



What are the attitudes of nurses employed by small, rural hospitals toward discharge planning?
by Dianna Lee Spies Sorenson

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Nursing
Montana State University

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Abstract:

Discharge planning is considered to be a part of professional nursing practice; however, no scientific investigations have been done to examine discharge planning in rural settings or nurses' attitudes toward discharge planning. Therefore, a descriptive-exploratory study was designed to answer the question, "What are the attitudes of nurses employed in small, rural hospitals toward discharge planning?". The conceptual framework, provided by attitude theories, was focused on the relationships between attitudes and behavior.

A 30 item, five-point Likert scale questionnaire was adapted to elicit responses to specific attitudinal information related to discharge planning. Validity was addressed by a panel of faculty and graduate students, prior to a pilot testing of the questionnaire.

Forty nurses employed at least part-time on medical-surgical units participated. Hospitals from three states were used to address reliability. Data were analyzed as a total sample after determining homogeneity. Descriptive statistical measurements, including numbers, means, S.D., percentages, and cross-tabulations, were used to summarize the data. This analysis was not intended to test hypotheses.

Demographically, this sample was different from national descriptions of nurses. Based on responses to the questionnaire, the nurses demonstrated a slightly favorable attitude toward discharge planning (mean score > 3). Areas influencing attitude were number of days worked per week, number of years as an R.N., educational preparation, and source of information. Because the sample was small and it is not known how representative the attitudes of nurses in this study are of all nurses employed in rural areas, broad generalizations beyond the population examined should not be made. Implications of investigation for nursing indicate a need for (a) well-written, practical discharge information which is specific to rural areas; (b) discharge planning inservices which incorporate peer interaction; (c) orienting nurses to policies and procedures; and (d) examining nurses' educational preparation to determine their knowledge of discharge planning.

WHAT ARE THE ATTITUDES OF NURSES EMPLOYED BY SMALL,
RURAL HOSPITALS TOWARD DISCHARGE PLANNING?

by

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of the requirements for the degree

of

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APPROVAL

of a thesis submitted by

Dianna Lee (Spies) Sorenson

This thesis has been read by each member of the thesis 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

Discharge planning is considered to be a part of professional nursing practice; however, no scientific investigations have been done to examine discharge planning in rural settings or nurses' attitudes toward discharge planning. Therefore, a descriptive-exploratory study was designed to answer the question, "What are the attitudes of nurses employed in small, rural hospitals toward discharge planning?". The conceptual framework, provided by attitude theories, was focused on the relationships between attitudes and behavior.

A 30 item, five-point Likert scale questionnaire was adapted to elicit responses to specific attitudinal information related to discharge planning. Validity was addressed by a panel of faculty and graduate students, prior to a pilot testing of the questionnaire. Forty nurses employed at least part-time on medical-surgical units participated. Hospitals from three states were used to address reliability. Data were analyzed as a total sample after determining homogeneity. Descriptive statistical measurements, including numbers, means, S.D., percentages, and cross-tabulations, were used to summarize the data. This analysis was not intended to test hypotheses.

Demographically, this sample was different from national descriptions of nurses. Based on responses to the questionnaire, the nurses demonstrated a slightly favorable attitude toward discharge planning (mean score > 3). Areas influencing attitude were number of days worked per week, number of years as an R.N., educational preparation, and source of information. Because the sample was small and it is not known how representative the attitudes of nurses in this study are of all nurses employed in rural areas, broad generalizations beyond the population examined should not be made. Implications of investigation for nursing indicate a need for (a) well-written, practical discharge information which is specific to rural areas; (b) discharge planning inservices which incorporate peer interaction; (c) orienting nurses to policies and procedures; and (d) examining nurses' educational preparation to determine their knowledge of discharge planning.

CHAPTER 1

INTRODUCTION

The Problem

Discharge planning, a companion to continuity of care, is composed of many nursing activities. Ideally, discharge planning lessens the chance of readmission, reduces patient care costs, and shortens hospital stays, while holistically considering the patient and significant others' needs. Because the degree to which discharge planning is carried out varies with the individual and agency, discharge planning is of special interest to practitioners of nursing.

The writer first became interested in the problems of discharge planning while working as a charge nurse in a rural community in Colorado. The small community hospital was typical of most area hospitals; there was no medical social worker on staff, and access to other health resources, such as the Public Health Department, was limited. The Director of Nursing at that time informed the nurses they were to include a summary statement of their discharge planning efforts in the medical record, in order to comply with the Joint Commission of Accreditation of Hospital's standards for care. While some nurses, from an observational viewpoint, were doing discharge planning activities, most failed to record those activities in the medical record. Many other nurses flatly refused to do discharge

planning, stating they were "too busy" or claimed they "did not know how to do it". The writer has often questioned the effect such negative attitudes had with respect to the performance of discharge planning.

Little scientific investigation has been done to determine the reason for the omission of discharge planning or the recording thereof though contributing factors have been suggested. Those factors include staff shortages and turnover (Brown, 1980), lack of role definition (White, 1972), educational preparation (Hicks & Ashley, 1976), and insufficient administrative support (Reichelt & Newcomb, 1980). One thread weaving those factors together may be nurses' attitudes toward discharge planning. Basic as it may seem, a positive attitude toward discharge planning may transcend the barriers resisting its completion.

Statement of the Problem

Rural hospitals comprised 49.4 percent of all the United States hospitals in 1979, treating one-quarter of the total population admitted to hospitals (Rosenblatt & Moscovice, 1982). Generally, little has been published about the nurses employed in the rural setting. Additionally, no studies have been found which examine nurses' attitudes toward discharge planning. Therefore, the problem this study is designed to answer is: What are the attitudes of registered nurses employed in small, rural hospitals toward discharge planning?

Statement of Purpose

Discharge planning is considered to be an integral part of professional nursing practice: The purpose of this study is to examine the attitudes of professional nurses employed in small hospitals toward discharge planning. Additionally, the study is a preliminary step toward determining whether attitude has an effect on discharge planning performance.

Significance to Nursing

Theorist J. Fawcett (1980) asserts that nursing independence and recognition can emerge only when nurses can identify a "distinct body of knowledge about the individuals, groups, situations, and events of interest to nursing" (p. 36). Therefore nursing practice must be based on professional knowledge and validated by scientific research. This study is important to nursing because a void occurs in the nursing literature: No scientific studies addressing nursing attitudes toward discharge planning exist. Nurses' attitudes are of interest because of their potential influence on discharge planning behaviors.

Because almost half of the nation's hospitals are located in rural areas, rural hospital nurses are of special interest. Prior experience and multiple interviews with Directors of Nursing (Merchant, 1982; Schreffler, 1982, Ver Steg, 1982) and an Inservice Director (Motsay, 1982) indicate that nurses who work in rural hospitals are often required to work in many or all nursing departments. These observations are supported by editors Rosenblatt and Moscovice (1982)

who also suggest that the diversity and complexity of tasks lead to the growing difficulty in obtaining and recruiting nurses to rural areas. These editors point out the growing maldistribution of nursing manpower, as nursing personnel are underrepresented in rural areas. Because of the uniqueness of setting and shortages of nursing personnel, nurses employed by rural hospitals are an important population to study.

A descriptive study examining the attitudinal characteristics of rural hospital nurses toward discharge planning will provide the basis for future research necessary to support the growing body of professional nursing knowledge. The following chapter provides the basis in the literature and conceptual framework for the study.

CHAPTER 2

REVIEW OF THE LITERATURE

Introduction

Discharge planning stems from concern over patients' well-being after discharge from the hospital setting (Phillips & Larkin, 1972). A number of interrelated activities are involved to provide adequate discharge planning. These activities are performed by many different health care providers; however, for the purpose of this study, the literature review is focused on the nursing aspect of discharge planning. Although discharge planning is recognized by nurses as a nursing responsibility, much of the nursing discharge planning literature is vaguely constructed, anecdotal, or speculative in nature. Furthermore, no published studies dealing with the nurses' attitudes toward the discharge planning process have been found.

Topics addressed in this literature review are: (a) the importance of discharge planning; (b) consequences of inadequate discharge planning; (c) discharge planning characteristics; (d) multidisciplinary discharge planning; (e) the nursing role in discharge planning; (f) conceptual framework; and (g) definition of terms.

The Importance of Discharge Planning

Discharge planning is a complex process composed of interrelated activities designed to meet patients' post-hospitalization needs. The importance of planning for post-hospitalization needs has long been recognized. In 1913 Cannon (cited in Davidson, 1978) pointed out that a patient leaving hospital care too soon or without adequate convalescent plans risked "grievous results of an incomplete recovery" (p. 44).

In a descriptive report of a continuing care program, LaMontagne and McKeehan (1975) state that discharge planning begins in the hospital. Additionally, Snyder (1978) discussed the importance futuristic goal setting has for meeting individual needs, and Isler (1975), addressed the need for continued care into the community after discharge. The need for discharge planning may arise from patients' disease processes, diagnostic procedures, medical regimens, or home environments (Cullinan, 1980; Husower, Gamberg, & Smith, 1978). Compounding these elements are patients' perceptions of illness which may affect the ability to cope with: (a) an altered body image (Brown, 1980), (b) functional changes (Brown, 1980; Stegal, 1977), (c) changes in family or social roles (Beaudry, 1975; Brown, 1980), (d) financial adversity (Brown, 1980; Kurtz, 1982), and/or (e) the uncertainty of treatment outcomes (Brown, 1980).

Discharge from the hospital setting disrupts the patient's ability to cope with illness by creating a shift from a dependent role to an independent role where patients must assume responsibility for their own care at home (Castledine, 1979; Gonnerman, 1969; Lewis & Roberts,

1976). Though the home environment does allow for comfort, convenience, and personal pride (Beaudry, 1979), it may also pose a multitude of problems to the recuperating patient, who has a reduced functional level (Brown, 1980). Castledine (1979), a lecturer at Manchester University in London, England, states that the transitions from hospital to home, and dependent to independent roles require a readaptation period which potentially creates hardship for the patient and/or significant others. Discharge planning identifies and meets those transitional needs by matching the patient's former and present coping mechanisms with available resources and support systems (Brown, 1980; Harvey, 1981; Hushower, et al., 1978).

Our culture traditionally accepts only a brief convalescent period between hospitalization and the resumption of accustomed or usual level of functioning. This tradition affects recovery by not providing assistance for those patients needing an extended recovery period (Fields, 1978; Lewis, et al., 1976).

Health Care Costs

Third party payment agencies, including the federal government and private insurance companies, have identified discharge planning as a means of reducing health care costs by shortening hospital stay, assuring appropriate resource utilization, and lessening the chance of readmission (Beaudry, 1975). Additionally, Isler (1975) claims that discharge planning reduces discharge delays and improves outpatient care.

B. Phillips (1972) exerts, from a social work perspective, that exorbitant health care costs are nationally significant, since they are not just a problem for the poor. Therefore, discharge planning is of relative importance to all patients. Concern over cost containment has created a number of new regulatory agencies, organizations, and committees because over 90 percent of consumer hospital bills are paid through third party payment agencies (Foster & Brown, 1978). Among the regulatory groups identified by one research team are utilization review boards, the Professional Standards Review Organization, quality assurance committees, and professional audit groups (Reichelt & Newcomb, 1980). All of those groups require the examination of health care delivery. Even legislative action, indicated in the Medicare and Medicaid bills, address the relationships among health care quality, accessibility and costs (McKeehan, 1979; Social Security Agency, 1982). However, after a survey of organizational factors in discharge planning, Reichelt, et al. (1980) state that regulatory functions have focused on hospital services documented in the medical record without regard to post-hospital services or follow-up. Therefore, regulatory groups neglect to comprehensively evaluate patient care delivery. The need for comprehensive evaluation of patient care delivery is not a new idea. Ferguson and MacPhail (cited in MacDonald & Ross, 1981) observed in 1954 that "what happens to a patient after he leaves the hospital may be of as much importance to him -- and to the community -- as what happens while he is still a patient in the hospital" (p. 615).

