Psychiatric patient needs assessment as it pertains to discharge planning
by Elaine Audrey Necker

A thesis submitted in partial fulfillment of the requirements for the degree of MASTER OF NURSING
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Abstract:
The purpose of this study was to describe the relationship between the post-discharge needs of psychiatric unit patients as assessed by the patients themselves and the nursing staff assigned to care for these patients. The same assessment inventory was sent to each patient following discharge to study the relationship between the needs identified while hospitalized and those identified following discharge.

A theoretical framework was formulated based on the concepts of needs, coping and adaptation. The exploratory/descriptive research design was used.

Thirty-five patients and their nurses (31) on psychiatric wards located in general hospitals (one in a large central Alberta city and two others in smaller southern Alberta cities serving a rural as well as an urban population) were sampled. Information was collected by means of a questionnaire and a personal data information sheet.

The questionnaire was designed to measure post-discharge needs as identified by the patient and his/her nurse during the patient's period of hospitalization. The data sheets were used to collect demographic material relative to the personal characteristics of the participants.

Data were analyzed by using the Pearson r correlation method which identified or defined the degree of correlation between the numerous variables.

Analysis of the data revealed that nurses better assessed those patients who were similar to themselves in such characteristics as age, sex and employment status. The overall correlation coefficient between the nurses' assessment of post-discharge needs and the patients' assessment of these needs was a low positive relationship.

As for implications to the profession, it is important that nurses become more aware of their patients' needs and that the patients become more involved in the discharge planning process. Further studies are needed to examine the effects of discharge planning on recidivism and the nurses' role in the discharge planning process.

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Signature Elaine A. Necker

Date March 10, 1982

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by

ELAINE AUDREY NECKER

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

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Approved:

Jacqueline Taylor
Chairperson, Graduate Committee

Kathleen Chaffey
Head, Major Department

Michael P. Malone
Graduate Dean

MONTANA STATE UNIVERSITY
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ABSTRACT

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Chapter 1

INTRODUCTION

The Problem

The "revolving door" syndrome is an unpleasant fact of life associated with psychiatric unit operation. The root causes of recidivism are many and varied. Ideally, psychiatric discharge planning is geared to minimize or eliminate the prospect of readmission. Fundamental to the discharge planning process is a health team approach whereby post-release patient needs are identified by the patient, doctors, nurses and social workers.

The writer first became interested in the problems of recidivism while working in a number of western Canada psychiatric units. From an observational viewpoint, seldom if ever was any attempt made to relate the nursing staff assessment of patient post-discharge needs to that of the patients themselves. In many cases, patients were not included in the initiation of their post-release care plans and the utilization of standards of care without individualization was a very common practice. The writer has often questioned the effect such discharge planning had with respect to the high rates of patient readmission to these psychiatric wards.

The nurse contributes a great deal toward the health team's efforts because of her twenty four hour accessibility to the patients and others in the hospital environment. The ability to accurately

identify the post-release needs of patients is an important aspect of discharge planning. The question arises, however, whether nurses in psychiatric units see things from the same perspective as their patients in assessing these post-release needs, goals and expectations related to the patient's return to the community or a care facility. Should differences in perception be the case, is the effectiveness of the discharge planning process jeopardized? What effect does inadequate discharge planning have with respect to the high rates of patient readmission to psychiatric wards? The foregoing three queries may not be related in a cause and effect manner; however, to adequately build a base for investigating the shared perspective of nurses and patients, the effectiveness of discharge planning as well as the relationship to recidivism, an effective investigation of the initial question is paramount.

Statement of Purpose

The writer acknowledges that to study the nurses' assessment of discharge needs is to consider only one part of the multidisciplinary team effort necessary for discharge planning. However, for this introductory study, the decision was made to explore the differences and similarities of the patients' perceptions of their needs and the nurses' perceptions of patient needs.

Chapter 2

REVIEW OF THE LITERATURE

Introduction

Although the concept of discharge planning is introduced early during a nurse's professional education (Johnson & Pachano, 1981), no published studies have been found which consider the variables or mechanics of this process, especially as they relate to psychiatric unit discharge. In fact, the whole subject of the discharge process is not well documented. Also, much of the available material on this subject is speculation and opinion.

Literature Review

Bristow, Stickney and Thompson (1975), nurse editors of a book on discharge planning ideas and activities, define discharge planning as a process and service wherein patient needs are identified and evaluated, and assistance is given in preparing the patient to move from one level of care to another. The process includes assessment of individual patient needs with consideration of what is best for the patient in terms of assisting him to return to as normal and productive a role as possible. The patient is the primary benefactor of the discharge planning process (Bristow et al., 1975). Since a number of options are available to the patient upon discharge, an effective discharge plan should consider the needs of the patient, the resources

available and the cost to the patient (Beaudry, 1975). This social worker's article emphasizes the importance of communication and coordination among health professionals.

Hushower, Gamberg and Smith (1978) state that the success of discharge planning depends, to a great degree, on identifying patient needs, matching appropriate resources to these needs and educating the patient. In their research report, these nurses cite examples of patients from a surgical floor and emphasize that a multidisciplinary team approach is the best method. They also assert that discharge planning assures continuity of care between units within a hospital, from hospital to another care facility or from hospital to home.

Concern over reducing health care costs, the shortage of short-term hospital beds, the formation of utilization reviews and professional standard review organizations has given emphasis to discharge planning policies (Barham, 1974; Jennings, 1977; Roberts, 1977). Concerns about costs, shortages of beds and reviews have stressed the need for planned approaches to provision of health care services. LaMontagne and McKeehan (1975) in a descriptive report of one continuing care program found that it is necessary to have a systematic approach to coordinate patient needs with available resources in the community. As nurses actively involved in this continuing care program, they assert that discharge planning emanate from the hospital and that formal programs be developed to provide a solid base for

successful planning. Although it has been found that much support is required immediately following discharge, these nurses believe that discharge planning for continuing care may involve a patient's entry and discharge from a hospital several times over a long period of time.

