



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

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

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

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

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

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

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

by

Allison Marie McIntosh

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

of

Master of Nursing

**MONTANA STATE UNIVERSITY
Bozeman, Montana**

June 1991

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Allison Marie McIntosh

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

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ACKNOWLEDGEMENTS

I wish to thank the members of my graduate committee for the invaluable attention and support they provided throughout the entire research process. My chairperson, Dr. Jan Buehler, allowed me the freedom to submit numerous unpolished drafts for scholarly critique. Ruth Vanderhorst and Dr. Janet Rhorer also provided a great deal of attention to this project, especially in the final preparation of the thesis.

My family was extremely supportive throughout my graduate program and research endeavors. My parents provided consistent encouragement. Carrie Pfeiffer, my grandmother, shared in my work on a daily basis and, at important times, widened my perspective. Todd Carson made personal sacrifices and allowed this project to take first priority in our lives, even throughout our engagement for marriage.

My typist, Judy Harrison, contributed a level of professionalism which increased my appreciation for detail and consistency.

Finally, I would like to thank the participants in this research study. The discharge planners and patient informants shared their perceptions in a way that was enriching to the research study and to the profession of nursing.

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ABSTRACT

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

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

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

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

CHAPTER 1

INTRODUCTION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Significance of the Study

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

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

Purpose and Research Aims

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

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

Definition of Terms

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

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

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

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

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

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

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

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

CHAPTER 2

REVIEW OF LITERATURE

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

Discharge Planning

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

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

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

Outcomes of Hospitalization

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

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

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

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

Informal Caregivers

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

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

Rural and Urban Elders

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

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

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

Formal and Informal Assistance

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

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

Importance of Perceptions

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

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

Summary of Studies Examined in Review of Literature

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

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

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

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

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

Conceptual Framework

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

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

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

CHAPTER 3

RESEARCH METHODOLOGY

Design

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

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

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

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

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

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

Setting

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

Study Population

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

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

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

Sample

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

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

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

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

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

Data Collection

Patient Informants

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

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

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

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

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

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

Discharge Planners

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

Follow-up Patient Informant Interviews

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

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

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

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

Procedures for Recording Data

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

Protection of Human Subjects

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

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

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

Data Analysis

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CHAPTER 4

FINDINGS

Qualitative Analysis

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

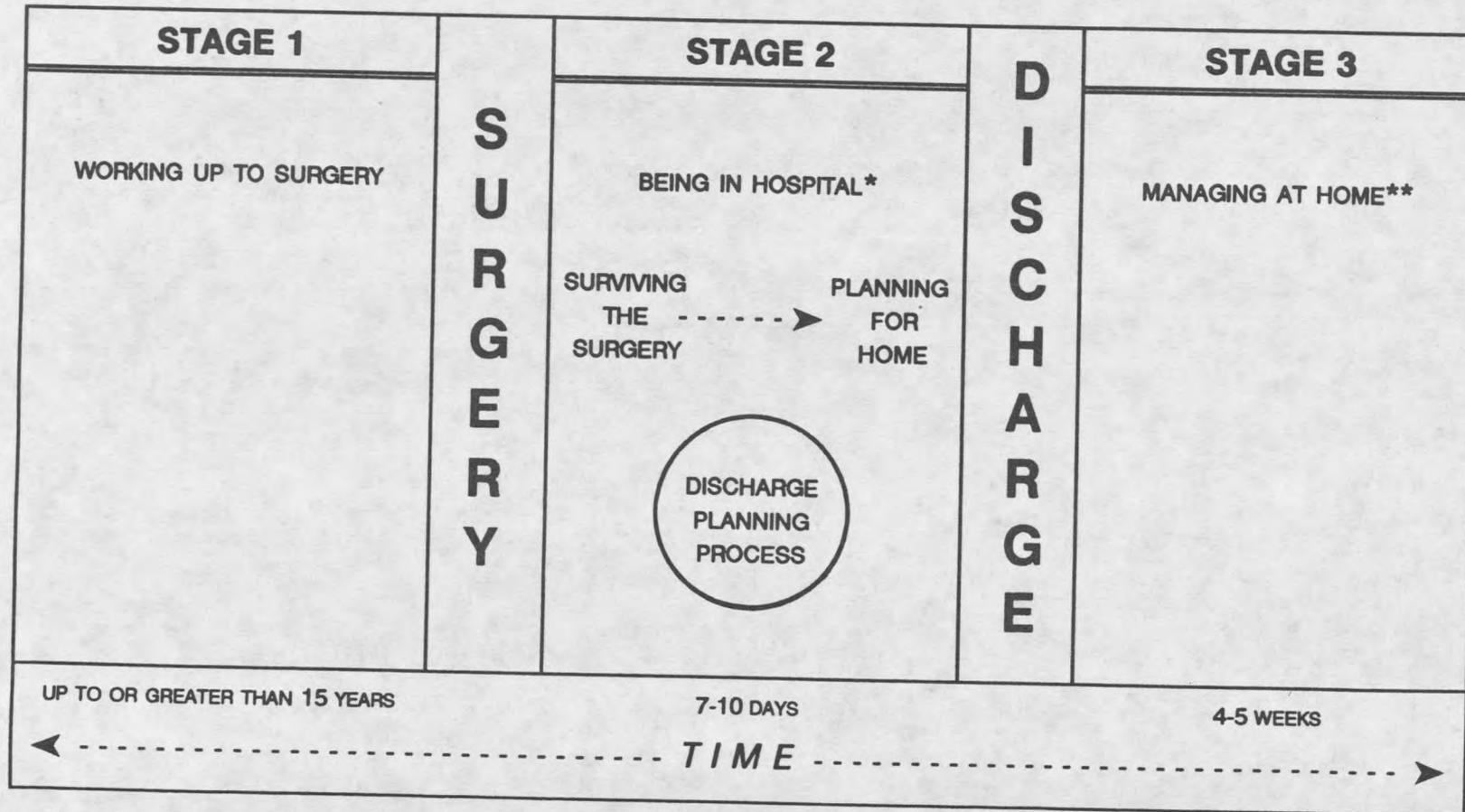
A qualitative approach which used grounded theory was selected to examine these issues. This approach was appropriate because it provided a way to examine and compare several social processes which were occurring simultaneously, and to generate theoretical concepts based on these processes. The main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

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

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

FIGURE 1.

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



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

Demographic Characteristics of the Sample

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

The Process of "Getting Fixed"

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

Stage 1: Working Up to Surgery

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

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