Length of Hospitalization

There is a nationwide trend toward shorter hospitalizations (Mezzanotte, 1980). Third party payment agencies are encouraging shorter hospital stays by placing pressure on hospital personnel and physicians to discharge patients after their acute care needs are met (LaMontagne, et al., 1975). Additionally, the broad range of health care coverage now available offers more alternatives to hospital care than ever before (Connolly, 1981). Some of the alternatives presently addressed in the literature are home health care, adult day care, and hospice (Steffl & Eide, 1978). Discharge planning also serves to shorten the length of hospitalization by reducing delays incurred during discharge (Isler, 1975).

Cucuzzo (1976) identified early referrals as an important aspect of discharge planning necessary to facilitate timely discharges. This idea was supported by a team of social workers (Schrager, Halman, Myers, Nichols, & Rosenblum, 1978), whose study of 29 patients, ages 51 to 85 years, presented evidence that earlier referrals by nurses, physicians, and interns to the social work department resulted in shortened hospitalizations. However, these researchers did caution that "one cannot infer a direct cause and effect relationship" (p. 13) between early referral to the social work department and a shortened hospitalization.

Resource Utilization

Resource identification and utilization were identified as important aspects of discharge planning by nursing administrators in

the Group Health Cooperative of Puget Sound in Seattle, Washington. (Brown, 1980). Discharge planning identifies patients' post-hospitalization needs and matches those needs with appropriate resources (Hushower, et al., 1978). Good communication networks among health care providers, established through discharge planning, enhance early referral and health care utilization by reducing fragmentation and duplication of services (Brown, 1980).

Readmission

Lessening the chance of readmission is another discharge planning function. Britton, Lambe, Madonna, Sharkey, and Wasczak (1980) used case studies to observe the positive effect discharge planning had in reducing unnecessary readmissions. Ulrich and Kelly (1972) added to that observation, saying that patients are often repeatedly hospitalized for the same conditions because they do not know how to care for themselves.

Consequences of Inadequate Discharge Planning

Inadequately assessed and planned discharges may result in a multitude of consequences for the patient, health care providers, and significant others. Some of the consequences are: (a) unnecessary hospital stay (Krell, 1977; Reichelt, et al., 1980); (b) rehospitalization (Britton, et al., 1980; Lewis & Roberts, 1976; Reichelt, et al., 1980); (c) additional hospital expenses; (d) wasted resources; and ultimately (e) a diminished life quality (Reichelt, et al., 1980). Less obvious consequences may also be experienced. Among those less

obvious consequences observed are: (a) personal trauma (Lewis, et al., 1976); (b) role change (Syred, 1981); (c) physical and emotional hardships; (d) adaptation problems; and (e) rehabilitation loss or relapse (Reichelt, et al., 1980).

The consequences of inadequate discharge planning rest not only with the patient, but extend to significant others. In working with families of mentally ill patients, Leavitt (1975) found that families who were unprepared for the patient's discharge continued to "demonstrate a tremendous uncertainty and lack of direction about the future: the possibility of recurrence, the recognition of symptoms, what to do, and how to get help" (p. 38). Personal experience suggests this pattern is not limited to mentally ill patients, but may be generalized to medical-surgical patients as well.

Discharge Planning Characteristics

Successful discharge planning characteristics described in the literature are varied in type and scope. Recurring topics are presented in this section and include general discharge planning characteristics, communication, significant others, education, timing, and culture.

General Characteristics

The scope of discharge planning is changing because there are declining lengths of hospital stays, increasing numbers of people with chronic health care needs (Lindenberg & Coulton, 1980), and more alternatives to health care (Connolly, 1981). Furthermore, the

concept of holistic health care, involving the "total" patient by identifying economic, psychologic, and social needs in addition to medically treated physical needs, has further served to broaden the scope of discharge planning. Health care providers are now holistically assessing the impact health and illness have on patients and their relationships (Phillips, B., 1972). Mezzanotte (1980), assistant professor at the University of Wisconsin School of Nursing, claims that all patients need discharge planning, even if the hospitalization period is short, and the patient appears to be adjusting and recovering well, without complaints or complications.

Communication

Communication is essential to discharge planning (McKeehan, 1972) because it provides the patient and significant others an active part in decision-making (Brown, 1980). Communication is so essential that LaMontagne, et al. (1975) assert that discharge planning is only as good as the quality of communication. Phillips and Larkin (1972) suggest that communication failures, lack of staff coordination, and inappropriate advice, due to unanticipated home circumstances, lead to patient difficulties in following medication instructions, diets, and appointments. Furthermore, Huey (1981) noted that readmissions are frequently caused by misunderstandings among patients, hospital nurses, and/or community agency personnel. The need for clearly communicated discharge instructions has prompted many hospitals to devise

written discharge instruction sheets (Burkey, 1979; Huey, 1981; Mezzanotte, 1980; Phillips & Larkin, 1972).

Communication networks provide a means of feedback which can be used for monitoring care quality, promoting personal satisfaction (Reichelt, et al., 1980), and increasing the awareness of resources available (Broomfield, 1979). Additionally, communication among health care providers and between the individual health care provider and patient is essential in order to reduce fragmentation and avoid duplication of services (Brown, 1980). Informal communication about patients and their post-hospitalization needs can lead to gaps in discharge planning (Reichelt, et al., 1980). Hence, formal discharge planning, which includes written communication, is necessary to provide continuity of care (Brown, 1980) and achieve effective interdisciplinary discharge planning (Frenwick, 1979). Many nurses agree that written discharge plans are not only a communication means, but also provide a record which documents that communication (McKeehan, 1979; Reichelt, et al., 1980; Reilly, 1979; Steagal, 1977). The medical record is the primary vehicle for discharge communication (Reichelt, et al., 1980), and provides compliance with the Joint Commission of Accreditation of Hospital's standards for care (J.C.A.H., 1981).

Significant Others

The literature presents supportive evidence which emphasizes the inclusion of family and friends (referred to as significant others) in discharge planning (Brown, 1980; Habeeb, et al., 1979; Snyder, 1978). A social work study on planning for post-hospital care by Lindenberg

and Coulton (1980) found that family and friends provided a large percentage of the patient's post-hospital needs. They also suggested that significant others become service providers because of a lack of community services. A resulting complication is that family functions may be altered when a family member assumes the role of service provider. B. Phillip (1972) also emphasizes family relationships, maintaining that they should be considered when assessing a patient's psychosocial needs. Nurse researchers (Habeeb, et al., 1979) expanded on the importance of the family relationship, stating that both family and friends can provide input necessary to assess the patient's way of coping with illness. In an editorial, Fields (1978) identified the ways families can affect post-hospitalization care. These impacts occur when: (a) the family is unwilling or unable to care for the patient after discharge; (b) the family is already burdened and consequently the additional stress of caring for the ill person places the family at risk for illness or disease; (c) the patient, family, and health care providers have conflicting needs; (d) interpersonal relationship problems among family members arise; and/or (e) there are limited family resources. Experience suggests that significant others can have impacts similar to those of family members on a patient's post-hospital care.

Education

Discharge planning, designed to prepare the patient for home care, is achieved "primarily through teaching activities which promote optimal health restoration and adaptation to the residual effects of

illness" (Pender, 1974, p. 263). According to Richards (1975), the purpose of education is to inform, educate, or reassure the patient. Education is, therefore, compulsory to provide continuity of care (Meisenheimer, 1980). Meisenheimer (1980) further asserts that all patients, regardless of diagnosis or length of hospitalization need individualized teaching to meet their personal learning needs. The amount of education required depends on: (a) the degree of illness or health, (b) expected care outcomes, (c) types of services required, (d) complications, and (e) available resources (Hushower, et al., 1978).

Simonds (1967) reported that the number of hospital readmissions was reduced when discharge planning for congestive heart failure patients included a continuing education program which was followed after hospital discharge. Pender (1974) conducted interviews with 138 medical-surgical patients and found that 58 percent "reported a need for more information before discharge on how to care for themselves at home, the effect of illness on daily living habits, possible complications of the present illness, and prevention of future illness" (p. 263). Conflicting with Pender's (1974) report is a study by Johnson and Pachano (1981). These nurses questioned 37 nurses and 82 patients from medical, surgical, psychiatric, obstetric, pediatric, and chemical dependency units. They found that 56 percent of the nurses felt the patients needed to know more about their illnesses and treatments, while only 16 percent of the patients expressed such a need. The conflicting results of these studies may be due to differences in methodology and a serious problem Johnson, et al. (1981) had with questionnaire returns. Interviews are more likely to produce information from

respondents than questionnaires, which are likely to have a low return rate (Treece & Treece, 1977). However, one cannot totally discount the disparity between the nurse and patient responses, since nurse and patient perceptions may be significantly different.

Timing

The day of discharge is often accompanied by a flurry of activities, which is compounded by the stress of fear and excitement (Brown, 1980). Because stress interferes with learning, discharge instructions may be satisfactorily given by the nurse on the day of discharge, but are unassimilated by the patient. Therefore, the patient may be discharged without information vital to a continued recovery (Mezzanotte, 1980).

It is agreed upon in the literature that discharge planning should begin at the time a patient is admitted to the hospital (Brown, 1980; Cullinan, 1980; Isler, 1975; LaMontagne, et al., 1975; McKeehan, 1979). This stems from: (a) the time needed to adequately prepare the patient for self-care activities (Britton, et al., 1980), and (b) less time available to prepare the patient for self-care activities, due to the declining number of hospitalization days (Connolly, 1981). Preparing the patient early prevents an unprepared discharge, should recovery be quicker than expected, or community resources become available for use (Mezzonette, 1980). However, in a survey by Johnson, et al. (1981) 100 percent of all patient and nurse participants felt that discharge planning was satisfactorily executed, even though the nurses felt it was initiated during the final one-third of a patient's hospital stay,

and patients thought it occurred the day of discharge. This study did not describe the discharge planning techniques or procedures used to prepare the patient, and the reader questioned whether the patients knew what activities comprise discharge planning.

Culture

Habeeb, et al. (1979) state that the patient making the transition between the health care setting and home brings with him a set of cultural elements which include personal habits, personality traits, and accumulated life experiences. Furthermore, cultural elements are described in an article written by a nurse educator on the abdication of the role of health education by hospital nurses (Syred, 1981). This article discusses the effect culture has on the patient's ability to respond to symptoms of mental and physical illness, thereby influencing health education needs and discharge planning.

Phillips and Larkin (1972), supporters of a staff education program on a continuing care unit, observed that patient needs may not be met because cultural differences between the patient and health care provider may block effective communication. Orlando (1961), a nurse editor, claims that in order to ascertain patient needs, the nurse must help patients express the specific meaning of their behavioral responses. Furthermore, advice given in the hospital may not be possible or easy to follow in different cultural settings, due to economic, social, or environmental differences. Examples of cultural misunderstandings were cited by Harvey (1981). She stated that grave misunderstandings may be created as the patient attempts to modify instructions

given in the hospital to an altered environmental context after discharge. This supports Syred's (1981) claim that compliance with the treatment plan can be enhanced if the patient's cultural background is considered during health education.