However, Bonander (1981) cautions that it is relatively easy to match a resource to a need. The essence of health care, Bonander states, is to fuse the person - need - situation to its resolution. To do so requires a detailed assessment of the patient and the situation. Writing from a social work perspective, Bonander maintains that discharge planning be patient-centered and emphasize goals which the patients themselves value.

Failure to undertake methodical and comprehensive discharge planning during the patient's hospitalization can have serious consequences according to a report by Reichelt and Newcomb (1980). These nurses state that patients and families may have difficulty in adapting therapeutic regimens to their living conditions which may in turn lead to rehospitalization, thereby diminishing the patient's quality of life. Hushower et al. (1978) contend that the consistency of discharge planning is very poor due to the fact that those involved with health care are so often caught up in the immediacy of acute care.

Current literature on discharge planning tends to emphasize referrals for post-hospital care; however, patient discharge certainly

involves a great deal more than this. To benefit from an effective discharge plan is the right of every patient admitted to a hospital and the plan itself should utilize the nursing process in assisting the patient to achieve and maintain high level wellness. The plan ideally begins at the time the patient is admitted and continues until discharge (Hushower et al., 1978). Above all, the discharge process must maximize effectiveness in planning and promote high level wellness.

Recently, Reichelt and Newcomb (1980) surveyed fourteen medical and surgical hospitals in the Chicago area to learn how discharge planning was carried out. Results of this study include the following: social workers often carried out the actual steps of discharge planning; nurses were responsible for assessing many of the needs for discharge; few of the respondents cited the patient's family resources and living arrangements as worthy of routine evaluation; and the most fundamental condition in providing adequate discharge planning was identified as being the satisfaction of the patient's post-hospital needs. These nurse authors maintain that a multidisciplinary approach with respect to anticipating patients' post-hospital needs is necessary for establishing a thorough and effective discharge planning service. However, this survey and the models described in the report gave little or no responsibility to the patient within the discharge planning project. The survey was more concerned with the various professional roles in discharge planning.

All disciplines that have contact with patients have the opportunity to assess patients' post-release needs. According to Kramer (1972), there is little disagreement that nurses must assess and identify the needs of their patients. She further states that the nurse's perception of these needs must be validated periodically with the patient and his family. She maintains that the nursing care plan be written with the patient and his family involved so that individualized patient care is achieved. Kramer contends that if individual nurses were made responsible for the development and periodic appraisal of nursing care plans for a limited number of patients, these plans for discharged patients would provide excellent clinical data upon which to analyse the effectiveness of care and practice.

During the investigation of a continuing care project, Castledine (1979) discovered that the criteria used by nursing staff to detect a patient's need are often unreliable and too broad. This can lead to a problem in identifying aftercare needs and the services to be provided. According to Castledine, the use of a nursing process approach and the appropriate assessment criteria provide nurses with objectively derived information on which to base their decisions and evaluations.

The need for a method of identifying patients with possible discharge problems soon after admission was emphasized in a study designed by Kulys (1970). She suggested that a plan of action be initiated as soon as possible after admission. The six month study

was conducted to try to determine whether contact with a social worker early in elderly patients' hospitalization could reduce the patients' length of stay and better prepare them for discharge. The results of the study indicated the average length of stay for patients age 65 years and over decreased by 1.63 days when early social worker contact was implemented. The incidence of patients being angry because they had to leave the hospital without having had time to make necessary preparations became almost non-existent. Furthermore, the study concludes that there is much more awareness among the total patient population that the hospital is there to help them with any problem. On an evaluative level, the study points out that the social worker might be serving the interests of the patients more constructively if, instead of helping them to accept basically unacceptable solutions, she would spend her efforts in engaging relatives in a problem-solving effort.

Hushower et al. (1978) contend that early identification of needs decreases the possibility of an unanticipated post-hospital problem for the patient and his family. They maintain that the initial admission interview begins the discharge planning process. At such a point in time, the nurse identifies the patient's physical, emotional and/or learning needs. She also assesses the psychological and social effects of his illness on both himself and his family.

Ambrosi (1979) emphasizes that the patient must be the center of

the discharge planning process. As a nurse involved in quality assurance, she is convinced that the services offered to the patient be individualized and that decisions related to the patient's future be made by the patient as long as he is competent to participate. Ambrosi asserts that patients' needs could be examined profitably in terms of the kinds of assistance the patient will require and at what point in time such assistance will have to be implemented. She further stresses the role of the nurse in the assessment and evaluation of the patient's needs.

Morgan (1973), a Canadian nurse, maintains that early contact with the patient and his family is essential and by including the family as part of the discharge planning group, the prospects of the plan resulting in success are increased. She goes on to state that patient assessments for discharge planning should include the "total" patient.

An approach to discharge planning in which more emphasis is placed upon the identification of the likely needs of discharged patients is suggested by Roberts (1977). This nurse suggests that such identification of needs would reduce the shortcomings of aftercare provision. Since the nurse's assessment of the patient's needs is fundamental to nursing practice, Roberts maintains that nurses have sufficient opportunity to improve the standards of discharge planning and, as a result, have an inherent responsibility to do so.

