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
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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 hopsitals 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 (mearl 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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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 hopsitals 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 recouperating 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