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Grasping the nettle

Understanding hospital discharge : a constructivist inquiry

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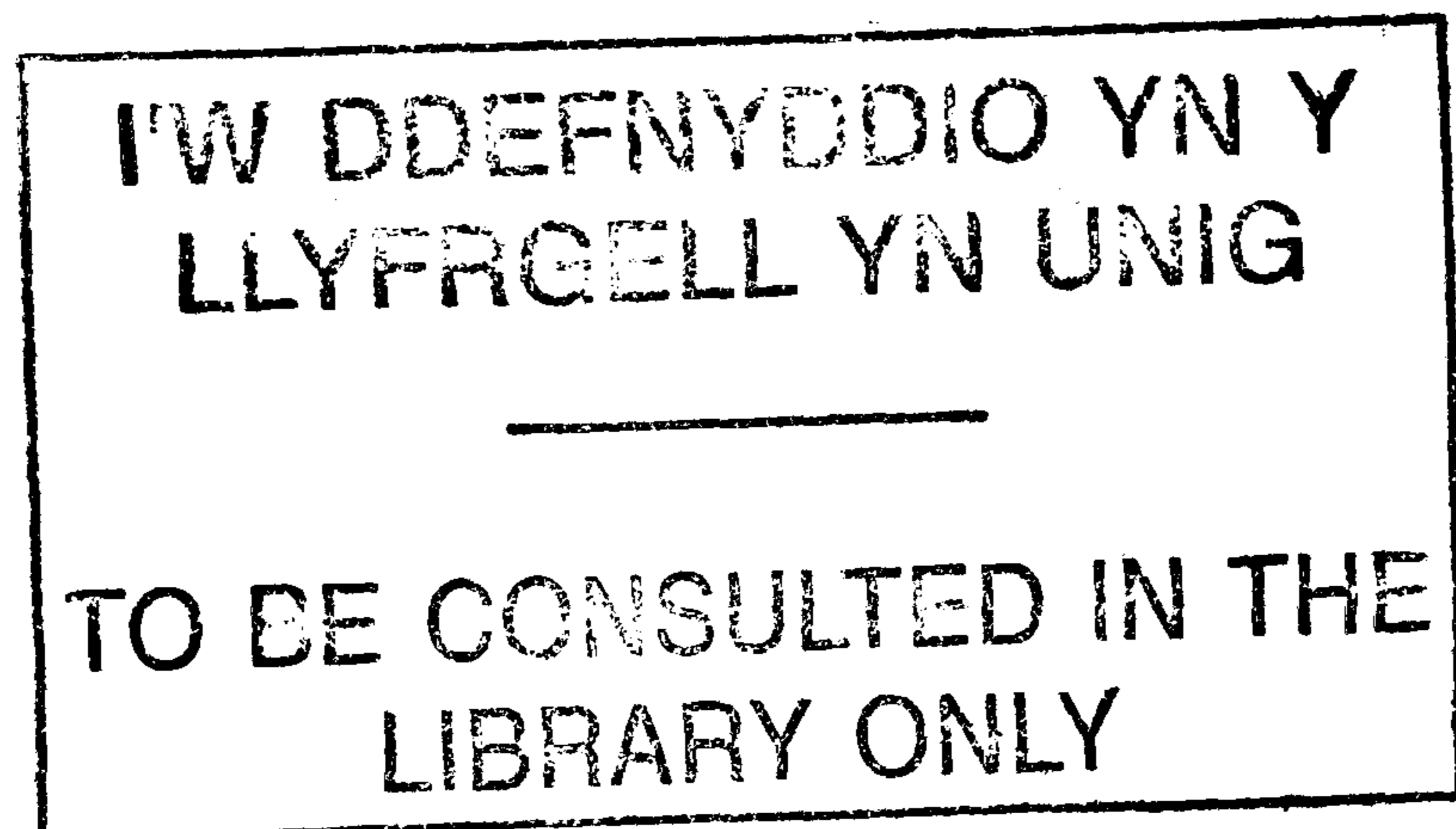
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Grasping the Nettle

Understanding Hospital Discharge:

A Constructivist Inquiry

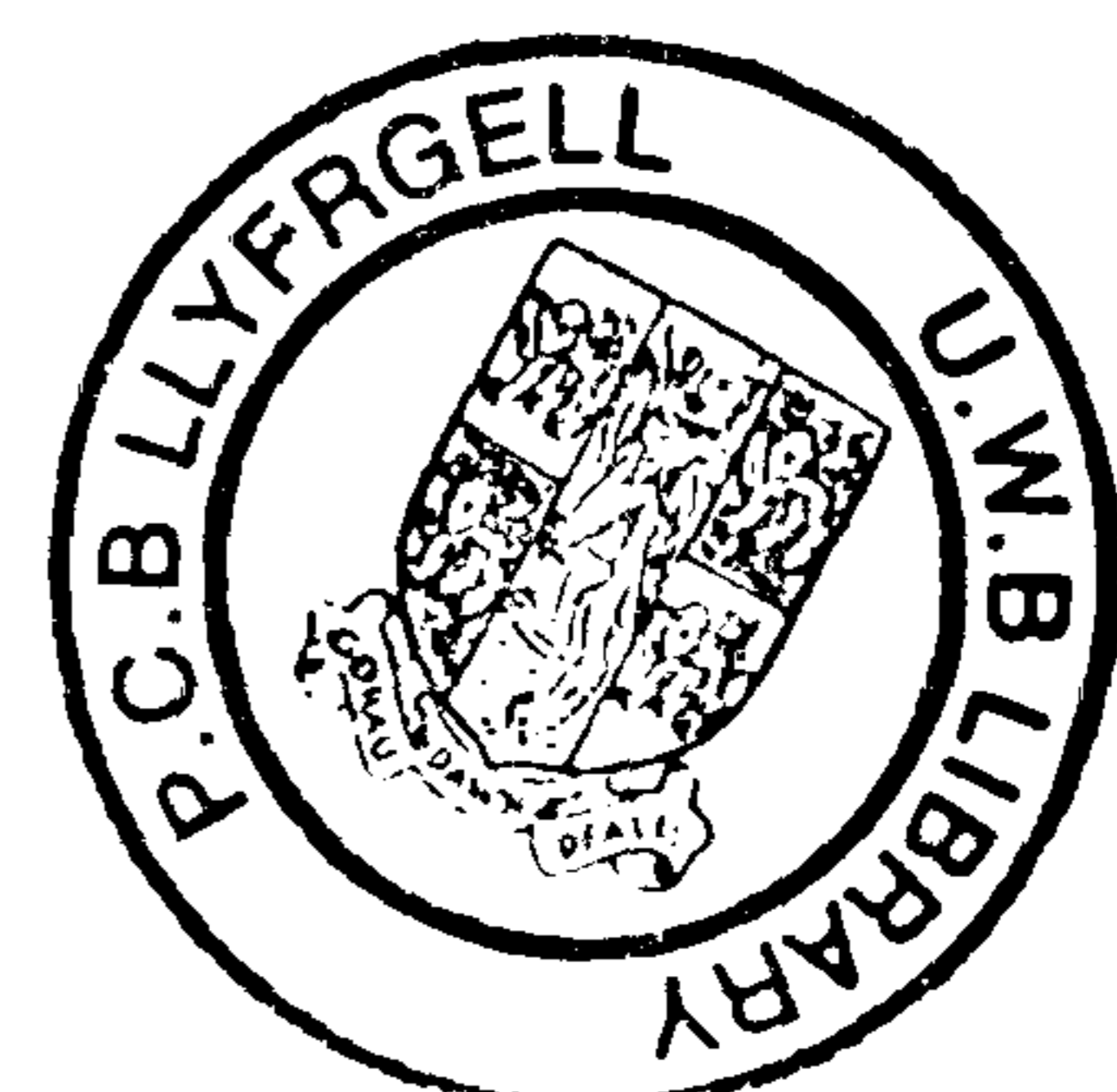


Thesis submitted in fulfilment of the requirements for the Degree of Doctor of Philosophy in the University of Wales, 2001

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DEDICATION

For Page and Sioned Page
And all those living with chronic illness

SUMMARY

This thesis explores the contrasting experience of the discharge of older people from hospital on a Care of the Elderly Unit and Medical/Surgical Unit in a District General Hospital in North Wales. It comprises both the results of a Fourth Generation evaluation (Guba and Lincoln, 1989) and the later development of a substantive grounded theory of the discharge process (Charmaz, 2000). Both elements of the thesis were informed by a constructivist approach to research and the presentation and style of the thesis reflects this orientation.

Data were collected from all the main stakeholder groups (members of the multidisciplinary team, patients and carers, members of the primary health care team) using a variety of methods including semi-structured interviews, documentary analysis and periods of observation. These data were then fed into a series of hermeneutic cycles in an effort to reach consensus about desired change. Barriers to both consensus and change were identified and explored largely in terms of the threat they posed to traditional medical power bases.

The subsequent theory suggested that the differences between the Units could be explained largely in terms of the orientations on the ward, one of which 'processed patients' with an emphasis on pace (speed of throughput) while the other 'processed people' with more recognition of the complex needs of older individuals. In both Units the role of the nurse was significant and comprised a number of key processes: *pushing*; *fixing*; *informing* and *brokering*. The ways in which these processes interact are considered and their impact on the discharge process described.

The quality of the thesis is considered on a number of criteria and the extent to which the results can be recontextualised is addressed. Finally, implications for policy and practice in the light of recent developments are discussed.

INTRODUCTION

'The model of Fourth Generation evaluation – indeed, this entire book – is a construction with precisely those characteristics that we have been inputting to constructions throughout this volume. That is, it is a social construction, built on the stuff of experience – our own and those of others, which we have absorbed in the form of vicarious learning – values, beliefs, the particular settings and contexts in which we have worked and been asked to work and the influence of others' constructions, from which we have tried to draw meaning and possibility. Thus, this book as in any construction is problematic, subject to reconstruction wherever and whenever new information and/or increased sophistication can be brought to bear.'

(Guba and Lincoln, 1989, p265)

This thesis presents an account of a journey, a journey to explore multiple perceptions of the experience of discharge from hospital. It is informed by a Fourth Generation approach to evaluation, and as such is itself a construction which attempts to distil and convey in the form of 'vicarious learning' the values and beliefs that influence the discharge experience in a particular setting and context.

In this instance the setting is a District General Hospital in North Wales, and the context was as part of a development project in which I played a significant role. The journey has been a long one and during its progress my own role has changed, and this will inevitably have impacted on the way that the final product, this thesis, has been constructed. As the journey started, I was a staff nurse working on the unit in which the development project began, over time I moved into a project officer role, and eventually into nurse education. However, the study was forged and enacted during my time as a practitioner and a project manager and it is that account that is initially provided here.

Presenting the account is difficult and challenging due to the plurality of stakeholders involved and the need to distil from their various constructions a version that presents as

accurate a reflection as possible. The extent to which this is achieved is in part for the readers of this thesis to judge, as is the degree to which the construction presented is consistent with their own understanding of discharge planning built upon their experiences, vicarious or real, and the extant literature.

It is also important to recognise that all accounts are imbedded within a certain temporal framework and, that as time marches on, new versions may emerge. Discharge planning has always been a contested area but recently it has again resurfaced as a policy and practice priority. While this will be alluded to later, it is important to recognise that the account given here needs to be interpreted in its historical context, and that much has changed in 5 or 6 years, as reflected in the current context of health care. It is therefore considered to be important at this point to provide a brief context for the study as a whole.

During the early 1990s I was a staff nurse working on an acute admission ward for older people in a District General Hospital (DGH) in North Wales. As part of my professional development at that time I was undertaking a Post-Graduate Certificate/Diploma in Advanced Social Studies (Gerontology) at the University of Wales, Bangor. This programme coincided with the integration of the (then) School of Nursing and Midwifery into the University as one of the first sites in the UK for the new nurse training, Project 2000. The coordinator of the Gerontology course at the time was Dr. Mike Nolan and he stimulated in me a desire to take my studies further. The final integration of the School of Nursing and Midwifery resulted in the establishment of a Research Division within the School to which Dr. Nolan was appointed as Senior Lecturer. Dr. Nolan had long established links with a small national charity, BASE (British Association for Services to the Elderly), and in consolidating these links a

limited amount of money was made available to support a higher degree study. I was approached to see if I was interested in pursuing this possibility and this led to more detailed discussions with senior nursing personnel within the DGH (see later for full discussion).

There was general support for the overall concept, but a mechanism was required that would enable me to be seconded from my duties for a period of time in order to undertake the empirical element of any potential study. As funding was limited it was felt that there needed to be mutual benefit for both myself and the DGH, and that any study should therefore focus on an area of interest to both the Care of the Elderly Unit and the hospital as a whole.

Coincidentally, at this time, there was considerable interest in the discharge of older people from hospital, with renewed emphasis being given to this area of practice by the Welsh Office. Although the existing arrangements for discharge on the Care of the Elderly Unit were generally seen as satisfactory, it was nevertheless considered that there was room for improvement. It was therefore decided that any study should focus on discharge arrangements, but that rather than be a straightforward research study, it should also have a developmental component so that the results could be fed back into the system and hopefully changes introduced as a consequence. This circle of activity comprised phase one of the study upon which the thesis is based.

As the above evaluation was drawing to a close the Welsh Office launched a major initiative to promote Clinical Audit in Wales and consequently funding was available to support new and innovative projects. Based on the results from the Care of the Elderly Unit a proposal was submitted to extend the evaluation, this time in the form of an audit, to the Medical and Surgical Units within the same DGH. Discharge from these

areas was more problematic than from the elderly wards and it was felt that the lessons learned could be applied to good effect. The bid to the Welsh Office was successful and this meant that I was appointed as project officer for the duration of the audit activity. It is this second round of activity that forms the other empirical component of the project upon which this thesis is based.

As it will be seen, the study, rather than being neatly planned from the outset, was the result of a series of fortunate coincidences and the account that is provided in this thesis, while being consistent with the events, will inevitably provide a rather neat and orderly impression, which on occasions belies the somewhat frantic activity that was undertaken. This should also be borne in mind when reading the thesis.

There are also other factors that it is important to bear in mind, factors which meant that the journey towards completion of this thesis was almost never completed. At the end of the hospital based study, another opportunity arose to further extend elements of the results into a community context (these do not comprise part of this thesis), and such was the level of activity that all my time had to be devoted to completing the significant amount of new work that was required.

Subsequently, another change of position, this time with a move into nurse education, the birth of a baby daughter and unexpected and long-term family illness meant that studies were all but abandoned. Therefore, although much of the first part of this thesis had been written, it seemed that the final chapters might not be added. However, a return to the data, some time after the hospital study had been completed, re-awoke enthusiasm and also a re-analysis of the data in order to try and provide some theoretical insights into why the studies on the two Units (Care of the Elderly/Medical and Surgical) produced such differing results. In the interim period the constructivist

methodology that underpinned this thesis had advanced and, armed with these new perspectives, the thesis also therefore provides a mid-range theory of the processes underpinning hospital discharge in the DGH with a particular emphasis on the role of the nurse.

Having provided this brief context, attention is now turned to the structure of the thesis, which is organised into a series of chapters.

Chapter One – This provides further detail about the context for the study, particularly the attention given to discharge planning during the early 1990s. The chapter does not comprise a ‘typical’ review of the literature but rather gives an account of the way in which the literature was used to underpin the initial study on the Care of the Elderly Unit, by highlighting the questions that were identified at this point.

Chapter Two – This focuses on the methodology that was adopted and describes how the study was conceived of as an action orientated evaluation informed by a Fourth Generation methodology (Guba and Lincoln, 1989), with an emphasis on negotiation and participation. Although the second phase of the study was formally described as an audit (in order to meet the terms of the funding), it too followed a participative approach that can be considered to fall within the general principles of a Fourth Generation model. In addition to providing the philosophical background to the studies, this chapter also gives a fuller account of the processes of data collection and analysis.

Chapter Three – This presents an overview of the results as they relate to both of the studies and highlights a series of tensions and difficulties that emerged as the studies unfolded. In particular the problematic nature of agreeing ‘shared constructions’ is

stressed, together with differences that become apparent between the two Units. At this point no attempt is made to account for differences.

Chapter Four – Although the original aims of the two studies were essentially pragmatic, that is their intention was to lead to practical changes in the discharge arrangements of older people from hospital, it was also considered important to seek explanation of the differences between the two units and to determine if such explanations could be used to help initiate change elsewhere. Chapter four therefore comprises a mid-range theory of the discharge process, at the heart of which lies the role of the nurse as a ‘fixer’ and ‘broker’ of the key arrangements. The ways in which the actions of the nursing team are pivotal to a better understanding of how a successful discharge is determined are discussed.

Chapter Five – This chapter draws the thesis to a close and identifies its contribution in terms of additions to debate in respect of discharge for older people from hospital. It also places the results into a contemporary context and considers their implications for the development of policy and practice.

CHAPTER ONE

DISCHARGE OF OLDER PEOPLE FROM HOSPITAL: A PERENNIAL CHALLENGE?

1.1: Introduction

The main aim of this chapter is to further elaborate upon the context in which the studies of which this thesis comprises were completed. As such it does not provide a 'traditional' review of the literature, although the literature that existed at the start of the 1990s is used to provide a platform for the original evaluation of the discharge arrangements, as they existed in a Care of the Elderly Unit in a North Wales DGH at the time.

At the time that the first study was proposed recent practice guidance from both the Department of Health (1989) and the Welsh Office (1990) had highlighted the importance of adopting a systematic approach to the discharge of older patients from hospital. These documents directed specific attention to a number of vulnerable groups, foremost amongst whom were frail elderly patients, particularly those living alone or with an elderly carer. The importance of adequate planning and coordination of discharge arrangements for such vulnerable individuals assumed even greater significance with the proposed enactment of Community Care Legislation in April 1993. The Welsh Office (1990) therefore stressed the need for an urgent review of discharge procedures and the implementation of necessary changes. It was recommended that on the basis of this review that a mechanism for the on-going assessment of discharge arrangements be established. The need for this was reinforced by an Audit Commission Report which pointed out that despite considerable attention to discharge arrangements:

'The practical administration of discharge remains poor and does not appear to have improved since the Department of Health published guidance in 1989.'

(Audit Commission, 1991, p25)

Therefore, when the opportunity arose for me to become involved in a research project under the auspices of the Research Division at the recently formed School of Nursing and Midwifery (see Introduction), discharge arrangements provided an ideal vehicle.

1.2: Developing a Research Project

At the time I was working as a staff nurse on one of the wards comprising the Care of the Elderly (as it was then called) Unit and an initial meeting was set up between the senior nurse for the Unit, the two ward sisters, and two of the three consultants responsible for patient care. At this meeting the idea of a research study focussing on the discharge arrangements of older people was introduced and, despite some reservations from one of the consultants, was eventually accepted with enthusiasm. It was agreed that while, in comparison to the situation in other units, the existing arrangements were probably good, it was nevertheless agreed that there was room for improvement. However, in order to maximise the chances for beneficial change, it was felt that a participative research approach was needed that would involve staff on the ward as fully as possible. At the same time it was considered important that the study should be conducted rigorously and be seen to have some merit as a piece of research. As will be apparent later (see next chapter), the resulting methodology that was adopted was informed by a Fourth Generation model of evaluation. However, following this initial meeting, the exact methodology was not the primary concern and it was felt that the study should begin with a brief consideration of recent policy documents, together

with extant literature in order that a baseline against which to consider the current arrangements could be established.

Following this initial meeting a series of broad aims were agreed in principle and these were:

- to evaluate the current discharge planning, especially in the context of frail elderly people and their carers;
- to identify any problem areas in the administration of discharge planning, from the perspective of all possible stakeholders, including professionals, patients and carers;
- to evaluate the role of the multidisciplinary team in the discharge planning process, the priority they afforded to discharge planning, and in particular the degree of coordination and the quality of communication that existed; and
- to explore the possibility of developing relevant standards and guidelines for good practice in relation to discharge planning.

It was the general opinion that the latter aim should be addressed first, not to provide some rigid or prescriptive framework, but rather to suggest some broad parameters to inform the study.

Once the amount of work that was required became clear it was apparent that I could not possibly complete the study while also fulfilling my regular duties. A second more formal meeting was therefore held with a planning team comprising senior nurses and the Assistant Director of Nursing Services (ADNS), where it was agreed that a period of secondment be arranged that would provide me with sufficient time to:

- appraise the relevant policy documents and literature as a background to the study, and to inform the development of the interview schedules;

- undertake a series of interviews with members of the multidisciplinary team (MDT), patients, carers, as well as members of the primary health care teams (PHCT) who liaised with the unit;
- facilitate data analysis; and
- provide feedback to the unit in a developmental fashion.

Although it was not possible to be seconded full time for the duration of the study it was agreed that time be made available in blocks of one week to complete the work. The first task was therefore to consider the relevant policy and practice context.

1.3: Discharge of Older People: A Context and Background

As noted in the introduction to this chapter, the period during which the study was planned had seen considerable activity in relation to the discharge of older people from hospital, with influential policy documents promoting a more rigorous and systematic approach. In order that the proposed study was informed as fully as possible it began with a brief overview of the existing literature. Neither time nor resources permitted a detailed critique, nor indeed was the intention to produce an exhaustive review. Rather the purpose of this phase was to distil some key messages from the literature and policy documents against which the current arrangements on the Care of the Elderly Unit could be gauged.

The problems relating to the discharge of older people from hospital are not new, with a number of early medical commentators noting the importance of adopting a systematic approach (see for example Brocklehurst and Shergold, 1968). Similarly, empirical studies had highlighted the poor communication that existed between hospital and community settings (Skeet, 1970), and these longstanding difficulties resulted in the

production of a shared set of standards by the British Geriatrics Society and the Association of Directors of Social Services (BGS/ADSS, 1989). In the same year a Department of Health circular and booklet 'Discharge of Patients from Hospital' (Department of Health, 1990a) added a further imperative to the now increasing concerns that this area of practice created.

Existing difficulties were seen to be exacerbated in the case of older people whose disparate needs add a further level of complexity, requiring even greater coordination and planning (Waters and Booth, 1991). Despite this, an Audit Commission report at the time noted that discharge planning was still accorded a low priority, and was generally poorly organised, due to ineffective multidisciplinary working and 'ad hoc' communication between both professionals and professionals/patients and carers (Audit Commission, 1991). Early research had reached similar conclusions (Armitage, 1981; Victor and Vetter, 1988) and in bringing these factors together Booth and Davies (1991) summarised the main activities necessary to ensure a smooth discharge home. These included:

- planning discharge goals;
- preparing a discharge package;
- adequate notice of discharge;
- discussion of aftercare arrangements;
- arrangements for aftercare; and
- liaison with primary health care services.

(Booth and Davies, 1991, p250)

These six aspects highlight the diversity and complexity of the tasks required in managing a patient's transition from one setting to another, involving, as it does, both

health and social care agencies (Neill and Williams, 1992). Although as Armitage (1981) noted, early accounts of discharge tended to see it as being largely unproblematic and primarily the responsibility of the medical team in the hospital. Skeet (1970) and Roberts (1975), as a result of their studies, emphasised the need to include community based team members and, especially patients, and carers as equal stakeholders in the planning process. However, their work, and that of others, concluded that this aspect of care was poorly addressed with there being only limited discussion of discharge arrangements with these stakeholder groups (Waters, 1987a; Neill and Williams, 1992). As a result of their study Neill and Williams (1992), as with Booth and Davies (1991), produced a set of recommendations for discharge, which included:

- giving the patient at least 24 hours notice of discharge;
- ensuring that patients have the opportunity to discuss, with a member of staff, how they may manage at home;
- having someone to accompany them on their journey home;
- having someone to meet them when they arrive home; and
- having someone to go and see them on the day of discharge.

The literature therefore confirms the multifaceted and complex nature of the discharge planning process which is not simply a procedure, but rather has a process with temporal dimensions. Therefore, good discharge planning must take account of what has preceded it, and what is to follow it (Armitage, 1981; Booth and Davies, 1991). A smooth transition seemingly requires good liaison and communication between both hospital and community teams and should include detailed discussion with patients and their family carers. However, despite acknowledgement of this, several studies

concluded that such canons were rarely achieved (Bowling and Betts, 1984; McCarthy, 1985; Waters and Booth, 1991; Young *et al.*, 1991; Macleod-Clark and Latter, 1992; Neill and Williams, 1992).

Partly in response to these obvious deficits, and in light of the forthcoming implementation of the NHS and Community Care Act, the Department of Health issued a circular stressing the need for a more structured and systematic approach (Department of Health, 1990a). The influence of the Parliamentary Select Committee report on inadequate discharge planning procedures, and the proposed implementation of community care reforms following '*Caring for People*' (Department of Health, 1989) provided a key impetus for the HC(89)5 circular and guidance (Department of Health, 1990a). However, the circular presented only a partial response to the difficulties identified in previous and contemporary research literature (Hockey, 1968; Skeet, 1970; Hirst, 1976; Gilchrist, 1987; Williamson, 1985; Russell and Read, 1986), with, for example, Waters and Booth (1991) being highly critical of the priority accorded to the role of the medical profession with only scant attention being given to the part played by nurses. It was also apparent that simply issuing guidelines would not in itself be sufficient and that there was a need to focus on a number of important areas of practice if improvements were to result. Any action therefore required a clearer understanding of the goals and purpose of discharge, and the type of assessment that was needed in order to provide a clear and agreed plan.

A central area of concern in the care of older people revolved around the core activities of assessment, planning and defining goals. As Waters (1987a) importantly notes:

'Identification of needs for aftercare can occur at any point along the continuum of the patient's hospital admission, existing problems may be ameliorated and new ones identified. The need for assessment and planning to commence at the point of admission is stressed' (p71).

The conceptualisation of discharge as a process by Armitage (1981) involving a period of preparation and consequences highlights the need to consider the patient's pre-admission health and social care context. This includes what Cass (1978 cited in Waters, 1987a) describes as a social diagnosis of the patient's home and social circumstances. The ability to plan for aftercare requires early assessment of patient and carer needs. Waters (1987a) highlighted the difficulties that can follow from poor discharge planning, with an exploratory study of outcomes for older people discharged from a geriatric unit highlighting marked deficits in their activities of daily living compared with similar groups in the community.

The consequences of poor planning for carers and community services were also identified in earlier research and reiterated not only by Waters (1987b) but other researchers (Victor and Vetter, 1988, Neill and Williams, 1992). Moreover, the introduction of an explicit policy of community care as proposed in '*Caring for People*' (Department of Health, 1989) further emphasised the importance of these two groups of stakeholders in successfully maintaining frail older people in the community. Furthermore, as Waters (1987b) pointed out, the concurrent emphasis being placed on a reduced length of stay would inevitably place greater strain on community resources:

'The emphasis on high turnover in geriatric units increases the likelihood of greater numbers of older people being discharged from hospital before full recovery had taken place' (p45).

This further reinforced the importance of early and comprehensive assessment of the needs of older people and the explicit involvement of their family carers. This was also stressed by Kennedy *et al.* (1987) and Wertheimer and Kleinman (1990) who argued for the more informed involvement of multidisciplinary teams both in the hospital and the community. Wertheimer and Kleinman (1990) suggested that there had to be more attention given to the functional abilities of older people as a key component of any assessment framework.

However, as Wertheimer and Kleinman (1990) contended, such a more holistic approach towards discharge would require a move away from the predominant medical focus, a focus which rather unfortunately had been reinforced by the Department of Health circular (Department of Health, 1990a).

The literature suggested that what was required was a more participative approach based upon the full involvement of older people and their carers. However, several studies indicated that this rarely occurred (Victor and Vetter; 1988; Ker and Davies, 1989; Congdon, 1990; Klop *et al.*, 1991), sometimes because relatives took control of events (Abramson, 1988; Coulton *et al.*, 1988).

However, usually carers themselves were not fully involved in discharge planning with Williams and Fitton (1991) stressing the need for improved communication between professionals and carers, with assessment including not only the role of the carer in supporting the older person, but also a consideration of carers' own needs. Based on their work they argued that there were often marked discrepancies between a carer's assessment of the needs of the older person following discharge, and assessments as made by professionals. This could lead to inadequate post-discharge support and subsequent readmissions. Existing difficulties were often worsened by the very limited

notice that carers received about the date and time of the intended discharge (Victor and Vetter, 1988; Harding and Modell, 1989; Neill and Williams, 1992).

Many of these potential difficulties were attributed to the differing perspectives held by the older people, their family carers, and key members of the multidisciplinary team. It therefore seemed that an improvement in the discharge planning process was unlikely to occur unless attention was given to the nature of multidisciplinary working.

1.4: Collaboration: A Key Component of Discharge Planning

The literature suggested that a highly significant feature in discharge planning was the nature and extent of collaboration both within MDTs and with other key groups of stakeholders. However, it was apparent that considerable problems existed (Kennedy *et al.*, 1987; Coulton *et al.*, 1988; Ker and Davies, 1989; Davidson, 1990; Wertheimer and Kleinman, 1990; Edwards, 1991; Hare and Hiller, 1992).

These difficulties further limited the extent to which older people and their carers were actively involved, despite the widespread acknowledgement that patients and carers should be central to discharge planning:

'Patients and carers should be at the centre of the planning and written information be provided on medication, diet, treatment, lifestyle and symptoms to look for and where to obtain help if needed.'

(Booth and Davies, 1991, p249)

However, the transfer of information between professionals and patients and carers was also the subject of difficulties. For example, Vaughan and Taylor (1988) noted the

discrepancies between the perceived need for information as defined by patients and that seen as required by professionals. Qualls and Czirr (1988) contend that this may be due to the differing perspectives that professionals bring to bear, and their own unidisciplinary focus which limits the extent to which they hold an holistic picture. In order to achieve a more complete view Booth and Davies (1991) highlighted the need for a focal point for discussion and suggested a 'discharge booklet' is used as an information source for patients, their carers and community based staff.

Suggestions of this sort provide a practical response to the discharge guidelines issued by the Department of Health (1990a) in that they can help to produce a more structured and systematic approach to the collection and transfer of information, the importance of which had been noted previously by a number of authors (Skeet, 1970; Bowling and Betts, 1984; Ker and Davies, 1989).

The use of such approaches would also potentially help to widen the focus of assessment, improve MDT working, and reduce a unidisciplinary focus (Wertheimer and Kleinman, 1990). For example, Wertheimer and Kleinman (1990) noted that if junior physicians were exposed to a more holistic focus in their early career then they were subsequently more likely to identify and act upon factors outside of the medical domain.

The literature would suggest that team working was better developed in care of elderly settings where, as Evers (1981) notes, it has achieved almost mythical status, with Herd (1990) arguing that enhanced team working has been one of the most important contributions of geriatric medicine to the care of older people. However, it is not without its difficulties, even in such contexts, with Lamberts and Riphagen (1975) suggesting that it constitutes 'dangerous country' and is the subject of a range of both

overt and covert influences (Qualls and Czirr, 1988). Gaitz (1987) in particular highlighted the importance of the MDT giving adequate attention to a range of psychological and social factors, in addition to the more traditional focus on physical needs in order that different disciplines work 'in parallel and collectively to develop and implement a treatment plan' (p553).

Achieving such an holistic view is, however, very challenging with critical analysis highlighting the complexity inherent in multidisciplinary working, with Evers (1981) arguing that the benefits of team working remain unclear, and that even a definition is elusive. Essentially it was Evers' (1981) view that teams tended to be based primarily on traditional power hierarchies rather than on genuine partnerships, particularly in 'complex' teams which involved a diverse range of skills and tasks. In such circumstances agreeing a shared therapeutic goal is likely to prove especially elusive as 'each professional group naturally has a vested interest, as well as belief, in upholding its own orientation' (Evers, 1981, p207).

Several authors (Dingwall, 1980; Evers, 1981; Qualls and Czirr, 1988) have noted that the adherence to professionally defined goals imposes a multiplicity of factors onto the assessment of need and is unlikely to result in a shared understanding unless there is strong team coherence and leadership. Despite these difficulties the ideology of the MDT is widely accepted in geriatric medicine, but in reality Evers' (1981) study found that it featured only as a pale initiation of its ideal model in most care settings. This is particularly the case in complex cases where the dominance of a biomedical perspective is questionable, especially in instances when cure is not a potential outcome. Rather for Evers (1981) the rhetoric of teamwork serves a number of functions, not all of which are necessarily beneficial for older people and their carers. These included:

- providing a strategy of coping with uncertainties;
- providing a means of social control over both patients and subordinate professionals by the dominant medical hierarchy;
- facilitating the management of the elderly sick as a low status social group;
- affirming elderly care as a definitive medical speciality requiring particular skills; and
- providing a strategy for avoiding difficulties in the division of labour amongst the multidisciplinary team and lay workers involved with the care of older people.

Qualls and Czirr (1988) elaborated on the difficulties involved in collaboration and multidisciplinary activity in the clinical setting, reaffirming Evers' (1981) point regarding the heterogeneous nature of elderly care noting that 'comprehensive care requires cooperation among professionals' (Qualls and Czirr, 1988, p372). They define cooperation as 'any situation in which professionals from more than one discipline see a patient and communicate their findings and plan to other professionals caring for the patient' (Qualls and Czirr, 1988, p373).

However, despite the importance accorded to teamwork and the assertion that the MDT is best exemplified in teams working with older people, the literature suggests that breakdowns in communication are a major problem in relation to discharge planning and that difficulties in collaboration are often due to the existence of latent and hidden models of practice (Clark, 1991). Qualls and Czirr (1988) argue that the basis for these implicit, and often unrecognised, professional schema are laid down in early training and the socialisation process. While some elements of professional identity are explicitly taught, others are acquired more passively and unintentionally as a

consequence of exposure to certain types and patterns of working. Qualls and Czirr (1988) argue that team functioning will not improve until each discipline has a better understanding of what drives the others. In order to promote better understanding they suggest a series of continua along which various team members' function. At the end of each continuum lies either an extreme biomedical/acute orientation or a social/chronic care orientation.

Thus, Qualls and Czirr (1988) argue, the way that teams function will be in large measure determined by the stance that various members adopt in relation to four continua, as Figure One illustrates:

Figure One

Team Function – Professional Continua

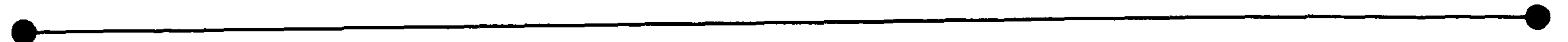
Biomedical orientation/acute

Social/chronic orientation

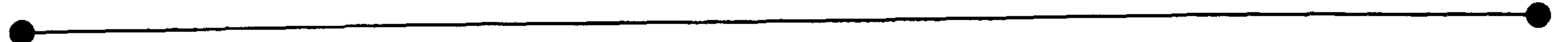
The logic of assessment



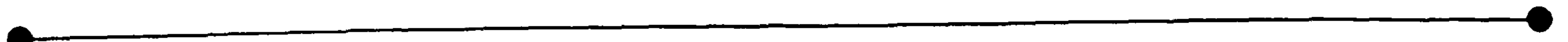
The focus of interventions



The locus of responsibility



The pace of action



(adapted from Qualls and Czirr, 1988)

None of these orientations is 'de facto' right or wrong, but rather each is either more or less appropriate in given sets of circumstances. However, Qualls and Czirr (1988) argue that if one perspective always dominates then the team is unlikely to function effectively, nor will it address the needs of patients and carers in an holistic fashion.

In order to appreciate how the model works it is helpful briefly to consider the ways in which the various continua interact.

The logic of assessment and the focus of interventions represent the method of defining the problem and generating a problem list. Professionals occupying the biomedical/acuity extreme adopt a 'ruling out' approach based on an 'eliminating hypotheses' (p374). At the opposite extreme 'ruling in' embraces a broad range of factors and provides a more comprehensive focus. Applying a pure 'ruling out' model to identifying problems 'works elegantly for a single acute illness' (p374) but difficulties arise in complex cases where a range of factors need to be considered, and choices between interventions are required. In the acute orientation the focus is simply on medical interventions, whereas the needs of most older people are far more complex.

As Qualls and Czirr (1988) note, problems are very likely to arise when working with older people:

'Although emphasis on one extreme to the exclusion of the other can cause deep conflicts within any team, the conflict appears to be especially likely in geriatric practice when most patients' problems are both multiple and chronic' (p374).

Interestingly, Qualls and Czirr (1988) identify discharge arrangements as being a flashpoint for such conflicts given the potentially differing and conflicting visions of the goals of care.

Locus of responsibility and pace of action direct attention to the area of implementation and change. In terms of responsibility, at one extreme professionals may occupy an executive position in which case the patient simply follows orders in a directive relationship. Conversely, at the opposite end of the continuum, the patient has an autonomous relationship and engages the professional as a consultant. Neither of these operates fully within the health care system in the United Kingdom (UK), but the literature would suggest that in practice it is the former rather than the latter model that predominates. With regard to the pace of action a biomedical perspective generally requires a rapid response, whereas in more complex cases, a far longer time frame is needed. As Qualls and Czirr (1988) note, the challenge in relation to older people is that both approaches may be needed at the same time.

In adding a further level of sophistication to their model Qualls and Czirr (1988) provide an additional three criteria relating to the way that the team itself functions. Again these are seen to operate from either an exclusively biomedical model or a more holistic social model. As Figure Two denotes, the remaining three continua can be depicted as:

Figure Two

Team Function – Teamworking Continua

Biomedical perspective

Social perspective

Focus of group attention



Expectation regarding decision-making



Beliefs about interdisciplinary dependence



(adapted from Qualls and Czirr, 1988)

In many respects these continua elaborate upon and further refine the previous four, and in part are interdependent. Therefore, the focus of group attention will be inevitably influenced by the focus on intervention and the pace of action. Similarly, expectations regarding decision-making will at times, be influenced by locus of responsibility. However, these continua are more explicitly concerned with the interaction between team members rather than those between team members and patients/carers. Beliefs about interdisciplinary dependence again might relate to an emphasis on the uniqueness of each profession, to the exclusion of the rest, or to a total integration.