In a study to document the process of discharge planning on an

acute medical ward, Schuman, Ostfeld and Willard (1976) demonstrated that improved discharge planning is possible. Moreover, these doctors believe that if individual nurses are assigned the responsibility for detecting the patient's needs and formulating nursing care plans for in-hospital and after-hospital care and, if these efforts were encouraged by those in authority, these nurses would be able to detect post-release needs and initiate the appropriate planning. The researchers suggest that nurses tend to be the most qualified personnel to delineate a patient's needs following discharge and that nursing staff have the greatest degree of awareness of their patient's need for ancillary services. They have documented evidence from other studies which reveal that, in selected diagnostic categories, better discharge planning will decrease hospital readmission rates including hospital admissions which would be preventable by patient compliance with medical regimen.

Johnson and Pachano (1981) state that the management of the discharge planning process centers around setting goals for the patient. In an attempt to provide holistic care, these nurses believe that the goals set for each patient must be integrated and totally individualized. Achievement of these goals will then ideally result in a resolution of the patient's health problems and prepare him for discharge. The major limitation of their study stems from the fact that the nurses responded to the questionnaires by describing generalized behavior and intentions

of former patients, whereas the patients filled out the questionnaires about a specific stay and responded on a personal level. When the data were viewed simultaneously, the study indicated a disparity between the nurses' and the patients' perceptions in the area of patient teaching prior to going home.

In developing a book titled "Guidelines for Discharge Planning", David, Hanser and Madden (1968) contend that the patient always be involved in discharge planning unless medical reasons specifically contraindicate it. A plan made for the patient rather than with him, one that is not compatible with his desires and culture, will fail. These nurses state that including the patient's perception adds his efforts to the help of others and contributes directly to his improvement, physically and psychologically. When a patient has relatives or friends who are involved in meeting his needs for care after hospitalization, bringing them into the discharge planning process would be of benefit. These writers consider teaching as an important role in discharge planning and state the nurse should set aside a specific time to teach whatever may be necessary to the patient, family or others who will share in the responsibility of care at home. They further recommend that consideration be given to the home situation and community agencies available in the area.

It has been recommended that the hospital officially integrate the discharge planning process into its total operation (Hushower et al.,

1978). Also, these authors emphasize that there must be a formal commitment to discharge planning with appropriate supporting policies, goals and objectives. The establishment of clear lines of responsibility and communication would insure that staff members would recognize their role in the process. Further documentation is found in the literature concerning the importance of: weekly discharge planning conferences (David et al., 1968; Smith, Buckalew & Rosales, 1979; Steffl & Eide, 1978); written discharge instructions to patients (Burkey, 1979; Steagall, 1977); procedure manuals, manuals containing information and evaluation of community resources (Bristow et al., 1974; Castledine, 1979; David et al., 1968; Smith et al., 1979); formal programs within the hospital that provide a solid base for successful discharge planning (Bristow et al., 1974; LaMontagne & McKeehan, 1975); and the importance of discharge forms (Barham, 1974; Bristow et al., 1974; Cucuzzo, 1976; David et al., 1968; Johnson & Pachano, 1981; Reilly, 1979).

Most of the previous literature concerning assessment tends to focus upon the physical needs of the patients. However, Bristow et al. (1974) state that the discharge needs of the mentally ill patient, hospitalized in his own community (i.e. the local general hospital), are much the same as those of the medical or surgical patient in that environment. Gammonley (1978), a nurse involved in mental health services, observed that patients who have increased knowledge relative

to their particular emotional illness are better able to cope with the illness and are able to maintain a higher level of functioning than those who are uninformed. Today, patients in psychiatry are being encouraged to understand their problems, relationships, environment and to take an active part in their treatment plan.

Two nurses have written articles which stem from an increasing concern for consumers and which point out the responsibility of nursing staff for psychiatric patient education. O'Brien (1979) emphasizes the need that mentally ill patients have to understand their illness and treatment. Sclafani (1977) concludes that there is mounting evidence to indicate that people experiencing emotional problems who are provided with planned experience and who take an active participating role in their own care are better able to cope with and follow treatment programs than those not afforded comparable experiences. However, it has been found that post-hospital needs of patients with respect to education for better understanding their illness and treatment are not being met in many instances. After interviews with 138 patients, Pender (1974) reported that patients indicated a need for more information following discharge on how to care for themselves at home, the effect of illness on their daily living habits, possible complications of their present illness and prevention of further illness. Ulrich and Kelly (1972), a nurse and administrator in a health education department of a large organization, report in a paper for the American Hospitals Associa-

tion that patients are often rehospitalized for the same conditions and, frequently, because they did not know how to take care of themselves.

Appraising and reappraising the patient's ability to understand his illness, his coping ability, his desires, beliefs and plans are essential to developing a discharge plan (Steffl & Eide, 1979). The process of identifying post-discharge needs is undertaken with the intention of increasing the patient's ability to cope following discharge. The extent to which a patient feels his needs are met may affect his ability to cope with the stress of illness. Steffl and Eide (1979), both of whom are nurses, have prepared a book that contains generalized steps for the implementation of discharge planning.

Williamson (1978) discovered that there are methodological problems in constructing questionnaires to measure the patients' perceptions of their needs and the nursing staff's perception of those needs during the period of hospitalization. This research report describes a test for the perception of needs and discusses the problems that occurred in the development of the measurement tool along with the exploration of possible solutions. Problems were encountered when it was discovered that there were substantial differences between the results of the pretest and the study group questionnaires. It was discovered that the items selected for testing failed to test physical and emotional needs adequately. Since data were collected by three interviewers, the interviewer variability may have detracted from the

reliability of the questionnaire. To avoid problems in the future, this nurse-researcher suggests selecting patients who are admitted to a single hospital unit (for example, surgery or medicine) or to select patients who have similar diagnoses. Williamson also believes that the concept of physical and emotional needs requires further elaboration and refinement.