Multidisciplinary Discharge Planning

Hushower, et al. (1978) stress that all professional health care providers coming into contact with the patient (including social workers, formal discharge planners, doctors, and nurses) should participate in the discharge planning process. Multidisciplinary discharge planning has been shown to provide a smoother transition between the hospital and home, and reduce the number of hospital readmissions (Cucuzzo, 1979; Huey, 1981; LaMontagne, 1975; Phillips & Larkin, 1972). This writer acknowledges the importance and effectiveness of a multidisciplinary approach to discharge planning; however, multidisciplinary planning is not always functional or feasible because of a limited number or lack of health care professionals, hospital administrative support, or interdisciplinary cooperation. Medical social workers are often not a part of the small community hospital staff (Gonnerman, 1969), and large hospitals commonly have too many patients to effectively process for the number of social workers they employ (Broomfield, 1979). Additionally, social workers must rely on referrals from other departments. Hospital administrators may not totally support discharge planning because they fear financial repercussions if alternative health care is provided (Harvey, 1981; Reichelt, et al., 1980). Physicians are seen as less supportive of discharge planning than other

staff members (Reichelt, et al., 1980) because they are frequently unfamiliar with the types of community care providers and facilities available (Gonnerman, 1969). Furthermore, B. Phillips (1972), a social worker, claims that physicians appear to be insensitive to the social and economic needs of the patient because referrals to one social work departments "come too late for appropriate planning" (p. 23).

The multidisciplinary approach to discharge planning, according to Reichelt, et al. (1980), is not without problem. They state, "when discharge planning is everyone's job, it becomes nobody's job" (p. 41).

The Nursing Role in Discharge Planning

Two direct nursing responsibilities are to ascertain patient needs and to assure those needs are met, either directly, through the nurse's own activity, or by calling in the help of others (Black, Morrison, Snyder, & Tally, 1977; Orlando, 1961). The staff nurse is the best qualified person to initiate discharge planning because of: (a) extensive contact with the patient and other health care providers; (b) familiarity with all aspects of patient care (Habeeb, et al., 1979; Isler, 1975; Johnson, et al., 1981); (c) being nonthreatening to the patient and significant others; (d) responsibility for assessing, planning, implementing, and evaluating patient educational needs (Pender, 1974; Syred, 1981); and (e) is most appropriate to introduce referrals (Schrager, et al., 1978). However, nursing participation in discharge planning activities is highly individualistic (Habeeb, et al., 1979), depending on the nurse's educational background, role definition, personal attitude, and institutional policy.

Accompanying the responsibility of identifying and evaluating the need for help (Black, et al., 1977) is the nursing responsibility to ensure continuity of care (Jennings, 1977). This is accomplished in the hospital setting by maintaining contact with patients and families from admission to discharge (Black, et al., 1977), and is continued into the community through discharge planning (Hushower, et al., 1978; Reichelt, et al., 1980).

Nursing Education

"Traditional" nursing education in baccalaureate programs segments clinical experiences, overlooking problems facing patients after they leave that clinical area (Hicks & Ashley, 1976). This emphasis on specialization in health care delivery leads to fragmentation of care (Jennings, 1977). Some nursing educators are beginning to examine this fragmentation. Hicks, et al. (1976) described a successful, innovative nursing program which was designed to give planned learning experiences in providing continuity of care through discharge planning.

Another educational difference lies within the competencies of associate degree, diploma, and baccalaureate degree nursing programs. There are nurses who question whether nurses without baccalaureate degrees are capable or comfortable performing discharge planning. Frederickson and Mayer (1977) described a comparison of baccalaureate and associate degree nursing students which indicated that the baccalaureate students scored higher in critical thinking. However, the two groups showed no difference in problem solving. Hover (1966) reported that diploma nurses selected patients requiring teaching

half as often as baccalaureate nurses. One report by the National League for Nursing (1979) identified the baccalaureate nursing degree as the only professional program which prepares the nurse for adapting care to the environment, and facilitating consumer control over health and environment.

A community health nursing background provides a working knowledge of home adaptation, community health theories, and an awareness of community resources and interactions (LaMontagne, et al., 1975). This background is well recognized by hospital administrators who employ formal discharge planning coordinators. Hence, a community health nursing background is often included in the job description of formal discharge planning coordinators (Gonnerman, 1969; Swartzbeck, 1981; Thoms & Mott, 1978). Since only baccalaureate nursing programs include a community health learning experience, many nurses may be educationally unprepared for designing continuing care instructions and discharge plans. Therefore, they must learn to perform the functions of that role by some other means (Cullinan, 1980).

Nursing education has been criticized by Syred (1981) for not equipping nurses with necessary communication, counseling, and teaching skills which are essential to patient education. She further claims that patient education is often ignored by the hospital nurse because of those skill deficits. However, Johnson, et al. (1981) disagree. They report that nurses do not see education as a primary role responsibility, rather than lacking discharge planning skills.

Referrals

Reichelt, et al. (1980) demonstrated that nurses and social workers are the groups most responsible for recording patient information on referral forms. But many nurses do not include referrals in discharge planning because they are unsure when referrals are appropriate, or assume someone else will complete them (Huey, 1981; Harvey, 1981). Phillips and Larkin (1972) described an increase in the number and kind of referral procedures used after nurses attended a series of inservice programs designed to instruct the nurse in discharge planning procedures.

Role Definition

In addition to educational deficits, nurses' uncertainty about how to do discharge planning reflects a lack of role definition. Defining professional roles is necessary to establish thorough and effective discharge planning programs (Reichelt, et al., 1980), and must include written policies and procedures (LaMontagne, et al., 1975). Although described as important, many institutions do not have established roles or policies and procedures for the nurses performing discharge planning. Reichelt, et al. (1980) support this statement in their study of Chicago hospitals where they found that only six of the 14 hospitals surveyed had policies or procedure for discharge planning.

Attitude

Discharge planning in hospitals across the nation has a low priority, and according to Broomfield (1979) is done only for hospital accreditation. White (1972) noted that both patients and nurses rated

discharge planning lowest of four types of nursing activities, including (a) physical care, (b) psychosocial care, (c) observing and implementing medical care, and (d) preparing for discharge. Although some nurses are interested in discharge planning, the following problems interfere with their efforts: (a) staff turnover (Brown, 1980; Reichelt, et al., 1980); (b) reliance on the physician to begin the discharge planning process; (c) a lack of awareness about community resources (Brown, 1980; Harvey, 1981); and (d) settings which discourage nursing participation in placement decisions (Habeeb, et al., 1979).

Many nurses are unaware they are already doing considerable amounts of discharge planning activities daily (Connolly, 1981), attributing those nursing actions to intuition. But according to one nurse (Orlando, 1961), intuition is a thought process which occurs in response to direct observations. Therefore, discharge planning does not double or triple the nurse's workload, if it is begun with an adequate admission assessment and consciously implemented throughout daily, routine interactions with the patient (Connolly, 1981; Cullinan, 1980; Hushower, et al., 1978). This collection of nursing data can be used to make many nursing assessments which are vital to good discharge planning. These assessments include: (a) readiness for transfer, (b) ability to provide physical self-care, (c) accommodation of functional states, (d) impact of psychological needs, and (e) personal habits (Habeeb, 1979).

Atwood, Puffenbarger-Smith, and Hinshaw (1981) attempted to study staff and significant others' perceptions of preparedness for discharge,

but received insufficient nursing responses to complete their first pilot study. They attributed the lack of responsiveness to poor nursing attitudes toward discharge planning, stating that staff and patients must "see the research topic, discharge planning in this case, as relevant to themselves and as a nursing function in order to respond to a questionnaire once they have them" (p. 4). The poor attitude toward discharge planning may be due to unconscious sociocultural norms which are supported by individual value systems evolving from patient care priorities, time shortages, and staffing problems (Broomfield, 1979).

It is the nurse's attitude and subsequent judgement about the importance of any nursing action, based on an understanding of patient needs and nursing knowledge, which determines whether it will be performed (White, 1972). Connolly (1981) asserted that in present nursing practice, discharge planning and documentation is not done. Brown (1980) explains that discharge planning skills may be developed and improved by changing the nurse's attitude and understanding of discharge planning for the patient and family in order to meet patient needs.

Conceptual Framework

Nurses' attitudes toward discharge planning are important to consider, since nurses are in a position to assist or hinder the development of discharge plans. Because attitudes are believed to affect behavior, the conceptual framework was derived from attitude theories. The following discussion is a summarization of attitude theory literature, focusing on the relationship between attitudes and behavior.

Allport (1967) defined an attitude as a "mental and neural state of readiness, organized through experience, exerting a directive or dynamic influence upon the individual's response to all objects and situations with which it is related" (p. 8). Attitudes have been studied by anthropologists, sociologists, psychologists (Suchman, 1970), social scientists, health professionals (Richards, 1975), and educators. These professionals have been conducting research since the early 1900's in an attempt to understand, predict, and alter behavior. However, these attempts have resulted in inconsistent research results, making the attitude-behavior relationship elusive and difficult to describe. Though research has generally failed to predict behavior from attitudes, attitudes have been shown to be more predictable from observing behavior (Keiser & Bickle, 1970). However, Regan and Fazio (1977) disagree, stating that "while the predictive relationship between attitudes and behavior does not appear to be simple or as general as traditionally thought, impressive attitude-behavior consistency is sometimes observed. The question is, therefore, no longer whether an individual's attitude can be used to predict his overt behavior, but when" (p. 30).

Researchers have described multiple factors which influence attitude-behavior predictions. Some of those factors are: (a) multiple attitudes, (b) attitude toward the object of behavior, (c) attitude toward the behavior, (d) form in which attitudes combine (Liska, 1974), (e) method of attitude formation (Regan, et al., 1977), and (f) social support (Linn, 1965; Liska, 1974; Suchman, 1970).

Fishbein (1967) emphasizes that attitude alone is not appropriate for behavior prediction, but it must be used in conjunction with other variables (attitude toward behavior, personal norms, motivation to comply with societal norms). Similarly, Proshansky and Seidenberg (1965) explain that behavior prediction depends both on the type of attitude involved and the extent to which the behavioral component is developed and expressed. Additionally, the complexity of the situation must be taken into account. Even though certain attitudes may be held, situational factors may arouse competing attitudes which are stronger.

Producing behavior change by altering attitude was only partially supported in the literature. Zwicher (1968) suggests that this results from inaccurate attitude measurements which are successful in measuring changes in general attitudes, but fail to measure changes in the underlying dimensions of attitudes which determine behavior. Nevertheless, many educational programs and inservices are based on the premise that altering attitudes will result in behavior change (Campbell, 1971; Richards, 1975; Walsh, 1971; Wilhite & Johnson, 1976).

Attitude and its relationship to behavior is viewed as a viable concept which warrants further study. A wide range of tested attitude measures exist; the challenge to nurses is to incorporate them into current research practice.

Summary

Discharge planning is recognized as an aspect of patient care which prepares the patient and significant others for continuing care after discharge from the hospital setting, therefore providing continuity of care. As cited in the section on the importance of discharge planning, the literature indicates that nurses are potentially the most appropriate individuals to implement discharge planning. However, not all nurses are prepared or encouraged to integrate discharge planning into their professional role. Additionally, the nurse's attitude toward discharge planning may be one reason why a role in discharge planning is not done.

Definition of Terms

1. Discharge planning - a multidisciplinary process which centers on patient needs in order to provide continuity of care between the hospital and community settings (Brown, 1980; Edwards, 1978; Hushower, et al., 1978). This process consists of "any and all activities involved in the preparation of the patient and/or significant others for patient care after departure from the current hospital setting" (p. 1), thus returning responsibility for care back to the patient and significant others (Atwood, et al., 1980).

2. Significant others - "a person who seems to be active in the patient's care. This person may be a family member, friend, neighbor, cohabitor, and so forth" (Atwood, et al., 1980, p. 2).

3. Nurse - a registered nurse (R.N.) who works full-time or part-time on a medical-surgical hospital unit, who is engaged in direct patient care. Educational background may be associate degree, diploma, or baccalaureate degree.

4. Continuity of care - a systematic process matching patient needs with resources (LaMontagne, et al., 1975) to provide "an uninterrupted connection, or unity of care" (Cook, 1979, p. 21).

5. Patient - "the client or consumer of hospital health services" (Cook, 1979, p. 21), on a medical-surgical hospital unit, whose age is between 18 and 65 years.

6. Communication - the assignment of meaning to cues (Wilmot, 1982). Cues may be verbal, written, or nonverbal, and are used for the specific goal of patient care formulation (Fensick, 1978, p. 13).