For Qualls and Czirr (1988) their model is best seen as a heuristic to help professionals identify and explicitly address their own varying positions. The authors themselves argue that well functioning teams do not hold to a particular model of working but

rather are flexible and move along the continua as a clinical need and patient circumstance dictate. As noted above, one of the main perceived functions of the model is to help make the latent manifest in order to help team members explore both their own position and to get a better appreciation of the position of others. This is captured by Qualls and Czirr (1988) as follows:

'Naming and monitoring these differences can help team members make sense of otherwise mystifying disagreements and can help diffuse personal conflicts.' (p376)

Considerable attention has been given here to the work of Qualls and Czirr (1988) because it provides an elegant, but easily understood model, via which to begin to unpack some of the complexities operating within with the MDT. However, this model was developed primarily within a hospital setting and does not fully consider the issue of cross-agency or cross-team collaboration. This was identified in the literature as another vital area.

1.5: Aftercare Arrangements and Multi-Agency Collaboration

Towards the end of the 1960s Hockey (1968) identified discharge as causing concern at the multi-agency interface between primary and secondary care, a point later reiterated by Victor and Vetter (1988) in the context of the forthcoming plans for community care in the UK.

As Henwood (1992) noted, one of the main challenges for community care centres on managing the interface between health and social care at a number of levels. The range of disabilities experienced by older people often requires complex packages of care and

with the drive towards ever faster discharge, mandates enhanced collaboration, and speed of response (Victor and Vetter, 1988). However, such rearrangements are difficult to coordinate but in their absence the risk of readmission is much higher (Victor and Vetter, 1988). At the time the study unfolded the tensions between health and social care were anticipated as being much exacerbated in the wake of the NHS and Continuing Care Act, with the transfer of much responsibility for aftercare from the health to the social services. Clearly, therefore, there was a need for any evaluation of discharge arrangements to give due attention to the ways in which after care was organised.

1.6: Moving Beyond the Literature

As previously highlighted, the intention of the overview of the literature was not to produce a comprehensive synthesis but rather to identify a number of key themes that could help to inform and underpin the evaluation process on the Care of the Elderly Unit. Moreover, as the evaluation was to be a participative process, neither was it the intention to produce a rigid and prescriptive set of criteria against which to 'judge' current practice. Instead the study was underpinned by the belief that change was unlikely to occur unless there was some ownership of the process by staff on the Units concerned. It was therefore considered important to adopt a fairly broad definition of discharge planning and to suggest a list of working criteria that were consistent with the emerging policy context, yet would not be seen as an imposition by staff.

Therefore, following the initial review, further discussions were held with the management team for the Care of the Elderly Unit and the following were agreed as the overall goals for the project:

- evaluating the process of discharge planning on the unit from the perspectives of the multidisciplinary team, patients and carers, and community teams;
- identifying the factors that seem to differentiate a good from a poor discharge process;
- evaluate the role of multidisciplinary working in achieving a good discharge;
- ascertain any consequences of poor discharge for the multidisciplinary team, patients and carers; and
- identify areas for improvement in the practice of discharge planning.

In order to provide staff with an appropriate frame of reference, the aims of discharge planning, as outlined by Jupp and Sims (1986), were agreed to be sufficiently inclusive to cover all of the main areas, but also flexible enough to accommodate new or emerging issues. The aims of the evaluation as outlined above were therefore set in the context of the following broad goals:

- to prepare patients and their family, both physiologically and psychologically, for their transfer home;
- to provide the highest level of independence for patient and family;
- to ensure a smooth transfer between hospital and home; and
- to provide continuity of care between hospital and community by encouraging effective communication.

(Jupp and Sims, 1986, p40).

Having provided a further context for the initial study, and outlined the parameters of the evaluation, it was necessary to decide upon an appropriate methodology. This forms the substance of the next chapter.

CHAPTER TWO

EVALUATION: SELECTING AN APPROACH

'I use the term evaluation quite broadly to include any effort to increase human effectiveness through systematic data based inquiry.'

(Patton, 1990, p11)

2.1: Introduction

Patton's (1990) definition above poses a dilemma for the researcher about to embark into the world of evaluation. At one level it is helpful to have a broad definition that does not restrict efforts unnecessarily, while on the other, such an inclusive definition provides few insights as to which of the many potential methods might be the most useful. The purpose of this chapter is briefly to explore a range of potential evaluation options, and to describe why a Fourth Generation evaluation was selected as being the most appropriate to use in the current study. Having outlined the principles upon which a Fourth Generation evaluation rests, the way in which such an approach was applied to the discharge of older people is outlined in order to give the reader a framework within which to consider the research process.

2.2: Evaluation Models and Approaches

Guba and Lincoln (1989) contend that there is no 'right' way to conduct an evaluation and that the method chosen should be the most appropriate one to address the issues of concern or interest. Nor is it necessarily the case that either qualitative or quantitative methods are inherently superior (Patton, 1990). Rather it is a matter of selecting 'horses for courses' and of recognising that even within certain paradigms that particular

methods may need to be adopted so as to suit particular problems (Patton, 1990). This is summarised by Patton (1990) thus:

'Models are developed to help evaluators know what steps to follow and issues to consider in designing and implementing a study. Models are not so much recipes as frameworks. Models help evaluators identify and distinguish among alternative approaches.'

(Patton, 1990, p115)

In selecting among 'alternative approaches' Patton (1990) himself suggests several options, which are briefly outlined below.

Goal based models are underpinned by a logic-deductive approach to evaluation and utilise primarily quantitative models in which well defined and clearly articulated goals or outcomes are assessed. Such an assumption accords with Suchman's (1967) early view of evaluation as being directed towards assessing the extent to which a planned programme meets its desired goal. Patton (1990) describes this as the 'classic' model of evaluation. However, the assumptions upon which such a model rests have been challenged on a number of fronts, not least of which is the extent to which programmes are rigorously planned with explicit goals in mind (Goldberg and Connelly, 1982). Moreover, as Nolan (1991) has noted, services and innovations may have both planned and unplanned outcomes, the latter of which are rarely anticipated. Such outcomes may be both beneficial and detrimental. Therefore, the use of a largely positivist approach to the evaluation of 'real world' innovations can be seen to have several limitations (Rossi and Wright, 1984; Cook and Shadish, 1986), and even if such studies are successful in linking outcomes to interventions, they rarely give an adequate account of **how** and **why**

events unfolded as they did (Glass and Ellett, 1980; Wortman, 1983; Cook and Shadish, 1986).

A growing awareness of the importance of situational and contextual factors saw a shift in emphasis towards more qualitative approaches, which was further reinforced by the need to account for the perspectives of a range of potential stakeholders who might be affected by the intervention or service (Redfern, 1984; Bond and Bond, 1987; Thomas, 1988). Thus some authors argued that the ultimate aim of evaluation should be enlightenment rather than generalisation (Sixsmith, 1986). Several variants of such a more holistic approach can be identified.

One such is goal free evaluation, which involves the examination of a broad range of effects in an attempt to account for the significance of final outcomes, rather than the achievement of a host of a-priori objectives (Watson and Herbener, 1990). Patton (1990) describes this approach as using an inductive and holistic strategy and sees it as marking a distinctive move away from the classic goal driven approaches.

Responsive evaluation based, on the work of Stake (1967, cited in Patton, 1990), views evaluation as comprising two basic components, description and judgement, which emphasise the 'personalising and human' elements of evaluation (Patton, 1990). This approach requires engagement with the stakeholders on a face-to-face basis in order to unpack their concerns and values. The result is a thick description and the triangulation of narrative based data with documentary evidence and reports gathered from a variety of sources.

Conceptually similar to responsive evaluation is the transactional model which is underpinned by a 'subjectivist epistemology that lends itself to naturalism' (House,

1978 cited in Patton, 1990, p119). The transactional model focuses on process and uses a range of informal methods in the form of a case study which sees each case as unique, and the product of a series of transactions between various stakeholders. Within such an approach all the stakeholders are viewed as active contributors and their transactions are best captured and understood by observing interactions in a natural context.

Another related approach is illuminative evaluation developed in the field of education (Parlett and Hamilton, 1976), and this studies the effects of innovative programmes in order to try and identify those factors that provide an account of the way in which the programme operates. As with Sixsmith's (1986) suggestion, Parlett and Hamilton (1976) see the goal being to 'illuminate' key processes in order to identify what they term 'recurring concomitants'. Therefore, whilst the goal of such an approach is not to generalise to other settings, the authors argue that certain common elements may emerge which may be useful in 'illuminating' similar processes in related contexts.

Several of the above models see the various stakeholders' views as being of primary importance, especially the responsive and transactional approaches. In contrast, the connoisseurship model sees the evaluator as the 'expert' with the focus on the study being largely decided in advance by the researcher and those sponsoring the study. While Eisner (1985 cited in Patton, 1990) does not view such 'prefiguring' as constraining, others argue that this marks a return to a more goal based philosophy in which the views of a privileged few dominate (Guba and Lincoln, 1989).

Most of the above models were developed in the United States (US) (with the exception of illuminative evaluation) and were designed primarily to evaluate specific or innovative new programmes. As such they did not readily lend themselves to the present study where the aim was to evaluate an element of an already existing service,

which did not fall into the category of innovation or intervention. One potentially useful model was an pluralistic evaluation developed by Smith and Cantley (1985; 1988) in their study of a day hospital for older people with dementia. They argued that for any evaluation to understand the complex reality of a day-to-day service, it needed to account for the views of multiple stakeholders and to examine and compare such views. It is these subjective perceptions, and not 'other defined' goals, that constitute the main benchmarks of success. Therefore, success may be defined in many (i.e. plural) ways and is not confined to the views or opinions of any one group of individuals. The result is not a neat and orderly set of conclusions but rather a complex 'ethnography' of a given case, which may raise as many questions as it answers.

Given the above diverse range of approaches it is hardly surprising that Glass and Ellett (1980) suggested that evaluation, more than any other science, is what people say it is. However, while choice is a good thing it can also be confusing for the new researcher and I found myself rather perplexed at the range of methods available, all of which seemed plausible when considered individually, but none of which seemed to present a convincing case for adoption in the present study. In particular, many seemed remote from the topic of study with their focus on new or innovative programmes. As Bond (1991) noted: 'evaluation research describes an endeavour which is partly social, partly political, and only partly technical' (p190). What I sought was a model that would overtly recognise all these elements while also incorporating the views of multiple groups of stakeholders.

As Patton (1990) contends, the purpose of an evaluation should be the most important guide as to which model is adopted, and it is here that I was taken with the writings of Guba and Lincoln (1989) who promoted a constructivist model of evaluation. This

approach is primarily focussed on the views of stakeholders, a standpoint Guba and Lincoln (1989) believe addresses the tensions inherent in many other approaches which mainly privilege the views of managers (or senior individuals) take it for granted that there is a consensus of views as to the purpose of the evaluation. In their text *'Fourth Generation Evaluation'* Guba and Lincoln (1989) describe the 'coming of age of evaluation' and outline the antecedent history of differing approaches which they term '*generations*' of evaluation research. In so doing they propose a case for the development of a Fourth Generation, which they argue is not an 'ultimately correct' formulation. However, they believe that it provides 'a more sophisticated and informed construction' (Guba and Lincoln, 1989, p22). In sustaining their arguments they suggest that evaluation had previously gone through three generations, each of which still exist and is still in use.

The first generation is characterised as 'measurement' with a focus on the technical role of the evaluator, who applies a range of instruments to measure the variables identified for investigation. Guba and Lincoln (1989) cite the development of tests in education as indicative of the adoption of such a measurement orientation. Although still in use Guba and Lincoln (1989) contend that the measurement approach fell out of favour as it was viewed as treating students simply as 'objects'. This was not consistent with educational philosophy in post-war America (WWII), which promoted new approaches that combined measurement with a more thorough description of the processes involved:

'Thus there emerged what we call second generation evaluation, an approach characterised by description of patterns of strengths and weaknesses with respect to certain stated objectives.'

(Guba and Lincoln, 1989, p28)

Significantly, the role of the evaluator is seen as a 'describer' who also retains elements of the earlier technical attributes of the measurement role. However, measurement was not now viewed as the main purpose of the evaluation, rather tests were seen as one of a range of tools which could be used. Guba and Lincoln (1989) suggest that Tyler, who is recognised as introducing this broader perspective, is often perceived as the 'father of evaluation' as a result.

The third generation evolved as a result of key limitations in the objectives orientated descriptive approach, with the Tylerian perspective being seen to lack an element of 'judgement'. Stake (1967) cited in Guba and Lincoln (1989) highlighted the neglect of 'judgement' in descriptive evaluation research and the need for evaluators to judge things against external standards. Furthermore, Stake (1967 cited in Guba and Lincoln, 1989) noted that 'both description and judgement are essential – in fact, they are the two basic acts of evaluation' (p30).

The third generation was thus characterised by Guba and Lincoln (1989) as a 'judgement' model in which the evaluator assumes the role of arbiter while still retaining some technical and descriptive functions.

As a result of the acceptance of judgement as an integral part of evaluation research a range of evaluation models (see descriptions earlier in this chapter) were devised by the proponents of differing schools of thought within education. In many respects these models are predicated on a continuum that defines the type of judgement needed. So, for instance, decision-orientated models resist an aggressive judging role whilst the connoisseurship model is explicitly judgemental, with the evaluator being selected specifically for their connoisseurship qualities (Guba and Lincoln, 1989).

Though contemporary forms and function of evaluation research draws upon all of these traditions, Guba and Lincoln (1989) cite what they see as fundamental and shared problems. These are concerned with the following:

- a tendency towards managerialism;
- a failure to accommodate value pluralism; and
- an over commitment to the scientific paradigm of science.

In essence the Fourth Generation evaluation research proposed by Guba and Lincoln (1989) attempts to address these issues by an explicit shift in the scientific paradigm:

'Fourth generation evaluation is a form of evaluation in which the claims, concerns and issues of stakeholders serve as organisational foci (the basis for determining what information is needed) that are implemented within the methodological precepts of the constructivist inquiry paradigm.'

(Guba and Lincoln, 1989, p50)

Based on their earlier text *'Naturalistic Inquiry'* (Lincoln and Guba, 1985) they argue that evaluation research requires the adoption of an alternative paradigm based on a rejection of the precepts of the positivist era, and its replacement with an explicitly constructivist inquiry paradigm, which empowers and enfranchises all stakeholders. It was this latter emphasis on empowerment of all stakeholders, combined with the constructivist model of study, that appealed to me and led to a much more detailed

consideration of the precepts upon which Fourth Generation evaluation is based. This provides the focus for the next section.

2.3: Fourth Generation Evaluation: A Methodological Rationale

'Before we undertake to describe the methodology of constructivist inquiry, it may be useful to note several caveats. First we may recall our earlier warning that any rendering of a complex methodology is bound to be simplistic.'

(Guba and Lincoln, 1989, p173)

Essentially Guba and Lincoln (1989) promote the utility of the Fourth Generation approach to evaluation because it engages the concerns of stakeholders, and this determines what information is needed from an 'insiders' (emic) perspective. Their model is firmly rooted in the principle of the naturalistic paradigm, which they outlined in their highly influential text *'Naturalistic Inquiry'* (Lincoln and Guba, 1985).

Here they argued that a naturalistic model provides a counter to what they see as the 'flaws' of positivism and they suggest that accepting the premises of naturalism 'involves a good deal more than simple accommodation in one's previous thinking, it is in fact a "revolutionary move"' (Lincoln and Guba, 1985, p47). They promote a naturalistic view of the world by seeking to counter the five axioms that they see as sustaining a positivist perspective. These are as follows:

Axiom One: The nature of reality (ontology)

Positivists define a single reality to be sought 'out there', which is divisible into a number of independent variables, and are accessible to direct empirical study. The

process of scientific study is described as being convergent on to that reality in order that it can be predicted and controlled. The naturalist asserts that rather than there existing a single reality a more plausible proposition is the existence of multiple constructed realities that can only be appraised and understood holistically and contextually. Such realities are described as divergent, where the aim is not prediction and control of outcomes, but rather of understanding or *verstehen*.

Axiom Two: The relationship of knower to known (epistemology)

Positivist inquirers argue that the objects under study are independent (following on from the arguments in Axiom One), and that it is both possible and desirable for the researcher to remain value neutral. On the other hand, the naturalist inquirer accepts that he or she, and the subject under study, interact and influence each other so that the knower and known jointly create the reality that they study.

Axiom Three: The plurality of generalisation

In the view of positivists the aim of scientific study is to develop a body of knowledge as a set of generalisations in the form of truth statements that are free from time and context (nomothetic knowledge). In marked contrast the naturalist argues that the aim should be to develop a body of knowledge as a series of 'working hypotheses' that relate primarily to the individual case (idiographic knowledge).

Axiom Four: The predictability of causal linkage

Positivist define actions as resulting from a real cause that precedes or is simultaneous with the effect. The naturalist argues that it is impossible to distinguish cause from effects given that all entities are in a continual state of natural and simultaneous shifting.

Axiom Five: The role of values in inquiry (axiology)

The stance of the positivist is that an inquiry is value free and such a position is grounded in the objectivity of the methodology. The naturalist on the contrary asserts that inquiry is value bound in five key aspects:

- 1 **Inquirer values** – influence the choice of problems, the evaluand, policy options and training boundaries;
- 2 **Selection of paradigm** – is mediated by a conscious choice of a framework to examine the identified problem;
- 3 **Substantive theory** – is selected and influenced by a range of values, such theory is important as a guide to analysing the data and the interpretation of findings;
- 4 **Contextual values** – implicitly situated in the context of a particular environment in which the inquiry is completed; and
- 5 **Value-resonant or dissonant** – values implicit in an inquiry are viewed by Lincoln and Guba (1985) as being either value-resonant or dissonant. This fifth domain provides one of the key parameters for naturalistic inquiry, in that the problem, policy option, paradigm, theory and context have to be congruent (value-resonant) otherwise the inquiry will not produce meaningful results (Guba and Lincoln, 1989).

The roots of Fourth Generation evaluation lie in the above five axioms which for Guba and Lincoln (1989) mark out its revolutionary characteristics. In many respects the starting point for Fourth Generation evaluation is the axiom that it must be value resonant, and this establishes the *why* of Fourth Generation evaluation. The *how* of the model is forged in relation to the pre-eminence given to a constructivist view of the world which for Guba and Lincoln (1989) signals Fourth Generation evaluation as:

*'an alternative paradigm in which constructivism constitutes the conceptual glue that enables the issues of value resonance to be explored via the constructions of the various stakeholders who are involved'.
(p173)*

The overall aim of Fourth Generation evaluation is therefore an enhanced and shared understanding of the nature of the issues involved and the generation of a set of 'working hypotheses' and an idiographic body of knowledge.

The Fourth Generation approach provides an elegant model for achieving Guba and Lincoln's (1989) stated aims of improving the specificity of evaluation work by addressing the perspectives of multiple stakeholders, resulting in more sophisticated outcomes. Such outcomes are responsive to the complex social dynamics involved in addressing multiple perspectives and the temporal influences operating in the social world.

In order better to understand how this is achieved it is important to give more detailed consideration to the tenets of the constructivist paradigm.

2.4: The Constructivist Paradigm

'The constructivist paradigm, also called the naturalistic, hermeneutic or interpretative paradigm (with slight shadings of meaning) has been in existence for several hundred years but has not been widely accepted or understood.'

(Guba and Lincoln, 1989, p83)

As noted earlier, the traditional positivist stance towards ontology, epistemology and methodology views the relationship between these concepts in a deterministic way. In the naturalistic constructivist paradigm such a belief is challenged, with Guba and Lincoln (1989) proposing a more integrated and symbiotic relation between these key elements of the research process. They base their case for such a model on the axiomatic arguments espoused in '*Naturalistic Inquiry*' (Lincoln and Guba, 1985), with the traditional tripartite framework of ontology, epistemology and methodology being re-defined by Guba and Lincoln (1989) as a prelude to proposing a Fourth Generation evaluation approach. Guba and Lincoln (1989) propose that the 'constructivist paradigm is its (positivisms) logical successor' (p84).

The constructivist paradigm develops the methodology of naturalistic inquiry (Lincoln and Guba, 1985) based on the precepts of multiple and socially constructed realities which are 'ungoverned by natural laws, causal or otherwise, a relativist ontology' (p86). In essence, such a relativist perspective starts from an emic view, with individuals attempting to make sense of their own experiences. Therefore, social reality is constructed through interaction between individuals in an iterative process, with previous knowledge being recast in light of new experiences as they emerge over time.

The individual not only brings prior knowledge to their interactions but also accrues learning from social processes. Individuals are thus seen as defining and responding to a phenomenon based on a range of characteristics, which constitute an emic perspective, and the constructed meaning for a particular phenomenon. However, an individual perspective is only part of the constructivist paradigm, and importantly Guba and Lincoln (1989) argue not only for individual realities, but also propose the sharing of such realities, leading to consensual agreement on the meaning of phenomena. However, this process of ‘common assent’ (p86) does not make such realities ‘real’ in a positivist sense, but simply shared:

‘If there is no objective reality then there are no natural laws and cause and effect attributions are simply that – mental interpretations.’

(Guba and Lincoln, 1989, p86)

It can thus be seen that the constructivist paradigm presents a differing account of the relationship between truth and reality. Rather than truth being judged as isomorphic, that is, positioned in a ‘one to one’ relationship with objective reality, truth is defined according to differing benchmarks. The operational definition for truth is described by Guba and Lincoln (1989) simply as that which is the:

‘...most informed and sophisticated construction on which there is consensus among individuals most competent (not necessarily most powerful) to form such a construction.’

(Guba and Lincoln, 1989, p86)

Moreover, such constructions are not fixed and are subject to change over time. However, they do not necessarily represent 'truer' constructions, but rather more complete or sophisticated understandings of an evolving reality. On the other hand, such constructions do not stand unchallenged, as Lincoln and Guba (1985) assert that:

'The moral imperative laid upon adherents of the naturalistic inquiry is that they continuously seek out challenging constructions with which to confront their own.' (p.87).

The way in which such constructions are 'sought out' comprises the methodology and methods of a Fourth Generation to evaluation. This is seen to comprise three essential elements:

1. Entry conditions which include conducting the study in natural settings, acknowledging and seeking out tacit knowledge, the use of qualitative methods and the key role played by the 'human instrument' as the main form of data collection;
2. The inquiry process, which is based upon a constant comparative analysis (CCA), which involves an inductive and interactive model of working. Incorporated within this is the notion of an emergent, as opposed to an a-priori, research design, purposive sampling, and inductive data analysis. Central to the inquiry process is the 'hermeneutic cycle' whereby negotiated or shared constructions are forged and modified (see later for a fuller description);
3. The inquiry product is in the form of 'joint constructions', which should also provide 'vicarious experience' for those not involved in the study. Therefore, reflecting the nature of a constructivist approach, the 'results' of any such study are not generalisable in the statistical sense and are only ever 'tentatively applied' to other settings. Nevertheless, as a result of reading the product or 'case report' of a

Fourth Generation evaluation the reader should feel ‘as if’ they had been there, i.e. vicarious experience. The value of such experience is that it provides further opportunities to learn so that it opens up the possibility that essentially idiographic knowledge may have relevance to differing but like contexts.

A key aspect of any Fourth Generation evaluation is the use of the human instrument as the main form of data collection. However, unlike the ‘human instrument’ in a positivist paradigm, who is seen as unaffected by, and non-reactive in, the research process, the human instrument in a constructivist inquiry is the primary conduit by which shared constructions emerge. The aim of the inquiry is to collect primarily qualitative data that deliberately explore ‘tacit’ knowledge as one of its main goals. The process by which this tacit knowledge is probed and made more explicit is reflected in the hermeneutic process, which is the lynchpin of constructivist methodology.

2.5: Tackling Constructed Realities: A Hermeneutic Process

‘It would appear that the constructed realities must depend on some form of consensual language.’

(Lincoln and Guba, 1985, p71)

As already established, the approach developed by Guba and Lincoln (1989) involves an iterative process focused upon making explicit both the values and constructions of stakeholders. Furthermore, the research process deliberately provides ‘opportunity for revised or entirely new constructions to emerge – a hermeneutic methodology’ (Guba and Lincoln, 1989, p89). Guba and Lincoln (1989) present the essence of a hermeneutic methodology in relatively straightforward terms, defining its aims as

enhancing *understanding* and then *making sense* of intention. Patton (1990) provides some further background context by affirming that hermeneutics places subjectivity centre stage and thus the objective, external world is meaningless without a subjectivity (a conscious human subject) to interpret it. This phenomenological perspective fits into Guba and Lincoln's (1989) emphasis upon the significance of stakeholders' mental constructions in the evaluation process and the importance of tacit knowledge.

Guba and Lincoln (1989) view the hermeneutic circle (illustrated in Figure Three) as a particular strength of Fourth Generation evaluation. However, they also establish a number of contingent conditions for the successful operation of the hermeneutic process (Guba and Lincoln, 1989) and these are:

1. a **position of integrity** is central with stakeholders avoiding any deliberate attempt to mislead or misrepresent meanings. Guba and Lincoln (1989) assert that the researcher has a role of scrutinising the process for purposeful deception but also believe that if participants understand the benefits of the process, then deception is unlikely;
2. **minimal competence** is required by all the stakeholders so that they're able to participate through **communication**, in order that individual constructions can be expressed;
3. a **willingness to share** power by all stakeholders;
4. a **willingness to change** perspectives if the negotiations which emerge are persuasive. Thus all parties must participate and engage in negotiation, recognising the possibility of accepting a shift in their own perspective;

5. a willingness by all stakeholders to reconsider their value positions as required;
and
6. a willingness by all stakeholders to make the commitments of time and energy that is required in such a process.

For Guba and Lincoln (1989) use of the *hermeneutic dialectic* is a key part of their constructivist methodology, with the dialectic being centred on comparing and contrasting divergent views and achieving a higher order synthesis of such views. They further expand their description by stating that:

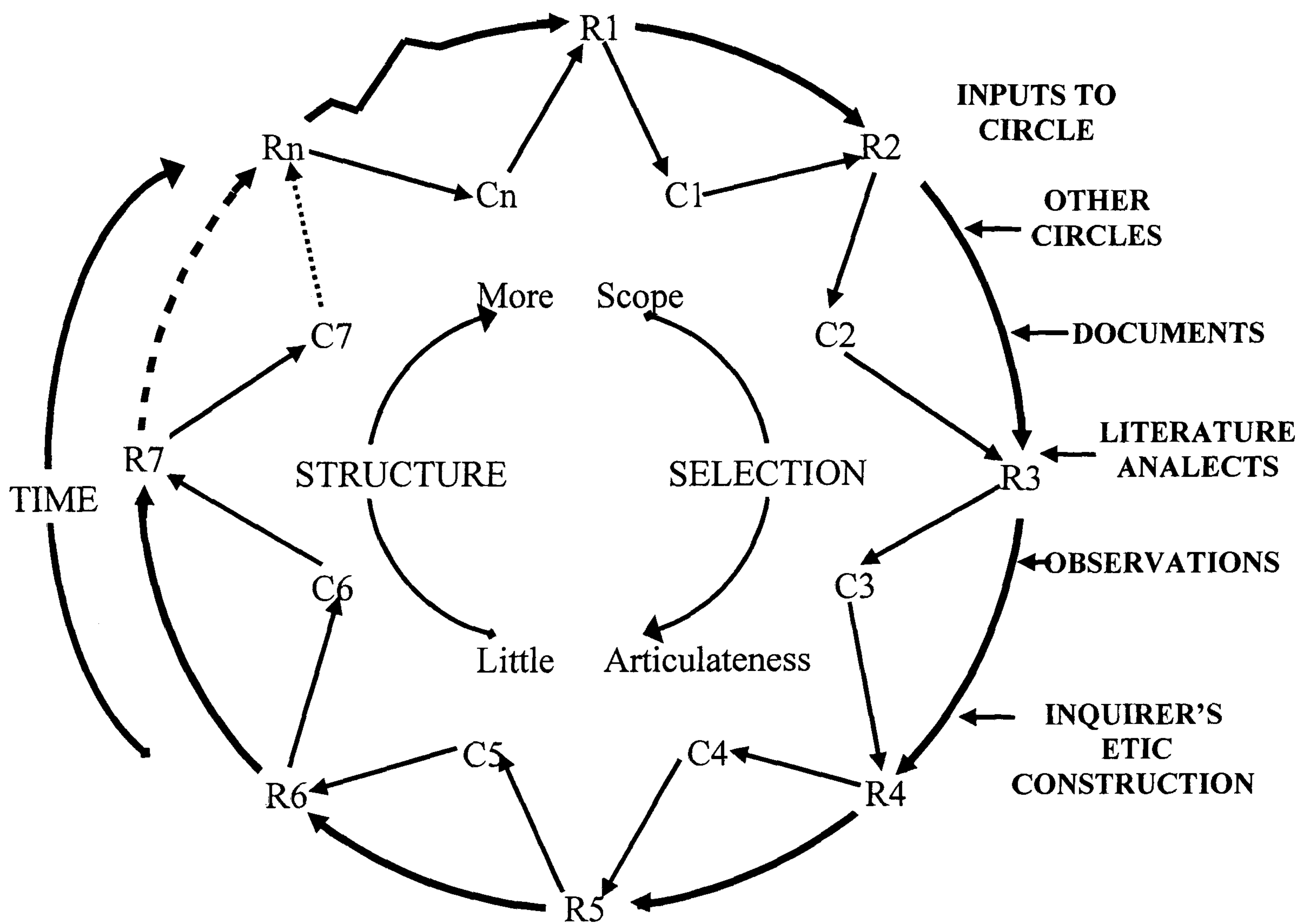
'The major purpose of this process is not to justify one's own construction or to attack the weakness of the constructions afforded by others but to form a connection between them ...to reach a consensus when that is possible, when it is not possible, the process at the very least expresses and clarifies the several different views and allows the building of an agenda for negotiation. All parties are thus simultaneously educated (because they achieve new levels of information and sophistication) and empowered (because their initial constructions are given full consideration and because each individual has an opportunity to provide a critique, to correct, to amend or to extend all the other parties' constructions.'

(Guba and Lincoln, 1989, p149)

Figure Three

The Hermeneutic Dialectic Circle
(Within-Circle Process)

Guba and Lincoln, 1989



R = RESPONDENT C = CONSTRUCTION

The hermeneutic cycle therefore lies at the heart of the inquiry process in Fourth Generation evaluation and shapes the form of constructions that emerge. Figure Three is intended to capture the dynamic and interactive nature of the cycle in which (R1) denotes the initial contact with a stakeholder or stakeholders (respondent) that are seen to provide a good first interview. The intention then is that:

'This respondent is engaged in an open ended interview to determine an initial and emic construction of whatever is being investigated or evaluated – the focus of the inquiry.'

(Guba and Lincoln, 1989, p151)

The stakeholder(s) interviewed is provided with an opportunity to comment on the resultant construction and hence the hermeneutic inductive process starts. Guba and Lincoln (1989) suggest that ideally the first respondent (R1) nominates the second (R2) as an informant with possibly divergent perspectives to those found in the first construction (C1). Such constructions are generated using the constant comparative method (CCA) described initially in the earlier *Naturalistic Inquiry* text (Lincoln and Guba, 1985). Data analysis procedures are considered in a later section of the chapter. However, it is important to note at this point the congruence between the hermeneutic circle and that of CCA developed as part of grounded theory (Glaser and Strauss, 1967), in that in both methods 'data analysis follows closely on the heels of data collection and is completed for R1 before R2 is applied' (Guba and Lincoln, 1989, p151).

Although the interview is the main form of data collection in a Fourth Generation model, other sources of data are also used in Figure Three. These include the constructions from other hermeneutic circles (if they exist), documents, insights from the literature (termed 'analects' by Guba and Lincoln, 1989), observations, and the inquirers own etic (or outsider) views.

In the context of this thesis the 'hermeneutic cycle' began with the first meeting with the senior nurse, sisters and consultants on the Care of the Elderly Unit (see Chapter One). These were the key stakeholders and following a consideration of 'analects' from

the literature (see Chapter One) the focus of the study was formed, underpinned by the broad definition of discharge planning of Jupp and Sims (1986) and the main research issues defined at the end of Chapter One. Having outlined the basic tenets upon which naturalistic inquiry is based, attention is now turned to the ways in which such an approach is operationalised. This involves a consideration of sampling issues, further detail as to data collection and also the process of data analysis. Following this is a description of how such principles were applied in the context of the present study.

2.6: Sampling in Fourth Generation Evaluation

Within a Fourth Generation evaluation sampling does not follow a random or non-probability method, but rather is based on a purposive approach:

'Sampling is not carried out for the sake of drawing a group that is representative of some population, to which findings are to be generalised. The sample is selected to serve a different purpose hence the term 'purposive sampling' is used to denote the process.'

(Guba and Lincoln, 1989, p178)

Again, Guba and Lincoln's (1989) approach is characterised by flexibility and a dynamic process, as they conceive an evolving response to sampling linked to the hermeneutic circle's aims of generating a range of perspectives then focusing on the salient constructs. Guba and Lincoln (1989) describe this process of *selection* as moving from *scope* to *articulateness*. Initially, the strategy of purposive sampling is focused on sampling the broadest scope of information in order to understand the particular context of the evaluation and the 'mental constructions' of stakeholders.

Such broad *scope* sampling involves two elements, with the sample being selected *serially* and *contingently*. The *serial* nature of sampling relates to the need for a particular sequence to data collection crucial to the integrity of the hermeneutic process so as to uncover relevant constructions systematically (Guba and Lincoln, 1989). *Serial* selection requires the researcher to proceed from one respondent to the next following the analysis of the first interview. Thus, as outlined earlier in the description of the hermeneutic cycle, the data from the first respondent (R1), and the results of the analysis (C1), are completed before commencing the interview of the second respondent (R2). Further, the selection of R2 is informed by R1 and the content of the interview will also reflect issues raised in C1.

The *contingent* element describes the evolving process of funnelling the selection process towards *articulateness* rather than *scope* and the sharpening of the researchers focus on dominant emergent constructions in the data. The process of contingency is informed by the analytic procedure of CCA utilised by Guba and Lincoln (1989) as identified in their earlier text *Naturalistic Inquiry* (Lincoln and Guba, 1985):

'Early on, for example we may need respondents who can provide constructions different from those we've heard before. Later in the process, however, as certain elements become identified that appear salient in that time/context frame, we may wish to select respondents who can be particularly informative and articulate about these items.'

(Guba and Lincoln, p178)

In many respects Guba and Lincoln (1989) utilise different types of purposive sampling at different stages of the hermeneutic circle.

The type of stakeholders required for the *serial* and *contingent* sampling are classified into three groups by Guba and Lincoln (1989). These are:

- **Agents** – are those individuals who are involved in producing, using or implementing the evaluation and are most easily identified, though they may consist of broad categories often with sub-groups;
- **Beneficiaries** – are those who profit in some way from the evaluation, they are also usually easily identifiable though ‘unintended beneficiaries’ (Guba and Lincoln 1989, p202) may also be identified as part of the research process;
- **Victims** – are those who may be negatively affected by the evaluation and this group is often the most difficult to identify being ‘virtually invisible’ (Guba and Lincoln, 1989, p202).

The identification of major stakeholders is an important element in the sampling procedure and as with other areas of the hermeneutic process is dynamic and reflexive, with the identification of ‘unintended beneficiaries’ or ‘victims’ during the research process.

As part of the research design the researcher may be unable to sample all stakeholders in a setting if the resources for the evaluation are limited, hence the significance of identifying major stakeholder groups. Guba and Lincoln (1989) address the problem by highlighting the need to apply the criterion of *relative stake* so as to include or exclude stakeholder groups. As Guba and Lincoln (1989) suggest, the relative stake enables the ranking of stakeholders in a setting yet is not about making absolute judgements but,

like most matters in Fourth Generation evaluation, 'it must be determined by negotiation' (p203).

2.7: Data Collection: The Interview Process

'Given that the human instrument is to be employed, the question of which method to use is easily answered: those that come most readily to hand for a human.'

(Guba and Lincoln, 1989, p175)

The use of interviews provides the most appropriate strategy for data collection, though as indicated earlier other strategies also contribute to the hermeneutic cycle (Guba and Lincoln, 1989). These strategies 'ferret out' (p177) data and those used in the present study will be examined in a later section.

In qualitative research the rationale for interviewing as a preferred method was described by Winter (1989) as being based on the belief that 'the sustained interaction allows the many subtle meanings of an unfamiliar perspective to be explained in detail and gradually clarified' (p21). This point is relevant since Guba and Lincoln (1989) note that constructivists address 'what is known' differently from the traditional positivist researcher. Guba and Lincoln (1989) state that whereas positivist inquiry commences from a stance of 'knowing' in principle what they don't know, constructivists typically face the prospect of 'not knowing what it is they don't know' (p175).

Denzin (1988) uses the metaphor of 'digging' to describe the interview and sees this method as the main data gathering strategy in qualitative studies (Denzin, 1988).

Dexter (1970 cited in Lincoln and Guba, 1985) suggests that interviewing can be

described as a conversation with a purpose, which enables in-depth explanation of issues leading to a richer understanding of issues.

Completing interviews is also a difficult and skilful task as they range in order and form from the totally structured interview, which follows and uses the same questions on each occasion, to the totally unstructured (Denzin, 1988). However Foote-Whyte (1991) suggests that in reality a totally unstructured interview does not exist and that every interview, at least in the context of research study, is minimally structured by the topic or subject under investigation. In Fourth Generation evaluation the nature of the interview varies as the process unfolds and the hermeneutic dialectic cycle develops in terms of *scope* and *articulateness*:

'Initially the interviews are very unstructured with the inquirer soliciting the respondent's emic constructions in the respondent's own terms. As the emerging construction or constructions (because there may be two or more in conflict) become clearer, the inquirer is able to ask more and more pointed questions'

(Guba and Lincoln, 1989, p153).

Thus as part of the logic of the hermeneutic dialectic circle the interview format shifts from *little* to *more* structure (Guba and Lincoln, 1989). This flexible approach accommodates the evaluation from *scope* to *articulateness*.