A study to determine (1) how decisions were made about psychiatric treatment and (2) who participated in the decision making was carried out in three in-patient units of a large mental hospital (Murray, 1974). Inferences drawn from the data which were collected by direct observation of patients and staff in decision making situations include two possibilities as to why staff did not choose to involve patients in the decision making process. The first includes the bureaucratic organization of the Department of Mental Health which encouraged top-level-down decision making and the second indicated that autocratic decision making is speedier and facilitates the rate of discharge. Murray (1974), a psychiatric nurse, suggests that efforts be made to study the effects of patients identifying their needs with programs set up to meet these needs and then examining the readmission rates to study the effect of this undertaking.

Summary

From the foregoing literature review, a void appears in that few,

if any, documented research studies are known which consider the variables of discharge planning, in particular the ability of psychiatric unit nursing staff to adequately assess and identify the post-release needs of their patients. Health team professionals on the whole acknowledge that discharge planning is important; however, little in the way of evaluation of existing programs seems to be available in documented studies. Many articles reflect the opinions of nurses and social workers who are concerned about discharge planning and suggestions based on clinical experience. In fact, in many cases, one has to question whether discharge planning does exist and to what degree the lack of discharge planning contributes to the high rates of readmissions to psychiatric wards. Clearly, there is a need for research in the area of discharge planning. In view of the aforementioned, this investigation will consider patients' and nurses' perceptions of patient needs before and following discharge.

Chapter 3

CONCEPTUAL FRAMEWORK

In the conceptual framework, needs theory, coping and adaptation are presented as they apply to discharge planning. Human needs are examined utilizing the theory of Maslow (1970) as well as the viewpoint of Cavanagh and McGoldrick (1966). The focus on coping processes and adaptive behavior is from a series of studies.

Webster (1976) defines need as a "lack of something useful, required or desired." A health need actually refers to an action necessary to solve a problem. Maslow (1970) has proposed a theory which assumes that needs are arranged along a hierarchy of priority or potency. When the needs that have the greatest potency or priority are satisfied, another step up the ladder is taken. The hierarchial order from most potent to least potent is as follows: physiological needs such as hunger and thirst; safety needs; needs for self actualization; cognitive needs such as a thirst for knowledge; and finally aesthetic needs such as a desire for beauty. Hunger and thirst always take precedence over a desire for approval or recognition but the latter are prepotent over the need for beauty. The needs below the level of self actualization represent the deficiency motives and present the individual with the task of working through the problems and inevitable frustrations in achieving gratification within these basic need areas.

Types of needs will differ with individuals depending upon age,

responsibilities and activities. Except for minor variations, the basic needs of all people are the same (Cavanagh & McGoldrick, 1966). These authors assert that needs are driving influences that are basic to all types of behavior. Their inventory of 13 "personality needs" resembles Maslow's hierarchy of needs in that it begins with basic biological essentials such as food, clothing and shelter and then goes on, finally culminating with the need for progressive moral and religious development. A self actualization process is not directly described although one of the 13 needs is defined as the opportunity to develop one's own specific unique personality. Unlike Maslow's theory, the "personality needs" listed by these authors is not presented solely in the form of a hierarchy. Their emphasis focuses upon a variation and fluctuation of needs in individuals which is relevant to partial need fulfillment at some levels.

Man is driven throughout his life to meet needs which must be satisfied. Maslow (1970) implies that strategies for meeting needs will vary in efficiency. As well, there are variations in environmental conditions which affect individual coping and adaptation. Maslow's theory has certain implications which affect the course of coping and adaptation in meeting these needs. Some of these are as follows:

1. coping is purposive and motivated.
2. coping is determined by external environment and cultural variables.

3. coping is most often learned and can be controlled.

4. coping is usually designed to cause changes in the environment.

5. coping requires effort.

According to Lazarus, Averill and Opton (1974), coping is regarded as problem-solving efforts made by the individual when demands are highly relevant to well-being and when these demands tax adaptive resources. This definition emphasizes the importance of the emotional context in coping, recognizes the overlap between problem-solving and coping and emphasizes adaptive tasks that are not routine or automatic. These authors emphasize the process of appraisal in which solutions to a threatening situation are achieved.

There is a growing conviction that the methods people use to cope affect their psychological, physical and social well-being (Folkman & Lazarus, 1980). Folkman and Lazarus assert that a comprehensive definition of coping must include emotion regulating and problem solving functions. Thus, an important aspect in assessment of needs would be information as to how the patient copes.

Assessment of adaptive behavior and the coping processes of man will increase the understanding of how he handles everyday stresses and major life crises. This can lead to the prediction of future behavior and an attempt to effect changes in adaptive behavior and in the coping process if necessary (Moos, 1974). There have been studies on coping that have resulted in important changes in institutional

policies - an attempt to understand the "fit" between people and their institutions (Langford, 1961). Langford presents evidence of how the reactions of children and their parents to various hospital policies have resulted in change of these policies. This is an excellent example of changing environments rather than individuals.

Utilizing the foregoing needs, coping and adaptation concepts, discharge planning is viewed as a process which focuses on meeting the patient's post-release needs in order to assist in bringing about a successful return to the community. In addition, to be meaningful, the plan must take into account the patient's ability to use appropriate coping mechanisms in attempting to adapt to the exterior environment.

PURPOSE OF STUDY

Assessment of needs is one of the most critical factors in discharge planning. The information relevant to needs and coping received from the patient during the assessment process is an important element to be considered in developing a discharge plan that is specific to the patient's needs following discharge. To explore the differences and similarities of the patients' perception of their needs and the nurses' perception of patient needs is a fundamental step in identifying potential problems associated with the discharge process.