7. Attitude - "a mental and neural state of readiness, organized through experience, exerting a directive or dynamic influence upon the individual's response to all objects and situations with which it is related" (Allport, 1967, p. 8).

8. Small hospital - any hospital which has 50 or fewer beds.

9. Need - "a lack of something useful, required or desired; when met or satisfied, it solves a problem" (Necker, 1981, p. 21).

CHAPTER 3

METHODOLOGY

The study design, subject selection, definition of terms, data collection instrument, and data collection method are presented in this chapter. Prior to implementing the research, approval for use of human subjects was requested and obtained. An expert panel addressed content validity and a pilot study further assessed the instrument and its administration.

Research Design

Fawcett (1980), an assistant professor at the University of Pennsylvania School of Nursing, states that descriptive studies are used to "examine the specific characteristics of an individual, group, situation, or event... when nothing or very little is known about the particular phenomenon" (p. 37). Since no studies were found which investigated nurses' attitudes toward discharge planning, the research design used was an exploratory-descriptive design. Therefore, no assumptions or hypotheses were made regarding findings.

Subjects

Fifty-one registered nurses working at least part-time on a medical-surgical unit in three small, rural hospitals were asked to participate in this investigation. No attempt was made to select the

nurses randomly, since any nurse who met the previously mentioned criteria and who volunteered participation was accepted as part of the sample.

Three small hospitals, located in different states, were the sampling sites. Each hospital serves a rural community whose clients come from an area geographically larger than the city limits. The first hospital was a thirty bed facility in Western Montana, whose average daily census was eight to ten patients. All twelve of the registered nurses employed by this facility were identified as suitable subjects by the Director of Nursing. The Montana town in which the hospital was established was located on the Flathead Indian Reservation and had a stable population of 925 (1980 census). The financial base of this community was agriculture.

The second hospital was a twenty-eight bed facility in Northwest Iowa, whose average daily census was eleven patients. All eighteen registered nurses employed at this hospital were identified by the Director of Nursing as being suitable subjects. The growing Midwestern town in which this hospital was located had a population of 2,706 (1980 census), increasing 22 percent in the past decade. The economic base of this community was largely agricultural with some light manufacturing and industry.

The third hospital was a forty-two bed facility in Northwestern Colorado whose average daily census was fifteen patients. Of the twenty-seven registered nurses employed, twenty were identified by the Director of Nursing as being suitable subjects. This hospital was located in an energy "boom town" with 1980 population census reporting

8,133, more than doubling its 1970 population. The economic base in this community changed in the past decade from agriculture as the primary base to coal mining (surface and underground), oil and natural gas production, construction, and electric power generation.

Protection of Human Subjects

Polit and Hungler (1978) identified three ethical factors to be considered in research: (a) involuntary participation, (b) freedom from physical or psychological harm or distress, and (c) anonymity or confidentiality of information (p. 32). The research proposal was reviewed by the local Faculty of Human Rights Committee in accordance with government regulations and those of Montana State University. No violations in human rights were found; therefore, approval to use human subjects was given (see Appendix C).

Participation in the research study was entirely voluntary. Each individual nurse gave implied consent to participate by filling out the questionnaire. Implied consent was explained by the introductory letter accompanying each questionnaire. Additionally, consent forms were obtained from the Directors of Nursing and/or Administrators of each hospital giving permission to use hospital employees in the study (see Appendix B).

Data Collection

Description of the Instrument

During the literature review and subsequent search for an attitude assessment instrument, an existing attitude rating scale was discovered:

Nursing Care Planning Attitude Rating Scale (Word & Fetler, 1979). The instrument was developed by E. R. Yurchuck, a nursing educator, to determine baccalaureate nursing students' attitudes "toward nursing care planning and perceptions of planning as an integral part of professional nursing practice" (Yurchuck, 1979, p. 327). After modification, this instrument was identified as the most suitable data collection instrument for this research study. Permission to use and modify the Nursing Care Planning Attitude Rating Scale was requested and granted by E. R. Yurchuck, Ph.D. (see Appendix D).

The Nursing Care Planning Attitude Rating Scale was a summated "thirty [item] 5-point rating scale (strongly agree -- strongly disagree) [which] addresses attitudes toward different aspects of planning nursing care" (Yurchuck, 1979, p. 327). Individual responses to a positive statement were assigned the following ratings: (a) strongly agree, 5; (b) agree, 4; (c) uncertain, 3; (d) disagree, 2; (e) strongly disagree, 1. For a negative statement, the numerical value for each type of response was reversed.

Instrument modification consisted of changing the following words or phrases: (a) from "nursing care plans" to "nursing discharge plans"; (b) from "planning of nursing care" to "discharge plans" or "planning"; (c) from "plan nursing care" to "plan for discharge"; and (d) from "planning" to "discharge planning" (see Appendix D).

Variables addressed by this instrument after its modification included: (a) the perceived value of discharge planning to the individual and others; (b) conditions influencing discharge planning by the individual; (c) responsibility for discharge planning; (d) types of

patients for whom discharge planning is perceived as being necessary; and (e) individual confidence in ability to plan for discharge.

Variables Operationalized

1. The perceived value of discharge planning to the individual and others reflects the attitude about whether the nurse thinks that discharge planning improves patient care.
2. Conditions influencing discharge planning by the individual reflects the attitude about whether the respondent believes the employer or supervisors should encourage and facilitate discharge planning.
3. Responsibility for discharge planning reflects the attitude about whether the nurse thinks discharge planning is a professional nursing responsibility.
4. Types of patients for whom discharge planning is perceived as being necessary reflects the attitude about whether the nurse believes that all patients benefit from discharge planning regardless of diagnosis.
5. Individual confidence in ability to plan for discharge reflects the individual nurse's confidence in their ability to plan for discharge.

Validity and Reliability

The instrument developer did not provide data to reliability, although content validity was established by the sources used during the developer's literature review and personal experiences. The instrument had been pre-tested by Yurchuck in 1971 and revisions were made

(following an item analysis) prior to its implementation in 1976. Since the original instrument was used in a study of student's competency and attitudes toward planning nursing care and not for registered nurses' attitudes toward discharge planning; validity and reliability had to be reestablished. An expert panel, comprised of nine graduate students and three faculty members at Montana State University School of Nursing, was used to determine content validity. This panel also helped determine whether the questionnaire was easily read and unambiguous. Time required for completion of the questionnaire was less than 10 minutes per respondent. Changes made in the questionnaire after the panel's review were: (a) the words "nurse practitioner" were changed to "nurses" or "registered nurses"; (b) the words "I think" were added to question 11; (c) the phrase "supervisors, and/or charge nurses" was added to questions 21 and 39; (d) the word "theorist" was changed to "educators" in question 27, and (e) "she" was added to question 32.

An effort to establish reliability was made by utilizing three separate nursing populations located in three different geographic locations. Additionally, the size of the population utilized contributed to the reliability of the instrument.

Pilot Test

A pilot test was carried out to obtain information for improving the project. Areas of particular interest were: (a) cooperation of participants; (b) questionnaire readability; (c) questionnaire distribution, and (d) questionnaire collection and return. The pilot instrument was mailed to the Director of Nursing at a Western Montana hospital

December 3, 1982, in the same manner and under the same conditions the actual research study was to be conducted. This rural hospital was a forty-seven bed facility whose average daily census was twenty-seven patients. Although the Director of Nursing identified twenty-six nurses as being qualified to answer the questionnaire, only twenty questionnaires were distributed. The Director of Nursing explained that all the questionnaires were not distributed because of existing staffing patterns. No problems with the questionnaire, its distribution or collection were identified or reported by the nineteen responding nurses or the Director of Nursing. Responses were returned to the investigator two weeks after the original mailing.

The only change implemented after the pilot test was to identify each questionnaire return envelope with the investigator's name and the title Discharge Planning. This was added because the Director of Nursing opened one respondent's questionnaire accidentally because the respondent addressed the returning envelope to the Director of Nursing.

Data Collection Method

The discharge planning questionnaires, instructions for questionnaire distribution, and agency consent form were mailed January 24, 1983, to the Directors of Nursing at their respective hospitals (see Appendix B). Each registered nurse sampled was to receive a questionnaire with an attached introductory letter and labeled return envelope. The introductory letter (see Appendix D) explained how to complete and return the questionnaire. Additionally, the letter was designed to

address the purpose of the questionnaire, solicit the cooperation of the respondent, and reinforce confidentiality.

No control was placed on the questionnaire distribution and collection method other than the one week time frame in which the nurses were to (a) complete the questionnaires and (b) return the questionnaire in the individual response envelopes to their Director of Nursing. The Director of Nursing was instructed to return the collected response envelopes to the investigator in the prepaid mailing envelope one week after questionnaire distribution.

The investigator contacted each Director of Nursing by telephone the day the questionnaire packets were mailed to introduce the distribution and collection instructions and explain the consent form. Ten days after the packets were mailed, the investigator contacted the Directors of Nursing by telephone to discern any problems with questionnaire distribution or collection and remind them of return instructions. No problems were identified or reported; however, the Colorado hospital required third and fourth contacts eighteen and twenty-five days after the original mailing date to reiterate questionnaire return instructions because the investigator had not received the questionnaires.

Data Analysis

Descriptive analysis methods were used to examine the collected data. These statistical methods included numbers, percentages, means, standard deviations, and cross-tabulations. The F-test was also used

in the Analysis of Variance to determine homogeneity among the three nurse populations.

Summary

This chapter has included descriptions of the research design, subjects, protection of human subjects, data collection methods, and data analysis. The following chapter presents the responses to the data collection instrument described in this chapter.

CHAPTER 4

DATA PRESENTATION

Introduction

In presenting the findings of this study, the reader is reminded that data in a descriptive study are used to summarize and describe the population under investigation, and are not intended to provide causal inferences or statements nor to support hypotheses. In an effort to identify possible relationships in the data, the following steps were performed. First, demographic data were used to construct a respondent profile of nurses employed by rural hospitals. The next step consisted of describing the attitudes of those respondents toward discharge planning. Using comparisons, relationships between the attitudes measured and the nurses' backgrounds were described. Because of the small population examined, it is not known how representative the attitudes of the participants are of all nurses employed in rural areas. Therefore, findings related to attitude toward discharge planning cannot be generalized beyond the population examined.

Demographic Data

In order to maintain constancy of conditions, thirty-two questionnaires were mailed to each Director of Nursing in Colorado, Iowa, and Montana for distribution. Because the total number of suitable

respondents possible, as indicated by the Director of Nursing, was 50, it was requested that extra questionnaires be returned to the investigator. Forty completed questionnaires (81%) were returned, with a response rate ranging from 60 percent in Colorado to 100 percent in Iowa. Of the total questionnaires returned, three (one Colorado, one Iowa, and one Montana) questionnaires were not used because respondents did not meet the requirements of working on a medical-surgical unit at least part-time. Table 1 represents the original and corrected response rates by location.

Two questionnaires returned from Colorado were not the original questionnaires printed and mailed to the Director of Nursing. These questionnaires had been mechanically reproduced on different paper. However, the responses were marked in the original ink and the return envelope did not appear to be altered. Since the responses closely resembled the responses of other nurses in the sample, they were retained and used as data.

Table 1

Questionnaire Response Rates by Hospital Location

Hospital Location	Possible Number of Respondents	Actual Number of Respondents	Questionnaire Return Rate in percent	Number of Suitable Respondents	Total Number of Suitable Respondents in percent
Colorado	20	12	60	11	29.7
Iowa	18	18	100	17	45.9
Montana	12	10	83	9	24.3
Total	50	40	81	37	100

Twenty-eight respondents (75%) were under the age of 41, and fifteen (40.5%) were younger than thirty-one (see Table 2).