A consideration of the degree of structure, however, only accounts for part of the complexity of interviews as a key method, for as Patton (1990) notes:

'Interviews are interventions. They affect people. A good interview lays open thoughts, feelings, knowledge and experience not only for the interviewer but also the interviewee.' (p352)

The potential for rich and in-depth data rests on the interview as an interpersonal process, reaffirming the 'human instrument' criteria established by Lincoln and Guba (1985) and Guba and Lincoln (1989). In the present context interviews were conducted through the medium of Welsh in addition to English to support such an interpersonal process, the research participant selecting their preferred language for interview. Patton (1990) describes the interview not as 'walk a mile in my shoes', rather 'walk a mile in my head' (p357). However, notwithstanding the relative flexibility of the interview in Fourth Generation evaluation, Lincoln and Guba (1985) do provide a guide to the best way of putting principles into action. This is as follows:

- Deciding who to interview – as noted earlier, this often begins with a key informant(s) followed by a 'snowball' sampling procedure if appropriate;
- Preparing for the interview – including the role of the researcher, the level of familiarity and so on;
- Initial 'muses' – begin with a 'warm up' or general questions of a 'grand tour' variety to establish a relaxed atmosphere and for the informant to clarify any queries they may have;
- 'Pace' the interview and use a variety of strategies such as reflection, use of encouragement such as 'mmm' or hand waving to signal a desire for elaboration;
- Terminating the interview and gaining closure – they suggest that this is best achieved by summarising the information obtained and seeking clarification, a process they call 'playback'. This allows for preliminary 'member checking'. At the end of the interview it is important to be courteous and to thank the informant for taking part.

However, once again reflecting the importance of the human instrument, the role of the interviewer is crucial as is the negotiation of consent, an issue that will be addressed shortly.

The role of the researcher in the interview process is appropriately highlighted by Patton (1990) who notes that:

'Effective interviews should cause both the interviewer and the interviewee to feel that a two way flow of communication is going on' (p327).

Hence the researcher is responsible for the interpersonal process of 'pacing the interview' (Lincoln and Guba, 1985) and the use of techniques such as probes to ensure the 'richness of the data' (Patton, 1990) by increasing the depth of the participants' response. Patton (1990) discusses at length the need for the researcher to be attentive to the interpersonal context of the interview. This involves attention to rapport as part of 'pacing' and neutrality in questioning. In Fourth Generation evaluation the issue of neutrality in the interview process is an important feature of the hermeneutic circle. Both rapport and neutrality enable the researcher to keep the interview 'productive' (Lincoln and Guba, 1985). Rapport emphasises the researcher's engagement with the person being interviewed, conveying empathy and understanding without being judgemental (Patton, 1990). In some respects neutrality is central to a hermeneutic style of interviewing as Patton (1990) describes:

'The person being interviewed can tell me anything without endangering either my favour or disfavour with regard to the context of their response. I cannot be shocked, I cannot be angered, I cannot be embarrassed, I cannot be saddened' (p 317).

The interview relies upon an effective interpersonal process guided by key principles and interviewing in naturalistic-constructivist inquiry requires attention to ‘openness’ in both the design of interview schedules, procedures and the interpersonal process. This involves avoiding ‘forcing new possibilities into new moulds’ (Patton, 1990, p347) and allowing constructions to emerge. Once again this is consistent with the constant comparative method and the idea of a progressive focus.

A discussion of the interview process is incomplete if the focus remains solely on the areas of the schedule design as the ‘digging tool’ and the complex interview process without a consideration of data recording and the relationship between data collection and analysis. The latter is discussed in some detail as a separate and key section, examining the way data analysis follows ‘close on the heels’ (Guba and Lincoln, 1989) of data collection. However, it is important to highlight the significance of these issues in the context of the interview process as part of the hermeneutic dialectic circle. The relationship between data collection and analysis has particularly important consequences for the interview, creating a process that is both interpersonal and analytic. In this context the recording of the data must also accommodate the collection – analytical continuum. This is achieved by using different methods of recording the data as part of the interview process (other multiple strategies apart from interviews as a means of extending data collection is considered later in relation to data collection - analysis and the hermeneutic circle as triangulation).

The interpersonal information gathering process can be best recorded by the use of tape recording and the transcribing of interviews. Tape recording interviews ensures that the researcher does not ‘tune out’ (Patton, 1990) what the participant has said in the

conversation in an attempt to manually record their responses. It allows the researcher to focus on the person being interviewed and complete field notes which can contribute to the analytic process (Patton, 1990). The full transcription of interviews provides the 'gold standard' approach in analysis, enabling independent scrutiny of the data. However, as Patton (1990) notes this can be prohibitively expensive and a compromise position can be obtained by working 'back and forth' between the sections of the tape recording on tape and the field notes, with only the most important sections of the taped interview being transcribed.

Field notes provide an additional and important tool for both data collection and analysis for the researcher. Field notes are not only significant as part of the 'face to face' interpersonal interview process but also for documenting the post interview analysis. The period following the interview presents the researcher with a number of key tasks, which Patton (1990) describes as follows:

- Check the tape recording, if a faulty recording has occurred the researcher should make extensive notes immediately;
- If recording is satisfactory the researcher should review the field notes made during the interview and uncover areas of ambiguity or uncertainty. This enables checking up of details for clarity with the participant as soon as possible, since 'guessing the meaning of a response is unacceptable';
- Recording of any observations made during the interview process, indicating when the interview occurred, who were present, the participants' response and the interviewer's own role and responses so as to 'establish context for interpreting and making sense of the interview' (p353).

Although this is a potentially demanding task the post interview period is a 'critical time of reflection and elaboration' despite the fact that 'interviewing and observation can be exhausting and it is easy to forgo this time of reflection' (Patton, 1990, p353).

As already noted, the role of the researcher as a 'human instrument' is central to the success of a Fourth Generation evaluation and this includes, but extends beyond, the interview process. Much, then, rests on the researcher. In the present context the role of the researcher was rather more complex as I was largely an 'insider' who already worked on the Unit that was the focus of data collection. As such it was important for me to try and shed my existing experiences, or at least to question them and not take them as fact. On the other hand, familiarity with the 'informants' helped to create a relaxed atmosphere and as I was already well versed with the language used, this potentially allowed better access to what has been termed 'backstage' information (Burgess, 1991). However, negotiating and sustaining the hermeneutic cycle involved considerable effort on my part, and the role of researcher was both tiring and exhilarating at the same time.

2.8: Multiple Strategies

Although much rests on the quality of the interview process in Fourth Generation evaluation, several other strategies can also be employed. However, Guba and Lincoln (1989) do not view these in the classical sense of triangulation, but rather see them as important adjustments to the hermeneutic cycle and the collection of 'emic' perspectives:

Multiple strategies therefore refers to a range of methods and sources of data to further elaborate upon the interview process, in order to develop the level of 'information and

sophistication' emerging from the hermeneutic dialectic process. This potentially involves the construction of other circles, documents, literature analects, observations and the inquirer's own etic construction (Guba and Lincoln, 1989) (see also Figure Three):

'It is the purpose of this step to systematically introduce such material into a further 'making' of the circles in order to inform the constructions further and raise them to a higher level of sophistication. (p209)

The purpose of using multiple methods is not simply to reach consensus but also to search for potentially differing constructions that might not yet have emerged. This may include material from other parallel circles, should they exist, but documents and literature 'analects' also serve an important function. Guba and Lincoln (1989) give a special emphasis to the use of documents suggesting that they are rich sources of information, but among the least used. Documents may further elaborate upon issues identified at interview, or introduce new lines of inquiry that have not yet been considered.

The explicit use of sections of the relevant literature (analects) is an interesting notion, as often qualitative researchers either eschew the literature altogether until after data collection and analysis, or else attempt to 'bracket' what they know. Guba and Lincoln's (1989) approach is quite the opposite in that they suggest that elements of the literature can be deliberately introduced into the emerging dialectic to either help confirm or to challenge emerging constructions.

Guba and Lincoln (1989) further contend that the aim of such strategies is to:

'extend experience vicariously, serve as a metaphoric springboard leading to insights, or simply add information, which, when taken account of, leads more rapidly to the evolution of a local construction' (p217).

In addition, literature analects may be introduced into interviews as part of the constructions utilised to clarify or refute emergent constructions as part of the hermeneutic dialectic process. Guba and Lincoln (1989) emphasise that such extracts from the literature do not have special status in the constructivist field:

'They are not ultimate truths, however scientific the process by which they were obtained' (p211).

The use of the literature in this way in the present study has already been noted, as literature overview was fed into the second meeting which shaped the direction of the project, and the broad purposes of discharge planning, as suggested by Jupp and Sims (1986), were used as a basis for the evaluation.

In addition to documents and the use of literature, Guba and Lincoln (1989) promote the use of observation as a method of data collection in a symbiotic fashion:

'Observations may be undertaken because of insights generated during the interviews, or observational data may be introduced into the interviews for comment. Observations and interviews can thus feed upon one another' (p154).

The authors see observation as being particularly important during the early stages of the study in order to increase the researchers' familiarity with the environment. However, in the present context this was not really necessary as I was already intimately familiar with the Unit. Furthermore, I did not really hold an 'etic' or outsider perspective. On the other hand, and as will be noted later, this became more relevant during the second study on the Medical and Surgical Units.

2.9: Data Analysis in Fourth Generation Evaluation

'Clearly the method of constant comparative analysis provides an excellent fit with our earlier account of continuous and simultaneous collection and processing of data.'

(Guba and Lincoln, 1989, p335)

Guba and Lincoln (1989) see CCA as the optimum method of analysis in achieving the aim of the hermeneutic dialectic circle of moving the *inquiry process* to an *inquiry product*. This is based on their argument for the use of CCA as one means for the naturalistic inquirer to operationalise inductive analysis. As indicated earlier, inductive analysis is central not only to the naturalistic inquiry but also to constructivism. The original framework of CCA, as developed by Glaser and Strauss (1967), in *'The Discovery of Grounded Theory – Strategies for Qualitative Research'* do not address the issues of working with the naturalistic inquiry and the stated goal of CCA in Glaser and Strauss' (1967) original work of 'enabling prediction and explanation of behaviour' does not reflect the aims of the naturalistic inquirer. However, Lincoln and Guba (1985) propose a case for CCA, not as a means of grounding 'theory' as emphasised by Glaser and Strauss (1967), but rather of 'grounding' constructions and the 'data

processing aspects' (Lincoln and Guba, 1985, p340). Arguably, this is a matter of emphasis rather than process, with the aim being to produce a 'construction' rather than a 'theory', and it is quite apparent that the two processes have a great deal in common.

The '*Naturalistic Inquiry*' text (Lincoln and Guba, 1985) provides an outline of CCA as described by Glaser and Strauss (1967), with the stages of CCA being based on the '*Discovery*' text (Glaser and Strauss, 1967) and consisting of the following four stages:

- 1 comparing incidents applicable to each category;
- 2 integrating categories and their properties;
- 3 delimiting the theory (construction); and
- 4 writing the theory (construction).

Implicit within this process is that 'each stage is transformed into the next' (Glaser and Strauss, 1967) and the analysis is continuously developed until 'saturation' is reached. The linkage to naturalistic inquiry and the later adoption of CCA in the constructivist methodology of Fourth Generation evaluation is the emphasis upon a continuously developing process.

This iterative process generates two types of categories, described respectively as descriptive and explanatory categories (Lincoln and Guba, 1985). The activity of memo writing further assists the analytic process by providing a kind of 'developmental history' of categories, thus facilitating the identification of the *properties* of any particular category.

Once categories start to be defined the process shifts to identify their properties and dimensions in order that categories can be integrated. This involves the process of ‘going back and forth’ in the data and moves away from tacit knowledge to the more explicit formulation of ideas. Consistent with a CCA approach is the idea of ‘theoretical sampling’. Although Guba and Lincoln (1989) do not explicitly use this term, an analogous strategy is nevertheless implicit in their conception of the hermeneutic cycle and is reflected in the following quotation:

‘Furthermore, if data collection and processing go on more or less simultaneously, later data collection efforts can be directed more specifically at fleshing out categories, filling in gaps in the larger taxonomy or category set, clearing up abnormalities or conflicts.’

(Lincoln and Guba, 1985, p343)

Guba and Lincoln (1989) further elaborate upon the process of data analysis in terms of the two broad strategies, ‘*unitising*’ and ‘*categorising*’ developed in ‘*Naturalist Inquiry*’ (Lincoln and Guba, 1985) and these strategies will be more fully explored below.

Unitising – relates to incidents with units being data that will ‘sooner or later serve as the basis for defining categories’. Such ‘units of information’ are characterised as being heuristic or the smallest unit that can be ‘interpretable in the absence of any additional information other than a broad understanding of the context in which the inquiry is being carried out’ (p345). The source of such units is varied and includes interviews and observational notes, which need to provide a detailed account of the source (interviews, documents), type (of respondent, site (hospital, school) and episode (data

collection fieldwork context) so as to enable the location of the 'unit of information' as part of the analytic process (Lincoln and Guba, 1985).

Categorising - this term refers to the process of assembling and making sense of categories so as to 'provide a reasonable construction' (Lincoln and Guba, 1985).

Constant comparison is the main *modus operandi* of categorising, and Lincoln and Guba (1985) provide a detailed account of the operational process, involving the following sequence of steps:

- 1 *Sorting* - based on the unitising process the recorded units of information (typically on cards) are examined and sorted until a series of provisional categories are assembled;
- 2 *Examining non-fit* – as part of the sorting process some units of information will be identified as not fulfilling the criteria for particular categories and these need to be separated and examined, again in later stages;
- 3 *Memo writing* – based on the accumulation of a number of units of information and their sorting into provisional categories, the researcher is required to start writing memos to outline prepositional statements about the properties of categories. Such statements provide the basis for a more formal 'rule of inclusion';
- 4 *Labelling* – the generation of a 'rule of inclusion' heralds the start of a more formal conclusion of categories which begins to more clearly articulate their boundaries;
- 5 *Checking* – the categories are now checked to ensure internal consistency and the reallocation of some units of information to a miscellaneous category or creating a new category if they do not fit the existing categories that have been developed;
- 6 *Review* – when the units of information and categories have been exhausted, the entire category set is reviewed including any miscellaneous categories. Some units of information may be reassigned from the miscellaneous category or discarded;

- 7 *Overlap* – the categories also require scrutiny for overlap and the avoidance of ambiguity as Lincoln and Guba (1985) state ‘categorisation can be accomplished most cleanly when the categories are defined in such a way that they are internally as homogenous as possible and externally as heterogeneous as possible’ (p349);
- 8 *Relationship among categories* – the next step is to examine relationships among categories, and see whether some categories may be subsumed within others, or conversely, if categories are so large as to need further subdivision;
- 9 *Follow up* – some categories may need to ‘be pursued in subsequent data collection efforts’ (Lincoln and Guba, 1985). This can be accomplished by *extension*, *bridging* or *surfacing*. As part of extension the researcher starts with known items of information and builds on these, utilising them as a basis for other questions or probes. In the case of bridging, the researcher starts with several known but disconnected items of information, in that their relationship is not understood. The aim is to clarify their relationship based on a reasonable probability of a relation of some sort given their inclusion in the same category. Finally, surfacing relates to the researcher proposing new information that might be expected be found in the field, based on the researcher’s increasing familiarity with the issues involved. It is in essence hypothesis formation following the logic of known categories to propose other related ones; and
- 10 *Saturation* – involves the judgement to ‘stop collecting and processing’ (Lincoln and Guba, 1985) based on four criteria: the *exhaustion of sources*, *saturation of categories*, *emergence of regularities* (integration), and *over extension* (does not contribute to the emergence of viable categories).

Although the above were described in their earlier text in ‘*Naturalistic Inquiry*’ (Lincoln and Guba, 1985), they are also still as relevant in the context of Fourth Generation evaluation. As part of the hermeneutic dialectic circle (Guba and Lincoln, 1989) the main aim of using CCA in data processing is to ensure that constructions are grounded and meet the criteria established for grounded theory by Glaser and Strauss

(1967), in that they ‘fit’ and ‘work’. *Fit* is accomplished when the categories and terms of the construction account for the data and the information that the construction ‘putatively encompasses’ (Guba and Lincoln, 1989). The criterion of *work* is seen to be met when the categories provide a level of understanding that is acceptable to the respondents and the researcher (Guba and Lincoln, 1989). Additional criteria applied are *relevance* and *modifiability* (Glaser, 1978 cited in Guba and Lincoln, 1989). The former develops the notion of work by indicating that the grounded construction must be able to demonstrate that it can ‘deal with those constructs, core problems and processes that have emerged’ (Guba and Lincoln, 1989, p179). Modifiability is concerned with the extent to which:

‘The construction must be open to continuous change to accommodate new information that emerges or new levels of sophistication to which it is possible to rise.’

(Guba and Lincoln, 1989, p179)

As will be seen, therefore, although not conceived of as a form of grounded theory the process involved in analysing data in a Fourth Generation evaluation draws heavily from such an approach. This is an issue that will be returned to later in a subsequent chapter (see Chapter Four).

2.10: The Reporting and Negotiation Process

‘To say that certain matters remain ‘unresolved’ simply means that no joint (collaborative, shared) construction as yet evolved. It may not be possible to come to a resolution because of value differences that are not open to negotiation.’

(Guba and Lincoln, 1989, pp215-216)

The task for the evaluator on completion of the hermeneutic analytic process is to ‘sort out’ claims, concerns and issues directed at eliciting satisfactory information and sophistication as a prelude to negotiation. Guba and Lincoln (1989) note that many issues that were identified at the commencement of the hermeneutic process may well have ‘vanished as further information was input to that group’ (p213). They note that such items should not be discarded but ‘set aside’ for the case report at the close of the evaluation process. Guba and Lincoln (1989) identify that the main task for the evaluator upon completing data analysis is to examine the findings, highlight unresolved items and prioritise items to feed into negotiation and action, as evaluations are unlikely to be able to deal with all issues emerging. However, consistent with the principles of a Fourth Generation model, prioritisation should be a shared undertaking:

‘In the spirit of hermeneuticism and the educational and empowerment themes that underlie Fourth Generation evaluation, this prioritisation task should be carried out in a participatory way that provides opportunity for input and control to each of the stakeholding audiences’
(Guba and Lincoln, 1989, p214).

As part of such a consensus-seeking process, Guba and Lincoln (1989) suggest that a ‘circle’ constituted of a representative of each stakeholding group should be assembled and be ‘at liberty to determine the criteria to be employed in prioritisation’ (p215). However, in order to aid this process, Guba and Lincoln (1989) identify three criteria:

1. *Possible ease of resolution* – it must be recognised that certain issues may remain unresolved due to a lack of information, whereas others may be readily addressed;

2. *Possibility of achieving an action compromise although dissensus might continue* – in many instances Guba and Lincoln (1989) note that practical concerns demand action and thus what is needed is information about the type of ‘action mechanisms’ that might be used, even in the absence of a complete consensus; and
3. *Centrality to the value system of one or more of the stakeholders* – certain issues may be bound up with major value positions and are ‘the most sticky’ to deal with, as they may be adhered to tenaciously by certain individuals.

As will be apparent later, the issue of achieving consensus, and the extent to which certain stakeholders adhere to their own positions was a major issue in the present study, especially on the Medical and Surgical Unit.

Preparing the agenda for negotiation involves the evaluator in drawing together conclusions and recommendations for negotiation with the stakeholders. As part of the constructivist methodology Guba and Lincoln (1989) affirm that data cannot ‘speak for themselves’ and thus attention to meaning and interpretation is also required in the reporting and negotiation stages. Guba and Lincoln (1989) indicate a series of criteria that facilitate the equitable presentation of findings from the *inquiry process*. These involve the presentation of constructions according to the stakeholding groups from which the respective findings ‘surfaced’, also ensuring that ‘competing constructions’ are clearly identified by indicating why unresolved items appear on the agenda (Guba and Lincoln, 1989). Negotiation of constructions relating to issues, claims and concerns is focused on achieving consensus where possible, as ‘whatever emerges from the group must come as the result of their deliberation and decision’ (Guba and Lincoln, 1989, p221).

A number of potential outcomes are possible: *full resolution* indicates the resolving of claims, concerns or issues with some limited refinement required, since 'resolution always involves action' based on all stakeholders coming to a shared construction (Guba and Lincoln, 1989); *incomplete or partial resolution* results in an inability to fully resolve issues for a number of reasons, action is thus deferred pending further consideration; *no resolution* in which conflicting constructions are retained and there is limited scope for working on the problem. Once again, as will be highlighted later, a number of the above outcomes were apparent in the present study, with an incomplete or partial resolution on the Care of the Elderly Unit, and limited or no resolution being possible on the Medical and Surgical Unit.

The reporting process concludes with the production of a case report to enable readers to 'see how the constructors made sense' of constructions in the context of the evaluation. The nature of the joint construction presented by the case report enables readers to judge their transferability. The case report should present multiple realities and reflect the plurality of constructions, while facilitating 'vicarious' experience for the reader.

Before going on to consider how a Fourth Generation methodology was applied in the present study, it is necessary briefly to consider two outstanding issues. These are the role of ethics and the criteria by which a Fourth Generation evaluation are judged.

2.11: Ethics in Fourth Generation Evaluation

An ethical approach to research underpins a Fourth Generation approach and involves, in addition to the usual ethical canons of ensuring confidentiality and anonymity and protecting subjects from harm, a consideration of the degree to which participation and

involvement are genuinely negotiated. This is essential in meeting the requirements of a collaborative, egalitarian, educative and empowering evaluation (Guba and Lincoln, 1989). Thus for Guba and Lincoln (1989) the ethical issue of consent is addressed as a dynamic concept that may need to be negotiated throughout the research process. Patton (1990) further elaborates upon some of the more implicit aspects of ethical precepts that need to be considered in this form of evaluation. Although some of these reflect traditional concerns, others provide interesting variants. Below is a brief summary of some of the tensions that Patton (1990) raises:

- Promises and reciprocity – this issue focuses upon obtaining cooperation from the interviewee – why should they participate? The researcher has to ensure that ‘promises’ to elicit participation are kept, such as promising to provide a copy of the report;
- Risk assessment – a number of areas of risk may be relevant to the evaluation process, these are psychological stress, legal liability, continued programme participation, being ostracised by peers and staff as a result of participation and political repercussions. Patton (1990) argues that such risks need to be anticipated and mediated;
- Confidentiality – how can confidentiality be fully assured, given the point identified by Guba and Lincoln (1989) that evaluations as case reporting cannot be truly anonymised;
- Informed consent – the area of consent is significant in the context of evaluation, and as noted above, may need to be an on-going process;
- Data ownership – as Patton (1990) notes ‘who will have access to the data, for what purposes? Who owns the data in an evaluation?’ (p356). The evaluation ‘contract’ needs to ensure clarity and mutual understanding;

- Interviewer effects – are there any implications for the interviewer as part of the research process, and will there be facilitation or debriefing as part of the research process if needed;
- Advice – who will be the researcher’s confidant and counsellor from an ethical standpoint during the course of the evaluation, since a range of ethical issues may arise as part of the emergent design?

In addition to the above, the broad context of potential political repercussions is highlighted by Guba and Lincoln (1989) as part of the Fourth Generation approach. The Fourth Generation evaluation approach incorporates a number of risks associated with the constructivist methodology. A number of these risks are outlined below:

- Risk One – this concerns the essential ‘human instrument’ (Lincoln and Guba, 1985; Guba and Lincoln, 1989) and the relationships that are formed which need to be protected from ‘violation of trust, shading of the truth, and misunderstanding’ (Guba and Lincoln, 1989, p132);
- Risk Two – the maintenance of privacy and confidentiality poses particular problems in constructivist inquiry. Utilising a hermeneutic process, participants make explicit their own constructions and expose their thoughts and feelings. Guba and Lincoln (1989) propose that risks to privacy and confidentiality can be mediated by the researcher ensuring that participants can ‘check’ that their constructions are represented faithfully, and have the chance to amend erroneous information (Guba and Lincoln, 1989);
- Risk Three – relates to the need to maintain and sustain a relationship of trust while at the same time ensuring that constructions emerge as quickly as possible given the limited time available for most studies. This requires a delicate balance between polite enquiry and a feeling of pressure on informants;
- Risk Four – the final stage of reporting is also fraught with difficulties, as the inquiry product requires a case presentation that involves a degree of

selectivity as to the data and construction intended. Again this requires often delicate negotiations.

Although the above should figure in all research studies, they are often not made fully explicit and it is one of the benchmarks of a Fourth Generation model that careful attention is given to such factors. The above do not, of course, override the usual ethical principles of beneficence (that we should try to do good), and non-malificence (that we should avoid doing harm), together with the need to obtain informed consent and to ensure confidentiality and anonymity. However, Fourth Generation evaluation does pose particular challenges in this regard, which Guba and Lincoln (1989) stress as noted above.

2.12: What Counts as a ‘Good’ Fourth Generation Evaluation?

Lincoln and Guba (1989) recognised at an early stage that a shift in paradigms would also require a different approach to judging the quality or robustness of a study. The traditional positivist canons such as validity, reliability and generalisability were, by their very nature, antithetical to a constructivist model. They therefore proposed (Lincoln and Guba, 1985), and later expanded upon (Guba and Lincoln, 1989), a set of what they termed ‘parallel criteria’. These are summarised in Figure Four:

Figure Four

Parallel Criteria for Quantitative and Qualitative Paradigm
(After Lincoln and Guba, 1985, Guba and Lincoln, 1989)

Quantitative		Qualitative
Internal validity	-----	Credibility
External validity	-----	Transferability
Reliability	-----	Dependability
Objectivity	-----	Confirmability

These parallel criteria were dubbed ‘trustworthiness’ criteria with credibility being concerned with the degree to which the constructions presented by the researcher are deemed to be genuine reflections of the constructions as held by participants. This is now seen as parallel (or the equivalent of) internal validity. Guba and Lincoln (1989) suggests several methods of pursuing this goal which include:

- Prolonged engagement – spending time to overcome ‘fronts’ and resistances at the site, and to build rapport. In the first of the two studies which comprise this thesis, this was largely unnecessary as I was already an ‘insider’ and well known to the other stakeholders (at least the professionals involved);
- Persistent observation – keeping familiar with the environment under study. With respect to the present thesis the above argument still applies;

- Peer debriefing – engaging with a ‘disinterested’ colleague to challenge emerging constructs and as a means of discussing personal stresses or difficulties. This was a role played by my supervisor, who while not strictly speaking ‘disinterested’ was nevertheless relatively divorced from the actual day-to-day ‘action’;
- Negative case analysis – looks for negative cases to ‘challenge’ constructions. This was a process engaged with by the use of CCA and theoretical sampling;
- Progressive subjectivity – this involves the researcher making as explicit as possible his or her ‘constructions’ and recording these as they evolve so that later checks can be made to see if this view was in anyway ‘imposed’ on the constructions of others. This was achieved using a field log or diary in which methodological or theoretical notes (or constructions) were recorded;
- Member checks – this is the ‘single most crucial’ method of establishing credibility and involves overt testing of the constructions with those who have provided them. This was undertaken on numerous occasions, often with surprising, and occasionally, disturbing results (see Chapter Three).

Transferability concerns the degree to which the constructions found in one site can be seen as relevant to another site. This, as will become apparent, was one of the explicit aims of the second study, which revealed that many of the results found on the Care of the Elderly Unit did not ‘transfer’ well to the Medical and Surgical Unit. Providing an explanation for this finding provides one of the main theoretical contributions of this thesis (see Chapter Four).

Dependability is parallel to reliability and is concerned with stability of data over time. Stability is not of course a feature of constructive inquiry as ‘constructions’ are explicitly expected to grow and mature as the study progresses. However, it is

important that the ways in which constructions do change can be ‘tracked’, so that outside readers can judge the ‘logic of the process’ (Guba and Lincoln, 1989).

Conformability is the degree to which the ‘processes’ of the research can be subjected to independent external scrutiny so that the way the process was enacted can be judged.

Guba and Lincoln (1989) suggest that dependability and conformability require an ‘audit’ if they are to be successfully demonstrated. However, they also note the expensive nature and general implausibility of such an approach for most research studies. This is particularly true of those that have little funding, as in the present case. It is to be hoped that the thesis itself provides a ‘proxy’ audit, albeit a limited one. Therefore, by consulting this thesis readers will be able at the very least to form some opinion as to the ‘logic of the process’ and the degree to which the product and process met the above criteria.

Although some of the above will be elaborated upon in more detail at a later point it is argued here that the thesis largely meets the above criteria, and, as will be noted, some of the reactions of various stakeholders when the results were ‘fed back’.

What is more interesting to consider is the extent to which the study meets the second set of criteria proposed by Guba and Lincoln (1989) – that is the authenticity criteria.

Although the trustworthiness criteria are widely cited, and indeed are often used as canons for qualitative studies generally, the authenticity criteria are less well known.

This is paradoxical as they are potentially far more relevant to a constructivist model.

Even as they proposed and elaborated upon the trustworthiness criteria, Guba and Lincoln (1989) admitted that these were ‘not entirely satisfactory’ and went so far as to suggest that these criteria left them with an ‘uncomfortable feeling’. The source of this

discomfort arose from the fact that they were parallel criteria and for Guba and Lincoln (1989) were therefore still too close to a positivist philosophy. Such discomfort grew as their thinking progressed.

Guba and Lincoln (1989) therefore suggested a set of fledgling 'authenticity' criteria that 'spring directly from constructivism's own basic assumptions' (p245). These authenticity criteria are summarised briefly below:

- Fairness - does the research allow the voices of all relevant stakeholders to be heard?
- Ontological authenticity - do the results improve each informant's understanding of their own individual experience?
- Educative authenticity - do the results allow individuals to better understand the position of other stakeholders/informants?
- Catalytic authenticity - is action stimulated by the results?
- Tactical authenticity - do the results not only stimulate action but actually empower it?

Although Guba and Lincoln (1989) make some suggestions as to how the above might be achieved, they also recognise that these criteria are still emerging. Therefore, rather than focus mainly on the trustworthiness criteria (although these will be alluded to further – especially in relation to member checking and transferability) the later methodological discussion in this thesis will attempt to illustrate how the authenticity criteria were addressed in the present study.

The purpose of this chapter has been to outline a range of potential evaluation models and to present a case for the use of a Fourth Generation approach. Having done so the assumptions underpinning such a model have been outlined. The next chapter goes on to consider how the method was applied in the studies comprising this thesis, and presents a description of the results.

CHAPTER THREE

EMPLOYING A FOURTH GENERATION EVALUATION

3.1: Introduction

The purpose of this chapter is to provide an overview of the initial evaluation that was conducted on the Care of the Elderly Unit, and a subsequent study on Medical/Surgical Wards. Commonalities and differences in the discharge process are identified and the ways in which the results were fed back to the participants is discussed. Consideration is also given to the extent to which the authenticity criteria, described in Chapter Two, were met.

It will be recalled from Chapter One that the focus on discharge arrangements on the Care of the Elderly Unit emerged following negotiated discussion with key stakeholders (the senior nurse, the 2 ward sisters, and 2 of the 3 consultants responsible for patient care). In terms of a Fourth Generation model this negotiation represents the first turn in the hermeneutic circle as explored in Figure Three on p52. As a result of this meeting it was agreed that the study should commence with a brief overview of the existing policy and practice literature on discharge, not to provide a rigid a-priori set of standards, but rather to identify and reaffirm key issues. These decisions arose out of an awareness on the Unit that, although current discharge arrangements were possibly “the best” in the hospital, there was still room for improvement. Following the literature review it was further agreed that the broad aims of Jupp and Sims (1986) should be used to inform the study – these are reproduced again as they are an important component of the study as

they represent the first major ‘construction’ that emerged. According to Jupp and Sims (1986) the aims of discharge planning are to:

- prepare patients and their families both physiologically and psychologically for transfer home;
- provide the highest level of independence for patient and family;
- ensure a smooth transfer between hospital and home; and
- provide continuity of care between hospital and community by encouraging effective communication.

Acceptance of these aims, by the key stakeholders, facilitated agreement as to the overall objectives for the evaluation (see Chapter One). It is the purpose of this chapter to consider how the evaluation unfolded from this point and describe salient markers in the research process; Appendix Ten outlines the entire interview log for the study. Before presenting the results, it is important to reiterate the commitment of the Unit in the study. The main stakeholders were receptive to the idea that current practice could be improved and also committed to the process, as clearly demonstrated by their willingness to second me out for periods of data collection. This openness and commitment, as will become increasingly apparent during the course of this chapter, were major factors in understanding the reactions of the Unit to the evaluation, especially when compared to experiences encountered on the Medical and Surgical Units.

This chapter will describe how I implemented a Fourth Generation method, as outlined in Chapter Two, on a Care of the Elderly Unit, and subsequently on Medicine and Surgical Wards. This chapter therefore presents the **how**, **where** and **when** of the research process.

The completion of the data collection and analysis provided a range of descriptive and explanatory categories (Guba and Lincoln, 1989) through the data analysis process of CCA resulting in the *inquiry products* in the form of case reports. This chapter also considers the development of the explanatory categories, termed *informal working*, *formal working* and the *nursing* role, and begins to consider how these might account for differences on the units studied (Lincoln and Guba, 1985, Guba and Lincoln, 1989).

I adopted the CCA technique of data analysis (as described in Chapter Two), which resulted in the identification of categories by unitising, categorising, filling in patterns and member checks (Lincoln and Guba, 1985). The Care of the Elderly study provided an understanding of the ‘constructions’ of discharge planning as held by the MDT, PHCT and patients and their carers. This helped to suggest relationships between the emergent categories, which were further elaborated upon in the second phase of the study in the areas of Medicine and Surgery.

3.2 Data collection and analysis: Using a hermeneutic method

In Chapter Two the precepts underpinning the Fourth Generation approach were outlined and the central role of CCA affirmed. Guba and Lincoln (1989) emphasise the continuous and simultaneous collection and processing of data as key to the constructivist method of inquiry. The framing of CCA within the hermeneutic dialectic provides a process for conducting inductive analysis focused on generating descriptive and explanatory categories (Lincoln and Guba, 1985).

This section describes the respective stages in data collection and analysis on both the Care of the Elderly Unit and the Medicine and Surgery phases of the study. The aim is to provide a transparent account of the hermeneutic process highlighting the dialectic

nature of the *inquiry process* which resulted in a number of *inquiry products*, which comprised a series of case reports subsequently used as a platform for negotiation and action.

To facilitate clarity I will present the relevant phases of the study as a chronological account, commencing with the hermeneutic cycles undertaken in the Care of the Elderly Unit, followed by the cycles in the areas of Medicine and Surgery. I will consider the emerging constructions from the Care of the Elderly Unit following the account of data collection and analysis at this stage of the study and describe the reporting and negotiation process. Such a consideration is important in highlighting the connections between the Care of the Elderly Unit stage of the study and the development of the second phase of the hermeneutic cycle in Medicine and Surgery.

3.2.1 Data collection and analysis: The Care of the Elderly Unit Evaluation

Following the initial meeting with the key stakeholders detailed in Chapter One, and prior to the study commencing, a submission was made to the Gwynedd Health Authority Ethical Committee (Appendix One) to conduct the study on the Unit. The necessary forms were completed, together with information about the intended project. Following the protocol of the Ethical Committee the information forwarded included not only details of the study design, but also the information leaflets that would be relayed to participants, including letters and consent forms (Appendix Two). Following clarification of the purpose of the study with members of the Health Authority Ethics Committee full ethical approval was duly granted.

As was stressed in both Chapters One and Two, the study was underpinned by the belief that a thorough evaluation requires the views of as complete a range of stakeholders as

possible. This was reflected in both the research questions and is a fundamental premise of a Fourth Generation model (Guba and Lincoln, 1989). In the present context these stakeholders included members of the multidisciplinary team on the Unit, older patients and their carers, and members of PHCT's that were in two of the geographical localities served by the ward. These same locations were also used for the study on the Medical and Surgical Units.

3.2.1.1 Sample and recruitment

The sampling procedure for the Care of the Elderly study was informed by the Fourth Generation Evaluation model as described in Chapter Two. A purposive strategy linked to the precepts of the hermeneutic process was employed in guiding the *selection* (Guba and Lincoln, 1989) of the multidisciplinary team as part of the interview process and strident efforts were made to include **all** team members. This recruitment was successful apart from one member of the nursing staff who was absent on sick leave. The same strategy was equally successful in the approach to the PHCT members in the two geographical areas. This involved the recruitment of General Practitioners (GPs) in the two community areas, Community Nurses, Community Social Workers and in one area a community physiotherapy and OT who were employed in partnership with community hospitals. However, the *selection* (Guba and Lincoln, 1989) of patients and carers recruited for data collection purposes required a different approach, as it was clearly not possible to attempt to include them all.

This issue was addressed through discussion with Dr. M. Nolan (Project Supervisor) and the Ward Sister and Senior Nurse on the Care of the Elderly Unit. It was agreed that allocating a specific time period for *selection* (Guba and Lincoln, 1989) would be the most appropriate mechanism. This was important given my limited time on

secondment, and the decision to interview most patients and carers within two weeks post discharge. Based on the discussion it was agreed that the data collection and data analysis for the study would be best achieved if the initial secondment periods were arranged so as to complete the cycle of data collection and analysis with each respective group of stakeholders. The multidisciplinary team in the Unit and the patients and carers interviews were to commence in September and to be completed in November 1992. The PHCT data collection and analysis were scheduled for February 1993 after the busy Christmas period which required all qualified staff to be working in the clinical area. As will be noted later in this section there were some minor alterations to these plans based on negotiating access to patients and carers following discharge.

At the meeting with Dr. M. Nolan, the Ward Sister and the Senior Nurse on the Care of the Elderly Unit it was also agreed that the sequence of interviews should begin with the multidisciplinary team, then move on the patients and carers and later the PHCT in the New Year (1993). Within the multidisciplinary team it was considered best to start with the nursing team because as a neophyte researcher the interview process was new and challenging, as an 'insider' to the nursing team this was considered an appropriate place to start. Moreover, the nursing perspective had been identified as being particularly important during the initial discussion with the key stakeholders, as noted in Chapter One.

There was consensus amongst the ward nursing team that the 'treatment room' on the ward was the most appropriate environment to conduct the interview. In contrast other multidisciplinary team members, such as doctors, physiotherapists and occupational therapists noted their preference for interviews to be held in their respective offices. It was considered important by all the stakeholders to conduct interviews with patients

and carers in their own home following discharge. It was agreed with members of the PHCT that interviews would be held in the community setting, with GPs interviewed in their respective surgeries whilst the venue for community nurses was to be their health centre base. The community social workers, physiotherapist and occupational therapist preferred to be interviewed in their offices.