The purpose of this study is to attempt to answer the question: to what degree are there similarities and differences between the

psychiatric patients' identification of post-release needs as compared to those needs that the nurse identifies?

DEFINITION OF TERMS

1. Discharge planning - a multidisciplinary health team approach whereby patient needs are identified as they pertain to leaving the hospital and returning to the community. These needs are then acted upon and, ideally, assistance provided in meeting them.

2. Psychiatric unit - a psychiatric ward located in a general hospital, often designated for acute care treatment with a limitation on the number of days of treatment.

3. Nurse - a registered psychiatric nurse (R.P.N.) or registered nurse (R.N.) who works full-time or part-time on the psychiatric unit. The nurse's training can vary from that of a diploma (two or three year) education to that of a degree. Some will be dually trained (R.P.N. and R.N.) and some may have post-graduate training in psychiatric nursing. There are no Associate Degree nurses in Canada.

4. Patient - a person age 16 or older who voluntarily enters a psychiatric ward for treatment.

5. Need - a lack of something useful, required or desired; when met or satisfied, it solves a problem.

6. Assess - to evaluate, appraise or estimate factors relative to post-discharge needs.

Chapter 4

METHODOLOGY

Research Design

The design of the study was exploratory/descriptive. No prior studies were found which investigated the relationship between psychiatric patients' identification of post-discharge needs and those identified through assessment by members of the psychiatric unit nursing staff.

Population

Sample and Setting

The patient sample consisted of 35 psychiatric ward patients age 18 and over who were hospitalized in the province of Alberta, Canada. Only those patients identified by their nurses as being appropriate (i.e. not acutely psychotic) were asked to participate. No attempt was made to select patient subjects randomly and any patient who met the previously mentioned criterion and who volunteered was accepted as part of the sample. In addition, there were 31 nurses assigned to care for the aforementioned patients who also participated in the study sample.

Three separate general hospitals in three different locales were the sites of the sampling. Two of the hospitals used as a setting were located in medium sized southern Alberta cities serving a rural as well

as an urban population. The remaining hospital setting was one in a large central Alberta metropolitan center.

The initial hospital is located in a city (with an agricultural based economy) of approximately 54,000 people. Hospital I (as it will be referred to in the study) is a 220 bed facility with a psychiatric ward containing beds for 21 patients. On the date the sample was drawn, census in the psychiatric unit was one over count, forcing the staff to assign this patient to a bed in emergency. Of the 21 psychiatric patients, 14 were identified by their nurses as suitable subjects and all 14 volunteered to take part.

The other small hospital has its setting in a city (known for its natural gas reserves industrial base) populated by roughly 38,000 inhabitants. Hospital II has a 14 bed ward for psychiatric patients among its total of 250 beds. When the sample was taken only nine patients, two of whom were actually medical patients, accounted for the census on the psychiatric ward. Five of the seven psychiatric patients were deemed as suitable for participation. Of this group, three consented while two declined because they did not want to sign a "consent" form.

The last hospital with sampled population is centered in Alberta's major manufacturing and business community, a city of close to 600,000 residents. Hospital III is a much larger and older structure, recently renovated to provide care for 970 patients. Within this building, two

psychiatric wards were used to gather information. Both units had 25 beds for a total of 50 beds made available for psychiatric patients. In the first ward sampled, the census was 14 of which seven were suitable. The other ward had a patient population of 21, 11 of whom were designated as suitable. All seven from the first ward and 11 from the second unit were willing to participate.

A diagrammatic scheme of the patient/nurse/hospital relationship as it pertains to the sampling in the study can be found in appendix H.

Protection of Human Rights

Participation in the study was entirely voluntary. The research proposal was reviewed by the local Faculty Human Rights Committee, the Montana Deaconess Medical Center's Nursing Research Committee and the Educational Director, Montana State University School of Nursing, Great Falls Extended Campus. No violations in human rights of the participants were found (see appendix A).

Letters of approval were also received from the administrators of the three hospitals wherein sampling took place (see appendix C). For patients in the large hospital sample (Hospital III), letters of consent were also received from individual psychiatrists (see appendix C). As well, one hospital administrator (Hospital II) requested written permission from patients involved in the study. The "Consent to Participate" form was utilized for patients sampled at this hospital

(see appendix D).

Data Collection Instrument

The literature review and subsequent search for an adequate needs assessment tool failed to identify a suitable data collection instrument for this study. Several tools were investigated - the Community Adaptation Schedule, the Discharge Readiness Inventory and the Wahler Self-Descriptive Inventory. None of these, however, were suitable for measuring post-hospital needs identified by hospitalized patients and their nurses. In view of this development, it became necessary for the writer to design a questionnaire that would facilitate collection of the required data.

With the assistance of a southern Alberta clinical psychologist, a social worker and two psychiatric nurses from a day treatment program, the writer identified a cross section of human needs deemed to have practical application for soon-to-be released psychiatric patients. In total, 14 different needs were selected for measurement (see appendix B). These 14 post-release needs include such things as: health teaching needs; need for support systems; need for understanding the use of medications and their side-effects; need for improved coping capacities and mechanisms; and financial/housing needs.

In order to elicit responses relative to each of the 14 needs, a series of 55 statements was formulated. Each need statement was then

clustered around one of the 14 need categories (see appendix G).

From the aforementioned, the statements were randomly arranged in the form of a questionnaire (see appendix F). A total of five response columns ranging from "strongly agree" to "strongly disagree" were added to complete the tool. An additional "not applicable" column was inserted for the last 10 statements of the inventory to reflect statements which may not have fit the patient-respondent's situation.