Table 2
Number of Respondents by Age and Hospital Location

Hospital Location	20-30 years	31-40 years	41-50 years	51-60 years	over 60
Colorado	1	6	1	2	1
Iowa	10	4	3	0	0
Montana	4	3	2	0	0
Total	15	13	6	2	1

All of the nurses responding were female, and thirty-two were married (86%). Greater than ninety percent of respondents from Colorado (90.9%) and Iowa (94.1) were married, while only two-thirds of the Montana respondents were married.

Thirty-four of the nurses (89%) sampled had been in nursing between 0 and 40 years, with the greatest number of nurses falling between 10 and 25 years of experience. All Montana nurses had worked less than 26 years as a registered nurse. The nurses in Colorado had a wider span of years employed as a registered nurse ranging from 0 to 5 years to over 40 years.

Respondents were asked to indicate how long they had been employed by their present agency. Thirty of the nurses (81%) had been employed at the present agency for two years or more; only two had been employed for less than one year (see Table 3).

Table 3

Number of Respondents by Length of Employment at Their Present Hospital and Hospital Location

Hospital Location	6 mo. or less	7-11 mo.	1-2 yrs.	2-5 yrs.	over 5 yrs.
Colorado	1	0	0	4	6
Iowa	0	1	2	3	9
Montana	0	0	3	6	0
Total	1	1	5	15	15

Within the participating hospitals, the majority of nurses, 17 (45.9%), worked the day shift. Twenty-seven percent (10) of all nurses sampled work the evening shift and 18.9 percent (7) work the night shift. In addition, a total of four nurses in Colorado and Iowa rotated shifts, comprising 10.8 percent of the total sample.

Thirty of the nurses sampled (81%) work two to five days per week on a medical-surgical unit. Three respondents wrote in work patterns other than the four choices provided for question number seven, "I work in direct patient care on a medical-surgical floor". These responses coded as "other" and were included in the sample. Three nurses did not meet the criteria for inclusion in this investigation. Questionnaires which indicated that the respondent was never involved in direct patient care on a medical-surgical floor were excluded from the sample.

Respondents were asked to indicate the type of basic nursing education they had completed. Diploma graduates comprised the majority of nurses, 25 (67.6 %). Baccalaureate graduates were second in total representation with seven (18.9%) of the population, and 13.5 percent

were associate degree nurses (see Table 4). Only two nurses indicated that they completed any advanced nursing education; one received a baccalaureate degree after first completing a diploma program, and one received a master's degree in nursing.

Table 4

Number of Respondents by Basic Educational Level and Hospital Location

Hospital Location	Associate Degree	Diploma	Baccalaureate Degree
Colorado	2	7	2
Iowa	1	15	1
Montana	2	3	4
Total	5	25	7

Question number ten asked the nurses to indicate the sources from which discharge planning was learned. Table 5 summarizes those findings.

Table 5

Number of Respondents by Hospital Location and Source of Discharge Planning Information

Source of Information	Colorado	Iowa	Montana	Total
Basic Education	4	14	9	27
Advanced Education	2	1	2	5
Professional Journals	8	5	7	20
Peers	8	10	7	25
Policies & Procedures	5	11	6	22
Inservice or C.E.	7	12	3	22
Have not Learned Discharge Planning	1	0	0	1

The most commonly indicated response to the question, "How have you obtained information about discharge planning?", was the basic nursing education program (73%). However, it must be noted that the number of respondents who learned discharge planning from the basic educational program was inversely related to the number of years the respondent had been a registered nurse (see Table 6).

Table 6

Responses According to Number of Years as a Registered Nurse and by Sources of Discharge Planning Information

Information Source	0-5 yrs. R.N.	6-10 yrs. R.N.	11-25 yrs. R.N.	26-40 yrs. R.N.	over 40 yrs. R.N.
Basic Education	11	8	7	1	0
Advanced Education	2	0	3	0	0
Professional Journals	4	7	6	2	1
Peers	6	7	10	1	1
Policies & Procedures	6	8	5	2	1
Inservice or C.E.	6	3	11	1	1
Have Not Learned Discharge Planning	0	0	0	1	0
Total Respondents	11	10	12	3	1

The demographic data from the respondents gave information concerning age, marital status, sex, number of years worked as a registered nurse, length of time employed by the facility, shift worked, frequency of work on a medical-surgical unit, basic and advanced nursing education, and the sources utilized for information about discharge planning.

Data Related to AttitudeAnalysis of Variance

Five variables were addressed by the questionnaire. The following list identifies both the variable and the question numbers which relate to that variable. The reader is requested to refer to Appendix D for the exact wording of the questionnaire.

- a) The perceived value of discharge planning to the individual and others; 13, 15, 17, 19, 22, 25, 31, 33, 34, 35, 36, 37.
- b) Conditions influencing discharge planning by the individual; 14, 21, 29, 39.
- c) Responsibility for discharge planning; 11, 20, 24, 26, 27.
- d) Types of patients for whom discharge planning is perceived as being necessary; 12, 16, 18, 28, 30, 32, 38.
- e) Individual confidence in ability to plan for discharge; 23, 40.

A one-way analysis of variance was used to analyze each variable to determine whether there was a statistically significant difference among the true mean attitudes of the three regional populations (Colorado, Iowa, Montana). Overall, the three regional populations could be considered a homogeneous group (see Table 7).

Where Colorado and Montana respondents do have significantly different means ($P < .05$) to the individual confidence in ability to plan for discharge variable (Colorado 3.5 and Montana 3.8889), it must be noted that they reflect only two questions on the instrument. Furthermore, confidence in discharge planning performance was not the primary concern of this investigation.

Table 7

Analysis of Variance by Variable

Variable	Source	D.F.	Sum of Squares	Mean Squares	F-ratio	F-probability
a (Value of D.P.)	Between groups	2	0.0244	0.0122	0.096	0.906
	Within groups	31	3.9513	0.1275		
	Total	33	3.9757			
b (Conditions influencing D.P.)	Between groups	2	0.2921	0.1461	0.562	0.5754
	Within groups	34	8.8396	0.2600		
	Total	36	9.1318			
c (Responsi- bility for D.P.)	Between groups	2	0.2861	0.1430	0.601	0.5543
	Within groups	33	7.8562	0.2381		
	Total	35	8.1422			
d (Types of Patients)	Between groups	2	0.7686	0.3843	1.453	0.2481
	Within groups	34	8.9953	0.2646		
	Total	36	9.7639			
e (Confidence to do D.P.)	Between groups	2	0.7574	0.3787	3.767	0.0333 ^a
	Within groups	34	3.4183	0.1005		
	Total	36	4.1757			

Note. Discharge planning is abbreviated D.P. ^aSignificant $p < .05$

Data Reported by Variable

The findings presented in this section are reported by individual variable. Comparisons were made using each variable and the demographic background of the respondents by location. Since respondents from all locations are statistically homogenous, specific locations are not reported.

Table 8 summarizes the overall findings of each variable. A slightly favorable (mean > 3) attitude was indicated by each variable. The variable addressing the types of patients for whom discharge

planning is perceived as being necessary received the highest mean response. The lowest mean response was indicated for the variable addressing conditions influencing discharge planning.

Table 8

Mean, Standard Deviation and Range of Responses by Variable

Variable	Number of respondents	Mean response	S.D.	Range	Missing observations
a (value of D.P.)	34	3.875	0.347	1.5	3
b (conditions influencing D.P.)	37	3.669	0.504	2.5	0
c (responsibility for D.P.)	36	3.978	0.482	3.0	1
d (types of patients for D.P.)	37	4.040	0.521	2.286	0
e (confidence for D.P.)	37	3.689	0.341	1.0	0

Note. Discharge planning is abbreviated D.P.

Perceived value of discharge planning: The perceived value of discharge planning to the individual and others reflects the attitude of the nurse that discharge planning improves patient care. The overall mean response to this variable was 3.875. This variable had the highest number of missing observations (three).

When age was compared with the variable addressing the perceived value of discharge planning to the individual, a trend was observed. As the respondent's age increased in years, the respondent gave a lower valued mean response.

The number of years the respondent had been a registered nurse did not demonstrate a recognizable pattern when compared with the perceived value of discharge planning to the individual. The highest mean responses (3.9417) toward the attitude that discharge planning improves patient care were demonstrated by eleven respondents who had been registered nurses 0 to 5 years (S.D. = 0.2751). The group with the lowest mean response (3.4167) was comprised of respondents who had been registered nurses 26 to 40 years (S.D. = 0.3536); however, there were only two respondents in this group.

The length of time the respondent had been employed by the present facility had a negative effect on their attitude toward the perceived value of discharge planning. The longer employed, the less the respondent thought that discharge planning improved patient care.

Based on responses toward the perceived value of discharge planning by the shift worked, nurses who worked the evening shift (9 respondents) had the highest mean response (3.9907). This was followed by nurses working day shift (3.8905) and then night shift (3.75). Nurses who rotated shifts had the lowest mean response (3.6944); however, only three respondents were in this category.

The number of shifts worked per week (1-5) did not seem to influence the respondent's attitude about whether discharge planning improves patient care. The highest mean response was 3.8944, for those working 2-3 days per week, and the lowest mean was 3.8056, representing those who work 4 to 5 days per week. Three respondents wrote in work patterns averaging less than one shift per week. Their mean response

was 4.0556, being somewhat higher than those working one or more shifts per week.

As the length of the basic nursing education program increased, respondents gave higher mean scores toward the value of discharge planning (see Table 9).

Table 9

Responses Toward the Perceived Value of Discharge Planning by Basic Nursing Education Program

Nursing program	Number of respondents	Mean response to the perceived value of D.P.	S.D.
Associate Degree	4	3.7292	0.2394
Diploma	24	3.8438	0.3013
Baccalaureate	6	4.0972	0.5121
Total	34	3.8750	0.3471

This trend was also evident for the two respondents who received advanced degrees in nursing. One nurse returned to school for her baccalaureate degree in nursing after first graduating from a diploma program (responding with an average score of 4.3333) and another received her master's degree in nursing (averaging 4.6667).

The influence the number of sources used to obtain discharge planning information had on attitude toward the perceived value of discharge planning was examined. Table 10 gives an overall view of this comparison. The majority (22) of the respondents used between three and five information sources; only one respondent used six sources.

Table 10

Number of Sources Used to Obtain Discharge Planning Information by Responses Toward the Perceived Value of Discharge Planning

Responses toward the perceived value of D.P.	Number of information sources used by respondents					
	1	2	3	4	5	6
Uncertain	1	1	0	0	2	0
Agree	4	5	6	8	4	1
Strongly Agree	0	0	1	0	1	0
Total	5	6	7	8	7	1

The most favorably rated source of discharge planning information, when compared with the perceived value of discharge planning, was advanced nursing education (4.4375 mean). The lowest mean response was 3.8254: This information source was policy and procedure. Respondents gave higher mean responses when any source was used for discharge planning information except when the respondent used professional journals.

Conditions influencing discharge planning. The conditions influencing discharge planning reflect the attitude about whether the respondent thinks the employer or supervisors should encourage and facilitate discharge planning. The overall response to this variable was slightly favorable, with a mean response of 3.669. This variable had no missing observations and received the lowest mean response of all five variables addressed by this investigation.

A slight trend was observed when conditions influencing discharge planning were compared with respondent's age. Responses given by fifteen nurses age 20 to 30 resembled the mean responses (3.6833) of

the 13 nurses age 31 to 40 (3.5) and one nurse over 60 (3.5). Similarly, the six nurses age 41 to 50 had a mean response of 3.9167, and two nurses in the 51 to 60 age grouping had a mean response of 4.0.

No trend was noticed when conditions influencing discharge planning were compared with the number of years the respondent had been a registered nurse. The highest mean response was given by the three respondents who had been registered nurses for 26 to 40 years (3.8333). The groups giving the lowest mean scores were those who had been registered nurses 6 to 10 years (10 respondents), giving a mean response of 3.575. One respondent, who had been a registered nurse over 40 years, responded with a mean score of 3.5.