During the first study a total of 21 hospital based professionals were interviewed comprising of nursing staff (n=12), medical staff (n=4), social workers (n=1), and the major therapy disciplines, that is, occupational therapy, (n=1) physiotherapy (n=2) and speech therapy (n=1). Subsequent interviews were conducted with patients (n=12), patients and carers together (n=3) and carers alone (n=1). Interviews were also completed with members of 25 PHCT's including GPs (n=14), community nurses (n=7), social workers (n=2), physiotherapist (n=1) and occupational therapist (n=1). As will be discussed later, these interviews also provided data that were used in the second phase of the study.

3.2.1.2 Interview schedule: Design and adaptation

The interviews in the first phase of the study in the Care of the Elderly Unit were informed by a semi-structured interview schedule (Appendix Three) designed to cover a broad range of issues. However, these topics were not always addressed in the same order as the direction and focus of the interview was controlled largely by the research participants. At the start of each interview I explained the purpose and goals of the study, ensuring informants of the confidential nature of the proceedings, and seeking consent to tape-record our discussion. Also, consent to take detailed interview notes was sought. As noted in Chapter Two some of the MDT, patients and carers preferred to conduct part, or all, of the interview through the medium of Welsh. In the presentation

of the research findings when reference is made to transcripts conducted through the Welsh language I have included both the original Welsh data and an English translation. The English translation was undertaken by myself.

The semi-structured interview schedules (Appendix Three) included a Discharge Planning Questionnaire organised as a Likert scale with a set of good practice statements to supplement the schedule. The statements on the Discharge Planning Questionnaire were drawn from the Department of Health (1989) and Welsh Office (1990) discharge policy guidance and my initial literature review. It was used in the first few interviews (n=10) in Ward A. Subsequently, however, it became clear that the situation faced by research participants was more complex than accommodated by the range of statements outlined in the questionnaire, and use of this questionnaire per se was discontinued as a part of the data analysis. However, following discussion with my research supervisor the statements were retained as a framework for exploration.

3.2.1.3 Analects: Documentary sources

In addition to interviews the study also drew upon a range of other data sources. As already noted, literature 'analects' (Guba and Lincoln, 1989) had been used to inform the initial set of constructions and to identify potentially important areas for inclusion in the interview guide (Jupp and Sims, 1986). In the study these 'analects' were supplemented by other sources of data that included:

- **Patient admission and discharge records** – Admission and discharge were recorded by the DGH as an account of the patients' career of hospital admission. It included admission date, reason for admission (emergency or arranged) and a discharge date and destination. In order to identify patients the patient's date of birth was included and a unique 'D' number was allocated to each patient. The full record was accessed through the DGH

Information Department as the information was held centrally on a computer system. Access to such records had been approved by the Gwynedd Health Authority Ethics Committee as part of the research proposal. The record allowed the study to gain an accurate account of the patient's length of stay and admission/discharge dates. As already indicated the patients recruited for the study were selected during a specified time period on Ward A and the availability of accurate information was important.

- **Medical case notes** – The medical case notes were key documents for the MDT providing a record of the assessment, treatment and discharge plans of the medical team. Furthermore they included ongoing assessment of the patient during their stay in hospital, any relevant details gained about the patient and, where appropriate, family carers. The disciplines of physiotherapy, occupational therapy and social work contributed to the medical notes on the Care of the Elderly Unit. Access to the medical case notes was important not only in recording the diagnosis and treatment but in examining the account of the patient's hospital stay. Again, gaining access to the medical case notes had been approved by the Gwynedd Health Authority Ethics Committee as part of the study. The physiotherapy, occupational therapy and social work staff had their own documentation but also made brief entries in the medical case notes. These three professional groups were unwilling for their documentation to be reviewed for the purpose of the study. The medical case notes were analysed prior to the interview with the patient/carer recruited to the study. The analysis focused on the following key areas:

- 1 Reason for admission and diagnosis;
- 2 Treatment plan and projected length of stay;
- 3 First record of discharge date;
- 4 Record of ward round/medical meetings with patients and/or family/carers;

5 Record of any MDT assessments and outcomes;

6 Record of discharge plan (if present) or proposed discharge date;

7 Record of medical review on day of discharge.

- **Nursing process notes or ‘Kardex’** – The nursing process documentation or ‘kardex’ was also a key document on the Care of the Elderly Unit and consisted of a number of sections. The first section provided details of the patient’s address, next of kin, date of birth and reason for admission. The second section consisted of the patient’s care plan, dated and where appropriate supplemented or changed during the patient’s hospital stay. The final section gave a daily record of care provided and included any significant events or decisions made by the MDT regarding the patient’s care. The nursing process document was not only used by the nursing team but also some members of the multidisciplinary team –the physiotherapist and occupational therapist, who provided brief summaries of assessment, meetings with the patient/carer and any outcomes of treatment. I also recalled from my experience in Ward A that the nursing process was also used as a reference point for information by the physiotherapist, OT and social worker. As in the case of the medical case notes the Gwynedd Health Authority Ethics Committee had approved the use of the nursing process in the study.
- **Ward diary** – The ward diary was a nursing document and recorded a range of information that acted as an ‘aide memoir’ for the nursing staff to account for the completion of various important elements of the discharge procedure, including: Medication (Pharmacy), Letter to Doctor (LTD), Transfer of Care Form (TOCF), Transport arrangements (Trans), and Relatives of the patient (Rels). As in the case of the nursing process, the physiotherapist, OT and social worker made reference to the ward diary to check on the arrangements for patient discharge.

These 'analects' proved useful in a number of ways:

- The admission and discharge records were helpful in approaching patients (and their carers) for consent to participate in the study following discharge home. They provided a contact address for the letter to be sent and a telephone number for confirming arrangements if consent was obtained. Furthermore the admission and discharge records provided corroboration of the length of stay and discharge date. The medical case notes, the nursing 'kardex' and the ward diary were key documents in summarising the 'whole process' of discharge planning.
- The analects were used to follow the processual issues identified in the interview data and to identify any evidence supporting or challenging the emergent constructions of the research participants.
- The entire range of documentation was examined by the researcher with reference to particular patients as a prelude to the interviews and also, on occasion, following the interviews. Again the aim was to 'follow through' issues raised at interview and appraise the documentary evidence supporting or challenging patients' or carers' constructions.

As noted in Chapter Two the purpose of using multiple methods is to allow potentially differing constructions to emerge and Guba and Lincoln (1989) emphasise the value of documents for this purpose. They consider that documents tend not to be used in conjunction with interviews despite potentially providing new lines of inquiry or elaborating on issues raised during interviews.

3.2.2 Data collection and analysis: Ward A

Essentially three sets of hermeneutic cycles were initiated to facilitate the data collection and analysis on the Care of the Elderly Unit (Ward A). These were the multidisciplinary ward team, patients and carers, and the PHCT. Each of these cycles provided an alternative construction of the discharge process.

Glaser and Strauss (1967) noted in their early text that grounded theory enables a focus on the 'whole process'. In my first six interviews between the 29th and 30th September 1992 with the Ward Manager, Senior Nurse, Senior Staff Nurse ('F' grade) and three Staff Nurses, the complexity of the 'whole process' of discharge planning activity began to emerge. These 'early' constructions focused particularly on information giving to patients/carers and information exchange between the MDT and patients (and their carers). In the first interview (Ward Manager), and from the very first question, the importance of information and information exchange in the discharge planning process, and the nurses' role in this emerged clearly:

"Patients and carers informed yes but not involved. Patients/carers involved after decision making unless specific problems exist – consultation after. Nurses have broad feel for issues of all MDT members and patients and carers"

(Ward Manager, A1, 29th September 1992, interview notes)

The way information was exchanged was seen as a significant factor shaping the discharge planning process, and the provision of information for patients or carers in relation to particular issues was highlighted as problematic, as the Senior Nurse (Transcript, A2, 29. 9.92) noted:

- Senior Staff Nurse “Patients and carers don’t get enough information about their diagnosis and treatment. Mmm, (pause) sometimes they do, sometimes, not always”
- Interviewer “Do you think they should get more information?”
- Senior Staff Nurse “Yes, it could be improved, mmm (pause) I think it could be improved”

A strong theme also emerged in relation to medication as described by a Staff Nurse (Transcript, A3, 30/9/92):

“With medication information is especially important. We don’t give enough, I mean especially regarding side effects.”

The broader issue of how much information about the discharge plan was relayed to patients and/or carers was also discussed during these initial interviews. In this respect the interviews identified the importance of the MDT, but in particular the role of the nurse. The interviewees described a significant role for nurses in liaising with patients, carers and the MDT, acting as “referral agents” and “mediators and translators for patients and carers” (Ward Manager, A1, 29/9/92, interview notes). Furthermore, it was clear that nurses recognised these roles as part of their work “nurses are aware of a liaison role between MDT members” (Ward Manager, A1 29/9/92, interview notes) and that they also on occasion ‘lobbied’ the patient or carer regarding their discharge plans, either before or after the ward round (Ward Manager, A1, 29/9/92, interview notes).

The preliminary analysis of the six interviews conducted between the 29th and 30th of September therefore indicated that a major issue was information and its exchange between key stakeholders, namely, the MDT, patients and carers and the PHCT prior to

and following discharge. I noted initially in my interview notes that information was an important issue that could be thought of in various ways:

- i. Information flow – the ‘flow’ of information was part of what ‘represented a good discharge’ with ‘poor flow’ presenting the main obstacle to successful discharge. The initial research participants (n=6) considered that information flow was a key issue and that nurses were an important conduit and exerted considerable energy, ensuring that information flow took place.
- ii. Information exchange – involved providing specific items of information as part of the arrangements for discharge, in particular medication.
- iii. Information and access to knowledge – it was identified that access to certain types of knowledge was not readily available and that some people had particular information or knowledge that was not also relayed to others, such as nurses. For instance, doctors had knowledge regarding the clinical picture, and social workers had information from their discussion with the family regarding community support. Such information was located with particular members of the MDT and it was important to ensure that ‘it all came together’ if the discharge was to work. Again the nurses spent much time on this.

In relation to this ‘informative work’ the nurses (n=6) considered that it impacted on them in two ways. Firstly, they had to ‘run around’ facilitating information flow and ‘making it happen’. Secondly, they considered that patients and carers had few opportunities to gain information, particularly from the medical team, and this involved nurses augmenting the information provided during ward rounds or clinical examinations by doctors.

The initial six interviews clearly highlighted the importance of information and the way it was exchanged, and suggested that the formal structures of the ward, that is the ward round and case conference, were augmented by the informal ‘behind the scenes’ work

of nurses (as I noted in the margin of the fieldwork notes). The respondents (n=6) considered that much of this 'informal working' was concerned with ensuring good 'information flow'.

As part of the process of data collection analysis I recorded, in the fieldwork notes, an account of the interview and any emergent ideas or affirmations of previous provisional categories. These were placed in the margin I created in my interview notes, a practice I continued to use throughout the duration of the study. The interview notes were used to map out the main issues and topics raised during the interview and to highlight key responses. This practice helped to develop a 'running analysis' that linked information provided by research participants to previously identified and formative categories. When interviews were not taped the interview notes, with near verbatim quotations, were written down as soon as possible after the interview.

There then followed a series of further interviews on the Unit conducted between the 31st of September and 2nd October 1992 with the remaining nursing staff (n=6) and the ward social worker.

The second set of interviews (n=7) was used to test out the provisional categories and to further elaborate upon them. As a result the category of 'information' was aligned to the 'complexities of discharge planning', as was the role of the nurse. Of particular importance was the interview with the ward Social Worker (2/10/92), which highlighted and corroborated the significance of the nurses' contribution to maintaining information flow. These data also confirmed that the formal structure of the ward round and case conference were supplemented by 'informal working' methods, on which they were dependent.

The Social Worker (2/10/92) emphasised the importance of nurses in augmenting the limited 'information opportunities' afforded to the Social Worker, describing how difficult it was to see key MDT members whilst also engaging in her own work of liaising with families and the PHCT. She noted that similar 'bridging work' was undertaken by nurses with patients and carers, since they too had difficulties in gaining access to 'information and knowledge' from other disciplines, especially the doctors.

Notwithstanding the importance of such 'informal working' the data also affirmed the significance of the formal structures of the discharge planning process, namely the ward round and case conference. These 'events' provided opportunities for the MDT to agree patient treatment and management plans, review clinical activities, engage in decision making, and to review, confirm and, if necessary, amend discharge arrangements. However, there was also a clear recognition of the importance of 'informal working' to discharge planning, and the delicate balance that needed to be struck between these formal and informal structures. Central to the operation of both 'formal' and 'informal working' was the information flow facilitated by the nurse. However, informal working was described as where the 'real work of discharge' took place.

Overall it was evident that 'information flow' between team members was seen as important but problematic. There was a perceived need for improved communication and enhanced collaboration, for as a Staff Nurse noted "Different people doing different things means communication breaks down" (A4, 30/9/92). The data suggested that 'formal working' in the form of the ward round and case conference did not always allow for good 'information flow' between team members, due to the relative inflexibility of such 'events' and their preoccupation with medical issues, as this quote illustrates:

“At present there’s ineffective timing and participation. Timing is crucial for all members of the team, having a specific time for attending and having a preamble before the ward round is useful to clarify problem areas prior to round. The ward round is ineffective in planning discharge and multidisciplinary planning, its focused on medical dominated issues”

(Senior Staff Nurse, A3. 30th September 1992, interview notes)

The content of team meetings also focussed mainly on medical issues, as captured below:

“Doctors - tends to put too much pressure on the ward round due to poor planning. There is too much emphasis on being consultant led, not enough delegating. It is consultant dominated to tell the truth. Planning questions and input consultant based not by other members of the multidisciplinary team, should be led by other members of the multidisciplinary team with collaborative working as required”

(Staff Nurse, A6. 30th September 1992, interview notes)

As a consequence discharge planning was felt to be adversely affected and became particularly disorganised when the team was under pressure, as frequently occurred with the advent of a ‘bed crisis’ in the Care of the Elderly Unit:

“Quality goes down with bed crises, (pause) nurses have bulk of stress due to being the liaising person in the ward”.

(Staff Nurse, A10. 2nd October 1992, transcript)

In such circumstances it was noted that the doctors “rushed and forced discharges” (Staff Nurse, A7, 31/10/92) and that this resulted in “inappropriate planning at times with ad hoc arrangements for discharge due to demand for beds” (Staff Nurse, A8. 31st September 1992, interview notes).

The data indicated that the nursing team and their ‘informal working’ served to co-ordinate and ‘glue together’ the discharge planning process, as nurses “brokered” the

discharge arrangements by liaising with different members of the MDT, patients and carers, which was a key part of ‘pulling it (discharge) together’ (Staff Nurse, A7. 31st September 1992, interview notes).

The Social Worker further emphasised the importance of this ‘informal working’ on Ward A and the pivotal role of nurses. She noted that “nurses tend to pick things up” and “nursing team do not direct but indirectly co-ordinate things” (A13, 2nd October 1992, interview notes).

While ‘brokering’ was part of the ‘informal working’ of discharge, nurses also “fixed” (Staff Nurse, A7, 31/9/92, interview notes) ‘formal working’ of the ward round, which depended on nurses acting as referral agents to appropriate team members, i.e. they were “the link person” (Staff Nurse, A11. 2nd October 1992, interview notes).

As part of the overall review of data I also noted that there was consistent reference in all the interviews to date (n=13) of the use of a ward ‘diary’ for recording discharge plans. The ward ‘diary’ was linked to the nurse’s role as ‘fixer’ in the discharge planning process, and nurses engaged in discharge planning ‘at the coalface’ emphasizing the importance of the diary in ‘tracking’ the patient’s discharge arrangements. To consolidate this belief I examined the ward diary and noted how the document reflected the often ‘hidden’ activity of the planning process. The memo included below captures the role of the diary as a record of activity:

Analytic Memo**Date: 31/9/92****Subject: Analysis of Ward 'diary' in Ward A**

Checked the diary after the interviews this week to document observations and look at it from a different perspective now as an outsider. The structure is as I remembered it – not changed but points raised in interview note how important it is for all the nurses in Ward A and draws together all the formal and informal work that goes on before the ward round and after. Doesn't really catch anything in detail – there's more detail/information in the kardex and case notes but diary includes bits missing from official documents with XXXX (Staff Nurse) having written notes by heading re: RELS what agreed before W/R (ward round). Shows how the whole process really is – and more store seems to be set by the diary as a discharge document than the official kardex or case notes. Nurses see the diary as their own though XXXX (physiotherapist) and XXXX (social worker) checks it as point of reference.

This reinforced the value of using other data sources to augment the insights gathered from the interviews.

3.2.2.1 Moving things forward

On completion of these two sets of initial interviews I discussed my ideas and provisional categories with Dr. M. Nolan. These were as follows:

- information flow;
- informal working;

- formal working;
- nurses 'fixing' and 'brokering' discharge.

I now engaged in a process of 'going back and forth' through the data prior to completing further interviews with the therapy staff and the medical team. It seemed that 'information' as a category remained of vital importance but what was also apparent was the significance of 'formal' and 'informal working' and the 'nursing role'.

It was clear that the nurse had a significant role in both 'formal' and 'informal working', and the term 'fixing' was coined by a Staff Nurse (A6, 30th September 1992) in an early interview in relation to 'formal working' during the ward round and in the case conferences, and the notion of 'brokering' was also used to capture the part played in more informal information exchange.

The interviews with the therapy staff and doctors (n=8) between the 2nd to the 8th of October allowed for these and other aspects of the discharge process to be explored.

The therapy staff, namely the physiotherapy team (n=2), the occupational therapist (n=1), and the Speech and Language Therapist (SLT) (n=1), emphasised the dominance of 'formal working' based on the ward round. As with the earlier data, these individuals did not see these as collaborative events but rather as being consultant centred "ward rounds are hit and miss in multidisciplinary team working work" due to its "medical bias" (occupational therapist, A14, 6th October 1992, interview notes). This was seen to result in "members of the team not pulling together" (physiotherapist, A15, 6th October 1992, interview notes). The SLT considered that the involvement of specialists, such as speech therapists and dietician, was limited.

Not surprisingly poor MDT working was described by the therapy staff (n=4) who highlighted the limitations of 'formal working'. The consequent poor information flow resulted in "team members working in isolation" and having "uncertain roles" (physiotherapist, A16, 6/10/92, interview notes). However, these interviewees stressed the usefulness of 'informal working', with the nursing team again playing a key role in facilitating 'information flow' and ensuring effective liaison and negotiation between MDT members (particularly doctors) and patients and their carers. This reinforced the idea that 'formal working' relied on primarily 'informal working' to act as 'glue' for the discharge process.

The interviews with the doctors (n=4) suggested that from their perspective that the discharge planning process was often dominated by professionals and the locus of control was with the MDT, which was led by the doctors. The ways doctors worked therefore largely defined the formal opportunities for MDT decision making about discharge arrangements and the information flow within the MDT and between the MDT and patients and carers.

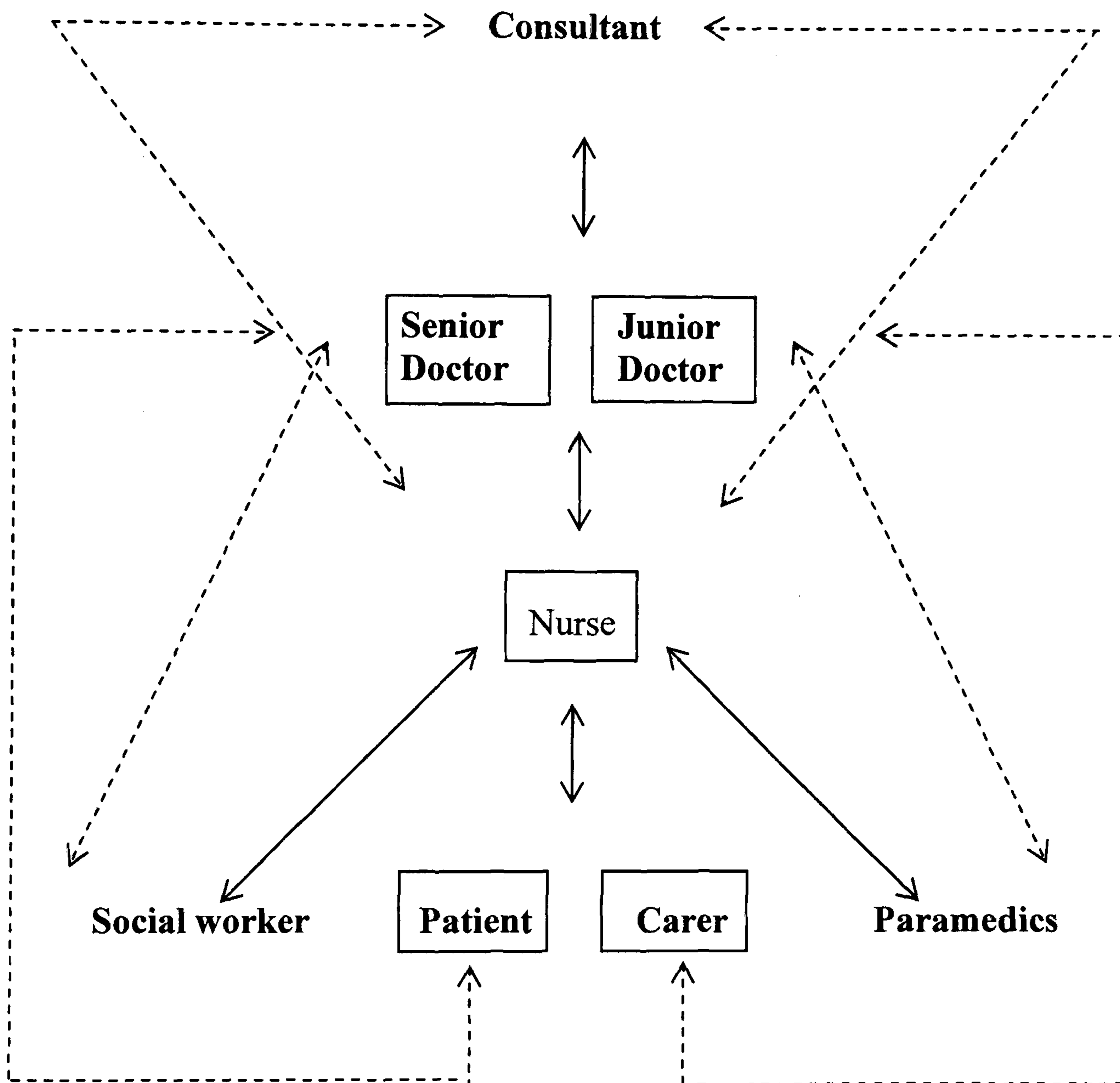
On completion of the interviews to date I noted that the 'actual practice' of discharge was at variance with the 'gold standard' as expressed in the benchmark statements obtained from the literature. However, the key to the complex structures of discharge planning seemed to be captured in the balance between 'formal' and 'informal working' and the 'hidden work of nurses'. The focus on 'information' flow as a major category was particularly important in highlighting the importance of 'formal' and 'informal working' and the 'nursing role', as depicted diagrammatically in Figure 5.

The data suggested that much of the information flow was 'brokered' by nurses, with brokering comprising a number of types of activity, which at this stage I tentatively named as follows:

- Mediation – a number of nurses (n=7) regarded this as a part of 'informal working', which involved nurses who acting as 'go-betweens' between patients and their carers or with patients/carers and the MDT. This involved the nurse acting as a 'neutral' player in the process.
- Negotiation – the doctors (n=4), the Social Worker (n=1) and therapy staff (n=3) highly valued and consistently identified this as a key activity of nurses' 'informal working'. The main exemplars identified were in negotiating the discharge date between the MDT and patients/carers, the venue of discharge and the need for additional support at home.
- Advocacy – a number of nurses (n=4) identified advocacy as a role for nurses in Ward A. In particular the role of the nurse as advocate for patients in disagreements with carers or families and the medical team. Here, in contrast to mediation, the nurse acted specifically on behalf of one party.
- Informing – that is relaying information and helping with its interpretation.

Figure Five

The nursing role and information flow



On the whole the MDT considered that 'informal working' was integral to the 'whole process' of discharge planning and recognised its value. For MDT members who could not access information on a regular basis, particularly social work and therapy staff. Such 'informal working' was an important feature of the discharge planning process,

particularly useful in bridging the gaps identified in 'formal working' caused by their limited access to the medical team.

However, the most visible part of the 'whole process' of discharge was 'formal working' and the doctors (n=4) attached great importance to the ward round as the main 'modus operandi' and the main forum for decision making. However, even this required the nurses to act as 'fixers' by ensuring the relatively smooth running of the formal aspects of discharge planning.

These two phenomena, i.e. brokering and fixing, were seen to facilitate the function of the team: 1) brokering as a form of informal working to overcome poor collaborative working; 2) fixing the formal working/mechanisms which were often not as effective as they seemed.

It was interesting that in their responses to the benchmark statements in the questionnaire (Appendix Four) that the MDT indicated that both patients (n=14) and carers (n=16) were always or mostly involved and informed about their condition and their discharge plan. Again, in response to the statement regarding written information the MDT recognized deficiencies and noted that only sometimes and rarely (n=12) was such information provided with some indicating (n=3) that this never applied. These responses mirrored the interviews reflected, indicating how 'information flow' was managed in Ward A. In the patient and carer interviews I hoped to further examine this area.

3.2.2.2 Patient and carer interviews

As I finished the interviews with the majority of the therapy staff in early October 1992 I commenced the patient and carer interviews and thus the second hermeneutic cycle.

The first patient interview on the 13th October 1992 was a key event and the differences between an older person as a patient in hospital and acting with greater autonomy at home was striking. Significantly, this first interview indicated the level of dependency following discharge was a major consideration, subsequently repeated in all the other interviews. Therefore, all the patient/carer interviews noted an increased level of dependency for a period of some weeks following discharge, which came as a surprise to both patients and carers. It appeared that the situation at home, and their ability to 'manage', differed from that 'anticipated' by not only patients and carers, but also the MDT.

The accounts of the patients' and carers' experiences and their descriptions of the discharge process was absorbing. Patients and carers described their experiences in the form of a 'story' of their admission and subsequent discharge, highlighting their sense of what was important. While the interview schedule was important in ensuring topics were covered, the accounts of patients and carers flowed readily once the interviews started. The interviews were, as Denzin (1988) noted, 'conversations with a purpose'. Again my technique of recording the thrust of the interview, key points and analytical comments during the interview provided a useful framework for probing and introducing topics and provisional categories after they finished their story.

In addition to their unexpectedly high levels of dependency the interviews with the first five patients during October 1992 highlighted their lack of awareness of a discharge planning process per se. There appeared to be no understanding of a 'whole process' by patients and carers, with their perspective being very much focussed on episodes from their 'story'. The acute nature of their admission precipitated this as there were no

opportunities for anticipation or planning and the 'illness episode' was the dominant feature. From the data, the influence of the 'illness episode' varied according to:

- The nature of the illness, for instance stroke and myocardial infarction differed considerably, the former being unpredictable, more catastrophic involving shock for patient and family with uncertain outcomes and timescale but was often highly visible.
- The severity of the illness, for example, a 'major' or 'minor' stroke.
- The extent to which the illness had precipitated a crisis in the family system of the older person.

As a consequence of their preoccupation with the illness, they paid relatively little consideration to the discharge process, and attention was only directed to it during the 'formal working' of the ward round. Therefore the need for discharge planning did not occur to patients or carers until these issues were raised by the MDT. At which point the 'next' ward round became the most significant part of any planning activity for patient and carers.

It seemed from the patient and carer data that there were particular dynamics at work in their 'construction' of their hospital stay and discharge home. A number of patients (n=9) indicated that they left the planning to the MDT as 'the professionals' and accepted a somewhat passive role awaiting the discussion at the next ward round ('formal working'). However, while they clearly relied on the MDT (primarily the doctors) to decide when they should 'go home', there was evidence that they asked the nurses about the prospect of discharge in advance of the ward round. The initially passive picture of the patient role did tell the full story, and that patients often enabled

nurses to either act on their behalf, or provide them with information. This was corroborated by nurses in the documentary evidence found in the nursing process or Kardex, which also indicated the nurses role in initiating certain aspects of the discharge process.

Fieldwork notes

Date: 15/10/92

Document: Nursing Kardex Ward A

‘Patient’s family seen this PM and checked arrangements for possible discharge after ward round with Dr. XXXX (consultant), discussion with patient about ability to walk once home and relatives worried about getting up in the morning and toileting. Left message with social worker to discuss further. Possible need for OT assessment and physiotherapy stairs assessment before going home.

Entry signed by XXXX (Staff Nurse)’

The data indicated that nurses ‘flagged up’ concerns, on behalf of patients either prior to or during the ward round, with the MDT. This often related to possible tensions about the ‘situation at home’ between carers and family. In the interviews with carers and patients (n=4), and a carer alone (n=1), nursing staff were usually the first point of contact for such ‘brokering’ by carers and family members.

The data suggested that patients and carers placed great store on information and patient involvement in discharge. However, what they meant by ‘involvement’ was by no means clear, and seemed to relate more to being ‘informed’ rather than involved. Both patients and carers focused on the importance of ‘being informed’, with the provision of good ‘information’ being their ‘gold standard’. However, they identified deficits and

highlighted the lack of information provided by the MDT. Patients and their carers described the fragmentation of information giving and the important role of nurses in providing a back up to information given by the MDT:

“The doctor did not involve me in discussions, nurse came to explain on occasions, not listened to as an individual.”

(Patient, A24. 15th October 1992, interview notes)

Not ‘being informed’ during ward rounds led to a feeling of exclusion by patients: “not enough information given ‘chatter among themselves’ nurses explained but would have liked more information from doctor” (Patient, A29. 22nd October 1992). However, the high status accorded to the ward round, together with the relative lack of patient/carer involvement, further served to reinforce their relatively passive roles. To counter this feeling of relative helplessness some patients and their carers would negotiate with nurses directly or ask nurses to intercede on their behalf (‘mediate’). The following extracts illustrate these active but hidden tactics used to ensure some involvement in the discharge process.

“Information was given by the Sister to my daughter and I was happy with that, she sorted it out with the nurses, she was involved in arranging since I wanted to go home straight away. Dr. XXXX (consultant) saw me on the ward round ‘go home tomorrow’ but wanted to go home today. Nurses gave my son a ring.”

(Patient, A24. 16th October 1992, interview notes)

“I was unsure whether I wanted to go home or not. I had some doubts, I wanted to stay till Monday. The registrar said if the ‘blood’ was okay and the tests were back, it would be possible to go home on Friday. The nurses phoned home and my family were prepared. I went home on Saturday morning but I did not feel ready. The nurse did check me but I felt anxious.”

(Patient, A27. 20th October 1992, interview notes)

Direct involvement for patients was further limited if carers ‘filtered’ information to patients, or vice versa. It seemed that patients or carers would not always relay all the information they had to their next of kin, but instead would select the information they thought others needed to know.

This presented difficulties as some patients and carers did not have complete information regarding discharge plans, or subsequent care: (Carer, A32. 29th October 1992).

“The nurses told me about going home in the afternoon, after the round, and said that the problem was to do with my heart, that’s why I had problems with the breathing, being short of breath all the time. I told the family I was okay and coming home on Thursday.”

(Patient, A29. 22nd October 1992, interview notes)

Irrespective of how involvement was perceived, all the patient/carer interviews identified ‘information flow’ as a key issue, and nurses were identified as the main conduit for information giving. Information given by other members of the MDT was seen as being ‘ad hoc’, lacking in sufficient detail, or being overly technical. In particular, information regarding the patient’s condition (n=12), and their medication (n=10), was seen as requiring ‘interpretation’. Moreover, information was not given in a co-ordinated or consistent manner to patients and carers, as a result of the fragmented approach by team members.

“Not given information about my condition, Dr. XXXX (consultant) mentioned ‘heart by pass’ out of the blue. My son saw a doctor but did not discuss it with me I’m in the dark really”

(Patient, A26. 16th October 1992, interview notes)

Information giving was often not structured, and written material was rarely given. This was particularly significant in relation to medication and information about the patient's condition that was needed by the PHCT. This is illustrated by the following extract from an interview with a patient having suffered a myocardial infarction and his carer:

<i>Interviewer</i>	<i>“Gafodd chi rywbeth wedi ei ‘sgrifennu I lawr I ddod adref?”</i>
<i>Carer</i>	<i>“Dim ond tablets”</i>
<i>Patient</i>	<i>“Ia, prescription tablets”</i>
<i>Interviewer</i>	<i>“Dim byd wedi ei ‘sgrifennu I lawr?”</i>
<i>Patient and carer</i>	<i>“ Naddo ”</i>
<i>Interviewer</i>	<i>“Fuasa chi wedi hoffi rywbeth wedi ei ‘sgrifennu I lawr felly?”</i> <i>(Pause)</i>
<i>Carer</i>	<i>“Mae ’n siwr os fuasa rywun yn medru dweud fedra’chi wneud hyn a gwneud llall, mi fuasa’n help”</i>
<i>Patient</i>	<i>“Buasa”</i>
<i>Carer</i>	<i>“Pan gafodd chi (patient) eich trawaiad gyntaf mi gaethon ni wybodaeth, pamffledi”</i>
<i>Patient</i>	<i>“Ia, be I wneud”</i>
<i>Carer</i>	<i>“Ella bod nhw’n meddwl bod ni wedi byw efo fo ers gymaint bod ni yn gwybod ond gafodd ni ddim byd, dim, <u>DIM</u> (original emphasis).”</i>

English Translation:

Interviewer	“Did you receive any written material to come home on discharge?”
Patient	“No”
Carer	“No only the tablets”
Patient	“Yes, only the prescription for the tablets”
Interviewer	“Nothing written down at all?”
Patient and carer	“ No not at all”

- Interviewer “Would you have liked to receive some written material?”
(Pause)
- Carer “If someone had given us information on what to do and what not to do that would have been a help ”
- Patient “It would have been”
- Carer “When you had (patient) your first heart attack we had some information, some pamphlets then”
- Patient “Yes, about what to do”
- Carer “Maybe they thought, because we’ve been living with it for a while that we knew but we had nothing at all, **NOTHING** ”

(Patient and carer, A33. 29th October 1992, transcript)

Their medical condition was usually poorly understood by both patients and carers, particularly the relationship between their medical condition and their treatment (n=11). It seemed that information given prior to discharge was episodic, unstructured and rarely reinforced with written information. This problem had already been identified in the interviews with members of the MDT, and the patient and carer accounts corroborated this finding. Medication in particular proved problematic. There was much confusion over different medication or its dosage (n=9). A number of patients (n=10) had long standing chronic conditions and any alteration in dosage caused concern and anxiety (n=4) further complicated by GPs changing dosages on discharge. Patients/carers were often unaware of side effects and contra-indications of their medication.

It was evident from the patient and carer interviews (n=16) that the discharge planning process and the workings of the MDT remained largely ‘hidden’. Patients and carers did not see themselves as being involved in a discharge process and their perspective was focussed primarily on the initial ‘illness event’, any further episodes of illness in hospital and the treatment given.

This focus on the 'illness episode' represents an important gap between the constructions of the ward MDT and the patient/carer. The professional focus on discharge planning did not coincide with the orientation of both patient and carer on the 'illness episode' and this resulted in a consistent delay in patients and carers engaging actively with the discharge planning process. This was noted in the following memo on the completion of the majority of patient/carer interviews (n=12):

Analytic memo

Date: 2/11/92

Subject: Patient/carer perspective on discharge and their illness/condition

The interviews to date (29/10/92) provide a clear account of the differences between the MDT understanding of a discharge planning process and the patient/carer perspective. The patients and families focus on the reason for admission (illness or condition) during the hospital stay and only think about discharge at a late stage in the patient's stay, sometimes some discussion with nurses at periods during that stay but these discussions are episodic and do not become part of the process until ward round or preparation for round. Patients and carers do not know of a planning process and only recognise the ward round as the way discharge is raised and 'sorted out'. Nurses identified as 'confidants' in the pre-planning stage for both patients and carers, as part of the consultation regarding the progress of treatment or queries regarding the patient's illness/condition. Constant focus on ward round as the start of discharge plan and a discharge planning process. The round becomes the key discharge event followed by the day of discharge as its conclusion. 'Process' of discharge takes place between these two 'events'.

On completing the patient/carer interviews I revisited the patient documentation to compare the comments on discharge with the post discharge picture. This was done by examining the patient's medical case notes kept by the secretarial staff working for the consultant geriatrician. The medical case notes were used by the secretarial staff to organise the outpatient clinic appointment and complete a full discharge summary for the GP. The medical case notes contained not only the medical details and a copy of the medical discharge summary but also the nursing process and any copies of therapy assessments. These were retained in the rear of the medical case notes. Combined with the patient/carer interview a sense of the 'whole process' of discharge was obtained. For instance, it was clear that the deficits in self care, reported by the patients, were not anticipated in the planning process and that both the MDT and patients and their carers overestimated the patients initial abilities within the first two weeks post discharge.

3.2.2.3 Data collection and analysis: The 'overlap' PHCT cycle

The MDT interviews raised the manner of liaison with the PHCT as problematic, highlighting poor 'information flow' and limited involvement of the PHCT in discharge planning. Early in January 1993 I was able to start the PHCT interviews in two of the sample community areas served by Ward A. These interviews were informed by emergent categories from the MDT and patient and carer interviews.

Additional resources enabled January and February to be allocated to the PHCT interviews, but arranging interviews with the respective GP surgeries was a time consuming process requiring numerous phone calls and correspondence, often through

the 'conduit' of practice managers. The interviews started on 3rd February 1993 and the venues were either PHCT offices in health centres or surgery consultation rooms.

The first four interviews with Community Nurses (3/2/93 to 8/2/93) identified the key deficits of the discharge planning process from their perspective:

"Not enough time and planning on discharges, very important issues, especially with some elderly, living on own and in their home, sudden decisions can cause big problems in the community."