Two types of statements were utilized throughout the inventory. One group of statements had a positive connotation wherein agreement with the statement by the respondent inferred an importance attached to the identified need. For example, "I wish I knew how to cope better with my problems." At the other end of the extreme, a disagreement with a positive statement would tend to indicate that the respondent does not consider the need of major concern for the person being assessed.

The second type of statements were phrased in the negative. For example, "I have no present need for medical services." Agreement with this type of statement by the respondent demonstrated an assessed "no need" situation while disagreement with the statement implied an inverse, positive requirement for assistance in a need.

Individual responses to a positive statement were assigned a specific rating. The ratings are as follows: strongly agree, 4; agree, 3; not sure, 2; disagree, 1; and strongly disagree, 0. For a

negative statement, the numerical value for each type of response was reversed.

Each of the 55 statements was categorized into one of the 14 need groupings. The number of statements in each need classification ranged from two to five. For purposes of measuring correlation, the total scores of the patient on the positive statements within each need category were compared to the total positive statement scores of the nurses (firstly the day shift nurse and then the afternoon shift nurse) assessing that patient. Following that, the patient's total score on the negative statements was compared to that of the nurses (both day shift and afternoon shift) caring for and assessing that particular patient.

During the month of June, 1981, a pre-test utilizing this inventory tool was administered to a small group of psychiatric patients and their nurses in a Montana hospital. The purpose of the pre-test was to determine if the questions were clearly stated and easily understood. People were asked to indicate any questions that were unclear to them. The pilot study indicated no changes were necessary.

Data Collection Method

Data were collected during the months of July and August, 1981. Each of the 35 patients sampled answered one questionnaire. Although there were 31 nurses involved in the sample, a total of 70 questionnaires were completed by this group. Each of the 35 patients was

assessed twice, once by the day shift nurse as well as by the afternoon shift nurse responsible for that patient. Some nurses assessed the needs of only one patient while others assessed the needs of up to five patients depending upon their patient load for the particular shift worked (see appendix H). Each patient and nurse respondent received an introductory letter with the questionnaires (see appendices D and E) which were designed to explain the purpose of the study and to solicit the cooperation of the respondent. As well, the covering letter was intended to reinforce the confidentiality of those participating.

Facts related to age, sex, education, hospitalization history, diagnosis and so forth were also collected from each patient by means of a demographic data sheet (see appendix D). As this information is somewhat more personal, overlapping-response type questions were used for the most part.

The nurses answered a similar demographic data sheet (see appendix E) and questions relating to the type of training, number of years experience working on a psychiatric ward, discharge planning training and practices were posed. Nursing staff were also requested to complete a short addendum to the questionnaire (see appendix F) for each patient whose post-release needs they assessed.

Between the months of September to November, 1981 as the patients were discharged, a post-release follow-up was initiated. The former patients were mailed another questionnaire and asked to respond to it

a second time in order to compare their need priorities now that they had returned to the community. An accompanying letter (see appendix I) was enclosed with the questionnaire and afforded a rationale to each ex-patient as to the purpose behind the pre-release and post-release comparison. Responses to the questionnaire were received from 16 of the original 35 patients, although in some cases only parts of the inventory were answered.

Chapter 5

ANALYSIS OF DATA

Introduction

The demographic data gathered as part of the study were used to construct a profile of the respondents prior to the actual analysis of their needs assessment replies. Utilizing the product moment correlation coefficient, also referred to as the Pearson r, the relationship between post-discharge needs assessed by the patients and their nurses was then measured. As well, comparisons and similarities expressed in terms of frequency distributions, rankings and correlations between specific segments of the overall sampled population were analyzed and are discussed in the following pages.

Demographic Data of Patients

Of the 35 patient respondents (22 females and 13 males), the age breakdown revealed that both the 21 to 40 range and the 41 to 60 range were each represented by 40% (14) of the sample. Of the remaining 20% (7), only 5.7% (2) were under age 21, while 14.3% (5) were over age 61.

Married patients accounted for 40% (14) of the sample; there were twice as many married (14) as single (7) patients included in the study. Of the remaining 14 patients, six were divorced, five separated, two were widow or widowers and one lived in a common-law relationship.

Forty percent (14) of sampled patients held a full time job while 28.6% (10) were unemployed and seeking work. Fourteen percent (5) were not looking for a job, the same percentage as those working part time, and one person did not respond. In terms of income maintenance, two out of every seven patients questioned were social assistance recipients.

The majority (60% or 21) of psychiatric patients in the study indicated that they normally lived at home with their family. Nine (25.7%) lived alone while two each resided in either a group home or had other living arrangements. One patient failed to respond to this question.

Patient length of hospitalization at the time of sampling varied from less than one week to over two months. Total length of patient stay at the time of discharge ranged from two days to 123 days with an average period of hospitalization of 33.26 days.

The question relating to frequency of admission to psychiatric wards revealed that 80% (28) were hospitalized only once during the past year. Approximately half of them (48.6% or 17) had no history of psychiatric unit hospitalization in the previous two to five year period.

Only 17% (6) of the sampled patients indicated that they lived in communities of 10,000 or less population where they planned to return after discharge. Forty percent (14) of the patient group indicated they were residents of municipalities with 50,000 or less population while

45.7% (16) said that upon discharge they would return to reside in centers of 50,000 or more. Five (14.2%) patients either did not know where they would go after discharge or did not choose to respond to the question.

Narrative comments relative to where the patients expected to go for mental health care after discharge revealed that 12 (34.28%) would choose a hospital or clinic, eight (22.85%) would seek out a doctor and four (11.43%) would turn to the Alberta Mental Health Services. A total of nine (25.7%) patients either did not know where they would go for this care, chose not to answer or felt they would not go anywhere for further treatment.