Based on the compared responses to conditions influencing discharge planning by the shift worked, nurses who rotated shifts (4 respondents) had the highest mean response (3.9375). This was followed by nurses working the evening shift (3.8611) and those working day shift (3.6765). Nurses who worked the night shift had the lowest mean response (3.25) toward conditions influencing discharge planning.

The fewer days the respondents worked on a medical-surgical unit, the higher the mean responses were toward the variable indicating that employers and supervisors should encourage and facilitate discharge planning (see Table 11).

The more nursing education the respondent had, the more favorably they felt toward the conditions influencing discharge planning. However, the one nurse who received her baccalaureate degree in nursing after first completing a diploma program had a somewhat lower mean

Table 11

Responses Toward the Conditions Influencing Discharge Planning by
the Number of Days Worked on a Medical-Surgical Unit Per Week

Number of days worked	Number of respondents	Mean response	Standard deviation
4-5 days/wk.	14	3.4821	0.6160
2-3 days/wk.	16	3.7656	0.3350
1 day/wk.	4	3.8125	0.5543
Other (averages less than 1 day/wk.)	3	3.8333	0.6292

response than those who completed only the baccalaureate degree (see Table 12).

Table 12

Responses to the Conditions Influencing Discharge
Planning by Educational Preparation

Nursing program	Number of respondents	Mean response	Standard deviation
Associate Degree	5	3.1500	0.7416
Dipoma	25	3.7100	0.3865
Baccalaureate (basic)	7	3.8929	0.5175
Baccalaureate (R.N. advanced degree)	1	3.7500	4.5000
Master's Degree	1	0.0	0.0

The relationship between the number of sources used to obtain discharge planning information and the response toward conditions influencing discharge planning was examined. Most respondents (31) used between two and five information sources and had a somewhat higher mean score toward the conditions influencing discharge planning.

The highest mean score was found in nurses with advanced nursing education (4.1500). However, five nurses gave responses to this source when only two nurses indicated that they had received advanced nursing (an earlier demographic question). All respondents who used any source, except professional journals, for discharge planning information had a higher mean score toward the conditions influencing discharge planning than those not using each source. One nurse indicated she did not learn about discharge planning from any source.

Responsibility for discharge planning. The variable addressing responsibility for discharge planning reflects the attitude about whether the nurse thinks discharge planning is a professional nursing responsibility. The overall mean response to this variable was 3.978. This variable had one missing response and had the largest range (3.0) of all five variables measured.

Twenty-nine respondents age 20 to 30, 31 to 40, and over 60 years had similar mean responses: 4.0133, 4.0462, and 4.0 respectively toward the responsibility for discharge planning. The remaining two groups, ages 41 to 50 and 51 to 60, had lower mean responses, 3.84 and 3.6.

The two respondents who had been registered nurses between 26 and 40 years had the lowest mean response (3.6) toward their professional responsibility for discharge planning. All other responses to this variable were essentially the same. Those who had been registered nurses 0 to 5 years (11) gave a mean response of 4.0; those registered 6 to 10 years (10) responded with a mean of 3.95; those registered 11

to 25 years (12) responded with 4.5; and the one nurse registered over 40 years gave a mean response of 4.0.

An inverse trend was observed when the mean responses toward responsibility for discharge planning were examined with the nurses' length of employment at the present facility. The longer employed, the lower the mean response given by the nurse to this variable.

Based on the compared responses of the responsibility for discharge planning by the shift worked, nurses who worked the night shift (4 respondents) had the lowest mean response (3.6857). Day shift nurses (16 respondents) had the highest mean response (4.075), followed by the nine evening shift nurses (4.0222), and four nurses who rotate shifts (4.0).

The more days worked on a medical-surgical unit, the less the respondents seemed to feel discharge planning was a professional responsibility. This trend is shown in Table 13.

Table 13

Responses to Responsibility for Discharge Planning by the Number of Days Worked Per Week on a Medical-Surgical Unit

Number of days worked	Number of respondents	Mean response	Standard deviation
4-5 days/wk.	14	3.7857	0.5947
2-3 days/wk.	15	4.0400	0.2414
1 day/wk.	4	4.2000	0.5416
Other (averages less than 1 day/wk)	3	4.2667	0.6427
Total	36	3.9778	0.4823

The more nursing education the respondents had, the higher the mean responses were toward the responsibility for discharge planning. This trend was visible also for advanced nursing education (see Table 14).

The relationship between the number of sources used to obtain discharge planning information and the response toward responsibility for discharge planning was examined. Most respondents (24) used between three and five information sources, and had a slightly higher mean score toward the responsibility for discharge planning.

Table 14
Responses to the Responsibility for Discharge Planning
by Educational Program

Nursing program	Number of respondents	Mean response	Standard deviation
Associate Degree	5	3.640	0.9423
Diploma	24	3.9500	0.2588
Baccalaureate (basic)	7	4.3143	0.5273
Baccalaureate (R.N., advanced degree)	1	4.4000	0.0000
Master's Degree	1	5.0000	0.0000

All respondents who used any source for discharge planning information had a higher mean response toward the responsibility for discharge planning than those who did not use those sources. The highest mean score for any source of information used was advanced nursing education. Although only two nurses indicated they had received advanced nursing education, five nurses indicated they obtained

information from this source. Professional journals elicited the lowest mean score for information sources used. One person indicated she did not learn about discharge planning from any source. Her mean response toward the responsibility for discharge planning (3.8) was lower than the 35 respondents who used one or more sources (3.9829).

Types of patients. Types of patients for whom discharge planning is perceived as being necessary reflects the attitude about whether the nurse believes that all patients benefit from discharge planning regardless of diagnosis. This variable had the highest mean score (4.050) of all the variables addressed in this investigation. However, it also had the highest standard deviation (0.521) of all the variables measured. No observations were missing.

A pattern of responses appeared when age was compared with the types of patients for whom discharge planning is perceived as being necessary. For nurses ages 20 to 60, as the age of the respondent increased, a lower mean score was elicited. The one respondent over age 60 responded most similarly to those nurses age 41 to 50 (4.0502).

A general trend was noticed when the types of patients for whom discharge planning is perceived as being necessary were compared with the length of time the respondent had been a registered nurse. The longer the respondent had been a registered nurse, the lower the mean score was toward this variable (See Table 15).

The longer a nurse was employed by the same facility, the less that nurse seemed to feel that all patients benefit from discharge planning. The highest mean score was given by one nurse who had been employed less than six months (4.4286) and another nurse who had been employed 7

Table 15

Responses Toward the Types of Patients for Whom Discharge Planning is Perceived as Being Necessary by the Number of Years the Respondent was a Registered Nurse

Number of years R.N.	Number of respondents	Mean response	Standard deviation
0 to 5 years	11	4.3117	0.4082
6 to 10 years	10	3.9857	0.4439
11 to 25 years	12	4.0238	0.5901
26 to 40 years	3	3.4762	0.5774
over 40 years	1	3.8571	0
Total	37	4.0502	0.5208

to 11 months (4.2857). The five nurses employed one to two years (4.1143) and the 15 nurses employed two to five years were more similar in response to this variable. The remaining 15 nurses employed over five years had a mean response of 3.9048, and had the highest standard deviation (0.5706) of the five groups.

Based on the response comparison of the types of patients for whom discharge planning is perceived as being necessary by the shift worked, those working the day shift (17 respondents) had the highest mean response (4.0504). This group was followed by the nine respondents working the evening shift (4.2222) and the seven working the night shift (3.9184). The lowest mean response to this variable was given by the four nurses who rotate shifts (3.8929).

The more days the respondent worked on a medical-surgical unit, the lower their mean score was toward the type of patients for whom

discharge planning was perceived as being necessary. Table 16 demonstrates this trend.

Table 16

Responses Toward the Type of Patients for Whom Discharge Planning was Perceived as Being Necessary by the Number of Days the Respondent Worked on a Medical-Surgical Unit

Number of days worked	Number of respondents	Mean response	Standard deviation
4-5 days/wk.	14	3.8265	0.5608
2-3 days/wk.	16	4.1964	0.4298
1 day/wk.	4	4.0357	0.6103
Other (averages less than 1 day/wk)	3	4.3333	0.5017
Total	37	4.0502	0.3208

The more nursing education the respondents had, the higher their mean score was toward the attitude that all patients benefit from discharge planning. This trend was also observable for the two respondents who had advanced nursing education.

The relationship between the number of sources used to obtain discharge planning information and the response toward the types of patients for whom discharge planning is perceived as being necessary was examined. Thirty-one nurses had favorable responses; of those 31 nurses, 20 used three to five sources for discharge planning information.

Respondents who used any source, except professional journals, for discharge planning information had a higher mean response toward the

types of patients who benefit from discharge planning than those who had not used the corresponding source. Basic and advanced nursing education programs increased the mean score more than any other information sources. The lowest mean score (3.9357) was found in 20 respondents who used professional journals as an information source, while the 17 respondents who had not used it as an information source had a mean score of 4.1849. One respondent indicated that she had not learned about discharge planning from any source. Her mean response toward the types of patients for whom discharge is perceived as being necessary was 4.1429, where the 36 respondents who used at least one source for information had a mean response of 4.0476.

Confidence in ability. The variable addressing individual confidence in ability to plan for discharge was related to only two questions in the instrument. Overall, the mean response to this variable was 3.689. This variable had no missing observations and had the lowest standard deviation (0.341) of the five variables measured.

When age was compared with individual confidence in ability to plan for discharge, the highest mean response was given by six nurses age 41 to 50. This group was followed by 15 respondents age 20 to 30 (3.7) and 13 respondents age 31 to 40 (3.6538). The lowest mean response was given by nurses 51 to 60 and over 60. Both groups, comprised of three respondents, had a mean response of 3.5. Additionally, these respondents had the least amount of nursing education.

A similar trend was noticed when the number of years the respondent had been a registered nurse was compared with individual confidence to plan for discharge. Respondents (4) who had been registered

nurses 26 to 40 years and those registered over 40 years had the same mean response (3.5). The group (11 respondents) that expressed the most confidence in their ability to plan for discharge had been registered nurses 0 to 5 years. This group was closely followed by 12 respondents who were registered nurses between 11 and 25 years (3.7083), and those (10) registered between 6 and 10 years (3.65).

Length of time the respondent had been employed at the present facility was compared with individual confidence to plan for discharge. The highest mean responses were given by nurses employed one to two years. Those employed less than one year had lower mean responses (3.0) than those employed one or more years.

Based on the responses toward confidence to plan for discharge as compared with shift worked, those working day shift (17 respondents) had the highest mean response (3.791). This group was followed by the nine respondents working evening shift (3.6667) and the four who rotate shifts (3.6250). The lowest mean response to this variable was given by the seven nurses working night shift.

The trend for nurses working one to five days per week, the more days worked on a medical-surgical unit, the higher they rated their confidence to plan for discharge. Three nurses working an average of less than one day per week had a mean response (3.625) which was similar to those nurses working 2 to 3 days per week (3.6563).

The respondents most confident in their ability to plan for discharge by educational background were the diploma graduates (mean 3.72); those least confident were nurses with associate degrees (mean 3.6). One respondent with advanced nursing education on the master's

degree level had a higher mean response toward individual confidence (mean 4.0). However, the nurse who returned for her baccalaureate degree had the lowest mean response (mean 3.0) of graduates from both basic and advanced nursing education programs.

The relationship between the number of sources used to obtain discharge planning information and the response toward individual confidence to do planning for discharge was examined by comparison. Thirty-three nurses had favorable responses; of those 33 nurses, 24 used three to five sources for discharge planning information.