(Community Nurse, A38. 3rd February 1993, interview notes)

These data highlighted poor collaboration with the ward area, and the community nurses felt that there was a lack of priority afforded to discharge and too much energy expended on managing the 'bed situation' in Ward A. However, the situation here was seen as better than on both Medicine and Surgery. There was little involvement of Community Nurses in discharge planning and they felt there was insufficient focus on the assessment of patient and carer needs in preparation for the post discharge period:

"Sometimes patients discharged home at weekends or Bank Holidays for instance, are seen by doctors on Friday morning 'not ready' then 3 hours later sent going home by the doctor, then very rushed."

(Community Nurse, A41. 8th February 1993, interview notes)

These four initial participants identified a need for improved liaison and voiced a desire to move away from the 'them and us' situation that they described as existing.

Paradoxically the nurses both in Ward A and the PHCT identified similar inadequacies in the discharge planning process, describing the relationship with the PHCT as being poor and the transfer of information as flawed. However, the Community Nurses did not consider that the MDT in Ward A "knew the patients", and consequently they had a limited picture of the needs of patients and carers as part of their preparation for

discharge. The Community Nurses felt that ward-based assessments of patients did not accurately reflect their functional ADL abilities or anticipate social-family problems in the home environment post discharge:

“Discharge planners do not know about home activities, for instance do not realise what patients can do in hospital is not the same at home.”

(Community Nurse, A40. 8th February 1993, interview notes)

The Community Nurses all agreed that the MDT assessment on Ward A did not result in any real insights into the “social situation at home”. It was in this context that the Community Nurses considered that they had a vital contribution to make to discharge planning, so that they could provide a more complete picture of social support or networks at home.

“Patients say that they are better to get out therefore lie to get out – say that carers are there but carers not really a legitimate role, such as neighbours, that’s why District Nurses should be involved.”

(Community Nurse, A39. 5th February 1993, interview notes)

I noted in an analytical memo that the account of the Community Nurses contrasted with the perspective of patients/carers discharged home from Ward A, but actually reflected the experience of patients once they were ‘back home’.

Analytical Memo**Date:** 5/2/93**Subject:** Community Nurses

Community Nurse today talked of patients 'lying' about their condition in order to be discharged home. It was interesting to compare such accounts with the interviews with patients and carers. Rather than 'lie' or misrepresent their 'real' home situation patients and carers had clearly identified that they overestimated their abilities once home and that 'getting out' was the priority. In the interviews patients and carers engaged in negotiation as soon as discharge was raised by the MDT as a possibility. Interestingly the patients and carers did not consider the PHCT as 'knowing them' any better than the MDT in hospital in contrast to the views of the Community Nurses.

A significant point I noted in these first four interviews was the failure of both ward staff and the PHCT to recognise the 'hidden work' of the other groups. There was no recognition by the PHCT of the discharge work of the MDT in Ward A, equally it was already apparent from the hospital interviews that the MDT did not fully consider the work of the PHCT in the community. The relevance of 'information flow' as noted in the MDT interviews in Ward A was reiterated by the PHCT. I introduced these topics as part of the next four interviews with a community physiotherapy, an occupational therapist, and two community nurses (8/2/93 to 10/2/93).

The Community Nurses (A43, A44) reiterated the points made in the earlier interviews and focused on the remote relationship with Ward A but emphasised that there was

more connection between the PHCT and Ward A, when compared to Medicine and Surgery.

“We don’t get much notice or contact with the ward staff, the patient comes home and that’s it – we sort it out. Its better on XXXX ward (Ward A) than medicine and surgery, its nonexistent there.”

(Community Nurse, A44. 9th February 1993, interview notes)

In addition, the Community Nurses (A43, A44) described that it took 3 or 4 days for them to be informed of a patient’s admission to hospital, and this proved to be an obstacle in providing the ward with additional information.

The therapy team provided a different perspective on the discharge process to the Community Nurses and described a better connection between the hospital and the community. In both cases there were good relations with their colleagues in Ward A and the appropriate information was relayed promptly. The physiotherapist and OT noted that there was a close working relationship within the therapy team and consequently they did not experience a ‘them and us’ situation. Rather, they described the difficulties within the PHCT and the poor ‘information flow’ as lying in the multidisciplinary community team.

Both the Community Nurses and the therapy staff identified the inadequate information given to patients and carers prior to discharge, in particular regarding their condition and their medication: “not enough information about expectations when home, treatment or diagnosis” (Physiotherapist, A46, 10/2/93). A Community Nurse noted this was likely to be due to the ward ‘construction’ of patient need and the fact that they did not have “enough information to know the patient as individual, very poor at

looking at the person holistically” (Community Nurse, A43. 9th February 1993, interview notes).

The GP interviews (n=14) were commenced on the 15th February 1993 and built upon the constructions developed by the Community Nurses, physiotherapist and OT. These were as follows:

- That patients ‘misrepresented’ or failed to provide adequate information on their home/social circumstances prior to discharge.
- That the MDT in Ward A did not adequately assess the abilities of patients/carers prior to discharge.
- The remote connection between the MDT in Ward A and the PHCT resulting in poor ‘information flow’.
- The difficulties in maintaining ‘information flow’ within the PHCT.
- The different construction of patient/carer need by the MDT in Ward A and by the PHCT.
- The paucity of information given to patients and carers.

The responses by the GPs during the interviews were often terse and I had to make greater use of probes and follow the interview schedule more closely than in previous data collection.

The first three interviews on the 15th February 1993 identified a similar pattern of responses to the Community Nurses. There was a consistent description of a discharge process dominated by the concerns and issues of the Acute Unit, described as the “emptying bed process syndrome” (GP, A49, 15/2/93) characterised by patients being “ejected on Friday afternoon” or prior to Bank Holidays. Liaison between community and the ward team was considered ‘disjointed’ (GP, A50, 17/2/93).

The GPs interviewed subsequently reiterated the significance of the 'emptying bed syndrome' and the dominant focus on hospital concerns rather than those of patients/carers and the PHCT. Furthermore, the GPs considered that staff in Ward A promised services for patients and carers on discharge without liaison with community staff. Difficulties were caused with carers in particular, when community staff felt that the 'promised' service was not required or unavailable and had to withdraw or reduce their input following discharge home.

The community Social Workers (n=2) provided a differing 'construction' of the relationship between the PHCT and the MDT in Ward A, and also the working methods within the PHCT. I had arranged an interview with a community Social Worker from each of the respective two community areas participating in the study. The interviews were completed towards the end of the PHCT cycle (23/2/93) after most of the GP interviews. The Social Workers (n=2) provided a separate but consistent account of the discharge process, indicating good liaison with the Hospital Social Work team and a good 'in-house' form of 'information flow' (A58, A59). They did criticise the medical approach to older patients and the dominance of the medical agenda. The crux of their difficulties was the 'pushing' of discharges when bed crises occurred or were anticipated such as during Bank Holidays or weekends. They highlighted that within the PHCT there were considerable difficulties in multi-agency working and again identified the 'medical agenda' as driving the operation of the PHCT. The Social Workers saw themselves as isolated and at the periphery of the discharge process, despite their central role in community care. GPs and Community Nurses were late informing them of patients being admitted to hospital and usually they only found out when their Home Carers went to the older person's home and discovered that he or she had been sent into hospital. They described poor 'information flow' and no sense of collaborative working

in the PHCT other than 'informally' developed networks with individual Community Nurses and other MDT members.

Of particular concern for the Social Workers (A58, A59) was the information provided to patients and their carers by the MDT in Ward A regarding their condition, their medication and the type and duration of support they would be receiving. They considered that both patients and carers perceived that support packages were 'written in stone' and did not realise that the community Social Worker would need to review any support and that this might lead to a reduction of services following discharge. Patients did not seem to have sufficient information regarding what they were able to do or indeed should do following discharge. Such grey areas were not clarified by the Community Nurses or GPs in the PHCT.

The final Community Nurse (24/2/93, A61) and GP interviews (27/2/92, A64) reinforced the picture of discharge planning and community relations described by the earlier research participants. The final interviews highlighted the particular difficulties of multidisciplinary working in PHCT. I noted the relevance of these observations in an analytical memo.

Analytical Memo

Date: 28/2/93

Subject: PHCT interviews

The community team suffers same problems as MDT as exists on Ward A with difficult 'information flow', MDT conflicts of agenda and medical dominance. Some sense of 'formal working' in the connection between acute and community based on the documentation:

1. Transfer of Care Form between nurses in the hospital and community.
 2. Letter to Doctor/medical summary provided for the GP.
 3. Pharmacy counterfoil provided for the GP to indicate medication provided on discharge home.
 4. The physiotherapy and OT referral between hospital and community teams.
 5. The Social Work referral between hospital and community teams.
-

The PHCT interviews emphasised the difficulties experienced by teams working in both community and ward areas. Research participants throughout the interviews described how problematic ‘information flow’ was within the PHCT and the detachment from the GP (other than in the case of Community Nurses). Conversely, there was an overwhelming feeling of detachment by the Community Nurses and GPs from the discharge planning process in hospital, whilst the therapy staff had good connections with their colleagues in Ward A and identified the ‘information flow’ problems lying within the PHCT. However, despite these difficulties, the experiences of discharge from Ward A were described as exemplary when compared to the standards of discharge from the Medical and Surgical Units. The PHCT perspective on the Medical and Surgical Units will be considered later.

3.3 Feeding back constructions: Reporting and negotiation

Having completed the data collection and analysis stages it was necessary to provide feedback to the research participants. I considered the advice by Guba and Lincoln (1989) to be a sound basis for the process of reporting and negotiating:

“The purpose of the hermeneutic process is not to attack or to justify but to ‘connect’ different constructions. It is ‘engagement’ not confrontation that leads to reconstruction.”

(Guba and Lincoln, 1989, p219).

As I stressed in the last chapter, reaching a consensus view of the constructions that arise out of a Fourth Generation evaluation is one of the cornerstones of the methodology. Guba and Lincoln (1989) described how this could be achieved in a number of ways, both within the hermeneutic cycle and with respect to the case report. This section considers the degree to which such a consensus was reached on the Care of the Elderly Unit, and also whether the authenticity criteria can be seen to have been met.

This phase of the project involved the use of three cycles of activity respectively with the MDT, patients and carers, and community staff. Data collection was undertaken in this temporal order and therefore by and large the views of the MDT were sought first, followed by patients and carers, and then community staff. Within each cycle efforts were made to develop a dialectic approach with initial analyses of interview data from one respondent being completed prior to the next interview being undertaken. It was, of course, not possible to have all the interviews transcribed before the next one was organised, but I made notes of issues at the end of interviews and listened to the tape-recording again. The interview guide was then revised in light of any emerging issues and if required was modified slightly. The guide therefore evolved as the study progressed, with new issues and emphasis being introduced in order to ‘check out’ constructions and attempt to take them to a higher level of sophistication. This process was reflected in Figure Three in the preceding chapter.

Moreover, at the end of each interview, my interpretations were fed back to each informant and discussion occurred until we had reached agreement about what was being said. In both these ways therefore it could be argued that within the resources available that the canons of Fourth Generation evaluation were applied with respect to the individual hermeneutic cycles.

It was also stressed in the preceding chapter that one tactic for reaching consensus is to look for overlap between cycles and to identify areas of agreement or disagreement. From the foregoing account of the data collection and analysis, it will be apparent that there was considerable agreement over the main issues that needed to be addressed and that these related both to within, and between, team issues (relating to the hospital and the community) and more importantly, patient and carer issues. Much hinged on channels of communication and the ways in which information was provided, or in many cases, not provided.

In an attempt to greater achieve consensus of these issues, a 'case report' was produced providing a basis for discussion (Appendix Five). Copies of this case report were circulated to all of the PHCT members that took part in the study for information and comment if felt appropriate and the MDT in Ward A. In writing the case report my aims were to:

- Summarise any insights about the discharge planning process Ward A (ontological authenticity);
- Elucidate differing constructions from stakeholders involved in the discharge planning process on Ward A (Educative authenticity);

- Generate potential actions based on the findings from the evaluation of discharge planning on Ward A (catalytic authenticity);
- Planning potential actions focusing on empowering all members to participate (tactical authenticity).

Guba and Lincoln (1989, p224) identify four criteria that need to be addressed at the stage of producing the written case report. These were:

- 1 Axiomatic criteria – The report must reflect multiple rather than single realities, consistent with the precepts of constructivism;
- 2 Rhetorical criteria – The report must be crafted simply and with clarity, openness and creativity;
- 3 Action criteria – The report must be able to evoke and facilitate action, related to authenticity criteria, being attentive to educative, actionability and empowering criteria;
- 4 Application or transferability – The report must enable the drawing of inferences by the reader that can be applied to their own context.

In preparing the case report I consulted the four criteria described by Guba and Lincoln (1989, p224) as guidelines.

The main focus of the case report (Appendix Five) was to the ward staff and in order to facilitate debate, meetings were organised in which the issues that had arisen could be discussed. Three such meetings were organised, two with the senior ward team (comprising the two consultants, senior nurse, sister, and representatives of all the other

disciplines) and one with the remaining nursing staff comprising staff nurses and enrolled nurses. These proved to be both interesting and, at times, challenging.

The meetings with the senior ward team presented the greatest challenge. The report was quite detailed and was divided into the perceptions of discharge as held by the three main stakeholder groups, i.e. the MDT, patients and carers, and the PHCT. I acted as a facilitator for the meeting and explained that its purpose was to try and secure agreement as to the conclusions of the report, and to identify what, if anything, needed to be done. What transpired was very instructive. It was apparent at an early stage that the majority of those present wanted to focus primarily on issues surrounding the work of the MDT within the Unit, the structures that supported it, and the way in which decisions were made. As noted earlier, there was a feeling, especially amongst the therapy disciplines and the Social Workers, that the focus of the ward round was too medically orientated, that the timing was arranged largely around the convenience of medical staff, and that while all those present could give an opinion, at the end of the day a medical view seemed to predominate. Moreover, there was a certain lack of clarity about roles and responsibilities, particularly with regard to recording and conveying information.

However, this line of debate met with strong resistance, particularly from one of the consultant medical staff, who did not perceive there to be a problem. Therefore, despite an airing of views and full discussion no agreement or consensus could be reached in terms of either the difficulties (or not) that existed, or of any potential action needed. It was therefore decided that there was a need for a second meeting to take the debate further.

At the second meeting it was quite apparent that the consultant in question felt that the issue of the MDT had been covered sufficiently and that there was a need to move the agenda forward. This meeting therefore focussed mainly on the need for information exchange, especially in relation to patients and carers. Here consensus was achieved far more quickly, and there was little dissent to the view that improving channels and means of information flow could only be a good thing. Several options were discussed and it was eventually decided that a form of information booklet should be devised and piloted, comprising two main sections. One would contain generic information and advice of interest to all older people, the other would be tailored to the needs of individual patients and would contain details of their treatment, medication and other information that they needed to hold. This leaflet was seen to serve a number of purposes, both acting as a written record for the patient but also as an adjunct to communication with Community Nurses and other community based staff. This initiative was eventually taken forward in the form of an action research study (see Lundh and Williams, 1997).

The meeting with the other nurses took a different direction and it was quite apparent that for this group the whole evaluation process had alerted them to a series of issues in relation to the discharge planning process, their role within it and the relative passivity of patients and carers. In this meeting there was little difficulty in reaching consensus about any of the issues in the case report and the participants readily identified and endorsed the conclusions regarding the MDT on the Unit. Subsequently, the debate focussed on their growing awareness of their own important, but often unrecognised, role in discharge planning. Many of these staff did not regularly attend the case conference or the ward round, as someone had to 'run' the ward when these events occurred. Therefore, whilst they were not explicitly excluded, pragmatic and resource

reasons meant that in reality the result was very similar. Their access to the 'formal' structures of discharge planning was therefore limited. Nevertheless, it was very apparent that much of the informal or 'backstage' work relied on these staff to convey information to patients and carers, as these nurses were in most frequent contact with patients. The interviews had helped them to reflect upon the involvement of patients and carers, leading most to the realisation that there was scope for much improvement, especially in relation to information giving. Most then readily accepted the idea of the information booklet that had been suggested but would also have liked greater attention to the issues of the MDT and more explicit recognition of their contribution.

A formal feedback and discussion with the PHCT was not held at this point, and in the event relatively little feedback was received from the community teams. However, some action was prompted by the report, which resulted in the role of the 'sector office' (the hub of the District Nurse (DN) service) being reviewed and the possibility raised of communication being routed directly through surgeries and to Community Nurses themselves rather than through the sector office. One of the senior nurses for Community Nurses seemed happy with this suggestion, but the other had reservations. In the event proceedings were overtaken by the formulation and introduction of a new district wide discharge policy for the hospital as a whole (see later).

In terms of a consensus of constructions it transpired that a genuine consensus could not be reached and that a negotiated compromise was the end result. The main stumbling block was the resistance from one senior figure to the idea that the MDT on the Unit was not working as well as it might. This raises a number of issues about how realistic some of the principles underpinning a Fourth Generation evaluation are. These will be more fully explored in the concluding chapter.

3.4 Judging the evaluation: The Fourth Generation evaluation criteria

As indicated in Chapter Two Guba and Lincoln (1989) propose a number of criteria so to judge the quality of Fourth Generation evaluation. The two standards indicated by Guba and Lincoln (1989) that are required to judge the “quality of goodness of a Fourth Generation evaluation“ (p233) are trustworthiness (‘parallel criteria’) and authenticity. These are sub-divided into a number of key elements:

1. Trustworthiness criteria

Credibility - As detailed in Chapter Two credibility is focused on the isomorphism between findings as constructed realities of research participants and the reconstruction’s that that are attributed to them. In this first phase I engaged in ensuring credibility by peer debriefing, progressive subjectivity, negative case analysis and member checks (Guba and Lincoln, 1989, p237-239).

Peer debriefing was facilitated by the role of Dr. M Nolan (now Professor) as the research supervisor at the University of Wales Bangor. Though involved with the design of the research process Dr. Nolan was not directly involved with data collection and analysis and was thus able to accommodate the peer debriefing role “helping to make prepositional tacit and implicit information that the evaluator might possess” (p237). Also as part of peer debriefing posing secondary questions and ‘testing out’ findings in addition to providing a confidant and professional relationship as a peer in “reducing the psychological stress that normally comes with fieldwork” (Guba and Lincoln, 1989, p237).

Linked to peer debriefing the activity of progressive subjectivity extended the role of ‘debriefing’ provided by Dr. Nolan. This centred on my own recording in the fieldwork journal (diary) of my constructions ‘a priori’ and during the research

process. My constructions regarding Ward A and any expectations about potential findings were recorded in a reflective manner and thus “archived” (Guba and Lincoln, 1989) throughout the research process. Dr. Nolan was able to challenge the influences of the author’s etic constructions avoiding the research process being “stuck” or “frozen” in my interpretation of the findings (Guba and Lincoln, 1989).

As already noted, as part of the feedback of constructions member checks were crucial to the research process and are a central part of CCA as described by Glaser and Strauss (1967) and Lincoln and Guba (1985). The preliminary categories and interpretation were checked with members and as Guba and Lincoln (1989) note: “this process occurs continuously both during data collection and analysis stage” and such member checks can be formal or informal with either individuals or groups. I adopted a flexible strategy utilising both formal and informal approaches centred on the hermeneutic dialectic circle.

Transferability – This relates to facilitating the judgement of others as to whether the findings are significant for other contexts. As part of the reporting process I presented the findings in the case report but also identified working hypotheses that informed the development of the second phase in Medicine and Surgery, and assisted in the later theory constructions (see next chapter).

Dependability and Confirmability - These two criteria involve an ‘audit trail’ of the research process as detailed by Schwandt and Hapler (1988) and adopted by Guba and Lincoln (1989). I ensured a ‘trackable’ and documented research process indicating constructions as they developed as part of hermeneutic process and highlighting shifts in the understanding of constructions and formulation of categories. This was accomplished by the use of the fieldwork journal (as noted in

relation to progressive subjectivity) to document my etic constructions and discussions in peer debriefing, interview notes, the transcription of some taped interviews (see appendix interview log) and the storage of all tapes for 'back and forth' analysis (Patton, 1990) as described in Chapter Two. The confirmability of the audit trail attempts to ensure "integrity" of the interpretation. Thus, the "raw products" and the "processes used to compress them" (Cronbach and Suppes, 1969 cited in Guba and Lincoln, 1989) were made available to be confirmed and examined by an external reviewer of the study. Such a review aims to trace the data sources and again required the author to document and record all aspects of the research process.

In many respects confirmability (Guba and Lincoln, 1989) is a core part of the hermeneutic dialectic circle and is embedded in trustworthiness criteria as a 'whole': "The opportunities for error to go undetected and/or unchallenged are very small in such a process" (Guba and Lincoln, 1989, p244). In my view the hermeneutic circle grounded the findings and addressed issues of confirmability.

2. Authenticity Criteria

I argued in the preceding chapter that the main emphasis on quality in this thesis would be placed on the often neglected but potentially important 'authenticity' criteria. These it will be recalled are: fairness; ontological authenticity; educative authenticity; catalytic authenticity and tactical authenticity. These will be considered briefly below in relation to this phase of the project, with further discussion taking place later in this chapter and in the concluding chapter

The application the authenticity criteria is seen as being of key importance by Guba and Lincoln (1989), linked to the basic assumptions of constructivism as noted in Chapter Two.

Fairness – This relates to the egalitarian values of Fourth Generation and the attention to equity of different constructions as part of the evaluation process. Issues of ‘fairness’ are a ‘risk’ area in the application of a constructivist methodology and I focussed much attention on minimising the risk to ‘fairness’. The hermeneutic process provided the bulwark against the compromising of ‘fairness’ in the present study, allied to the use of CCA and the adoption of a case reporting strategy in order to display the findings openly and fairly (Guba and Lincoln, 1989). Attention to ‘fairness’ is an important criteria given the hierarchical arrangement of healthcare in general and the political repercussions for participants in an evaluation (Patton, 1990, Guba and Lincoln, 1989).

With regard to fairness, that is, were all the voices heard, I would suggest that this criterion was largely, but not perhaps fully met. I had thought that every effort had been made to include all the main stakeholders and indeed I was at pains to ensure that all disciplines within the MDT were consulted, that patients and carers were fully included and that a diverse number and range of PHCT members were also able to participate. In retrospect two potentially important groups of ward staff were not consulted, nursing auxiliaries and the ward clerk. These may well have played an important role in the ‘informal’ backstage work of discharge planning as auxiliaries had a key role to play in the delivery of direct care and were therefore well placed to consult with patients. Ward clerks were at the centre of several

channels of communication, but unfortunately their contribution was not captured and could not figure in the constructions that emerged.

Ontological authenticity – This criterion focuses on case reporting and the benchmark provided by Guba and Lincoln (1989) states that individual respondent's own emic construction are "improved, matured, expanded and elaborated in that they now possess new information and have become more sophisticated in its use" (p248). Though such 'improvement' can take place during the hermeneutic process it is most evident at the case reporting and negotiation stage.

Ontological authenticity therefore concerns the extent to which participation in the study results in an enhanced emic perspective. That is, were participants able to form a fuller and more sophisticated view of their own situation? This was certainly the case with the SN/EN's as described above, and might have been the case with regard to the consultant. However, for ontological authenticity to occur it has by definition to be acknowledged by the individual concerned. This was not the case with the consultant in question who failed to see that some aspects of the difficulties relating to the MDT were due to his own managerial style.

Educative Authenticity – As with ontological authenticity I viewed this criterion as being most evident in the case reporting and negotiation stage, since: "Stakeholders should at least have the opportunity to be confronted with the constructions of others very different from themselves" (p244). I attempted to 'capture' such a process as part of the audit trail (Schwandt and Halpern, 1988) which continued through the reporting and negotiation stage as the final part of the research process.

Educative authenticity occurs if participants gain renewed insights into the perspectives of other stakeholders who are not part of their group. This could be said to have occurred to a limited extent between the MDT and the PHCT, although it was apparent that there was still a need for further reflection. The potential for educative authenticity that could have been achieved within the MDT largely failed to materialise due to the failure to achieve consensus. Despite this the discussion provided an element of catharsis for several disciplines but many of the underlying issues remained unresolved.

The most potent form of educative authenticity to emerge related to the realisation of the largely passive role of patients and the need for more structured and efficient methods of providing information.

Catalytic Authenticity - The evidence in support of addressing the catalytic criterion is also best understood as part of the case reporting and negotiation stage. Since the criterion is focused on “the extent to which action is stimulated and facilitated by the evaluation process” (p249). For Guba and Lincoln (1989) this forms an important element in Fourth Generation, since “action is singularly lacking in most evaluations” (p247). The fact that an, albeit limited, action resulted from the study suggests an element of catalytic authenticity.

Tactical Authenticity – The tactical criterion concerns the empowering of stakeholders to take action. I considered that ‘making explicit’ constructions and providing the outline of a joint construction through the production of a case report, provided the means for ensuring equity as a prelude to empowerment.

In the case of both catalytic and tactical authenticity (whether the evaluation process stimulated 'catalytic' and empowers or enables 'tactical' action) I considered that the evaluation made a contribution to developments in Ward A. The potential for this was raised with regard to liaison between the PHCT members and the Unit but, as will become apparent shortly, other events overtook the early discussions for change. However, a tangible product did emerge in the form of the information booklet and whilst this was not entirely successful (see Lundh and Williams, 1997), it nevertheless raised the profile and awareness of information giving which did result in changes to current practice.

Notwithstanding the above difficulties, what was heartening about the evaluation on the Care of the Elderly Unit was the general willingness of everyone to participate, to recognise in principle that there was a need for improvement, to at least meet and discuss the potential for change, and to agree an albeit only partial consensus on a way forward. The second phase of the study was to provide quite a contrast.

3.5 The Second Phase: Discharge planning in Medicine and Surgery

As the evaluation on the Care of the Elderly Unit was drawing to a close two significant events occurred that greatly influenced the way in which the project unfolded. The first was the introduction of a hospital wide discharge policy fashioned in response to the Welsh Office Guidance. The second was the opportunity to bid to the Welsh Advisory Group on Nursing and Midwifery Audit (WAGNA) for funding as an audit development site. A meeting was therefore held with the ADNS when it was agreed that a proposal to audit the intervention of the new discharge policy on the Medical and Surgical Units be submitted to WAGNA. Within the bid was sufficient funding to

second me from my position as a staff nurse to that of project officer for a year full-time. This would allow for a much more in-depth study across four wards.

Although for the purposes of the WAGNA submission the bid (Appendix Six) was considered an audit, it was still intended to use the Fourth Generation Methodology so that the study would be based on the need to identify shared constructions. Based on the first phase of the study in the Care of the Elderly Unit I argued that Schwandel (1978 cited in Schwant and Halpen, 1988) provided a workable definition of audit as “the process of evaluation of something proposed or asserted” (p17). The introduction of the Acute Unit Discharge Policy (1993) also provided a framework against which practice could be evaluated. This is important as a systematic review audit, is defined by Schwandl (1978 cited in Schwant and Haplern, 1988), as being planned, orderly and methodical:

- Audit is conducted on some procedures, operation, outcome or product against a set of standards or criteria.
- An audit is independent and an empirical investigation.
- An audit involves the exercise of professional judgement in applying a set of criteria.
- The outcome of an audit requires communication to 'interested users' and is thus made public.

Schwant and Halpen (1988) asserted that such an evaluative process results in judgements based on ‘disciplined inquiry’ (p19). The use of Guba and Lincoln (1989)

as the evaluation research methodology provided such a 'disciplined inquiry' through its adoption of a hermeneutic dialectic process and CCA.

I suggested to the Steering Group that the Fourth Generation approach had clear benefits for the conduct of an audit under the terms of the WAGNA proposal and funding arrangements. It was argued that the completion of the study in Ward A provided a template for the evaluation of the wards in Medicine and Surgery and that the values of audit (as described by Schwant and Halpern, 1988) were congruent with the precepts of Guba and Lincoln's (1989) approach. However, as the discharge policy had been created centrally, albeit following widespread discussion, there was inevitably a more top-down approach with less scope for the negotiation of the goals of the study.

The Gwynedd Health Authority Ethics Committee was consulted and though strictly no submission was required the audit proposal was forwarded to the chairman for consultation. The existing ethical approval for the Care of the Elderly Unit study was extended to include the Medical and Surgical areas.

The study was presented to the units concerned and it was argued, as the discharge of older people from hospital had been the subject of study for over 30 years, and yet there seemed to have been little improvement in practice, that this area merited further consideration. At the time, Tierney, in a contemporary review of the literature (Tierney, 1993), summarised the key areas that remained a cause for concern, namely:

- poor two-way communication between hospital and community teams before, during and after discharge;
- limited assessment and planning for discharge;
- inadequate notice of discharge to patients and carers;

- limited statutory service provision and over-reliance on informal support; and
- failure to identify patients and carers who are vulnerable, or have special needs.

Findings such as these reinforced the need to adopt a systematic approach to the discharge of patients from hospital, particularly vulnerable groups, such as frail older patients living alone or with elderly carers. The results of the still on-going study on the Care of the Elderly Unit reaffirmed some, but not all, of the above and also highlighted the importance of information giving and good use of the MDT as essential elements of a good discharge process.

As the DGH was in the process of introducing a discharge policy it was important that this was evaluated and the potential availability of funds from WAGNA presented an ideal opportunity. The WAGNA strategy (1992) defined nursing and midwifery audit as:

“The systematic, critical analysis of the quality of nursing and midwifery practice, including the process, the use of resources and the resulting outcomes for the patient” (p2).

The proposed audit project in the DGH, based on the WAGNA strategy, initially had three principal aims:

- 1 To carry out an audit of existing discharge arrangements for elderly patients (65+) from two medical and two surgical wards in the DGH. The audit was intended to elicit the views of professionals in the community and hospital and the perspectives of patients and carers;

- 2 On the basis of this audit, to identify and attempt to introduce any necessary improvements to current practice;
- 3 After a suitable period of time, it was proposed to evaluate the effectiveness of the change process by undertaking a further audit of discharge procedures.

Although the audit was intended to consider the role of all the main stakeholders in the discharge process, the importance of a nursing role in managing both the ‘formal’ and ‘informal’ work of discharge had clearly emerged from the study on the Care of the Elderly Unit and the proposal was therefore intended to further illuminate the role of the nurse in the wider context of the multidisciplinary team.

The proposed project was divided into a number of overlapping stages designed to facilitate rapid feedback into the clinical setting and provide information to inform change in identified areas. It was based on the WAGNA definition of audit and the audit cycle, but modified to meet the current situation in the DGH.

In the Acute Unit, standard setting and the identification of quality indicators had not been fully established at the time the submission was made. Therefore, the project was a precursor to initiating the audit cycle. In addition to providing an audit of an important area of practice, one of the aims of the project was therefore to act as a catalyst for the more widespread adoption of an audit culture.

The bid to WAGNA was successful and the monies that this provided, together with some additional funding from the DGH, were sufficient to fund the study for a year.

In the absence of explicit standards for discharge a number of broad criteria were developed based on the official guidance, the research evidence (including that from the

Care of the Elderly Unit), and the new Acute Unit Discharge Policy (Gwynedd Health Authority, 1993). On this basis it was agreed that discharge planning should:

- where appropriate, begin prior to admission;
- in other circumstances, commence as soon as possible after admission;
- involve the patient (and, where appropriate, the carer) at every stage;
- include a full and detailed assessment of the patient and carer needs, including home circumstances, functional abilities, assistance needed with the main Activities of Daily Living (ADL) and domestic tasks. The source of previous help and any supplementary assistance required on discharge should be noted;
- incorporate systematic efforts to teach/instruct patients and carers in important areas, especially regarding medication and on-going treatment;
- provide patients/carers with written advice;
- be coordinated on a multidisciplinary basis, with each team member being aware of their own role and that of other members. There should be a defined list of responsibilities for each individual involved;
- be communicated widely to patient and all professions involved, both in the hospital and the community, giving adequate notice of the proposed discharge;
- ensure that all the relevant information was recorded in a systematic fashion, including a complete list of all actions taken. This should be filed in the patients' notes to provide a permanent record.

The above were used as the 'benchmarks' against which current practice would be audited. As in the previous study it was intended that there be several hermeneutic cycles on-going for the three main stakeholders, i.e. the Unit MDT, patients and carers, and PHCT members. However, the situation was more complex here as there were four wards involved and not just one.

The four wards selected for study were:

- General surgical/urology and breast care speciality (Ward B);
- General surgical/vascular speciality (Ward C);
- General medical/chest speciality (Ward D);
- General medical/cardiac speciality (Ward E).

As part of the second phase in Medicine and Surgery I intended to further elaborate on the understanding of the complex discharge planning process identified in Ward A.

3.5.1 Method in the Second Phase: The sample, data collection and analysis

As outlined earlier in Chapter Two the first and second phase of the study utilised the hermeneutic dialectic approach to data collection and analysis described by Guba and Lincoln (1989). The commencement of the second phase represented a continuation of the strategy developed in the Care of the Elderly Unit. The methods that I had used were retained, namely interviews and the examination of documentary evidence – the nursing process or kardex, the medical case notes and the ward diary (if used in discharge planning). The semi-structured interview schedule (Appendix Three) had evolved as part of the dialectic process during the course of the interviews on Ward A and with the PHCT. This interview schedule was used to guide the interview process, but supplemented by the categories which had emerged from Ward A, and informed by the benchmarks created for the study.

The experience of conducting fieldwork in Ward A had also included a particular etic construction as part of the analysis process, acknowledging that as a Staff Nurse on the Care of the Elderly Unit I needed to recognise my own constructions as part of the hermeneutic dialectic. The areas of Medicine and Surgery were relatively unfamiliar

and I approached data collection from a somewhat different etic stance. I conducted data collection in the same manner as Ward A, which was important in ensuring continuity. In this respect I felt that the transition from the first phase to the second phase was seamless. Dr. M Nolan also now had a role as part of the Steering Group for the second phase project with the ADNS and the Audit Quality Facilitator.

A framework and timetable were required to organise the data collection and analysis in the four sample wards and a provisional strategy was agreed with the Steering Group (Figure Six).

In the second phase I intended to follow a similar pattern of fieldwork to the first phase with the hermeneutic cycles uncovering the constructions of each respective group of stakeholders. As outlined earlier the PHCT represented an 'overlap cycle' as part of the earlier interviews were directed at Medicine and Surgery in addition to the Care of the Elderly Unit.

I negotiated access initially by letter to each respective consultant in the four sample wards and then by meeting the Medical Directorate Managers for Medicine and Surgery. At a higher organisational level in the DGH the ADNS acted as the negotiator in tandem with the Director of Nursing Services and the Unit General Manager. I provided a brief presentation for other members of the MDT in Medicine and Surgery to outline the audit project aims and the rationale for engaging in the Fourth Generation Evaluation research process. I focused on the advantages of the using the existing constructions gained from Ward A in an evaluation of discharge planning in Medicine and Surgery. The launch and introduction of the Acute Unit Discharge Policy at the same time provided a platform for highlighting the importance of the study in developing understanding of the 'whole process' of discharge planning.

Figure Six

The framework for the study and timetable for fieldwork in Medicine and Surgery

STAGE ONE			
JANUARY	FEBRUARY	MARCH	APRIL
Steering Group Formed			
Information sessions on project aims and objectives and research design			
	Data collection and analysis: completion of PHCT 'overlap' interview cycle		
		Data collection and analysis: conduct MDT interviews in four sample wards as first hermeneutic cycle	

STAGE TWO

MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER
Preliminary feedback the production of first stage MDT case report accompanied by ward and directorate sessions.					
	Data collection and analysis: conduct of patient and carer interviews in four sample wards.				
			Case reports produced to describe MDT and patient/carer cycles and suggestions for action.		
			Ward based and directorate negotiation of action plan based on case report.		
				Completion of final report for the DGH and WAGNA with 'transferability' presentations in DGH, WAGNA symposium and Welsh Office.	

The Ward Managers and Senior Nurses, physiotherapy and OT staff were supportive and the Social Work team were particularly enthusiastic given the advent of the Acute Unit Discharge Policy. The Quality Facilitator for the DGH also attended to outline the place of the study in the broader audit strategy.

I discussed the selection of the sample wards with the Steering Group and the choice of Ward B (general surgical, urology and breast care), Ward C (general surgical and vascular surgery), Ward D (general medical and chest speciality) and Ward E (general medical and cardiac speciality). There was consensus that the sample wards provided exemplars of a range of situations that might shape the discharge planning process and that this would prove useful in the formulation of the case reports and negotiations at the completion of the study.

Interviews were subsequently conducted with multidisciplinary staff in the sample wards (n=58); these consisted of ward nursing staff (n=37 including senior nurses and specialist nurses), junior medical staff (n=8), 6 consultants and the social work team on the respective Units (n=2 team leaders), physiotherapist (n=3) and occupational therapists (n=2). The two community sectors already identified in the first phase of the study comprised the selected sample as an 'overlap cycle'.

The patient samples were selected from those individuals who met the study criteria, namely, were aged 65 and over and discharged home from one of the four identified wards to either of two defined community areas. Two main samples of patients and carers were used. The first sample comprised of a number of patients and carers who were visited at home following discharge at approximately two weeks after discharge and others were interviewed at approximately six weeks. The second sample of patients was identified on admission, and the progress of their discharge planning was regularly

observed throughout their hospital stay. A small number of these patients were also interviewed. In total, 40 patients were interviewed; 29 approximately two weeks after discharge; 11 approximately six weeks after discharge. In most cases, main carers were interviewed at the same time as the patient.

As with the fieldwork in Ward A, patient documentation was examined by accessing the medical case notes. The case notes were available from the Ward Clerk or the consultant's secretary with all additional patient documentation contained in the rear of the case notes including the kardex or nursing process.

The framework for the study and interview timetable identified the ward MDT as being the first cycle of interviews to be completed from March to April 1993. The initial intention on developing the research design was to attempt to 'cluster' the interviews according to ward areas, such as completing Ward B interviews before moving to Ward C. In the event it soon became apparent that access to the MDT would not be straightforward and a more flexible approach was required. I discussed this with the Steering Group and it was agreed that the aims of the project were not prejudiced by the sequence of interviews nor was theoretical sampling compromised.