Three (8.6%) patients indicated a travelling distance of over five miles up to 15 miles to the closest facility. The same number of patients replied they would have to go over 30 miles to the closest facility for mental health services. Four (11.42%) of the patient group answered that they would be required to travel over 15 miles up to 30 miles. Six (17.14%) did not respond to the query.

Patient identification of the reason for (diagnosis of) their illness revealed that 10 of the 35 said they suffered from depression. It is interesting to note that six described their illness in terms of a physical complaint while another six were unable to identify their illness at all. Table 1 gives a breakdown of the diagnoses that patients gave for their illness.

Table 1. Patient Identification of Diagnosis

Diagnosis	Number (N=35)
Depression	10
Manic-Depression	2
Neurosis (Anxiety)	4
Schizophrenia	3
Don't Know	6
Alcohol Addiction	1
Suicide Attempt	1
Physical Complaints	6
Drug Addiction	1
Did Not Respond	1

Demographic Data of Nurses

Thirty one nurses were included in the study. The majority (64.5% or 20) ranged in age between 20 and 30. Almost all (93.5% or 29) were age 40 or under.

The demographic data sheets also revealed the following: the sample consisted of 29 females and only two males; 24 of the 31 nurses surveyed worked on a full time basis, 12 of these holding a permanent

shift; and 16 of the nurses were married, 13 were single and two were divorced.

From the standpoint of educational level, only three of the respondents had a baccalaureate degree while over 90% (28) were diploma nurses. Within this group of 28, 19 were registered nurses, seven were psychiatric nurses and two were dually trained (see page 20).

There was a wide cross-section of psychiatric ward experience in the nurse group sampled. Approximately 29% (9) had been working on this type of unit for less than one year while 58% (18) had up to two years of psychiatric ward experience. Those with over five years of experience (25.8% or 8) numbered more than the staff with over two years and up to five years experience which accounted for the smallest (16.13% or 5) group.

Some of the problems the nurses experienced with discharge planning could be grouped into four areas. Table 2 presents the frequency with which these problem areas were identified by the nurses sampled.

With respect to the discharge planning process in their particular hospital, two-thirds of the sampled nurses felt that the time allowed for discharge planning was adequate. Only 10% (3) felt that the time was satisfactory and 23% (7) stated it was unsatisfactory.

Table 2. Problems With Discharge Planning

Problems	Number (N=31)
Lack of agencies, placement, follow-up	11
Lack of communication - nurses/doctors/patients	7
Not started early enough	5
No comment	8

Within the hospitals where these nurses were employed, 25 of them (over 80%) said that they had access to a discharge planning consultant or social worker for guidance relative to discharge planning. Only two of the 31 said that they had benefit of an in-service training course during the past year while four indicated they had taken this type of training in the previous year or before.

All the nurse group felt that discharge planning in their hospital began well before discharge orders were written. Eight (25.8%) of the respondents answered that discharge planning began on the day of admission while the remaining 23 (74.2%) indicated that it began at patient conferences when indication of discharge was given.

Overall, the nurses tended to be a much more homogeneous group than the patients sampled. This was especially so in terms of age

range and sex.

Relationship Among Measured Variables

In presenting the quantitative findings of this study, one should keep in mind that the descriptive statistical method of presentation is geared to summarize and describe the data only and is not construed as providing a means for making inferences and drawing conclusions.

The first step taken by the writer in analyzing the data obtained through the questionnaire was to examine the frequency of responses relative to the identification of patient post-discharge needs. The frequency measurements were then ranked in order of importance as indicated by the group of respondents. Table 3 identifies the rank order of needs in terms of frequency as assessed by the patient group. Overall patient responses give the highest priority to a need for support systems and the lowest frequency rating to the need for post-release follow-up in the community by a mental health worker. Needs are numbered to assist in discussions.

The frequency distribution of nurse responses was sub-divided according to the shift worked at the time of assessment. The mode identified in both distributions was, as in the case of the patient group, the need for support systems. In ranking the needs in terms of frequency as assessed by the two nurse groups, a similarity in

Table 3. Rank Order of Frequency of Patients' Post-Discharge Needs as Assessed by Patients

Rank	Need	Description
1	14	support systems
2	5	understanding use of medications and side-effects
3	6	health teaching needs
4	8	financial/housing needs
5	7	improve communication skills to deal with post-release situations
6	13	develop improved coping capacities/mechanisms
7	1	adequate state of physical health
8	9	belong and have close relationships
9	11	increased amount of independence
10	2	increased self-acceptance and self-esteem
11	3	vocational/occupational improvement
12	4	assistance in meeting role expectations
13	10	to be productive, creative, useful
14	12	for post-release follow-up in community by a mental health worker

rankings is evident. Needs 1, 2, 6, 7, 10, 11, 12, 13 and 14 all fall in the same rank order as assessed by both groups of nurses. Table 4 illustrates the rank order of important post-discharge needs by frequency for the day shift and afternoon shift nurses.

Following the ranking of frequencies of responses, the prime statistical relationships on which the study was based were examined. Utilizing Pearson's product moment correlation coefficient formula, the desired relationships in terms of patient post-discharge needs were calculated. Correlational coefficients were obtained for all 14 need categories by comparing overall responses of the three sampled groups: patients compared to day shift nurses; patients compared to afternoon shift nurses; and day shift nurses compared to afternoon shift nurses.

For the most part, the results indicated a number of weak positive correlations and a few moderate positive correlations, some of which were considered significant within probability levels ranging from .001 to .05. Only five of the 42 correlation coefficients had negative values. None of these negative correlations were significant at the .05 level. The entire 42 correlation coefficients are presented with reference to the 14 need categories in table 5.

