ ] Not Exempt Under Federal Reg. 45 CFR 46

**Proposal sent to University Human Subjects Committee for review by College of Nursing Dean on* _____

Notes: Distribution of this form:

Original: Investigator(s)

Copies: Extended Campus Human Subjects Committee File
College of Nursing Human Subjects Review File in Bozeman
University Human Subjects Committee through College of Nursing Assistant Dean's Office

APPENDIX J

COPY OF LETTER OF APPROVAL FROM PARTICIPATING HOSPITAL

COPY OF LETTER OF APPROVAL FROM PARTICIPATING HOSPITAL

Enclosed in this packet is a copy of the research proposal, "Perceptions of Available Assistance to Patients Following Total Hip or Knee Joint Surgery: A Rural-Urban Comparison in Montana." This thesis proposal is for partial fulfillment of the Master in Nursing degree at Montana State University. Please consider my request for permission to conduct this study at _____ (facility).

As described in detail in the proposal, I am requesting permission to interview approximately 16 patients who have undergone an uncomplicated total hip or knee joint surgery several days prior to their hospital discharge to home. I also request permission to briefly interview the discharge planners and orthopedic unit nurses involved in discharge planning regarding their perceptions of the types of assistance (both formal and informal) available to each surgical patient. It would be helpful if I could attend the discharge planning conferences held on Monday mornings during the weeks of data collection. I also wish to briefly review the charts of those patients who agree to participate in this study. I plan to approach the discharge planners and patient informants individually, as outlined in the proposal, to seek their consents.

This proposal has been approved by both the faculty at the Montana State University College of Nursing and the University Human Subjects Review Committee. Confidentiality will be assured for the patients, the discharge planners, the orthopedic nurses, doctors,and other caregivers, as well as your facility. You need not feel obligated to participate and your consent should be voluntary. Please review the proposal and contact me if you have any questions. You have the right to withdraw the participation of the orthopedic unit at any time and you will not be asked to provide any reason. If you agree to involve the orthopedic unit and feel informed about the study and your right to withdraw at any time, could you please sign below? Thank you.

☆ ☆ ☆ ☆ ☆

This is proof of consent for Allison McIntosh to conduct her thesis study, "Perceptions of Available Assistance to Patients Following Total Hip or Knee Joint Surgery: A Rural-Urban Comparison in Montana," at _____. We have granted her permission to interview patients, interview discharge planners and nursing unit supervisors, and to view the charts of patients that are included in the study. She may also attend the discharge planning conferences held on Monday mornings during the weeks of data collection.

_____ _____

Signature/Title *Date*

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