The first MDT interviews commenced on the 4th March 1993 in Ward B in the Surgical directorate and were followed subsequently with a series of interviews in the other adjacent sample wards. As with the first phase in Ward A I commenced the MDT interviews with the nursing team members, with interviews again being conducted largely in the treatment room or in the Sister's office. The MDT were also interviewed on their respective ward areas either in the treatment room or their office accommodation.

3.5.2 'Fleshing out categories': Data analysis and theoretical sampling in

Medicine and Surgery

It emerged from the first interviews on the 2nd, 3rd and 4th March 1993 that MDT working in Medicine and Surgery was key to understanding the tensions within the discharge planning process. The first research participants were nurses from Ward B (B1, B2, and B3), a nurse and doctor from Ward E (E1 and E2) and an OT from Ward D (D1). They noted that the introduction of the Acute Unit Discharge Policy had provided a set of benchmarks which in many ways did not match the reality on their units. The dominant and most significant data to emerge in these interviews related to the 'pace' at which patients progressed through the wards. The interviewees (n=6) felt that the Acute Discharge Policy had been introduced in a 'top down' fashion by the General Management of the DGH and was inconsistent with their aims of ensuring the patient's smooth and rapid progress through the ward.

However, one of the Ward Managers on Ward B (B1, 4/3/93) recognised the need to marry the 'pace' of a patient's career in the 'fast flow' of urological surgery with the importance of a more comprehensive assessment of older people. Her 'vision' was closer to the 'official construction', as in the new policy, and from the interview with the staff nurse on Ward B (B3, 4/3/93) it emerged that the shifts supervised by this Ward Manager demanded greater attention to negotiating discharge and ensuring a more comprehensive approach to assessment. Yet the other Ward Manager in Ward B (B2) favoured the 'status quo' and maintained that 'pace' (that is the relative speed of discharge) was the primary concern on Ward B and that it was the responsibility of nurses was to ensure a smooth and speedy discharge process. Her 'vision' was not consistent with the 'official construction' of the Acute Discharge Policy as indicated in the following extract:

“Doctors decision who is discharged – with input from other team members, the ward round’s role is to plan, ward round in XXXX ward (Ward B) revolves around the discharge of patients, nurses work with medics, social worker does not come on the ward round but comes after. Patient informed of what’s going on.”

(Ward Manager, B2. 4th March 1993, interview notes)

The role of ‘information flow’ identified initially was again prominent, and again a number of deficiencies were identified. The nurses described the poor information flow between the PHCT and the ward area and the problems of information flow within the MDT. They characterised themselves as being the most important ‘informants’ and complained about the amount of time such ‘informing’ took. The ‘informing’ process involved liaison with patients, their carers or families, members of the MDT ‘not present’ on the ward (OT, physiotherapy staff and Social Worker) and the PHCT. The nurses (B1, B2, B3 and E1) interestingly did not see such ‘informing’ as a legitimate part of the nursing role but considered that this detracted from “getting things done” (Staff nurse, B3, 4/3/93, interview notes). Much of this ‘informing’ work related to the ‘formal working’ of the ward round, what had been described as part of the ‘fixing’ role in Ward A. I noted that importantly the interviews did not recognise the link between this activity and the coordinator role that was defined for nurses in the Acute Unit Discharge Policy, I noted this in the analytic memo below:

Analytical Memo

Date: 7/3/93

Subject: Policy and practice gap

First set of data suggests differences in the construction of discharge planning activities in Medicine and Surgery when compared to the Care of the Elderly Unit. ‘Informing’ seen as not part of nursing role and a distraction from ‘getting things done’ on the ward

and administrating the discharge plan. Gap in the way nurses see discharge in practice and the policy statements from the DGH.

Interestingly the doctor (E2, 3/3/93) took a different view and saw 'informing' and facilitating 'information flow' as the most important role of the nurses in discharge planning:

"Sometimes not enough time for detailed information for patients and carers – nurses to do that, fill communication gaps. Nurse liaises with social workers therefore we (doctors) can focus on clinical duty and nurses contact continence adviser."

(Doctor, E2. 3rd March 1993, interview notes)

For the nurses in the first (B1, B2, B3, E1) sets of interviews 'negotiation', which comprised part of the 'brokering' role in Ward A, was seen as an even greater distraction which resulted in nurses "running around all the time after people" (Staff Nurse, B3, 4/3/93, interview notes) to ensure that "usually last minute arrangements or everything that's been changed by the XXXX (consultant) at the ward round is done" (Staff Nurse, B3, 4/3/93, interview notes).

A further set of interviews on the 4th and 6th March consisted of nurses (B4, B5) and a physiotherapist (D2) and these explored further the impact of the new Acute Unit Discharge Policy. These interviews reaffirmed that the Acute Unit Discharge Policy, as the 'official construction' of the DGH, was at odds with the reality of practice as experienced by the MDT at the coalface. Importantly the focus on the 'pace' of discharge became an increasingly apparent feature of the MDT interviews as further data were collected. The interviews from the 8th to the 12th March 1993 further elaborated upon the dominant role 'pace' played. For example, the seven nurses (B6,

B7, D4, D5, D6, E3, E4) interviewed from the 8th March 1993 to 12th March 1993 all described a discharge process dominated by the need to 'clear beds' and how they worked with doctors to achieve this. Other MDT members were referred to as a part of the discharge plan but not as part of the 'whole process' as the nurses viewed it. This was confirmed by doctors and nurses. I noted that the category of 'information flow' identified in Ward A was also significant in mapping the fragmented nature of MDT working in Medicine and Surgery:

"The ward round is the nurses and medics with information for physiotherapist or social worker percolated through the nurses or sometimes they see the House Officer, never other than the nurses on the ward rounds. Liaison with the patient varies per consultant, generally poor."

(Staff Nurse, D5. 9th March 1993, interview notes)

I noted in the interviews with the MDT including social workers (B9, D3), doctors (D7, D8) and the OT (B8) that on the Medicine and Surgery units it was 'formal working' that was seen as the main forum for discharge planning, with there being little recognition of 'informal working' by the MDT. However, there was some evidence of 'informal working' between the nurses and some of the doctors, especially those below consultant grade. However, the forms of brokering used were more circumscribed when compared to Ward A, with the nurses focussing on 'negotiating' with patients and carers or family to ensure that the discharge plan was delivered according to the agenda agreed in the ward round, i.e. pace still dominated. However, there were some differences in relative emphasis of the nursing role in differing ward areas.

The seven nurses in Ward B (B1, B2, B3, B4, B5, B6, B7) described a nursing role concerned primarily with ensuring throughput and negotiating or administrating the discharge on behalf of the doctors. In Ward D three nurses (D4, D5, D6) described a

more complex nursing role which comprised a close relationship with the doctors but also involved them acting autonomously. This was seen by the Ward Manager (D4, 8/3/93) and the Staff Nurses (D5, 9/3/93 and D6, 10/3/93) as part of their 'informal' working in which they engaged in 'brokering' activities before and after the ward round to facilitate the discharge or sometimes to 'put the brakes on' as the Ward Manger described it. This involved the nurses acting autonomously after the ward round to alter the details of the discharge as agreed on the ward round. This was based on a decision made by the nurses independently or in combination with the patient or carer. Typically the discharge date would be moved back by a number of days and the nurses would 'persuade' (Ward Manager, D4, 8/3/93) the Registrar or Senior House Officer to 'go along with it'. If the doctors did not accept the 'brokering' of the Staff Nurses then they referred to the Ward Manager and she negotiated on their behalf and usually swayed the decision in the nurse's favour. Here there was recognition by the staff that 'pace' did not always reflect the complex needs of some patients.

In many respects Ward E represented a mid position between Ward B and Ward D. The three nurses (E1, E3, E4) here described the ward round as the main decision making mechanism, and saw discharge planning as centred on the ward round and the doctors. The nursing role was 'in support' of the doctors and there existed a close relationship between the nurses and doctors as in Ward B, to relative exclusion of other members of the MDT, such as social workers. However, there was an active backstage nursing role as described in Ward D in which nurses sometimes 'informally' engaged in 'brokering' and 'fixing' activities. The nurses (n=3) described how they were the 'fixers' going around the MDT and working with the patient and family to 'pull it together'. Data produced examples of 'negotiating' with family, patients and the Social Worker regarding the date of discharge to ensure the support required was received.

The doctors interviewed up to the 12th March 1993 (n=3) emphasised that ‘informing’ and facilitating ‘information flow’ was a core part of the nurses role. These three doctors from the first and second set of interviews in Medicine and Surgery (D7, D8, E2) described a construction of discharge planning that relied on the ‘fixing’ role of the nurse. These doctors were at the coalface of the discharge planning process being Senior House Officers and a Registrar. They noted the problems associated with ‘formal working’ and the reliance on the ward round as the decision making forum. On probing during the interviews they acknowledged the discharge process became an ‘event’ rather than a process and that the nurses ‘fixed’ the process by ‘informing’ patients, families and the MDT. The nurses had a key role in facilitating information flow such as ensuring the medical summaries were provided for patients on discharge:

“House Officers need to organise themselves, I (Registrar) personally do it every day and depend on the nurses, how pushy, if they push, the doctor does this.”

(Doctor, E2. 3rd March 1993, interview notes)

The interviews with the Social Workers (n=2) and OT provided a differing perspective. The term ‘outsider’ aptly described how these individuals viewed themselves and their role in discharge planning and the decision making process. The Social Workers (D3, 8/3/93 and B9, 12/3/93) observed that there was no sense of MDT collaboration, but they also indicated how some nurses were skilled at ‘informing’ patients, carers and the Social Work team prior to, as well as following, the ward round. Specialist Nurses were identified as being particularly skilled in combining ‘formal’ and ‘informal working’ and they liaised widely with the MDT, and particularly patients and carers.

The interview with the Social Worker (B9, 12/3/93) in the surgical sample areas provided a telling account of the discharge planning process:

- Interviewer* “Be ydi'r ‘obstacles’ fwyaf I ‘successful discharge’ heblaw am ‘short notice’ a bod ddim ddigon efallai o ‘planning’ ar admission?”
- Social Worker* “Mm, un o'r ‘obstacles’ ydi does dim ddealldwriaeth ar y ward, fuasa na lot fwy o ddeall be mae bob person a proffesiwn yn ei wneud a lot mwy o drafod ynglyn ydi'r person yma gyda angen arbenning ac y ballu , mm, a bod na llai yn disgyn trwy'r net ond unwaith yr wythnos, fuasa pobl yn medru gwiethio yn glos gyda'i gilydd (pause) a rhannu mwy ynde, nyrsys ar ‘junior doctors’, fuasa ddim yn arferiad i'r consultant ddod a gobeithio sawl or ‘therapists’. ‘Discharge’ ar Ddydd Gwener yn broblem yn amal iawn mae pobl yn cael ei dischargio ar y ‘weekend’. A mae'r amser mor ddrwg am bod ni ddim yn cael gofal cartref dros y pen wythnos (pause) adeg mwyaf anodd i gael cefnogaeth i bobl”
- Interviewer* “Da chi'n teimlo bod na dipyn o broblem felly?”
- Social Worker* “Da'ni cael dipyn o ‘phone calls’ pnawn Dydd Gwener”
- Interviewer* “Da chi'n teimlo bod y ‘patient’ yn ‘involved’ yn y ‘discharge planning’ yn bwysig?”
- Social Worker* “Yndi, yndi, yndi achos mae'n digwydd lot yn yr ysbyty bod y claf mewn ffordd, bod pobl eraill yn penderfynnu dros y fo felly, efallai bod dim digon o sylw, digon o bwer I'r claf, ac mae lot yn anodd achos yn amal mae na ‘pressure’ gan y teulu a da ni yn cael ei'n tynu i fewn i, Mmm, i ymateb i ‘panic’ y teulu efallai bod nhw'n gofyn am ofal preswyl ond bod well gan y claf fynd adref”
- Interviewer* “Lle da chi'n meddwl bod cyfirfoldeb hefo trefnu'r ‘discharge’?”
- Social Worker* “O fewn ir tim amddisgyblaeth mae'r cyfrifoldeb yn y pen draw gan y ‘consultant’, ar ddiwedd y dydd fo sy'n cario'r ‘can’ ynde, yn tydi, Mm, ac yn siwr mewn ‘practice’ bydd y ‘consultant’ ddim yn ‘involved’ yn uniongyrchol yn y siarad a'r cynllunio”
- Interviewer* “Da chi'n teimlo ddylsa bod na fwy o ‘shared responsibility’ o fewn y tim – oedd a chi yn dweud bod angen fwy o drafod”
- Social Worker* “Buasi, buasi o ochor gweithio gyda'r cleiant, dwi ddim yn gwybod os buasai bosibl newid huna, penderfyniad amddisgyblaeth ddylai fo fod ynde yn y pen draw, mi ddyliai fo fod Mm, yn enwedig lle mae un proffesiwn yn bwysiciach na leill ynde (pause) achos mae hyna yn ‘frustrating’ i ni, a wedi bod dros y blynyddoedd mewn ffordd dim ots ffaint o gynlluniau da ni yn ei wneud ney ‘recommendations’ ar ddiwedd y dydd mae XXXX (consultant) yn medru newid rhain os ydi eisiau, mae'n ‘frustrating’ ”
- Interviewer* “Da chi'n teimlo bod na rol i ‘specialist nurses’ mewn ‘discharge’ ”
- Social Worker* “O siwr (pause) achos mae XXXX (social worker) yn gweithio yn XXXX (Ward C) a mae'r ‘specialist nurse’, a mae nhw yn cael cyfarfodydd ar fore Dydd Mawrth, Mm, efo'r OT a'r physio a'r gweithwyr cymdeithasol, does neb o'r tim meddygol yn mynd, mae nhw'n ffendio hynny'n biti dwi'n meddwl a biti arall mae XXXX (social worker on Ward C) yn wastad yn dweud na mond rhai hefo'r

problemau 'vascular' sy'n cael ei trafod a felly mae cleifion arall ar y ward yn cael gwasanaeth sydd ddim mor dda, di nhw ddim (pause) yn sicr mae o yn gwneud gwahanaeth"

Interviewer "Da chi'n meddwl bod y penderfyniad 'discharge' reit effeithiol ne does na ddim fframwaith meddygol a llai o sylw o broblemau cartref ac y ballu?"

Social Worker "Mm, 'medical led' yndi sw'ni yn dweud ei fod o, yndi (pause) mae'n tueddu i fod penderfyniad yn cael ei wneud ar y ward rownd a wedyn y nyrs yn gorfod galw ni mewn ffordd i ddweud fod y doctor wedi penderfynu mae o yn mynd adref Dydd Gwener Mm, (pause) fedrw chi drefnu gwasanaethau neu beth bynnag, Mm, 'fait accompli' mewn ffordd a ni rhoi y pisiau at ei gilydd (pause) ac os na broblemau yn y 'stage' yna wrth gwrs mae'n golygu cael mynd yn ol yn sydyn i'r ward a trio, ymdrechu i ddad-wneud rhywbeth syd wedi ei wneud yn barod sydd lot mwy anodd achos erbyn hynny mae'r claf yn edrych ymlaen i fynd adref, mae'n creu fwy o broblemau"

(Social Worker, B9. 12th March 1993, transcript)

English Translation:

Interviewer "What's the most significant obstacle to successful discharge other than the short notice and maybe the lack of planning on admission?"

Social Worker "Mm, one of the obstacles is that there's no shared understanding on the ward, there could be more understanding what every person and profession did and a lot more discussion about does this person have particular needs and so on, mm, and that there would be less people falling through the net only meeting once a week, people could work quite closely together (pause) and share more, nurses and junior doctors, it wouldn't be the thing for the consultant to attend but hopefully the therapists. Discharge home on a Friday is a problem quite frequently people are discharged on the weekend. It's the worst time of all because there is no home care available at the weekend (pause) the most difficult time to get support for people"

Interviewer "You think that there's quite a problem then?"

Social Worker "We have quite a lot of phone calls Friday afternoon?"

Interviewer "Do you feel that the patient is involved in discharge planning and that the patient's involvement is important?"

Social Worker "Yes, yes, yes because it happens a lot in the hospital that the patient in a way, that other people decide for the patient, perhaps there's not enough attention to the patient's perspective, perhaps the patient isn't given enough power and often it's difficult because there is a lot of pressure from the family and we get pulled into it all, Mmm, to respond to the family's panic they ask for residential care but the patient wants to go home"

Interviewer "Where do you think responsibility rests for organising the discharge home?"

- Social Worker "Responsibility rests with the MDT but in the end its with the consultant, at the end of the day he is the one that 'carries the can' isn't he, Mm, of course in practice the consultant is not involved directly in the discussions, the talking and the planning"
- Interviewer "Do you feel that there should be more shared responsibility within the team – did you say earlier that the team needed to have more discussion?"
- Social Worker "It should, it should from the side of working with the client, I don't know if it would be possible to change, it should be the ultimate decision of the MDT, it should be Mm, especially where there is one profession seemingly more important than the others (pause) because that is frustrating to us (social workers) over the years, in a way it does not matter how many plans we make or recommendations, at the end of the day XXXX (consultant) can change them all if he feels like it, yes its very frustrating"
- Interviewer "Do you think there's a role for the specialist nurses in arranging discharge?"
- Social Worker "Oh yes (pause) because XXXX (social worker) that works in XXXX (Ward C) and the specialist nurse, and the social worker have meetings every Tuesday morning, Mm, with the OT and the physio and the social worker, no one from the medical team goes to the meetings, I think that they find this is a disappointment, it's a shame as well as XXXX (social worker on Ward C) constantly says that only the vascular patients are discussed therefore the other patients receive a service that's not so good, no they don't (pause) certainly it makes a big difference"
- Interviewer "Do you think that the decision to discharge the patient is effectively managed or does it follow a medical framework with little attention to problems that might be at home for instance?"
- Social Worker "Mm, medical led I would say, yes (pause) the tendency is to make the decision on the ward round and then the nurse has to call us in to say that the doctor has decided that the patient is going home on Friday Mm, (pause) can you fix up and arrange some services, Mm, its a 'fait accompli' in a way and we put the pieces together (pause) and if there are problems at this stage then of course it means going back quickly to the ward and try, try as hard as possible to undo something that's been already arranged which is a lot harder because by then the patient is looking forward to going home, it creates much more problems"

(Social Worker, B9. 12th March 1993, transcript)

During the course of this interview the social worker identified a number of key issues as illustrated in the above extract. Firstly, she noted the poor understanding between the MDT regarding their respective roles which contributed to 'patients falling through the

net', this was compounded by the tendency to discharge patients home on a Friday with little regard for the difficulties faced by social workers given the lack of services at the weekend. Secondly, associated with the limited shared understanding of MDT work there was little shared responsibility by the MDT and a decision making process that pivoted on the 'medical led' ward round. Social workers were only connected to the ward and the decision making through the nurses 'calling them in' and this was contrasted with the practice in Ward C. Here the vascular Specialist Nurse facilitated a more integrated approach with the physiotherapist, OT and social worker involved in weekly planning meetings. However, even in Ward C there was no collaborative involvement of the doctors and the non-vascular patients received a service that was 'not so good'. Thirdly, the patient's involvement in their discharge plans was influenced by what 'other people decide'.

At the end of the interviews up to 12th March 1993 a picture was emerging of a discharge planning process that differed from Ward A yet shared some similarities. There seemed to be 'formal', and to a much lesser extent in the Medical/Surgical Units, 'informal working' in both areas with some nurses engaging in 'fixing' and 'brokering', however, there was great variability. Differences were evident in the MDT 'constructions' of discharge planning, with pace and the pressure to discharge quickly being a key feature in Medicine and Surgery, particularly for doctors and nurses. However, the nurses in some units (Ward D in particular) and the other members of the MDT recognised that the onus on pace was sometimes in conflict with the complex needs of older patients.

I commenced a further series of interviews in the sample wards from the 14th to the 24th March 1993, comprising nurses (n=9), doctors including consultants (n=5), and a

physiotherapist (n=1). These interviews elaborated on the analysis gained from the earlier interviews.

The additional three nurses interviewed from ward B (B10, B11, B16) described a rapid throughput of older patients, particularly in the case of urology. This was confirmed by the four doctors (B12, B13, B14, B17). I noted in the memo below that the nurses and doctors in Ward B had a very particular construction of discharge planning.

Analytical Memo

Date: 23/3/93

Subject: Ward B data

Interviews with staff nurses and doctors have been really interesting with discharge planning being a very particular construction here. It is quite distinct from other wards so far, Registrar noted that discharge in surgery and in particular in Ward B suffered from 'benign neglect'. Strong sense of unity between the nurses and doctors and a shared construction focused on getting the patients out because of push from admissions for arranged admissions (TCI's) already planned on set days. Planning the discharge is not seen as necessary apart from the ward round, despite the obvious structured admission of urology patients. Nurses saw the need for more information for urology patients and they noted that the consultant provides a description of 'bladder warts' for cancerous growths. They considered this was inappropriate and that the written information provided for patients and carers was out of date and photocopied so often it was very faint. Doctors felt the information provided was not a problem. Nurses drew direct comparison between approach to older patients in urology (representing majority older men for Trans Urethral Resection of the Prostate) and those in for breast care surgery. They noted that in breast surgery the Specialist Nurse and consultant has a

particular approach that is not 'on the hoof' as with urology ward rounds. Consequently, the decision making process is more patient focused and both the patient and carer is involved in any discussion and involvement (in 'real' sense as described in the results on Ward A – 'informed' and 'involved' with choice and time given for discussion and consensus decision making).

The interview with the physiotherapist in the Surgical Unit (B15, 16/3/93) highlighted the detachment of other MDT from nurses and doctors and the 'closed' decision making/discharge planning process. Views of physiotherapist is the opposite to nurses and doctors and there were parallels drawn with the physiotherapist's experiences in Care of the Elderly Unit. The situation in the Care of the Elderly Unit was described as a 'gold standard' for MDT collaboration. Also the role and construction of discharge planning by the Specialist Nurse differs considerably from the other ward nurses.

Discharge checklist seen as being a 'pain in the neck' and yet another document with no relevance – nurses note that often completed after or on discharge.

As noted in the above memo the nurses and doctors in Ward B operated in a 'closed' manner and were focused on moving the patient through the 'system' as fast as possible. I identified this as an important issue to explore in forthcoming interviews. The Acute Unit Discharge Policy and the introduction of the discharge checklist was described as either an irrelevant document that had to be completed or as a obstruction to the conventional way of working.

In contrast on Ward D 'informal working' as a behind the scenes activity was described more clearly, allowing for an autonomous nursing role in discharge planning outside the

'formal working' of the ward round. The nurses (D4, D5, D6, D9 and D10) considered that they completed the 'real work' of discharge planning 'informally', before and after the ward round. This involved a complex network of relations with the MDT, patients and carers. One of the research participants (D10) had worked on the Care of the Elderly Unit and she noted that her discharge practice in Ward D was based on her previous experience. Here the nurses interviewed (n=5) described themselves as informal 'fixers' of the discharge plan. I noted in a memo that they engaged in the activities that had been described as 'brokering' and 'fixing' in Ward A.

Analytic Memo

Date: 26th March 1993

Subject: Brokering and fixing in Ward A/Ward D

Nurses in Ward D describe a similar pattern of informal work as detailed in Ward A though they noted it generally as 'fixing' the discharge. The description of what they considered as 'fixing' reflects the early description of 'brokering', these being the activities of:

- i. Mediation – acting as 'go-between's' with patients and their carers or with patients/carers and the MDT.
- ii. Negotiation –again this was consistently identified as a key activity as part of 'informal working' between the nurses and the MDT, and the MDT and patients/carers.
- iii. Advocacy – the role of the nurse as advocate for patients in disagreements with carers or families and the medical team.

- iv. Informing –as ‘informants’ nurses provided information and information flow within the MDT and between the MDT and patients/carers.

The ‘fixing’ activities described in Ward A earlier in the first phase also matched those described in Ward D:

- i. Liasing –acting on behalf of members of the MDT generally this was for the doctors and liaising with the MDT, the PHCT, the patient and/or carers or family. This involved actively seeking or passing information.
 - ii. Informing –a passive role providing items of information, such as informing patients and carers of the discharge date.
-

A key piece of the jigsaw in Ward D seemed to be the shared constructions held by nurses which focused on what they described as nurses as ‘fixers’ of the discharge, being ‘busy behind the scenes’ (Staff Nurse, D9, 15/3/93).

The seven nurses interviewed in Ward E (E1, E3, E4, E5, E6, E7, E9) confirmed the earlier description of nurses working ‘informally’ as part of the backstage activities of discharge planning. However, it appeared that on Ward E the nature of ‘fixing’ differed somewhat from other wards, due to the working pattern of the consultant. Here the consultant would change all the arrangements established by the MDT or provisionally planned from the previous ward round at a whim. The observation by the nurses (n=3) that the consultant ‘changed everything on the day’ was confirmed by junior doctors (E2, E8), who complained that all the backstage preparation between the junior doctors and nurses and the ‘brokering’ activities of the nurses was ‘turned on its head’ by the consultant on the ward round.

The consequences were significant for nurses as they then had to engage in frantic ‘fixing’ following the ward round and intense ‘brokering’ focused on ‘negotiation’ (E1, 3/3/93). The nurses constructed discharge as being problematic because of the nature of the ward round which meant that arrangements had to be confirmed in a very short period of time, with ‘fixing’ and ‘brokering’ merging into a chaotic rush of “running around” (E3, 9/3/93, E4, 9/3/93 and E6, 15/3/93).

I had now gained a clearer picture of how the discharge process on the wards was at odds with the discharge checklist and the Acute Unit Discharge Policy. The discharge checklist was seen as largely irrelevant, though the nurses noted they ‘had to fill it in’ as an additional part of the documentation. All the nurses noted that the ‘named nurse’ did not relate to the person completing the checklist or more importantly was not the person who coordinated the discharge plan. It was clear there was usually ‘no plan’ per se other than that identified at the ward round (‘formal working’) which comprised the bare-bones approach to discharge planning – notifying relatives or family, making transport arrangements and ensuring medication slips were completed.

I discussed the emerging analysis with the Steering Group and indicated that I would examine these preliminary findings in the next series of interviews, to be completed from the 25th March to the 25th April 1993.

As part of the analysis to date I had noted that there was a ‘shared construction’ of discharge planning across the sample wards by stakeholder groups. For instance the nurses and doctors described a dissonance between their discharge practice and the Acute Unit Discharge Policy. Other members of the MDT, the Social Worker, physiotherapist and OT detailed a discharge planning process that was ‘closed’ and focused on the nurses and doctors. They viewed the Acute Unit Discharge Policy as

encouraging a more 'open' approach to discharge, paying greater attention to MDT working.

In the final set of interviews (from 25th March to 25th April) the MDT in Ward C were interviewed, consisting of nurses (n=10), doctors (n=2) and Specialist Nurses (n=2). During the initial interviews on the 5th, 8th and 11th March with the nurses (C1, C2, C3, C4) it soon became clear that Ward C was different in that it had two contrasting models of discharge planning operating in tandem for different patient groups.

The pattern of discharge planning in Ward B had suggested different models of discharge planning, with the research participants contrasting the approach adopted in the case of urology and breast care patients. The key issue seemed to have been the 'construction' of discharge planning held by the consultant, with the breast care surgeon approaching patient discharge as part of a broadly holistic model of care. A significant aspect to the breast care MDT approach was the Specialist Nurse who fulfilled the 'fixing' and 'brokering' roles identified in the Care of the Elderly Unit. The nurses in Ward B had identified this as a feature of breast care surgery which was not applied to other patient groups.

In the case of Ward C there were two opposing and well defined models of discharge planning in operation, and again significantly influenced by 'personal construction' of discharge planning as held by the individual consultant, together with the role of the Specialist Nurse for a defined and readily identifiable patient group. The two opposing models were sketched out rapidly during the first few interviews with the nurses (n=4) from the 5th April to 11th April 1993.

The nurses included Staff Nurses (C1, C2), the Ward manager (C3) and the Senior Nurse (C4). They collectively described the first model of discharge planning as operating for all 'non-vascular patients' in Ward C. The discharge process was managed by the Ward Manager and the Staff Nurses and included both TCI and emergency admissions, involving general surgical patients. The Ward Manager made a distinct, but rather barbed, point that 'vascular patients' were dealt with differently by the Specialist Nurse. The two Staff Nurses (C1, C2) emphasised that there was a second model of discharge, focused on vascular patients alone which was outside their remit. Here the Specialist Nurse was 'in charge' of the discharge arrangements for vascular patients and dealt directly with the consultant and other members of the MDT (C1, 5/4/93 and C2, 8/4/93).

The further eight interviews (C5, C6, C7, C8, C9, C10, C11 and C12) from the 12th to the 23rd March in Ward C with nurses and the doctors (C13, 25/4/93 and C14, 25/4/93) confirmed the differing constructions represented by these two models. It seemed that patients receiving general surgery experienced a discharge process similar to that described in other sample areas, dominated by the 'formal working' process of the ward round and the pressure to manage 'beds' and ensure throughput. Nurses worked closely with the doctors and 'fixed' the discharge following the ward round and generally 'informed', but did not 'involve' patients. Limited 'brokering' in terms of 'negotiation' was evident in their descriptions (C6, 12/4/93, C8, 20/4/93 and C9, 20/4/94) which focused on arranging the discharge on behalf of the doctors. One Staff Nurse (C9, 20/4/93), who held a different 'personal construction' of discharge planning and tried to 'advocate' for the patient and family, had been told to "stop fussing" by the Ward Manager.

The 'vascular model' matched more closely the description of MDT working in the Care of the Elderly Unit but with the 'nursing role' undertaken only by the Specialist Nurse. I was interested to explore these issues with the Specialist Nurse (C11, 24/4/93) during her interview and with the consultant (C13, 25/4/93). It was evident that there was a 'closed' discharge planning process in the case of vascular patients managed completely by the consultant and the Specialist Nurse who acted as 'fixer' and 'broker' with patients and carers and the MDT, including the Social Worker, physiotherapist, OT and other ward nurses.

Importantly the interviews on Ward C emphasised that differences in the discharge planning process were often due to personal factors and were not necessarily a feature of the wards being medical or surgical. Furthermore, it was clear that both Medicine and Surgery differed from the Care of the Elderly Unit but at the same time demonstrated similar processes of 'formal' and 'informal working', with the nursing role involving 'fixing' and some 'brokering' activities. However, these activities were somewhat different in nature, as later interviews illustrated. In Ward D further MDT interviews were completed with two nurses (D12, 27/3/93 and D15, 25/4/93) and two doctors (D13, 25/3/93 and D14, 25/4/93). The earlier accounts of discharge practice were reinforced by the nurses but the interviews with the two consultants were tense but provided some useful information about their 'personal constructions'. I used a great deal of probes and noted the strength of their 'personal construction' of discharge planning and how the MDT were expected to accept this as correct.

In Ward E an additional number of interviews were also completed with a nurse (E10, 26/3/93) and two doctors (E11, 26/3/93 and E12, 26/3/93). As with Ward D the interviews with the consultant was disappointing and required a great deal of probing.

However, once again the strength of the consultant's 'personal construction' of discharge planning was evident, with discharge planning being seen as driven by medical concerns with the 'details left to the nurses'.

I met with the Steering Group and discussed the findings to date at the end of the MDT cycle. The commonalities and differences across the sample wards were identified and the need to provide feedback to the MDT prior to the patient and carer interviews was suggested in order to facilitate action as part of the audit component of the evaluation. It was agreed that the perspectives of the MDT and the PHCT as stakeholders in the discharge planning process would be presented in a series of feedback sessions prior to detailed negotiations regarding action to be undertaken in Medicine and Surgery areas.

As noted earlier in Chapter Three the 'overlap cycle' of the PHCT interviews in two community areas had considered discharge planning from Ward A (Care of the Elderly Unit), Wards B and C (Surgery) and Wards D and E (Medicine). The interviews had been completed in February, 1993 prior to engaging in the MDT interview cycle on Medicine and Surgery. The issues identified by the PHCT in relation to Medicine and Surgery will now be described before I outline the feedback process provided for the hospital MDT.

3.5.3 Stepping back: Data collection and analysis in the PHCT 'overlap' cycle

As I described earlier in the first phase of the study interviews, during the PHCT 'overlap cycle' I asked research participants in two community areas about the discharge planning process on Ward A (Care of the Elderly Unit), Wards B and Ward C (Surgery) and also Wards D and Ward E (Medicine). Data collection was completed during February 1993 prior to commencing the MDT cycle in the Medical/Surgical

wards. The account of the data collection and analysis of the PHCT interviews pinpointed the stark differences research participants identified (without the need for probing) between the Care of the Elderly Unit and the areas of Medicine and Surgery.

The major issue was the different standard of discharge planning practice in Ward A as compared to the sample wards in Medicine and Surgery, although deficits had also been identified on the Care of the Elderly Unit.

The tone and direction of the interviews in the PHCT cycle was set by the first few research participants. Two Community Nurses (A38, 3/2/93 and A39, 5/2/93) had identified the substantial problems they experienced with patients discharged from Medicine and Surgery. They described Ward B in particular as being “terrible” with patients being “rushed home” and suffering a range of problems, especially in relation to TURP. These numerous problems such as blood in the urine or pain once at home had to be “sorted out by the GP or us” (Community Nurse, A39, 5/2/93, interview notes). The Community Nurses reported that patients (older men) had not received explanations that blood might be passed in the urine and had been ill prepared for discharge. The Community Nurses felt that Medicine and Surgery hardly paid any attention to assessment prior to discharge.

The series of additional interviews with Community Nurses (A40, A41, A43, A44) reinforced largely the negative observations of the earlier interviews:

“Discharge planning doesn’t exist, patients just get thrown out of hospital, weekends, bank holidays, its all a shambles”

(Community Nurse, A43. 9th February 1993, interview notes)

However, some positive comments did emerge in relation to the input of Specialist Nurses and their community follow up and liaison with the PHCT and patients and carers. The work of the breast care, stoma, continence and vascular Specialist Nurses were identified as being the 'gold standard' of what could be achieved in practice.

A particular issue with the Medicine and Surgery wards was the very poor 'information flow' between hospital nurses and doctors and the PHCT. Community Nurses (A43, A44) described how patients "landed back home with nothing" (Community Nurse, 9/2/93, interview notes), lacking information, dressings and the aids they needed.

The OT (A42, 8/2/93) and the physiotherapist (A46, 10/2/93) had highlighted good communication with their hospital counterparts on the Elderly Unit but described a more difficult situation in Medicine and Surgery. This was seen as resulting from the difficulties experienced by the OT and physiotherapy team as part of the MDT in the sample wards and the small number of staff in Medicine and Surgery. They noted good and well established links with the vascular team and the Specialist Nurse but highlighted "a lack of resources to do community care properly" (OT, A42, 8/2/93).

The GP interviews (n=14) from the 15th to the 22nd February 1993 were highly critical of the discharge planning process on the sample wards and described a complete lack of 'connection' to the areas of Medicine and Surgery. The GPs identified the poor medical information obtained on discharge from the sample wards as an area of particular concern. Frequently the only information they had was the TTO form retained by the patient or carer (A50, A51, A54, A56, A57) as noted by one GP:

"We don't get any letters for a while, a long time in the case of urology, but mostly patients present with their TTO slip at the surgery and that's the first we know about the discharge home".

(GP, A54. 19th February 1993, interview notes)

In particular severe delays were noted in communications regarding urology patients, despite the high number of 'call outs' post discharge to this patient group. This was an area of particular concern to GPs as the patients and carers became anxious when patients suffered bleeding once home. A number of GPs (A49, A52, A54) noted that patients had not been informed that some bleeding might occur once home after a TURP and patients were unaware of what constituted serious bleeding. All the GPs described how discharge summaries (LTD) were consistently delayed from both Medicine and Surgery, as was the full discharge letter. The only exceptions were the case of vascular and breast care patients.

The two Social Workers (A58, A59) described great difficulty with the arrangements made for discharge by nurses and doctors in Medicine and Surgery, with poor 'information flow' between the MDT and patients and carers. Furthermore, although they had good liaison with their hospital counterparts complexities arose because of the premature discharge of patients and the changes made to provisional plans. Discharge planning in the sample areas of Medicine and Surgery was described as a 'nightmare' with little appreciation of the situation patients faced once at home (A58, 23/2/93 and A59, 23/2/93).

3.6 Preliminary feedback: Attempting to agree emerging constructions

On completion of the MDT interview cycle a series of feedback meetings were organised to discuss emerging constructions and provide a descriptive account of 'how' discharge was approached in the sample wards and what 'issues' required consideration. In consultation with the Steering Group I produced a written case report to inform MDT

discussion. The case report not only presented the findings from the MDT and the PHCT interviews but also provided suggestions for action.

The case report noted the similarities and differences in the MDT interviews and described the generic themes relevant to all sample areas. There were also separate sections focussing on particular issues affecting specific wards. The format of the case report produced for Ward A was used to highlight the constructions of different stakeholders and provide 'areas for consideration'. The 'generic' element was organised into the three following sections:

- collaborative working;
- organisational consequences and environmental change;
- information and patients/carers.

The section dealing with 'collaborative working' was further divided into a series of main themes, with each presenting the constructions of the main stakeholder groups.

The case report outlined a number of areas for potential action in relation to information flow focusing on improving hospital and community liaison between the nursing and medical teams. This suggested a review of the TOCF and its adaptation to the differing needs of the various wards in Medicine and Surgery rather than the use of a generic form. It was suggested that improving PHCT documentation on admission might be reviewed in consultation with the FHSA and greater use made of liaison in complex discharges. In addition to the TOCF it was suggested that the discharge checklist might be adapted to the demands of each clinical area to facilitate ownership.

The second area identified in the case report from the MDT and the PHCT cycle was entitled 'organisational consequences and environmental change'. The dominance of the ward round as the 'formal work' of discharge planning resulted in what were described as 'short notice discharges'. As a consequence there were regular delays to discharge with changes to medication regimes on discharge and the late completion of TTO forms by the junior doctors after the ward round. Transport arrangements with the ambulance service became fraught and liaison with family relied on nurses having to 'ring around' if they had not already engaged in 'informal work' prior to the ward round.