Upon examining those correlation coefficients in table 5 to which a significant probability level are attached, it was decided to re-

Table 4. Rank Order of Frequency of Patients' Post-Discharge Needs as Assessed by Nurses

Need	Description	Rank Day Shift	Rank Afternoon Shift
1	physical health	9	8.5
2	self-acceptance/self-esteem	5	3.5
3	vocational/occupational improvement	13	13
4	meeting role expectations	10	10
5	understand medications	6	6
6	health teaching needs	2	2
7	communication skills	3	5
8	financial/housing needs	4	3.5
9	belonging/close relationships	8	8.5
10	productive, creative, useful	12	12
11	increased independence	11	11
12	post-release follow-up	14	14
13	increased coping mechanisms	7	7
14	support systems	1	1

Table 5. Patient Needs Assessment Correlation Coefficients

Need	Patients compared to Day Shift Nurses	Patients compared to Afternoon Shift Nurses	Day Shift Nurses compared to Afternoon Shift Nurses
1	.072	.255	.319*
2	.545***	.418**	.254
3	.459**	.427**	.310*
4	.248	.021	.435**
5	.087	.096	.188
6	.011	-.081	-.270
7	-.089	.067	.253
8	.449**	.512***	.369*
9	.458**	.008	-.099
10	.192	.223	.482**
11	.271	.382*	.152
12	.106	.266	.252
13	.192	.377*	-.094
14	.412**	.402**	.277

*** $p < .001$ ** $p < .01$ * $p < .05$

arrange presentation of the data in terms of ranking the significant correlation coefficients from highest to lowest. Tables 6, 7 and 8 are the end results of presenting some of this data from a different perspective.

Table 6. Rank Order of Significant Need Assessment Correlation Coefficients Comparing Assessment by Patients With Assessment by Day Shift Nurses

Rank	Need	Description
1	2	increased self-acceptance and self-esteem
2	3	vocational/occupational improvement
3	9	to belong and have close relationships
4	8	financial/housing needs
5	14	support systems

Table 7. Rank Order of Significant Need Assessment Correlation Coefficients Comparing Assessment by Patients With Assessment by Afternoon Shift Nurses

Rank	Need	Description
1	8	financial/housing needs
2	3	vocational/occupational improvement
3	2	increased self-acceptance and self-esteem
4	14	support systems
5	11	increased amount of independence
6	13	to develop improved coping capacities/mechanisms

Table 8. Rank Order of Significant Need Assessment Correlation Coefficients Comparing Assessment by Day Shift Nurses With Assessment by Afternoon Shift Nurses

Rank	Need	Description
1	10	to be productive, creative, useful
2	4	assistance in meeting role expectations
3	8	financial/housing needs
4	1	adequate state of physical health
5	3	vocational/occupational improvement

The rankings of significant correlation coefficients (tables 6, 7 and 8) are totally independent of the frequency of response rankings (tables 3 and 4) and should not be interpreted as being rankings of similar measurements. For instance, need 14 (support systems) was identified through frequency of response to be the need with the highest priority for all groups of respondents assessing patient post-discharge needs. However, in terms of the actual correlation coefficients used in comparing needs assessments made by the groups, need 14 (support systems) was significant and ranked fifth (table 6) among the correlations between patients and day shift nurses; was significant and ranked fourth (table 7) in the assessment by patients as opposed to the assessment by afternoon shift nurses; and was not considered significant (table 8) at the probability levels being utilized when comparing day shift nurses' assessments to afternoon shift nurses' assessments.

The next relationship explored was the one with the individual hospitals as the variable to be analyzed. As was expected, the lowest correlation coefficient comparing all patient responses to all nurse responses on all need statements was the one calculated for the large metropolitan hospital (hospital III). Of the two medium sized hospitals which serve a rural as well as an urban population, the one where 14 patients were assessed (hospital I) had a greater positive correlation coefficient than the hospital where only three patients were assessed

(hospital II). Overall, however, correlation coefficients for all three indicated moderate positive relationships with significance at the .001 probability level. Table 9 illustrates these relationships.

Table 9. Correlation Coefficients by Hospital Comparing All Patient Responses With All Nurse Responses on All Need Statements

Hospital I	Hospital II	Hospital III
.561***	.489***	.415***

*** $p < .001$

Totalling all group responses together and making comparisons in assessment totals was the basis for constructing table 10. The overall correlation coefficient of .241 represents a weak positive relationship with a probability level of .05 and takes into account the comparison of all patient responses to all nurse responses on all need statements.

The need assessment responses of nurses tended to have a higher positive correlation with the need assessment responses of patients who were female, were age 30 or below, were employed, did not receive social assistance, did not live alone, had spent less than two weeks on the ward and had been admitted as a psychiatric patient only once

within the past five year period. The actual correlation coefficients comparing the relationship between the need assessment responses of nurses to differing groups of patients are presented in table 11.

Table 10. Pearson Correlation Coefficient Matrix for Four Respondent Variables on All 14 Needs

Variable	Day Shift Nurses	Afternoon Shift Nurses	All Nurses
All Patients	.230	.247	.241*
Day Shift Nurses		.265	

* $p < .05$

Within the nurse group, the following sub-groups had need assessment responses which were correlated highest (on a positive level) with the need assessment responses of the overall patient group: part-time nurses; those without access to a discharge planning consultant; those with up to five years experience; those working on afternoon shift at the time of sampling; female nurses; those with no previous in-service course in discharge planning; and those age 30 and under. Table 12 presents the aforementioned in tabular form with the