Respondents who used any source, except professional journals, for discharge planning information gave a higher mean response toward the individual confidence in ability to plan for discharge than those who had not used the corresponding source. Basic and advanced nursing education programs were the most positively rated information sources. The lowest mean response was toward the professional journal as an information source. Those who used professional journals had a lower mean response than those who had not used it as an information source. One respondent indicated that she had not learned about discharge planning from any source. Her mean response toward the individual confidence in ability to plan for discharge was 4.0, while the mean response of the 36 nurses who used at least one source for information was 3.6806.

Summary

Thirty-seven nurses employed in three different geographic locations responded to a two-part questionnaire. The first part was used

to gather the general demographic characteristics of the nurse respondents. The second part of the questionnaire was composed of thirty statements dealing with five dimensions of discharge planning. Participants responded to each statement using a five-point Likert scale. An ordinal measurement was utilized to differentiate each statement on the basis of their relative standing to each other on a specific attribute (Polit & Hungler, 1978). Based on their responses to these statements, the majority of nurses did perceive discharge planning favorably with respect to all five variables.

CHAPTER 6

DISCUSSION

Introduction

The purpose of this investigation was to examine the attitudes of professional nurses toward discharge planning. Registered nurses working at least part-time on medical-surgical units from three small rural hospitals participated. These hospitals were located in Colorado, Iowa, and Montana. In addition to determining the overall attitudes held about discharge planning, a comparison of attitudes and demographic information was done. Data were analyzed as a total sample after an analysis of variance was performed to determine homogeneity. In this chapter, the findings (reported in Chapter 5) are discussed and related to the literature. The discussion begins with an overview of the questionnaire return rate before proceeding with general demographic characteristics and demographic characteristics as they relate to the variables. This section is then followed by the remaining characteristics of the variables, and the overall findings. Lastly, the conclusions, limitations of this investigation, implications for nursing practice, and recommendations for further study are discussed.

DiscussionQuestionnaire Return

The questionnaire return rates by hospital location were: Iowa 100 percent, Montana 83 percent, and Colorado 60 percent. Collectively, the return rate was 81 percent. Treece and Treece (1977), coauthors of a nursing research book, state that mailed questionnaires usually average a 50 to 60 percent return rate, and a return rate of 75 to 85 percent is extremely good. But why were there such differences in return rates among the three hospitals? Since distribution and collection methods were not controlled, the differences in return rates probably reflect differences in methods of distribution and collection methods within the individual hospitals.

Age

Moses, Spencer and Roman (1980), investigators in the second National Sample Survey of Registered Nurses, report that the median age for employed nurses was 36.3 years; 29.5 percent were under age 30 and two-thirds were 44 or younger. The rural sample in this investigation revealed that 40.5 percent of the nurses were between age 20 and 30, and that 75.6 percent were under age 41. Though regional values may contribute to the differences, the rural nurse population in this investigation was younger than the total population of working nurses. Neither Iowa nor Montana had any nurses over age 51, but Colorado had three respondents 51 and older. The Third Report to Congress (1982) indicates that 19 percent of nurses age 65 and over were employed in 1977.

In general, as the age of the participants in this investigation increased, the attitude toward discharge planning decreased. Respondents age 51 to 60 saw discharge planning as less of a professional responsibility and demonstrated the least amount of confidence in their ability to plan for discharge. B. Phillips (1927) suggests that holistic health concepts have influenced the recent incorporation of discharge planning into nursing education programs. Because respondents in older age groups indicated that they did not receive discharge planning in their basic nursing education, the inverse relationship between age and attitude may be due to changes in the educational preparation of nurses rather than to age itself.

Nurses age 40 to 60 had a stronger attitude about the necessity for employers and supervisors to encourage and facilitate discharge planning. Those responses may be related to the beliefs older nurses have regarding the role of supervisors and employing agencies in providing assistance for the employee.

Marital Status

Eighty-seven percent (rounded) of the nurses sampled in this investigation were married. This was well above the findings in the 1980 nurses survey (Moses, et al., 1980) which identified 70.8 percent of employed nurses as being married. The difference in findings may be due to a difference between urban and rural value systems. This explanation is consistent with observations made by Coop (1976), professor of sociology at Texas A & M University, who claims that rural populations change slowly and are characterized by residual stability.

Sex

All nurses who responded to the questionnaire were females. According to the National League for Nursing (1981) the number of male nurses is growing at a rapid rate, expanding to 5.54 percent in 1978. This difference may again be attributed to the rural values which have more rigidly defined sex roles.

Length of Employment

Nationally, the annual turnover rate of employment among nurses ranges from 37 to 67 percent. The rural nurses examined demonstrated a more stable employment pattern. Only 5.4 percent of the respondents had been employed at the present facility for less than one year, while a large majority (81 percent) had been employed at the present facility for two years or more. This finding was consistent with rural health care literature which indicated that rural nurses tend to be immobile and unwilling to relocate (Rosenblatt, et al., 1982).

Generally, the longer the respondent was employed by the present facility, the less they felt discharge planning was a professional responsibility. This could be due to an unwillingness to incorporate discharge planning into their responsibilities, because many nurses, according to Connolly (1981), Cullinan (1980), and Hushower, et al. (1978) fear it would change work loads and/or routines. These authors also suggest that this fear is a major obstacle to discharge planning. Another explanation could be that the older nurses, who have already been identified as not seeing discharge planning as a professional

responsibility, may comprise a large percentage of the nurses employed longer than five years.

The groups least confident of their ability to plan for discharge had been employed for less than one year. This finding was most likely related to the lack of familiarity with hospital policies and/or referral agencies. As indicated by Huey (1981) and Harvey (1981) many nurses do not include referrals because they are unsure when referrals are appropriate. If the hospitals in this sample are similar to those examined by Reichelt, et al. (1980), the majority may not have written discharge policies and procedures. Therefore, the newly employed nurse may be uncertain how to initiate discharge planning until they become familiar with hospital "norms". While this finding may have reflected the lack of familiarity with hospital policies and/or referral agencies, this same group of nurses may have included new graduates or nurses who had not been employed for a period of time.

Shift

The percentage of nurses responding by shift worked probably reflected the usual staffing patterns; the largest number of nurses work days while the smallest number work nights or rotate shifts..

The respondents who worked nights least felt that discharge planning was a professional responsibility. Additionally, night nurses least wanted their employer or supervisor to encourage discharge planning. These responses raised the question, what professional image does the night nurse have? If discharge planning was seen as a duty

which cannot be done at night, it was possibly not a part of the night nurses' role definition.

Nurses who rotated shifts had the least confidence in their ability to plan for discharge and would have liked to have employers and supervisors encourage discharge planning. Those responses may stem from the nurse's inability to identify with the routine duties on any one shift, or they may reflect a mixture of attitudes displayed on several shifts. Nurses who rotated shifts also indicated they were the least convinced that all patients benefit from discharge planning. This response seems to be inconsistent with their desire to have employers and supervisors encourage discharge planning.

Nurses working evening shift felt that discharge planning improves patient care and that all patients benefit from discharge planning. Evening shift nurses may have more time to assess the benefits of discharge planning and note patient improvements secondary to discharge planning than other shifts.

Days Worked in Patient Care

Nationally, 30.8 percent of hospital employed nurses worked part-time in 1980 (Moses, et. al., 1982). This percentage is much lower than the nurses sampled in this investigation, where 63 percent worked part-time (4-5 days per week). The difference in findings may be partially due to the questionnaire which was specific to those working on a medical-surgical unit. As was pointed out in the literature review (Merchant, 1982; Schreffler, 1982; Ver Steg, 1982), rural nurses are frequently expected to work in all clinical areas; therefore, some

nurses may be full-time employees, but work only part-time on a medical-surgical unit. The investigator is unable to determine the exact number of nurses working full-time/part-time on any unit other than medical-surgical.

Overall, the fewer number of days the respondents worked per week, the better the attitude reported toward all variables except that discharge planning improves patient care. This finding suggested that there was a difference between nurses who work full-time and nurses who work part-time. One of those differences was educational preparation. Ten out of 14 respondents working full-time were diploma graduates, where 5 of the respondents working one day or less had their bachelor's or master's degree.

Nursing Education

According to the Third Report to Congress (1982), an estimated three-fourths of the registered nurse population has been prepared at the diploma level of education despite the dramatic reduction in the number of diploma programs. Diploma programs, once the leading educational supplier of nursing graduates, now produces little more than half the total nursing graduates. At the same time, the number of baccalaureate programs has more than doubled in the past 20 years. Associate degree programs, first established in the 1930's, have experienced the most rapid growth, demonstrating a 12-fold increase in that same 20 year period. Diploma graduates remain in the highest concentration in the Mid-west, constituting 42 percent of the nursing population (NLN, 1981, p. 38). Moses, et al (1979) report that nurses

with the highest educational attainment reside in the West, South-Central, Mountain, and Pacific regions of the nation. These researchers also indicated that only about four percent of all registered nurses have their master's degree, and only 30 percent of those prepared at the master's level are employed in the hospital setting. The findings in the literature regarding nursing education trends are similar to the demographic description of the participants in this investigation. The majority of nurses (67.6 percent) were diploma graduates, with the highest concentration of diploma graduates being from the Iowa hospital (88.2 percent). The Montana hospital had the largest number of baccalaureate prepared nurses and the only participant with a Master's degree.

As the length of the respondent's educational program increased, the higher the mean responses were to all variables except confidence in ability to plan for discharge. These findings may be partially explained by Cullinan (1980) and Johnson, et al. (1981), who suggest that nurses from educational programs other than baccalaureate programs may not have a working knowledge of discharge planning, or may not see it as a professional responsibility. However, the baccalaureate degree nurses felt less confident than the diploma nurses in their ability to plan for discharge. The investigator cannot account for this difference, other than the baccalaureate graduates examined were younger and may lack self-confidence because of their inexperience. Additionally, it may take a greater length of time for this group of baccalaureate nurses to get experience in discharge planning since they tended to work fewer shifts on a medical-surgical unit per week.

The respondent receiving advanced education leading to a baccalaureate degree had mean responses similar to those nurses initially receiving a baccalaureate degree. The one nurse who had a Master's degree in nursing gave the highest mean responses to all variables addressed. These findings suggest that attitude toward discharge planning may be influenced by the initial educational program the nurse attend, and that attitude may be improved by receiving advanced nursing education.

Information Sources

The literature review indicated that nurses who were educationally unprepared to do discharge planning must learn to perform the functions of that role by some other means (Cullinan, 1980). The findings in this study , however, demonstrate that most of the nurses were prepared to do discharge planning during their basic nursing program, and augmented that basic education with information from other sources. Those nurses learning discharge planning during their basic education felt most strongly that all patients benefit from discharge planning, and that it was a professional responsibility. Additionally, they felt least strongly that employers and supervisors should encourage discharge planning activities. One explanation is that as professionals, nurses may not feel a need for encouragement to perform the duties of their professional role.

The respondents who used professional journals had a lower mean score than those respondents who did not. This finding may reflect the type and/or quality of discharge planning literature available for use

by the nurse. The investigator found that much of the discharge planning literature was anecdotal and unrealistic to the rural situation. The investigator questions the type of journals the respondents consider "professional journals", since quality varies among the nursing journals. The respondents' lack of confidence in their ability to plan for discharge may reflect the quality of the journal used.

Peers provide a source of discharge planning information which appeared to raise the mean responses to the variables of professional responsibility and the kinds of patients that benefit from discharge planning. Most of the nurses with higher education in this investigation were employed part-time and, therefore, would be less likely to be available to give information to their peers. Since peers provide information which raises the mean attitudinal response rate toward discharge planning, it would be interesting to know whether the different educational preparations of the peer group affected the attitude, or if peer support alone made the difference in mean scores.

Respondents who learned discharge planning from policies and procedures expressed a higher belief that all patients benefit from discharge planning. This finding may be related to Joint Commission on Accreditation of Hospitals and medicare requirements which demand discharge plans for all patients. Therefore, policies and procedures in some facilities may reflect this requirement in order to receive accreditation.