The case report detailed the impact on discharge planning of 'environmental changes'. As part of the MDT cycle the research participants had focused on the Acute Discharge Policy and Community Care Act as being significant influences on discharge. I noted the mixed response to the discharge policy by the MDT and its 'patchy' implementation by some members of the MDT. In particular the poor response of the doctors and nurses was highlighted as a feature of the MDT cycle and the incomplete or inappropriate completion of the discharge checklist. Despite the fact that the nursing role was clarified in the policy (and facilitated by the nurse as coordinator in the discharge checklist) there had been little impact on working practices. The case report suggested that there was a relative lack of understanding of community care legislation and its impact on the MDT or the PHCT by the majority of the MDT with the exception of the Social Workers.

As part of the areas for consideration the reports highlighted the importance of improving collaborative working in the MDT and reviewing decision making processes and the planning undertaken by nurses and doctors prior to ward rounds. The

organisational problems of discharge were related to the way in which discharge was 'constructed' by the MDT – in particular the doctors and nurses. Further consideration of the implementation of the Discharge Policy was required and it was suggested that the introduction of the policy provided a platform for discussing and tackling the broader issues of MDT work and decision making in 'formal' and 'informal working'.

The third and final section of the case report identified the area of 'information and patients/carers'. It described the issues raised in the MDT regarding the quality of information provided to patients about their diagnosis and medication. Furthermore, it highlighted the poor 'information flow' between the MDT and patients and their carers and the patterns of 'informal working' by some nurses and Specialist Nurses that augmented the limited 'information flow' seen in general across the sample wards. Again, It identified areas for consideration that focused on clearer information giving and an inclusive approach to 'information flow' between the MDT and patients and their carers.

The generic sections of the case report were followed by additional topics relating to the individual sample wards. In this way a full account of the situational factors described during the MDT cycle was provided for research participants and stakeholders in the study.

In keeping with the principles of the Fourth Generation approach to evaluation (Guba and Lincoln, 1989) I attempted to ensure equity in access to the case report as part of the feedback and negotiation process. Therefore, a copy of the case report was sent to the Steering Group, the Ward Managers and MDT members in the sample wards, the PHCT in the two community areas sampled and the Director of Nursing Services (DNS) and Quality in the Community Unit.

Formal feedback meetings were held with the MDT from the sample wards in Medicine and Surgery, the Steering Group and representatives from WAGNA. In the MDT feedback session the Ward Managers, ADNS, the Social Worker team and the OT and physiotherapy team were present. A Senior Nurse representing the Community Director of Nursing Services and Quality and the consultant surgeon from Ward C in his role as the Directorate Manager attended the feedback session. The Directorate Manager for the Medical Unit did not attend the feedback meeting. There was a lively discussion and the participants decided to forward the findings to date to the Acute Unit Health and Social Care Group for consideration. Consequently, a joint Acute and Community Unit Transfer of Care Group was set up and Ward Managers in consultation with the ADNS were to draw up an action plan. The Community Unit DNS commented in a memorandum dated 3rd June 1993:

“Thank you for sending me a preliminary report and action plan as a result of your project work. I found it easy to read and it was a very useful document. May I take this opportunity in congratulating you on the work you have undertaken. I hope that many of your objectives will be reached. Certainly the Community Unit will play their part in helping with the areas you have clearly identified. I am sure there are many lessons that we can learn from your work. I look forward to working with you.”

A series of meetings were then planned at the completion of the patient and carer interview cycle to fully consider the broad range of issues raised by the evaluation.

3.7 Data collection and analysis in the second phase: The patient and carer cycle

The patient and carer interviews commenced in May and were completed in July 1993. The patients were drawn from each of the respective sample wards with ten cases being sought from each ward area. In the event eleven were recruited for Ward D. As noted

earlier the majority of patient cases were interviewed within two weeks of discharge with a small number seen at 6 weeks post discharge (n=4). Patients were selected on discharge home to the two community areas already involved in the first phase of the study (having included patient, carer and the PHCT).

Patients were selected from the sample wards during a set period and a purposive technique was employed consistent with a Fourth Generation approach. As indicated earlier the patients were required to satisfy the inclusion criteria and were approached by letter requesting an interview. As in the case of the first phase I provided information regarding the study and its purpose and in the event of an interview being arranged patients (or carers if applicable) completed a consent form. I recruited the patient sample from Ward B, Ward C, Ward D and Ward E by examining their discharge records held by the Ward Clerk during the sampling period and selecting a number of patients to approach for interview. On occasions patients or carers would decline to be interviewed and indicated they did not want to participate in the study. The initial target number as part of the WAGNA proposal had been n=60 patients. However, this was reviewed on commencement of the study and a total of n=40 patients were agreed by the Steering Group.

As described earlier in Chapter Two the semi structured interview schedules (Appendix Three) used in the first phase in Ward A were utilised for the second phase patients and carer interview cycle. The interview schedules were supplemented by emerging topics and issues raised in the PHCT and MDT data in the same way on the Care of the Elderly Unit. As with these earlier interviews, the first few 'opening' questions provided a catalyst for patients and/or their carers to provide an almost complete narrative account of their discharge.

I used probes from the interview schedule to 'visit' issues not initially discussed by research participants. The experience of conducting interviews with patients and carers during the first phase provided a good platform for the second cycle of interviews. Prior to the interview I examined the patient case notes to obtain basic details of the discharge, such as discharge date, diagnosis, and access to the MDT record of the discharge plan, when these were present. The case notes were difficult to obtain and often required a 'paper chase' around the hospital with case notes being on the ward in the Ward Clerk's 'pile', returned to Central Filing, the OPD clinic or being used by the consultant's secretary.

The use of documentary data had proved useful in the first phase in Ward A and again the use of such 'analects' was informative in preparing for the interview. The discharge plan was largely sketched in the nursing kardex and the case notes, with more detailed MDT documentation being available for vascular patients. A particular issue that was checked by both interview and documentary analysis was the planning and notice of discharge. I scrutinised the medical case notes, the nursing kardex and the discharge checklist for evidence of planning, such as possible dates for discharge, comments noted by the doctors or/and nurses. The case notes indicated possible discharge dates following ward rounds, for instance 2/7 (in two days) and the nursing kardex would 'fill out' details such as conversations with patient or family regarding transport. The interview schedule increasingly focused on probing the patient or/and carer about any planning process and notice of discharge, exploring the patient and carer constructions of their needs.

Another key area of reference between documents and interviews regarded the information provided relating to diagnosis and medication. The latter was featured

mainly on the discharge checklist and the former in the case notes and nursing kardex. The interview schedule asked patients and their carers specific questions regarding the information provided on medication. Data from the interviews made it clear that little information was provided, apart from that given by the Specialist Nurses. It became clear that Specialist Nurses were engaged in information giving as part of planning for discharge with the Stoma Specialist Nurse and Continence Specialist Nurse in particular providing structured information, together with demonstration sessions. They would also discuss medication as part of the patient's on-going treatment. Apart from the Specialist Nurses, medication information provided by nurses was given on the day of discharge, typically as patients were preparing to leave the ward.

The area of diagnosis was clearly stated in the medical case notes, usually in abbreviated form and this was replicated in the nursing kardex. However I found that there was some ambiguity in patient and carers' understanding during interview, with comprehension generally being poor. In some cases patients and carers indicated they had been given "opportunities to discuss their concerns about discharge home during the visit by the consultant and team on the ward rounds". This did not seem to be a common experience and 'discussed' in the documents did not seem to be reflected in the patient and carers understanding of their situation. I will now elaborate upon these and other key issues identified in the patient and carer cycle and their 'constructions' of discharge from hospital.

The first series of interviews (n=13) was completed in late May (from 1st to 31st May 1993) and included one patient from Ward B (B18), two patients from Ward C (C15 and C16), six patients from Ward D (D16, D17, D18, D19, D20, D21) and four patients from Ward E (E13, E14, E15, E16). The initial interviews from Ward E and Ward D

focused my attention on the patterns of discharge in Medicine with some comparison with Surgery. The interview schedule included the issues raised in the PHCT but more importantly the MDT interview cycle. I was particularly interested in issues of 'formal' and informal working' and the 'nursing role' raised in the MDT interviews and the different models of working linked to some wards and the Specialist Nurses. It was the patient interviews in Ward D that provided a clear construction of the 'nursing role' and the relationship between 'formal' and 'informal working' in Medicine and Surgery.

The patients in Ward D (D16, D17, D18, D19, D20, D21) described how the 'formal' work of the ward round was the forum for decision making, even if formative plans had been made beforehand. As part of the patient's 'story' the role of nurses was seen as very important in bridging the gap between patients, families and the doctors, as well as the gap between the ward round decisions and how 'things actually happening' (patient, D16, 25/5/93, interview notes). Patients reported how it was the nurses that 'informed' them that it was the ward round where decisions would be made. Patients also asked nurses to explain what the doctors had said during the ward round. Furthermore, it was the nurses that explained any information to relatives and then 'coordinated' the discharge and "made things happen" (patient, D17, 25/5/93).

Patients were not aware of a 'named nurse' per se that was responsible for their care in any of the wards, however, in Ward D they had a sense of coordinated activity by a group of nurses making 'things happen'. The nurse looking after patients on the day of discharge seemed to be identified clearly as the 'coordinating' person 'that pulled together' a discharge plan following the ward round (D16, D17, D18).

Patients were largely unaware of a planning processes in all the wards. They described an admission process on their entry into hospital, punctuated by doctors visits and being

attended to by nurses. There was no sense of 'involvement' rather they described being 'informed', which in some cases was seen as acceptable (C15, C16, D19, D20, D21, E14, E15). Others, however, reported a preference for greater involvement (E16, D16, D17, D18). As with the Care of the Elderly ward the patient's condition or episode of illness dominated their 'hospital experience' and little thought was given to discharge or the 'discharge experience'. I noted that following in a memo on completion of the sixth interview in Ward D (D21):

Analytic Memo

Date: 31/5/93

Subject: Data so far (31/5/93) in Ward D and E

Note: three themes clearly emerged from interviews with pts (patients) to date:

- Named/defined nurse not generally recognised or another person responsible for care/discharge.
- Patients unaware of planning process in most cases, decision to discharge following ward round by consultant or other senior medical officer.
- Majority of sample seen by Social Worker prior to discharge and questioned re-support services.

Also the separation of patient stories into phases:

- Hospital experience
 - Discharge experience
 - Post discharge experience
-

In the Ward D interviews the separation of the patient's 'story' into phases was striking and I thought this 'separateness' of each experience to be particularly significant. It seemed that patients and their carers 'constructed' their experience into discrete blocks of 'experience' starting with the reason for their admission, how it was addressed by the MDT and any resolution. Subsequently, and almost unexpectedly, the discharge was raised by doctors during the ward round. On some occasions patients had been 'primed', for instance by the nurse looking after them on the previous day or on the morning prior to the ward round (D18, 28/5/93).

In these first interviews all the patients described the discharge experience as a series of fast occurring events with nurses liaising with relatives, pharmacy for tablets to collect 'on the way down' from the ward or long journeys in the ambulance, preceded by 'hanging around'. This 'construction' of the discharge experience was developed further in Ward E by patients emphasising the speed of their discharge and the pivotal role of the ward round in discharge planning (E14, E15, E16). The separation of the patient's account into clearly defined phases was reflected in the descriptions provided by research participants in Ward E, however as part of their 'story' there was no sense of coordinated activity and the 'nurses making things happen' as in Ward D. Patients described how nurses liaised with them after the ward round to 'inform' and to fix a discharge with their relatives, as captured below:

Interviewer "When were the arrangements for going home first mentioned, was there an idea given to you when you were going home?"

Patient "I suppose we were told, well like everyone was hanging around waiting for the doctors to come and then, she's happy she's going home tomorrow, (another patient) I was told I was going on the Thursday (pause) I think it was a Thursday but one of my daughters was alright with her for me to go straight back (home) which I did and then there were no other arrangements made"

Interviewer "So how many days was this before you went home, the day before?"

Patient "Two days before"
(Patient, E14, 11/5/93, transcript)

The 'post discharge experience' was consistently reported as something of a 'shock' for all the patients from Ward D and E.

Interviewer "Did you feel ready to leave hospital, in your self?"
Patient "I (pause) must have done really, I feel much worse now than then I can tell you"
Interviewer "Thinking back, looking back, do you think you left hospital at about the right time, too early, too late, how would you describe it?"
Patient "No, I should say, looking back it was maybe the right time but if I knew about it now I would have liked to stay a bit longer"
Interviewer "Did anyone actually discuss what your requirements would be to go home, did anyone ask what your situation was at home, if you needed help?"
Patient "Not to me as I remember but they might have done to my family"
Interviewer "Looking back now how would you describe your health compared to how it was before going into hospital?"
Patient "(pause) I don't feel as well now"
Interviewer "Why do you think that is?"
Patient "I don't know, I mean when that all started I had ghastly pain in my chest but I haven't got those now but I've got so much breathlessness, when I get up in the night, I have to get up and by the time I get to the bathroom I (pause) I (hand gesture to indicate being wet)"
Interviewer "I know (pause) how far is the bathroom, is it quite a distance?"
Patient "Its just down from my bedroom up the end, down from the door you came in"
Interviewer "So by that time you're quite short of breath?"
Patient "Awful, I'm glad to sit down, but I do get breathless doing the odd jobs"
Interviewer "You say you do less now than before?"
Patient "Yes, very much less"
Interviewer "So your daughter does the shopping for you?"
Patient "Yes and cooks the odd meal"
Interviewer "Are you able to wash, do you find that quite difficult with your breathlessness"
Patient "I am able but I don't do it more than I need to"

(Patient, D18. 28th May 1993, transcript)

The experience of returning home was different to how patients had imagined it might be, and they had generally underestimated the impact of their illness on both their stamina and their abilities of self care once home (D16, D18, E13, E15). Patients described being keen to go home, underpinned by the belief that as one patient noted “I’ll be better once I’m home” (E15, 14/5/93).

Furthermore, in Ward D and Ward E information and its ‘flow’ was described as ‘hit and miss’ by the patients and their carers (D20, D21, E14, E15, E16) and was largely dependent on individual nurses or doctors ‘spending time’ with them either before or after the ward round. The poor level of ‘information flow’ was described as having a direct impact on the ‘post discharge experience’ for patients. Patients did not feel prepared for their return home and were uncertain and anxious about scenarios once at home, such as how much to do, in terms of washing, dressing and housework. Another major concern was who to contact with questions about their condition or any problems once at home. Patients generally described a state of being “very wobbly” (patient, D21, 31/5/93) at home, characterised by fatigue, weariness, weakness and limited ability to function as before. This was the case irrespective of different conditions or treatments (D16, D20, D21, E16). Patients generally reported that they had underestimated the impact of their hospital stay and discharge on their well-being. As a consequence they relied more heavily on family or carers in the immediate post discharge period than they had thought would be necessary when in hospital.

In this first series of interviews (25th to the 31st May 1993) the ‘separateness’ of the phases of the patients experience was of particular significance in their ‘stories’ of

admission to hospital and discharge home, with this being more acutely felt on the medical wards.

To compound matters in Wards D and E patients reported being 'moved around' from the admitting ward to the consultant's own ward. They described how this led to a feeling of being "out on a limb" (patient, D19, 31/5/93) and of causing confusion among the ward MDT as to what was happening to them and when. One patient (D18, 28/5/93) described being transferred from the ward she was admitted to back to the consultant's ward in time for the ward round and then being discharged home the same afternoon.

The second series of interviews (n=22) in the patient and carer cycle from the 2nd to the 30th June 1993 focused on patients from Ward B (n=7), Ward C (n=7), Ward D (n=6) and a small number from Ward E (n=2).

The early interviews with patients from Ward B (from 2nd to the 8th June 1993) established the relevance of the three phases of patient (and carer) experience, as described in the first series of interviews. The lack of awareness of a planning process by the patient and carer was evident, except where a Specialist Nurse had been involved (C17, C18, C19, C21). In such instances the patient and carer recorded a greater sense of continuity and planning (C18, C19), with the 'hospital experience' being more closely related to the 'discharge experience'. The Specialist Nurses also provided a thread of continuity by making follow up visits post-discharge.

The overall impressions to emerge from the first and part of the second series of interviews was provided to the Steering Group on 11th June 1993. The Steering Group were informed of the three phases of patient experiences I had identified from the

interviews in Wards D and E and their verification in the subsequent interviews.

Additional issues raised were:

- Patients being unaware of a named/defined nurse responsible for their discharge;
- Patients being unaware of a planning process other than the ward round;
- Patients moved from admitting ward to the consultant's ward if there emergency admission. This resulted in poor continuity and distress for patients;
- Limited number of Social Work 'packages' organised on discharge and the provision of post discharge support by informal (family based) care;
- Follow up visits by GP or PHCT very limited;
- Poor information flow between MDT and patient/carers regarding condition, discharge plans, guidance regarding what to do or not do once at home (and for how long) and information about their medication;
- Contradictory information provided by some members of MDT, and the MDT and PHCT members;
- Post discharge advice being limited to small groups served by Specialist Nurses;
- Patients overestimating their abilities prior to discharge and reporting difficulties at home following discharge. Fatigue or malaise were commonplace experiences, as were poor ambulation/mobility;
- The first few weeks post-discharge required unexpected additional support by informal carers;
- Rapid turnover noticed by patients and pressure on beds – this reinforced the decision to go home by some patients, even if they did not feel ready to go home.

As part of the final series of the patient and carer interview cycle from the 2nd to the 12th July 1993, patients were interviewed from Ward B (n=2), Ward C (n=1) and Ward E (n=2). These issues provided no further insights or elaborations on the existing findings.

With the completion of the patient and carer cycle I prepared to feed back the patient and carer data and emerging 'constructions' to the MDT in the sample wards and the DGH as a whole.

3.8 Negotiating and Feeding Back the Case Report(s): Tackling the 'benign neglect' of the discharge planning process

Based on the earlier case report and feedback I decided to present the PHCT and MDT with data alongside that from the patients and carers. In this way a more complete picture of discharge could be presented in the draft case report, highlighting the perspectives of each stakeholder group. In order to facilitate discussion and negotiation I produced a series of draft case reports based on the earlier format of general and specific feedback for each of the sample wards. Consistent with the Fourth Generation methodology (Guba and Lincoln, 1989) underpinning the audit, it was considered important to feedback the results of the analyses to the various stakeholders and, if possible, to negotiate an agreed case report that could be used to provide a basis for action.

As described earlier, the initial feedback to the clinical areas had occurred prior to the patient and carer interviews. This section will consider the manner in which the final results were fed back to both the hospital and Community Units, and outline the actions which were agreed, together with what had been achieved by the end of the project.

This approach is consistent with both the audit cycle and a Fourth Generation evaluation.

Following completion of the patient and carer interviews and analysis of these data, a summary case report of the whole project was produced. As with the earlier discussion documents, this had both a general section relevant to all areas and a specific section relating to individual wards. This document therefore brought together all the main findings and highlighted key themes. It also presented a comparison of professional and patient/carer constructions, together with some of the potential implications of the results. Plans for action, including possible medium and longer-term objectives were built into this document for discussion and negotiation. These potential implications were also individualized for particular wards. Detailed verbal feedback and dissemination of the results to stakeholders occurred in a series of meetings with the sample wards. A presentation to the community nurses and the Director of Nursing and Quality in the Community Unit was also undertaken to ensure equity in the consideration of the draft case reports.

The potential objectives in the draft case reports are presented below.

3.8.1: Short to medium term objectives

- To formalize and consolidate the development of the discharge checklist;
- To ensure that the recent audit of discharge checklists in the acute Unit could be used as a baseline for future evaluation;
- To encourage the provision of follow up details (OPD etc.) to patients by the ward on the day of discharge, across all sample areas;
- To discuss possible improvements in providing approximate transport pick up times for wards (and thus arrival times for relatives/carers) with the ambulance service;

- Information giving by team members (mainly medical/nursing) to patients/carers requires attention, specifically in relation to diagnosis, cancerous growths and terminal care patients;
- To facilitate discussion between pharmacy and medical and nursing staff may be useful to improve the way in which TTOs are organized, particularly at peak times, e.g. Friday;
- To develop improved communication and liaison between community and acute medical staff, in particular the need to dispatch the discharge note either on discharge, or within 48 hours of discharge;
- To ensure greater use of written information for patients/carers at ward level, utilizing existing booklets/pamphlets etc, which are available to practitioners;
- To produce information sheets providing basic information on treatment/condition and post discharge advice;
- To refine the Acute Unit Discharge Policy with an emphasis on the assessment process to facilitate more consistent screening and targeting of patients who require a particular focus on discharge planning; and
- to review the format for assessment used by the nursing team, with a view to providing greater consistency.

3.8.2: Longer term objectives

- To develop greater collaborative working within the MDT in the acute Unit, and closer liaison with the PHCT;
- To utilize outpatient department as a frontline contact point for elective admissions, to enhance early social referral, pre-admission preparation and the provision of outline information on the patient's condition/treatment and its possible implications for discharge.

As noted above, the draft case report, together with the above implications for practice, were presented at a series of meetings in order to try and agree a way forward. These meetings are briefly described below in the sequence in which they occurred.

Stage One

A separate feedback session was organized for the Medical and Surgical Units, and all members of the MDT were invited. Other than medical colleagues, members of all the other disciplines attended. Medical staff from the medical Unit did not attend, nor did they seek any other opportunity to familiarize themselves with the results. They were, however, forwarded a copy of the results. Whilst the surgeons did not attend the meeting, I was invited to present the results to the surgical audit group at a later date (see Stage Four below). At the time of the meetings, work on the revised checklist was also coming to a conclusion. On the Medical Unit, each of the two sample wards agreed to introduce and implement a revised checklist. This was felt to provide a good focus for subsequent improvements to discharge planning. On the surgical wards, work on the discharge checklist had not really progressed. However, staff had decided to focus on information giving as a key target for action. The intention was that a group would be established to look at the information needs of urology patients on one of the surgical wards and the information needs of non-vascular patients on the other surgical ward. The needs of the vascular patients were already being adequately met.

Stage Two

Following this initial feedback to the wards, a second much larger feedback session for relevant staff was organized to include: staff throughout the DGH; all the GPs who had participated in the audit; representatives from community nursing staff and paramedical

disciplines; social services personnel; and members of the Community Health Councils (CHCs). Nursing and social work staff were well represented at this meeting, and representatives from community nursing attended, as did members of the CHC. Members of the medical team from all settings were notable by their absence. The intention of this meeting was to provide a general forum for discussion and debate on a number of key areas, rather than to agree any specific action. It was also intended to raise the profile of audit and to reinforce its importance to those who had been invited.

Stage Three

A well attended meeting was convened for all the senior nurses (community), including mental health nursing. The summary report had been circulated prior to the meeting, which provided an opportunity to explore issues of particular relevance. The report was generally well received and a lively discussion ensued on a number of important topics. However, other than a commitment to continue to look at the transfer of care documentation, no other action was agreed.

Stage Four

My attendance at the Surgical Unit audit group provoked lively and, at times, stormy debate. Overall, the perception was that because of the relatively small number of patients and carers who had been included, that the evaluation should be viewed as no more than a pilot study. Therefore, whilst not all those who attended dismissed the findings out of hand, little concrete consensus emerged from the meeting other than acknowledgement of the need to pay greater attention to the information needs of patients.

An indication of the climate for the meeting can be gauged by the fact that almost immediately it had started one of the most senior surgeons (the consultant urologist) stood up, declared that the results were ‘crap’, and walked out. He stated that the only problem with discharge planning was “bloody Social Workers”.

Although the reactions of his colleagues were not so extreme, it will by now be apparent that the responses of all the senior medics were less than enthusiastic. This, together with the impact of the extensive changes that were being introduced at the time of the evaluation, served to limit its impact. A summative report (Appendix Seven) was produced to describe the findings and indicate the actions taken so far, providing a vehicle for others in the DGH to examine the ‘transferability’ of the study. The benchmarking criteria from the Acute Discharge Policy were used as a framework to present the findings.

Having presented the overall ‘results’, attention is turned briefly to the extent to which this phase of the study can be said to have met the authenticity criteria in this phase of the study.

3.9: Meeting the Authenticity Criteria

Fairness

During the nine months of the evaluation, considerable amounts of data were collected and analyzed. Feedback of results occurred both formally (in meetings and via reports) and informally (during discussions between myself and staff in all four areas). Every effort was therefore made to involve staff at all levels across disciplines and in all settings throughout the project.

Despite this, similar limitations apply to this phase of study, as they did on the Care of the Elderly Unit, in that ward clerks and nursing auxiliaries were not included and therefore their voices did not figure in the evaluation.

Furthermore, although patients and carers had an opportunity to clarify issues at the time of the interview they were not provided with the detailed feedback reports and did not, therefore, have the opportunity to contribute to the negotiation phase of the study.

However, at the time that the study was undertaken, the involvement of patients and carers was still in its relative infancy and was not so well developed as it is in contemporary practice.

Notwithstanding the above limitations, it is considered that within the resources available to the project that rigorous efforts were made to address the fairness criterion.

Ontological authenticity

This, it will be recalled, is concerned with the extent to which participation in the evaluation resulted in renewed personal, or within stakeholder insights. Although ontological authenticity could be said to occur for some individuals it was less apparent on the Medical/Surgical Unit than it had been on the Care of the Elderly Unit, especially for staff nurses and enrolled nurses. This might be due in part to the very medically dominated processes on the Medical/Surgical Unit, which allowed fewer opportunities for innovation and autonomy by the nursing team, other than the specialist nurses.

Educative authenticity

The extensive round of feedback sessions that were organized, and the diverse mix of the participants at some of the meetings, provided numerous opportunities for differing stakeholder groups to reflect upon the situation of others and to begin to form new

constructions as a consequence. In other words, the potential for educative authenticity was significant. However, the impression that I gained was that this potential went largely unrealized. Although there is no doubt that temporary awareness was raised there did not seem to be any lasting new constructions formed. This in part may have been due to the seeming intransigence of certain groups, especially the senior medics and their inability to appreciate any other viewpoint. Another significant factor was the changes that were occurring at the time of the evaluation which meant that many individuals found it hard to keep pace.

Catalytic and Tactical authenticity

The extensive list of the potential implications of the project described above testify to the potential for catalytic authenticity, and indeed a number of initiatives aimed at addressing some of the deficiencies were identified. In the event, despite the extensive efforts made, it proved very difficult to fully engage staff in the change process. This was due in large measure to the fact that the project took place at a time of great organizational change with, for example, moves towards Trust status and the implementation of the NHS and Community Care Act (Department of Health, 1990b), coinciding with the introduction of a new discharge policy and the introduction of the 'named nurse'. Furthermore, the complex nature of discharge planning and the fact that despite 30 years of research and subsequent policy guidance practice has improved little, reinforces the difficulties that the project faced.

Whilst the project did make some progress in introducing improvements, for example, attempts to tailor the checklist to individual ward requirements (Appendix Eight) and the focus on the transfer of care documents, this was limited, especially when the level of feedback that was provided is taken into consideration. The project certainly served

to raise awareness of a host of issues surrounding discharge planning and audit. However, at the time the study had little prospect of achieving substantial change, due not only to the events that unfolded as the project developed, but also due to the failure to engage with the aims of the project among key medical staff.

On a wider platform the findings were used to inform policy debate at the Welsh Office regarding the complexities of discharge planning process (Appendix Nine). I presented the findings and highlighted the challenge of tackling discharge due to the range of stakeholder.

As Guba and Lincoln (1989) note, the reporting and negotiation process is a key stage in any Fourth Generation evaluation, and particular difficulties are likely to occur when the results threaten the value base of one or more sets of stakeholders. It was apparent in both phases of the present study, although to differing degrees, that the process and the product of the evaluation were seen as a threat by medical staff. I believe that I followed faithfully the advice provided by Guba and Lincoln (1989) in preparing an agenda for negotiation and producing a series of potential recommendations for consideration. Despite this, incomplete or partial resolution occurred on the Care of the Elderly Unit, and more limited resolution of issues on the Medical and Surgical Unit.

This can perhaps be partly understood in terms of the continua suggested by Qualls and Czirr (1988) (see Chapter One for a complete description), in that an almost exclusively acute orientation was adopted on the Medical/Surgical Unit, whereas on the Care of the Elderly Unit, at least some greater consideration was given to a non-acute orientation. This is an issue that will be explored more fully in the following chapter, where an attempt is made to provide a theoretical explanation of the differences that were found in the empirical phase of the study.

CHAPTER FOUR

BEYOND EVALUATION: TOWARDS EXPLANATION

4.1: Introduction

The two separate evaluations that had been conducted respectively on the Care of the Elderly Unit and the Medical/Surgical Unit demonstrated that the discharge process was not perfect in either area and that some of the difficulties or problems that existed were shared. Many of these difficulties related to failures adequately to communicate both within and between several key players. Therefore, there was evidence of a failure to communicate within the MDT but also between the MDT and the PHCT, and vice versa. Both of these failures to communicate impacted on patients and carers who were often 'in the dark' rather than 'in the know' about key aspects of their treatment and condition. At the best it seemed that patients/carers were 'informed about' things rather than being 'involved in' things, and even then there were few efforts to ensure that the information, which had been relayed, was understood and retained. However, a failure to communicate adequately was not confined solely to professionals, as there was also evidence that both patients and carers sometimes 'filtered' the information that they had been given. For example, patients might be given a full account of their situation and then only relay to their families what they thought they 'needed to know', and vice versa. This 'filtering' was sometimes motivated by vaguely altruistic reasons and a desire to 'protect' the other party, but such protection could also be seen as paternalistic in that it limited discussion and the ability to contribute fully to decisions.

4.2: Mapping the Discharge Process

It seemed that many of the above difficulties were, at least in part, due to the channels of communication and the ways in which various types of information were relayed. The main formal mechanism of communication on both units was the ward round and to a greater or lesser extent this was seen as dysfunctional by several stakeholders on both the Care of the Elderly Unit and the Medical/Surgical Unit. On the Care of the Elderly Unit timing was sometimes a problem and consequently it was difficult for all the main disciplines to attend. On the Medical/Surgical Unit the situation was somewhat clearer but potentially even less conducive to good MDT functioning in that the other disciplines were not expected to attend, as the ward round was an almost exclusively medical/nursing occasion. Subsequent to the ward round there was no agreed format in either area for the detailed documentation of the decisions made, apart from a brief record in the medical notes, and possibly some further information in the nursing notes.

As highlighted above, from the perspective of the MDT the main formal forum for the sharing of information was the ward round but this was complemented on the Care of the Elderly Unit by occasional case conferences which were called to consider difficult or complex cases. Case conferences did not occur on the Medical/Surgical Unit. Notwithstanding the availability of a case conference on the Care of the Elderly Unit, these suffered from similar problems to the ward round; indeed, difficulties were often exacerbated as the organisation of case conferences was often 'ad hoc' and they could be called at short notice. This made it difficult for all the main disciplines to attend. However, a potentially significant difference on the Care of the Elderly Unit was at least all the main disciplines were invited to attend and, if they did so, to make a contribution.

Despite this all of the major disciplines (even on occasion junior medical staff) bemoaned the fact that the ward rounds, and the case conferences when they were called, were dominated by medically related issues. Even though there was relatively more discussion and debate on the Care of the Elderly Unit the overall impression was that at the end of the day these 'formal' structures were little more than 'rubber stamping' exercises to legitimate medical decision making.

The ward round was of course a major event for patients, accorded great importance and status by the presence of the 'consultant'. This particular generation of older people, especially in rural North Wales, had a great respect for, and deference to, authority figures, notably the doctor. The ward round therefore assumed great significance but actually provided few, if any, opportunities for patients to contribute meaningfully, or even to seek further information. This was in part a function of the limited time available and the lack of privacy to discuss delicate issues. More importantly, however, it was due to the etiquette and ritual of the ward round with the consultant at the hub, and the various other medics 'in attendance' to provide information as requested. As a consequence the whole affair could be quite overpowering for patients. In most instances the ward round was 'followed up' by the nurse who would return to the patient after to provide explanations. However, this mechanism effectively precluded genuine participation and also relied heavily on the skills and abilities of the individual nurse.

Complementing these formal mechanisms were informal and less obvious ways of working which often had the nurse at their heart. Therefore, it was the nurse who would coordinate events following the ward round and who would try to ensure that all the key players were informed of decisions and their consequences. To a greater or lesser

extent it was recognised that the 'real' work of discharge planning was completed outside of the formal structures. Once again, however, the success or otherwise of these less formal mechanisms depended largely on the skills of individual nurses.

Although the above issues were apparent on both units it nevertheless seemed that discharge on the Care of the Elderly Unit was more successful (in terms of the criteria that had been used to frame the evaluation) than on the Medical/Surgical Unit. Certainly this was the case from the perspectives of the PHCT who identified better, but by no means perfect, communication between hospital and community, and vice versa. Moreover, on the Care of the Elderly Unit all of the disciplines had a place as of right in the formal structures, even though the way in which these structures were organised and enacted made it difficult for them to play as full a part as they might have wished. Furthermore, although a medical influence was dominant in both areas, there was greater flexibility on the Care of the Elderly Unit with the two main consultants involved encouraging more active participants in all negotiations. Therefore, even though it had proved impossible to reach a full consensus (due to one consultant not acknowledging the concerns of others about the state of the MDT) the consultants had been very willing to be fully involved in the negotiations of the case report.

This stood in marked contrast to the Medical/Surgical Unit where the senior medical personnel had been willing to be interviewed but had taken no subsequent part in the various negotiations, despite the numerous opportunities that had been provided. As highlighted earlier, on the one occasion that I had been asked to attend a meeting of the surgical team, the opportunity fully to explore some of the implications of the project were lost when at an early stage one of the most senior consultants pronounced that the results were meaningless and left the meeting. Although his colleagues, probably out of

politeness, stayed, it was clear that the credibility of the study as a whole had been seriously undermined. This led me to begin to ask questions about why these differences existed and whether there were lessons to be learned that extended beyond the local context of the evaluation.

4.3: Seeking Explanations

It is important at this point to reiterate the natural history of this thesis in order to place the remainder of the text in context. The two evaluations had taken place between 1992-1993 and the early stage of organising the thesis and the writing up process began shortly afterwards. During this period I had changed jobs again and become closely involved in a major project introducing a novel way of team working in the community, which followed on the heels of the introduction of the community care legislation. This was exciting but demanding work which inevitably impacted on the time I had available to work on the thesis, which of course was now in addition to a full-time job. However, slow but steady progress was made over the next couple of years. It was then that a series of events occurred that made it seem as if the thesis might never be completed. I had recently become a father and also another career move ensued, this time into nurse education, where the demands placed on a new teacher meant that most evenings were spent doing 'lesson preps'. Superimposed on the above was insidious but progressive long-term family illness. As an additional factor my supervisor left to take up a post elsewhere, and although he had agreed to continue to act in a supervisory role it was difficult to sustain momentum. Moreover, life now presented a series of challenges which, in the larger scheme of things, meant that completing a thesis was necessarily low in my order of priority.

More recently, however, events took a slightly different turn. My supervisor returned to Bangor, albeit for a brief period, and I re-engaged with the work. Furthermore, greater experience of teaching, a growing daughter and well established routines to manage other demands, meant that there was relatively more space, particularly over the last 18 months, to commit to completing the thesis. However, after a gap of several years I felt that it was very important to thoroughly re-acquaint myself with the data and also to reflect upon the type of questions I was seeking to address.

The initial evaluations had been fascinating and proven to be a huge learning curve both professionally and academically. Professionally they allowed me, as a fairly junior staff nurse, entrée to all levels of the organisation both within and outside the hospital setting. Academically, although I had a degree prior to entering nursing, the post-graduate course in gerontology had re-awakened my interest in study, but the opportunity to pursue doctoral level work was a new and rather daunting challenge. In a way a series of fortunate coincidences had occurred that paved the way for the study, but these brought with them a certain pragmatism, in that the choice of topic, i.e. discharge planning, was to a large extent driven by the prevailing issues of the day. This was not seen to detract from the studies in any way, indeed it was an area that was close to my day-to-day work and therefore of great relevance. In seeking a broad philosophical approach I was struck by the tenets of Fourth Generation evaluation, which at the time the initial study commenced was still a relatively new and 'revolutionary' way of conceptualising evaluation.

I returned to the data still fascinated by the topic but I was not now so intimately involved in the 'world' of discharge planning. I once again became interested in whether there were lessons to be learned from the study that might have broader

theoretical relevance beyond the 'shared constructions' and 'case reports' that represented the product of a Fourth Generation evaluation. I still felt that the constructivist view of the world was relevant but thinking in this area had now moved on and in seeking to update myself on the methodological literature I was greatly influenced by the work of Rodwell (1998) and Charmaz (2000).

4.4: New Thoughts on Constructivism

Constructivism, as my approach to evaluation (see Chapter Two), has its roots in educational evaluation. However, Rodwell (1998) argued that the principles of constructivism could be applied in other contexts than education and could also underpin research other than evaluation. Rodwell (1998) approaches constructivism from a social work perspective and argues that it represents a different way of 'rigorous knowing' that is congruent with social work values and goals. Therefore, this approach potentially provides a way of informing both research and practice and she notes that:

'Basically constructivist inquiry provides a mechanism for providing rigour and relevant information for social work interventions.'

(Rodwell, 1998, p3 original emphasis)

She goes on to state that central to both social work and constructivism is an 'interactive, context based attention to dignity, individuality and empowerment' in terms of understanding the relationships between the individual and society. In reading her arguments I felt that they applied equally well to nursing and that the data from the evaluations (which had been collected in a manner entirely consistent with both Guba

and Lincoln's (1989) and Rodwell's (1998) views of construction) therefore had the potential to generate knowledge that would, as Rodwell (1998) asserts, '*enhance the individual's power to make informed choices that can lead to effective change*' (p27).

In other words, I felt that a second analysis of the data might provide new insights which whilst not generalisable in a statistical sense might nevertheless be useful in the wider context of discharge planning. As Rodwell (1998) notes, the analyses of data and the 'final report' should contain sufficient detail for 'an informed reader to determine their relevance for another context' (p32). The report of the initial evaluation had been produced primarily as a basis for shared negotiation and was therefore intended for a purely local audience (this is reflected in the manner of reporting in the last chapter). However, a re-analysis might enable the generation of insights of wider relevance.