The respondent who indicated she had not learned about discharge planning from any source seemed to have some working knowledge of discharge planning because of her confidence in ability to plan for

discharge. This respondent's mean response was higher (4.0) than the mean response of the 36 nurses who used one or more information sources (3.6597). If the respondent had no knowledge of discharge planning, it seems unlikely that she would express such a high confidence level. However, a high confidence in ability to plan for discharge does not necessarily mean one is knowledgeable about discharge planning.

Variables

Because there were three missing responses to the questions reflecting nurses' attitudes about whether discharge planning improves patient care, the investigator questions respondents' certainty levels. How certain were the respondents about this variable; do the missing responses reflect this uncertainty? The missing responses may be due to a problem with the questionnaire. Although three different questions were left unanswered, those questions may need to be re-examined for clarity.

The variable addressing whether the employer or supervisor should encourage discharge planning received the lowest mean score. According to Broomfield (1972), discharge planning is often done only for hospital accreditation. Therefore, nurses may not view employers as being truly supportive of discharge planning because of the inconsistent support given. Or, as addressed earlier, the professional nurse may not see encouragement by the employer as being necessary to perform role requirements.

Professional responsibility toward discharge planning is most influenced by educational background; the higher the educational

preparation, the higher the mean scores reported toward this variable. The findings in this investigation reflect the highest mean response for the variable addressing the type of patient that benefit from discharge planning. These findings support reports by Meisenheimer (1980) and B. Phillips (1972), indicating that all patients benefit from discharge planning.

Confidence in ability to plan for discharge may have been affected by a number of things such as frequency of performance, role definition, and experience. Connolly (1981) suggests that nurses are unaware that they plan for discharge planning throughout their daily activities. Perhaps the low mean response toward this variable reflect nurses' lack of awareness or confidence their ability to record the discharge planning activities.

Questionnaire

The questionnaire was comprised of thirty items which were measured on a Likert scale. The overall value of a Likert format is the ability to ordinally rank responses (Babbie, 1973; Sellitz, Janhoda, Deutsch & Cook, 1964). Theorists, Fishbein and Ajzen (1975), claim that Likert scales used for attitude measurement are "highly reliable, yielding comparable results when measured on different occasions" (p. 108). According to Sellitz, et al. (1964), "some of the differences in response patterns leading to any given score may be attributable to random variations in response. However, they caution that the scores may "arise because specific items involve not only the attitude

being measured but also extraneous issues that may affect the response" (p. 369).

Limitations

Limitations of this study include those associated with a small sample size, mailed questionnaires, and questionnaire design. Despite the high return rate of questionnaires for the three different hospitals utilized in this study, the actual number of respondents was small. Because of the small sample size, some of the demographic groupings had only one respondent. Therefore, it was difficult to interpret some of the study findings, and inappropriate to generalize those findings beyond the group examined.

Mailed questionnaires have several limitations applicable to this investigation. Respondents who did not understand the questions or general directions did not have an opportunity for clarification. Also, there was no way for the investigator to gain information from questionnaires which were incomplete. A further limitation involves a lack of certainty that the intended respondents were the ones who completed the questionnaires.

Though Likert scales are highly reliable, a person's attitude may not be correlated with the performance or nonperformance of a given behavior. Fishbein, et al. (1975) states that "a person's behavior with respect to an object is largely determined by his attitudes toward that object" (p. 335). Therefore, generalizations cannot be made at this time about the nurses' attitudes toward discharge planning and the affect those attitudes have on specific discharge planning behaviors.

Conclusions

In this investigation, the attitudes of nurses employed in small, rural hospitals toward discharge planning were described. This population of rural nurses was different demographically from national descriptions of nurses. The majority of respondents were under 41 years of age, married, had between 10 and 25 years of experience as a registered nurse, worked part-time on a medical-surgical unit, and had been employed by the same agency for two or more years. Educationally, the largest group of nurses were diploma graduates without advanced nursing education. Most nurses used between two and five sources for discharge planning information, with the primary source being the respondents' basic nursing education.

Based on the analysis of data, the overall population examined held a slightly favorable attitude toward discharge planning. Areas which seemed to influence respondents' attitudes most were the number of days worked on a medical-surgical unit per week, number of years worked as a registered nurse, educational preparation, and sources used for discharge planning information.

Although the results of this investigation cannot be broadly generalized, the investigator hopes the material presented will add to the data base for rural nursing and stimulate additional research in discharge planning.

Implications

As a result of this investigation, several implications for nursing practice may be drawn. Since the nurses indicated that they learned about discharge planning from peers and continuing education or inservice programs, the hospital could provide regular discharge planning programs which incorporate peer interaction.

Discharge planning literature was noted by the investigator as being vaguely constructed, anecdotal, or speculative in nature. Furthermore the findings indicate that nurses who used professional journals as a source for discharge planning information had a lower mean score than those who did not use professional journals. Therefore, there appears to be a need for publishing well-written, practical discharge planning information which is specific to rural areas.

Policies and procedures for discharge planning need to be examined to determine clarity and practicality for use. Additionally, nurses must be oriented and familiarized with those policies and procedures in order to feel comfortable in planning for discharge.

Finally, the educational preparation of nurses employed by each facility should be examined. If discharge planning was not an integral part of the nurse's professional education, basic discharge planning information may need to be given. Since nurses' attitudes toward discharge planning are improved when nurses receive advanced nursing education, encouragement to pursue advanced nursing education may be indicated.

Recommendations

This investigation has raised a number of questions relative to discharge planning. In view of the findings, the following recommendations for future study are made:

1. Replicate this investigation using a larger sample to reinforce reliability.
2. Compare the attitudes of rural nurses with the attitudes of urban nurses toward discharge planning.
3. Determine what discharge planning activities are being done and relate those behaviors to attitudes toward discharge planning.
4. Discover what activities nurses describe as being important to discharge planning.
5. Examine the attitudes of hospital administrative personnel toward discharge planning.
6. Determine what factors influence nurses' attitudes toward discharge planning.
7. Explore components of discharge planning within basic and advanced nursing education to determine effects on attitude formation.
8. Expand the five-point Likert scale to a seven-point Likert scale to provide a greater degree of attitude differentiation.
9. Explore the demographic trends of rural nurses using larger studies to determine what affect those trends have on attitude toward discharge planning.

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APPENDICES

APPENDIX A

PILOT STUDY

Montana State University
School of Nursing
612 Eddy Avenue
Missoula, Montana 59812
December 3, 1982

Jean Clary, D.O.N.
Marcus Daly Memorial Hospital
1200 Westwood Drive
Hamilton, Montana 59840

Dear Ms. Clary:

Thank you for agreeing to participate in my discharge planning study. Please find enclosed the following materials:

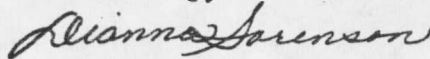
1. One consent form for institutional participation,
2. Thirty-two questionnaires with attached introductory letters and envelopes,
3. One stamped, addressed mailing envelope.

After completing the consent form, please distribute the questionnaire to all the registered nurses employed by your facility. The nurses are instructed to return the questionnaire to you sealed in the attached envelope. One week (seven days) following the questionnaire distribution return the consent form and all the questionnaires collected to me in the mailing envelope provided.

Please contact me if you have any questions concerning the consent form, questionnaire distribution, collection, or return.

Thank you for your time and participation.

Sincerely,



Dianna Sorenson, R.N.

[Faint handwritten notes and signatures at the bottom of the page]

CONSENT FORM

Research Topic: Discharge Planning
 Name of Researcher: Dianna Lee (Spies) Sorenson

I, Jean A. Clary willingly grant permission for the use of Mercus Dale Memorial Hospital employees in this project and have been informed of the following items:

- I. I have been informed of the general project description, its purpose and benefits;
- II. I have been given an explanation as to why I have been asked to participate;
- III. I am aware that participation in this study is entirely voluntary and that each individual nurse provides his/her individual consent to participate by completing the questionnaire;
- IV. I have been given an explanation of my specific involvement, and potential risks, if any;
- V. I have been given the opportunity to ask questions about the experiment from the principal investigator and these questions have been answered to my satisfaction.

Jean A. Clary
 Signature

R.C. Ottens
 Authorization

12-8-82
 Date

APPENDIX B
INVESTIGATION

Montana State University
School of Nursing
612 Eddy Avenue
Missoula, Montana 59812
January 24, 1983

Sharon S. Merchant, D.O.N.
The Memorial Hospital
785 Russell Street
Craig, Colorado 81625

Dear Sharon:

Thank you for agreeing to participate in my discharge planning study. Please find enclosed the following materials:

1. One consent form for institutional participation,
2. Thirty-two questionnaires with attached introductory letters and envelopes,
3. One stamped, addressed mailing envelope.

After completing the consent form, please distribute the questionnaire to all the registered nurses employed by your facility. The nurses are instructed to return the questionnaire to you sealed in the attached envelope. One week (seven days) following the questionnaire distribution return the consent form and all the questionnaires collected to me in the mailing envelope provided.

Please contact me if you have any questions concerning the consent form, questionnaire distribution, collection, or return.

Thank you for your time and participation.

Sincerely,

Dianna Sorenson, R.N.

Dianna Sorenson, R.N.

CONSENT FORM

Research Topic: Discharge Planning
 Name of Researcher: Dianna Lee (Spies) Sorenson

I, Sharon M. Merdant willingly grant permis-
 (please print name of representative)
 sion for the use of The Memorial Hospital employees
 (please print name of hospital)
 in this project and have been informed of the following items:

- I. I have been informed of the general project description, its purpose and benefits;
- II. I have been given an explanation as to why I have been asked to participate;
- III. I am aware that participation in this study is entirely voluntary and that each individual nurse provides his/her individual consent to participate by completing the questionnaire;
- IV. I have been given an explanation of my specific involvement, and potential risks, if any;
- V. I have been given the opportunity to ask questions about the experiment from the principal investigator and these questions have been answered to my satisfaction.

Sharon M. Merdant, RN
 Signature

Dist. Admin. - Nursing
 Authorization

Jan 31, 1983
 Date

Montana State University
School of Nursing
612 Eddy Avenue
Missoula, Montana 59812
January 24, 1983

Sandy Ver Steg, D.O.N.
Hegg Memorial Hospital
1200 - 21st Avenue
Rock Valley, Iowa

Dear Ms. Ver Steg:

Thank you for agreeing to participate in my discharge planning study. Please find enclosed the following materials:

1. One consent form for institutional participation,
2. Thirty-two questionnaires with attached introductory letters and envelopes,
3. One stamped, addressed mailing envelope.

After completing the consent form, please distribute the questionnaire to all the registered nurses employed by your facility. The nurses are instructed to return the questionnaire to you sealed in the attached envelope. One week (seven days) following the questionnaire distribution return the consent form and all the questionnaires collected to me in the mailing envelope provided.

Please contact me if you have any questions concerning the consent form, questionnaire distribution, collection, or return.

Thank you for your time and participation.

Sincerely,

Dianna Sue Sorenson, R.N.

Dianna Sorenson, R.N.

CONSENT FORM

Research Topic: Discharge Planning
 Name of Researcher: Dianna Lee (Spies) Sorenson

I, Brad Sorenson and Linda H. #109 willingly grant permission for the use of St. Paul Hospital employees (please print name of representative) (please print name of hospital) in this project and have been informed of the following items:

- I. I have been informed of the general project description, its purpose and benefits;
- II. I have been given an explanation as to why I have been asked to participate;
- III. I am aware that participation in this study is entirely voluntary and that each individual nurse provides his/her individual consent to participate by completing the questionnaire;
- IV. I have been given an explanation of my specific involvement, and potential risks, if any;
- V. I have been given the opportunity to ask questions about the experiment from the principal investigator and these questions have been answered to my satisfaction.

Brad Sorenson, Adm. 1-31-87
 Signature

Linda H. #109
 Authorization Director of Nurses

1-31-87
 Date