Furthermore, notwithstanding the change orientation inherent in constructivist evaluation, Rodwell (1998) contends that such study can also connect the results to 'theoretical concerns' via the generation of working hypotheses and the production of a 'grounded theory' (as opposed to the ground constructions promoted by Guba and Lincoln (1989)). The result she suggests is 'theory in context', the aim of which is to posit relationships between and amongst categories, in order to 'create understanding'. Reflecting its emancipatory character any theory produced in a constructivist inquiry should, according to Rodwell (1998), be written in a transparent, easy to understand language that makes it accessible to as wide an audience as possible. This text should be in narrative form but must be grounded in the data and should present a 'warts and all' thick description of the context.

For Rodwell (1998) the empowering elements of constructivist research should not be confined only to those who participated in the study, but the results should also be of

potential use to others. The product should therefore raise consciousness in those who read it by alerting them to areas of their own experience and thereby create the potential for change:

'Generalisability is not the goal of a constructivist process but empowerment is. All types of empowerment potential should be considered, including whether or not an uninvolved reader might become empowered as a result of exposure to the story.'

(Rodwell, 1998, p188)

The similarities between grounded theory and many aspects of Fourth Generation evaluation were considered in Chapter Two and Rodwell (1998) makes these even more explicit. However, it was Charmaz (2000) who 'squared the circle' and called for the development of constructivist grounded theories. For Charmaz (2000) the idea of a constructivist grounded theory provides 'another vision for the future of qualitative research' which in her view occupies the mid-ground between post-modernism and positivism, and thereby offers an accessible method for taking qualitative research into the twenty-first century. Her conception of constructivism assumes:

- the existence of multiple realities;
- the mutual creation of knowledge by the viewer and viewed; and
- an interpretive understanding of subjective meanings.

However, in a contrast to traditional approaches to grounded theory which Charmaz (2000) argues are 'rather formulaic', constructivism offers a 'flexible heuristic strategy'. For Charmaz (2000) the major methodological technique, as in both traditional

grounded theory and Fourth Generation evaluation, is CCA which is used to identify the 'basic social processes' that specify and help to raise awareness of the relationships between key concepts.

The resulting 'theory' does not provide prediction in the positivist sense but aims to include 'multiple voices, views and issues in their rendering of lived experience' (Charmaz, 2000, p525). As with Rodwell (1998), Charmaz (2000) eschews the use of 'awkward scientific terms' but instead promotes the telling of a story with simplicity, but also clarity and depth based on the premise that 'simple language and straightforward ideas make theory readable' (p527). The ultimate aim of theory is not therefore to provide a prescriptive framework, but instead to provide 'signposts' which help to identify potentially important relationships.

I was greatly encouraged by these texts as they seemed to offer a view of constructivism consistent with, but beyond, the canons of a Fourth Generation evaluation. I felt that the account I presented in the previous chapter had served well as a basis for negotiating a consensus but that it didn't provide a sufficient set of 'signposts' to help others understand the ways in which the various concepts might interrelate in shaping how and why discharge planning operated as it did. This therefore prompted a reanalysis of the data with the aim of producing a constructivist grounded theory of the discharge planning process, as it existed on the study wards. It is that grounded theory that is presented in this chapter.

4.5: Towards a Grounded Theory of Discharge Planning

Although the data were by now several years old they had been collected following an explicitly constructivist philosophy and adhered to the methodological principles of a theoretical sample and a progressive focus. In many ways therefore the second analyses of these data did not differ in **method** from the initial one in that a constant comparative approach was applied. However, what did differ was the **purpose** of the analysis. The purpose of the initial analysis had been to provide a case report that was used as a basis for negotiating a joint construction and a shared consensus that could be used as a basis for action. The purpose of the second analysis was to identify the basic social processes that would help to understand why discharge planning operated in the way that it did. Of course the gap of time meant that it was impossible to go back to the original informants and determine if the categories and their relationships made sense to them. However, this does not represent a fatal flaw as the primary purpose of a constructivist grounded theory is to provide 'vicarious experience' so that readers will be able to engage with the story 'as if they were there' and so make their own judgements as to the usefulness or otherwise of the account with respect to their understanding of the phenomenon under study. This was my aim in conducting the second analysis and it is hoped the account that is provided here will indeed offer readers a 'vicarious experience'.

The initial results of the analysis, as summarised at the start of this chapter, had suggested that although the two areas of study (Care of the Elderly and Medical/Surgical Units) experienced similar problems in respect to discharge planning, that the result in the Care of the Elderly Unit was qualitatively different from that on the Medical/Surgical Unit. Both areas had 'formal' structure for enacting the symbolic work of discharge planning (notably the ward round, and to a lesser extent the case

conference), which acted as a forum for discussion, but in reality served mainly as a vehicle for medical decision-making. Most of the 'real' work of discharge planning occurred outside of the formal structures and to a greater or lesser extent relied mainly on the nurse to fulfil a number of roles. The data seemed to suggest that it was the balance between these activities that was influential in determining the nature of the discharge experience. Although the nurse did play a role in both formal and informal activities on the Medical/Surgical Unit, the major emphasis was on the formal structure of the ward round. In contrast on the Care of the Elderly Unit the informal role of the nurse was far greater, much more fully recognised by other disciplines and accorded a degree of legitimacy as a result. As will become apparent, the second analysis reaffirmed and expanded upon this basic premise.

Essentially the unfolding theory suggested that two differing *modus operandi* could be identified in the data, which have been termed 'processing patients' and 'processing people'. The ultimate aim was the same, that is to move older people through the hospital system and out again, ideally into the community. However, whether individuals were treated mainly as 'patients' or mainly as 'people' during the discharge 'process' depended on whether the main efforts on the MDT focussed on either 'pace' or 'complexity'. Where 'pace' was the main primary focus the goal was to move individuals as quickly as possible through the system and out again. The patients' medical or surgical condition is the main driver and complexity is thought of only in terms of the complexity of the condition itself. The older individual is viewed very much as a 'patient'. This tended to be the main *modus operandi* on the Medical/Surgical Unit and such an aim determined how the formal structures on the ward round functioned and also reinforced the importance of the medical input.

In contrast, in situations where complexity was the main focus of effort, although there was recognition of the complex nature of the presenting condition (indeed this was often more complex on the Care of the Elderly Unit with multiple pathologies and polypharmacy exerting a significant influence), attention was also given to the wider social context within which the 'condition' was embedded. The older individual was therefore viewed mainly as a 'person' rather than as a 'patient'. This is not to say that length of stay (pace) was not an issue, but that it only exerted a major influence at times of bed crisis. The ways in which pace and complexity influenced the discharge experience and the various processes that were given a priority are now presented as the basis for the grounded theory.

The influence of pace as the main driver on the Medical/Surgical Unit was reflected in the importance given to the formal structure of the ward round and the fact that it comprised mainly doctors and nurses. The main business of the ward was transacted here and, at least from a medical perspective, other factors were seen as distractions. There was far less scope for multidisciplinary discussion and more limited opportunities for influencing the decision making process. Consequently, there was less 'informal business' outside of the ward round and that which occurred was mainly directed at expediting the discharge. The main exception, as will be highlighted later, was when there was a specialist nurse involved.

On the Care of the Elderly Unit more emphasis was given to complexity and this was partly reflected in the more elaborate composition of the MDT and the existence of case conferences. Although several respondents still complained that a medical model prevailed, nevertheless there were far more opportunities for discussion and debate. Moreover, there was far greater recognition that the 'real' work of discharge planning

occurred outside of the formal structures and that the nurse played a pivotal role. The ways in which these two differing scenarios unfolded will be described in greater detail shortly.

The second analysis of the data reinforced the fact that the nurse played a major, albeit often quite different, role in both areas and that this could be understood in terms of four main processes. These have been named: pushing; fixing; informing and brokering.

Pushing – refers to activities which are designed primarily to expedite the discharge process as rapidly as possible. The team used here in the colloquial sense of ‘to push through’ – to get things completed or accepted quickly’ (Compact Oxford Dictionary, 1996). Pushing therefore involved a number of activities designed both to get people to accept the discharge decision, and to complete the discharge as quickly as possible.

Fixing – denotes activities of a largely procedural nature used in the colloquial sense of to ‘fix up’ – ‘to arrange, organise or prepare’ (Compact Oxford Dictionary, 1996) and relates primarily to activities undertaken outside of the formal structures which ensured that the necessary elements were in place for discharge and that, as far as possible, all interested parties were aware of these.

Informing – ‘to tell or advise’ (Compact Oxford Dictionary, 1996) is related to, but distinct from, fixing in that it is about relaying information (part of which may be necessary to arrange, organise or prepare, i.e. to fix) for purposes other than procedural matters.

Brokering – in the sense it is applied here can be seen as analogous to the idea of to ‘broker a deal’ or ‘act as a middleman’ (Compact Oxford Dictionary, 1996) in that ‘brokering’ describes a range of activities concerned with the interpersonal aspects of discharge planning, in which the nurse plays a more proactive role.

All of the above processes (pushing, fixing, informing and brokering) comprise several kinds of distinct activities, which will be elaborated upon in greater detail shortly.

Having at this point delineated the main elements of the theory, the rest of the chapter provides the empirical data that support such a conceptualisation.

4.6: Processing Patients: A Triumph of Pace over Complexity

What follows is an account of the main modus operandi of discharge planning on the Medical/Surgical Units. It illustrates the major influences, and their consequences, from the perspectives of the MDT, identifies the impact on patients/carers and the effects on liaison between the MDT in the hospital and the PHCT.

It was suggested earlier that the notion of ‘processing patients’ best captures the discharge experience on the Unit in that the main goal was to ‘push’ people through the system as fast as possible, with the ward round being the key formal mechanism. This was dominated by a medical/nursing perspective. This view is captured eloquently in the following quotation from one of the consultants:

*'The ward round is a key part of MDT working, problems are brought together and discharge is mainly done by medicine and nursing, some input by physio on Monday, Social workers attendance is patchy. Acute medical ward not the place for dealing with social problems, more pragmatic approach required. Medical problems are the chief concern of medicine, others need to coordinate and take responsibility for taking it on board. The patient **has to** leave the bed'* (original emphasis).

(Doctor, E11. 26th March 1993, interview notes)

As a consequence of the above only rather cursory attention was paid to things other than medical, as reflected in the following observation from another consultant:

'Medical primary responsibility for discharge, to get further information we ask the nurses. If afebrile and we ask the patient if they feel okay then that's the criteria for discharge.'

(Doctor, B14. 16th March 1993, interview notes)

Although it should not be thought that social and other needs were totally neglected, the main emphasis was definitely on vacating beds and it was recognised that this 'view of the world' was predicated on a particular definition of a successful outcome, which was not necessarily consistent with the views of all members of the team. One of the sisters on the Surgical Unit pointed this out as follows:

'Mr. (name) (Surgeon) sees work in a certain way – a process approach. Outcomes seen differently by medical team and my view. Bed crises are a critical factor, if beds needed (the surgeon) will push patients out and be antagonistic to social needs, if not then says its okay to keep them in.'

(Ward Manager, B1. 4th March 1993, interview notes)

In many ways the new discharge policy had been introduced in an attempt to overcome this limited attention to patients' wider needs, with a key component of the policy being the discharge checklist. This was intended to serve a number of purposes and acted as a trigger to prompt action, an aide memoir to ensure that appropriate action was taken, a multidisciplinary record which could be referred to chart the progress of the discharge, and a permanent record of whether all necessary action had been completed. However, introducing the checklist proved challenging, and it struggled against the prevailing medical model and the need to vacate beds:

'The policy is all well and good and the discharge checklist has helped things by giving us a list of questions to ask, especially the social work referral early on, but you know its miles away from what its like here in doing discharge. It's the consultant's decision and responsibility and after the ward round the patients are discharged home, to clear the beds and you can't do the TTO's (Pharmacy scripts) because the doctors change their minds on the ward round. It's all a rush and policies don't change the medics do they?(pause) They run the show and what they want is beds emptied.'

(Staff Nurse, D5. 9th March 1993, interview transcript)

There were also indications that the checklist had not, as intended, widened the focus of activity but was used simply as a better way of expediting the patients' discharge. Moreover, rather than being seen as a means of working holistically (as had been the intention), some viewed its purpose as being to provide a record that 'your' bit of the process had been completed and that if there were any deficits then this was the responsibility of others:

'We assess the patient with the discharge checklist and tick the boxes as appropriate and also use the nursing process on admission, check their ADLs and make sure they are medically fit and that's it- that's our assessment, we have to check for any medical problems they may have.'

(Staff Nurse, E4. 9th March 1993, interview notes)

'The discharge planning we do here is concerned with organizing all the different bits required to get the patient home after treatment and they are medically fit, if there's problems our responsibility is to refer to the Social Worker and so on, we ask on completion of the discharge checklist if they need a referral to the Social Worker then, so that's covered and it covers us as nurses that we have assessed their needs.'

(Staff Nurse, C5. 12th April 1993, interview transcript)

Such was the sense of 'urgency' that seemed to prevail at times that the completion of the checklist could become a retrospective activity:

'Should be a team effort in an ideal world involving patients and carers, reality is – doctor happy and nurses turn around and go along with it or say hang on, this and this needs doing or sorting out. There needs to be more time required for discharge planning sometimes the late shift is filling out the discharge checklist after the patient's gone – there's a tendency to rush through if its busy.'

(Staff Nurse, D7. 10th March 1993, interview notes)

This very limited view of discharge, with its prime focus on medical need, with little involvement of the wider MDT, had been accepted by some nurses who saw it as their own role to 'push' the patient through the system:

'Its our job to get patients through the ward and make sure they are okay for surgery and recover and get them ready for discharge, the discharge planning bit is ensuring they have transport, family are aware of arrangements and they have their tablets and dressings and that the District Nurse knows they need sutures or clips removed.'

(Staff Nurse, Ward B6. 8th March 1993, interview notes)

However, there was awareness among many of the nursing staff that the emphasis on throughput was not necessarily to the patients' advantage and that it often precluded their involvement:

'Doctors say they have to go home and push them out, too quickly really, more time is required with patients and relatives – preparation for home is not good, as they're pushed out and its difficult to involve patients in the process though once home they are the ones that need to manage.'

(Senior Staff Nurse, E1. 3rd March 1993, interview notes)

However, 'bucking' this trend or questioning its validity were not actively encouraged, with the implicit culture of 'pushing' still being dominant:

'Sometimes its really frustrating that other people (nurses) don't focus on talking to the patients and assessing them properly, they do the checklist and that's it. I get told I'm fussing by the ward sister but I think nursing in surgery is about caring for your patients and making sure that you know about their needs ready for discharge. Its very important in the care of the surgical patient, it's not a conveyer belt.'

(Staff Nurse, C6, 12th April 1993, interview transcript)

However, the formal structures, and particularly the ward round, often made it difficult to obtain a full picture. Indeed this was not seen as its main purpose, rather it seemed that the ward round was a forum for 'rubber stamping' medical decisions. A nursing team leader captured this in the following way:

'The ward round is the spark but not the whole thing, superficial input by the patient, its not a good place for decision making proper. The key

criteria is that they are medically fit, priority and time, given to discharge but mainly in terms of safety of the patient for transfer, but decision making is one way, biased medically.'

(Staff Nurse, E6. 15th March 1993, interview notes)

The current structures were seen to overlook the complexity of discharge, especially for older patients:

'Sometimes medical staff do not see your perspective and there are times to be assertive to get the point across, they have no idea of discharge planning being complex, they think that once they have said 'go home' its fine.'

(Staff Nurse, D15. 25th April 1993, interview notes)

It was not only nursing staff who identified the difficulties with the existing system as the following two quotes from SWs demonstrate:

'People work in isolation on the medical unit; worst culprits are the medical staff, not interested at all in planning. Nurses initiate discharge arrangements and fix them up with the patients, carers or relatives and team members in the wards and District Nurses. The ward sister has some influence on the decision as part of the ward round, but it's the Consultant and the medical staff that make the decision – we all fit around that.'

(Social Worker, D3. 8th March 1993, interview transcript)

'Decision-making initiated by consultant, need to broaden, should be more equally shared amongst multidisciplinary team, working with patient. It becomes fragmented quite easily as discharge is a delicate area.'

(Social Worker, B9. 12th March 1993, interview notes)

The key role of the nurse and the rather tenuous position of other disciplines, especially SWs, were succinctly, if rather bluntly, summed up by one of the consultants thus:

'Nurses actively involved in the discharge process, there's a good liaison with nurses. Social service – conflicts with them – never met a Social Worker who could deliver no direct access – can't get to know them. That's the key problem with discharge –Social Workers.'

(Consultant, B14. 16th March 1993, interview notes)

The above data provide a powerful indication of the dominant medical culture operating in the Medical/Surgical Unit where the main goal is to 'push' the patient through the system as quickly as possible. Metaphors such as a 'conveyor belt' were used to denote the factory like approach, which overlooked other needs and neglected the complexity of the discharge of some patients. Although the discharge checklist was introduced in an attempt to stimulate a more 'holistic' perspective, it struggled to overcome a culture in which pace (the speed of the discharge) was viewed as more important than complexity (attention to the wider needs of patients and carers). Moreover, some nurses seemed to sanction, or at least not actively to challenge, the system and colluded, or actively participated in 'pushing' patients through the system in order to complete the processes as quickly as possible.

On the other hand, disquiet was expressed by other nurses and members of the MDT who acknowledged that the emphasis on pace often resulted in hasty discharge. This is an area that will be discussed in more detail shortly.

The nurse, as described above, played a key role in the ward round and further analysis suggested that after the ward round the nurse continued to exert a major influence but that the main activity was now 'fixing', as in to 'fix up' or 'arrange, organise or prepare':

'Discharge planning is based on the ward round that's where the decisions are made and plans are outlined and then it's up to the nurses to try and influence the decisions in the ward round or sister and then its us as nurses who have to fix the discharge up, run between the relatives, patients if needed other team members like the Social Worker if a problem has come up or phone the community team. The SHO or reg ' (registrar) does the TTOs (pharmacy scripts) and letter – well discharge note to the GP. There's usually a delay in getting the TTOs 'cause they go down to pharmacy late because its after the ward round has finished and it's a rush to pull everything together, contact the relatives or tell ambulance control to get some transport, try to tie all the loose ends up and fix the problems.'

(Staff Nurse, E6. 5th March 1993, interview transcript)

This sort of 'fixing' role was recognised by other disciplines such as Social Workers:

'As for the ward round, the doctors tend to leave the nurses to sort out arrangements and fix them, whether help is needed, and work out with the medics the date for the discharge. (pause) There's not enough time and planning in discharge, need time to arrange things with other agencies.'

(Social Worker, D3. 8th March 1993, interview transcript)

However, the success or otherwise of this fixing seemed to be largely dependent on the skills and abilities of individual nurses:

'Usually the nurses – who organise everything – medics responsible for medication and needs, and ensure that all is done and nurses ensure that everything done by the medics. Some nurses are better than others at discharge, checking that things are done satisfactorily and liaising with the team.'

(Staff Nurse, E3. 9th March 1993, interview notes)

'It all falls down if nurses don't know where the discharge is up to. In the ward round everything is decided formally but doctors tend to put it on the nurses to arrange everything, doctor's don't involve themselves much, Social Worker, physio do not normally attend the ward round, only nurses. Everything is filtered through the nurse, it depends on how good the nurses are sometimes – it's variable, running around and pulling it together between the patient, relatives, the community staff – getting the doctors to sort tablets, follow up, L.T.D. (letter to doctor) and all that – Social Worker liaison.'

(Staff Nurse, E1. 3rd March 1993, interview notes)

The marginal position of disciplines other than medicine and nursing will by now have become clear, and one of the key 'fixing' duties of the nurse was to act as a conduit to the wider MDT, indeed the nurse often seemed to be the only mechanism to trigger involvement of other disciplines. This might involve both 'formal' work in the ward round and more 'informal' or behind the scenes work.

'Nurses will suggest about the patient needing OT and the nurses will refer to physio and speech therapy because if you don't do it informally at the same time as getting the doctor to do a referral this will cause delay, getting the doctor to sign and get referral through is a problem.'

(Staff Nurse, D15. 23rd March 1993, interview notes)

'Information for physio or Social Worker passed on through nurse or sometimes from House Officers through nurse to them (physio and Social Workers), nurses on the ward round.'

(Staff Nurse, B4. 6th March 1993, interview notes)

Moreover, this notion of acting as a conduit to ‘connect’ together various members of the team did not simply refer to professionals, and it was also apparent that ‘connecting’ as part of ‘fixing’ also served a major role with regard to relatives and patients:

‘Nurses get hold of doctors to talk to relatives, its easier if relatives are proactive but generally it’s the nurses that are catalysts for information and discussions between doctors and relatives.’

(Staff Nurse, D13. 12th April 1993, interview notes)

‘The nurse communicates with the Social Worker, we were seen by the social worker prior to discharge – the nurses were good in working it out and setting it up, the nurse put the request in to see the social worker for us.’

(Family Carer, B27. 12th July 1993, interview transcript)

As noted above, much of this work was informal and occurred outside the ward round:

‘Nurses have a key role with the family and carer; the patient and other team members informally. Informal stuff is the key to discharge.’

(Staff Nurse, E9. 24th March 1993, interview notes)

However, in addition to ‘connecting’ it emerged that, not only did other disciplines rely on nurses to be kept informed of the discharge and to bring them in as and when needed, but also to act as their ‘eyes and ears’ on the ward round or elsewhere, and to be ‘alert’ to patients who might otherwise slip through the net. This process of ‘alerting’ is noted by the Social Worker below:

'Patients are at risk – there is potential risk with patients for discharge, generally 'at risk' patients are picked up but not always. The key is the nursing role, they care for patients on a day-to-day basis and have insight into patient condition and dependency.'

(Social Worker, D3. 9th March 1993, interview transcript)

Once again, however, the major focus on the medical needs (processing patients) often meant that important aspects could be missed and the complexity of case overlooked, unless it was in one of the specialist areas, most notably the Vascular Unit:

'Nurses pay attention to the functioning of the patient – getting them mobile, washing and dressing and all that but they don't seem to pick up on the wider issues of the patient coping and managing at home, its not an in-depth assessment unless they are under the vascular team and carers don't get assessed if they are able to care and have all the information and support that they need.'

(Social Worker, B9. 12th March 1993, interview transcript)

'I get a referral and become involved mainly by liaison with the nurses they pick up a problem or there's closer liaison with the specialist nurse, such as the breast care nurse or stoma care- that's good with good communication and relationship, otherwise you are on the outside a bit the nurses and surgical team are mainly involved with decision making and I haven't the time to be involved with all the ward round since I have so many ward areas to cover, its very time consuming but also frustrating, you know patients are not getting the focus they need at times, people slip through the net and the focus is only on discharge – get them home. The vascular team is different and multidisciplinary in its approach and the specialist nurse xxxxx (named) is a focal point for everything pre-op, post-op and following on at home, that's good.'

(Social Worker, B9. 12th March 1993, interview transcript)

Nurses too were aware of the risks of an incomplete or cursory approach to things other than medical:

'There's a tendency to get through the job and that's it and a lack of communication via stuff that's been done for the patient but really its often not been done therefore assumption is that things are done 'everything done for the patient for discharge' but it hasn't been done at all or not completely.'

(Staff Nurse, D5. 8th March 1993, interview notes)

The consequences of overlooking complexity were particularly noted with respect to older people, and there was an almost wistful desire that things could be organised as they were on the Care of the Elderly Unit:

'Timescale is a key problem, pressure on the system to push people through but it doesn't work for 65+, when you take into account major changes of lifestyle and position in terms of wealth, cannot be done in 2 / 3 days. And there's so much ineffective communication between staff it's a major problem and the formal forum is incompatible with matching throughput and efficiency with meeting patients' needs.'

(Occupational Therapist, D1. 2nd March 1993, interview notes)

'The ward round is not a good place for decision making, medical review yes, but best forum is an informal conference at the end of the round with social work input and the nurse pulling it together like on the Care of the Elderly Unit. Need to share information to have a successful forum. There aren't any case conferences on the medical unit, the issue of personality is a key issue in MDT working and a problem and how much they know about older patients, not knowing enough about problems with the elderly and the extent of frailty or the point of discharge following treatment, there's a need for more education.'

(Physiotherapist, D2. 4th March 1993, interview transcript)

A consequence of the focus on 'pace' was that if referrals to other disciplines were made at all these were often last minute leaving little time for a more comprehensive assessment. This did not relate just to members of the MDT but also to things such as transport arrangements: much of this was put down to a lack of communication and the dominance of the consultants. Even junior medical staff recognised the difficulties:

'There's a lack of communication in terms of team input, the ward round is focused on the nursing and medical staff together but not other members of the team. Not enough of team effort, with insufficient information, nursing staff have to explain everything to patients and House Officers – what's happening, information is scarce. The Consultant, Dr. (name) (ward D) decides everything on the ward round, if the patient's going to be discharged, so everything hangs on him, it's all tied up to the ward round and it's up to the consultant and he changes things around all the time at the drop of a hat, any arrangements are only provisionally organised.'

(Junior Doctor, D7. 10th March 1993, interview notes)

'You have to liaise with the nurses mainly to get through to the medics and push for a consideration of social issues rather than just a quick discharge, the medical 'fit for discharge' seems to be the main criteria and everything else is peripheral – so there's quite a job to put the brakes on a discharge when other things aren't in place and the referral for social work assessment comes in late certainly not on admission all the time or everyone gets a referral when they (nurses) ask about referral as part of the discharge checklist.'

(Social Worker, D3. 9th March 1993, interview transcript)

'There needs to be a timeframe for discharge not just at end of week but on a suitable day with all the services in place – a realistic timeframe. If there is need for involvement the OT is contacted by the nurses, they come looking for us – it's an unstructured approach. Its all highly variable. Referral tends to be last minute from the consultant, the medics have to sign a referral form/card – nurses tend to fill it in for them they suggest referral often, the awareness of OT depends on the sister, some good others not so good.'

(Occupational Therapist, D1. 2nd March 1993, interview notes)

'Team liaison is required in discharge planning but general lack of collaborative working, medical team members in acute care problematic. Need for early referral – timing crucial, for instance Social Worker was referred to see someone on xxxxx ward she spotted that the patient could not get out of chair and wife could not lift, OT had not been contacted until Social Worker had been involved. Vascular patients okay – main focus on them, other patients problematic.'

(Occupational Therapist, B8. 10th March 1993, interview notes)

'There's a constant problem with transport request forms being filled in incorrectly and this has implications for resources (pause) inappropriate referral for stretcher will take up the space for 3 patients (pause) not assessed properly. And the notice of discharge is another big issue. Ambulances try to be flexible but need to receive requests prior to 3 pm to organise for the following day. There's poor comprehension of what is involved and there is late notice from surgery and medicine all the time and sometimes the requests are unsafe as well as inappropriate (pause) such as requesting a car ambulance with one, not two, men for a heavy and ill patient. The doctors are supposed to fill in the form but we know that's impossible, I know the nurses role and think they sign the forms for them.'

(Ambulance Officer, A45. 9th February 1993, interview transcript)

All of the above highlight the tensions seemingly inherent on the Medical/Surgical Unit and the difficulties they occasion for members of the MDT. However, these tensions also almost inevitably impacted upon patients and their carers, serving to limit their involvement in the whole process. Once again this draws attention to the primacy of 'pace' over 'complexity', as noted by the Social Worker below with respect to family carers:

'In particular the MDT is not sensitive enough to carers' needs and the relationship with the family, the focus can be too overtly on throughput and not tackling issues which need to be looked at by the MDT prior to discharge, bed crisis can be a factor.'

(Social Worker, D3. 8th March 1993, interview transcript)

Again the role of the nurse in 'connecting' the various parts concerned was also highlighted by social work staff:

'Access to relatives is a major problem; delays in the process can be massive. Discharge plans made in liaison with MDT but patient can't go

home – have to liaise with relatives, because relatives turn up and come up with something different, nurses are useful because they can access relatives when they visit, avoid wasting of time because of relatives and access to them. ’

(Social Worker, B9. 12th March 1993, interview transcript)

In particular, however, it was patients who seemed to suffer as a consequence of the focus on pace, with there being little time to relay information, and often the limited information given was vague, and occasionally deliberately misleading. There was a general feeling amongst many of the staff that doctors did not wish to, or were poor at, conveying information, and especially bad news, in a sensitive and comprehensible manner.

‘In the case of Dr. (name)’s patients with cancer, Dr. (name) does not provide detailed information for the patient or carer, (name) talks about inflammation of the lung, they are kept in the dark and feel anxious and also it makes making arrangements difficult, such as hospice at home, information is neglected by the medics. ’

(Staff Nurse, Team Leader, B4. 6th March 1993, interview notes)

‘Dr. (names consultant) is too blunt and Dr. (names consultant) is too vague talks about ‘inflammation’ when its cancer, not enough in his direction about information and input – whose role is it anyway? Big problem with diagnosis information. Also patients need information about the planning process and carers otherwise you get problems. ’

(Sister, E5. 14th March 1993, interview notes)

Part of the problem was attributed to the over reliance on the ward round as the main focus of activity:

‘The ward round is the decision making mechanism, the involvement of patients is variable, tendency not to bother with some patients, then

seems to be more of a focus by Mr. (names consultant) to discuss with men rather than women. There are two (original emphasis) nurses on the ward round, one to explain the discussion and give information to patients and one to do the ward round with the consultant and team.'

(Staff Nurse, C9. 10th April 1993, interview notes)

Conversely, some others felt that doctors were evasive and that this disempowered patients. It was often left to others to provide an accurate picture:

Interviewer: 'What about good information on discharge?'

Staff Nurse: 'Far from it, they are denied information, lied to and misled, left feeling out of control which makes them ill and worry, for instance, a woman in hospital for weeks on tests and doctor says sending her to 'Clatterbridge' (oncology unit) for treatment. Not prepared for it, information given general, no discussion, she felt angry and deceived and uninformed when given accurate information provided by the Social Worker, new attitude by patient, therefore gained control and could make plans, difficult adjustments, positive.'

(Staff Nurse, E7. 15th March 1993, interview transcript)

This was reaffirmed by other staff, both nursing and social work:

'In my view information given to patients is only adequate at times, 'bladder warts' not tumours is a good example – patients are unclear about what's going on here with 'bladder warts' and the implications.'

(Sister, B2. 4th March 1993, interview notes)

'Doctors are generally poor in giving information – use of euphemistic terms, they 'dress up' information.'

(Social Worker, D3. 8th March 1993, interview notes)

As noted above, these difficulties were compounded by the reliance on the ward round, which medics apart, was widely recognised as being a poor forum for the provision of information:

'Superficial input by patients and ward round is not good place for decision making and discussion, its all on the hoof and the patients are seen quickly by the medical and nursing team, there's a great pressure for beds and discharge.'

(Sister, B2. 4th March 1993, interview notes)

Sometimes the onus seemed to be placed on patients to be assertive and to ensure that their needs for information and involvement were met:

'More information given if they ask, if they don't ask don't tend to get. More information should be given – should be more written, tend to forget once home but there's not much time and information about medication tends to be given as they are about to leave the ward.'

(Staff Nurse, D10. 13th March 1993, interview notes)

'Not given enough input, talk over patients or ignore them, depends on patient, there's not much active involvement in the decision making – they are provided with a closed question – okay to go home tomorrow or later on today, on the ward round after the team, well nurses and medics mostly discuss the patient case and then address the patient.'

(Staff Nurse, E4. 9th March 1993, interview notes)

However, patients found this difficult, due both to the 'formal' nature of the ward round and the 'technical' nature of the information that they were given:

'The ward round was rather stiff not able to discuss everything, (long pause) it frightens you, don't ask any questions and the nurses are very nice but not all are competent, some are come day – go day.'

(Patient, E15. 14th May 1993, interview transcript)

'I was given a explanation by doctor and nurse but did not really understand, something about the aorta.'

(Patient, C21. 8th June 1993, interview notes)

Another important role recognised and fulfilled by some, but not all nurses, was to 'interpret' and relay information to patients in order to improve their understanding:

'Dr. (name) (Consultant) chatters and talks to the doctors, it's the nurses responsibility to refine what the doctors have said to patients. Patients need more information, nurses tend to give information to them, the doctors give them a diagnosis but the patients go first to the nurses.'

(Sister, E5. 14th March 1993, interview notes)

'Insufficient information about everything, especially diagnosis, for the patient and carer, nursing point of view is okay in how much information is given but more medical information input required. Nurses take on the doctor's role, nurses give information to both patients and carers.'

(Staff Nurse, E7. 15th March 1993, interview notes)

On one of the wards there was more explicit recognition of this role and two nurses went on the ward round. One to 'service' the round in terms of its smooth running and the other to interpret and relay what had been said to patients. However, this was not always possible and indeed was frowned upon in some areas:

'Medics dominate 'frowned upon' if chip in. Poor liaison with patients and carers, nurses have to waffle to them especially if unpleasant diagnosis –difficult.'

(Staff Nurse, B6. 8th March 1993, interview notes)

However, consistent with much of the data from other informants, things were generally far better when there was input from a specialist nurse, especially on the vascular unit:

'Mr. xxxxx explained well and xxxxx (specialist nurse) – higher than others, explained everything comprehensively pre-op 'plastic tube' shown.'

(Patient, C19. 4th June 1993, interview notes)

In most cases, however, the result was often the feeling of a 'rushed' discharge from a patient perspective, especially when it was necessary to move them between wards on the unit. Once again the metaphor of a 'production line' is intimated in the following quotation and succinctly conveys the emphasis on 'pace' and 'pushing':

'I felt I went home too quick bit like a 'production line job' and there was a lack of communication between the consultant and the registrar on the two wards, I was admitted to one then moved over when there was a bed on Dr. xxxxx (consultant) ward, consultant said I could go home on Thursday morning I didn't know that, as I said I thought that was a bit quick.'

(Patient, B24. 21st June 1993, Interview transcript)

Such an emphasis also had a negative effect on communication with the PHCT.

4.7: Pace and pushing: Impact on the PHCT

The perceived need to discharge patients as rapidly as possible also had an impact on the liaison with the PHCT at numerous levels. Typical comments from the several different members of the PHCT were concerned with:

- the speed of discharge, the short notice given and the general failure to differentiate between 'routine' and 'complex' cases;
- lack of essential information, particularly regarding new or differing treatments;
- a failure to understand the role of members of the PHCT; and
- a failure to appreciate the reality of life 'in the community' so that unrealistic promises regarding further treatment were made which could not subsequently be matched.

The Medical/Surgical Unit was singled out as causing particular problems in this regard, and unfavourable comparisons were made with the Care of the Elderly Unit.

The following sets of comments reflect the above issues, beginning with the speed of discharge, and the failure to recognise 'complex' cases. These comments capture the tensions between pace and complexity, which seemed to lie at the heart of many of the difficulties on the Medical/Surgical Unit:

'Not enough notice is given, time is needed to provide equipment and allocation of time and priority for work, difficulties not appreciated by hospital. It can lead to disastrous things at home, you need one week's notice with complex cases, not 48 hours.'

(Community Nurses, A40. 8th February 1993, interview notes)

'It seems to be that there is a lack of communication in the hospital MDT which causes the problem, especially in bed crisis patients, sent home with a tendency to be rushed, plans made but changed, e.g. Registrar prior to weekend vacates bed therefore plans change – goes 'out of the window'. DNs not consulted with acute staff, not liaising in case conferences or ward rounds, though they should be in complex cases – older people and terminally ill, due to their knowledge of patients.'

(GP, A54. 19th February 1993, interview notes)

A perceived lack of involvement by members of the PHCT and the absence of formal structures to facilitate communication (such as case conferences) were also alluded to, again with particular reference to 'complex' cases:

'Notice of discharge is inadequate and inadequate planning with frequent discharges at weekend and late discharge after 6 pm. Late discharges have implications and poor notice, community contacted at 4.15 – 4.30 to arrange cover for the weekend and no involvement with complex cases. No case conference apart from a few isolated examples.'

(Community Nurse, A41. 8th February 1993, interview notes)

Even though in principle the named nurse initiative and the discharge policy should have improved the situation, members of the PHCT considered that they were met with short shrift, even when they had taken the trouble to contact the ward:

'A major issue for us is late, short notice discharges prior to weekend, 48 hours notice needed by Social Work Team to organise home care services. There is difficulty contacting the nurse on the ward, the named nurse means nothing, they are on annual leave (or sick or on a late shift), no continuity present in the system at all – and the person you speak with does not know the patient.'

(Community Social Worker, A58. 23rd February 1993, interview transcript)

The short notice of discharge was further compounded by the limited and/or slow transfer of information from the wards to the PHCT. This was noted by both GPs and DNs, and could on occasion cause difficulties with continuity of care and treatment:

'A main theme is the lack of information about patients, the limited information in the LTD (letter to doctor discharge summary) can be delayed at least 14 days, surgical unit is the worse, time length is even greater and the initial summary is poor quality no details (pause) which are needed for GP and for relatives via GP. The hospital and District Nurses relationship are a problem especially patients requiring procedures not passed on to District Nurse for instance clips to be removed therefore patient turns up in surgery having waited for District Nurse to come and promised by hospital. Disjointed services, patients feel that they have a lack of information, little warning, preparation or advice, ejected on a Friday afternoon and it's the acute area's responsibility, its their ball game.'

(GP, A52. 18th February 1993, interview transcript)

'Patients not checked properly on discharge, a major venflon in their hands and surgical dressings – patients with dressings not change before discharge and in a state. There's inadequate dressings that aren't available in the community.'

(Community Nurse, A41. 8th February 1993, interview notes)

'Urology is particularly bad, patients and carers communication gap, don't really know what is being done, no GP letters, patients aren't clear themselves who they have seen and what's been done, and we haven't the information to inform them once discharged. Patients have sometimes died before the letter arrives in the post.'

(GP, A50. 17th February 1993, interview notes)

Underlying many of these difficulties was a perceived failure of the hospital staff to understand both the roles of community practitioners and the reality of community care:

'There is a 'them and us' situation, not feeling of 'all as one' – it seems that the hospital thinks that DNs can only do blanket baths and enemas.'

(Community Nurse, A43. 9th February 1993, interview notes)

'The Transfer Of Care Form reflects the misunderstanding about DNs and the way things aren't assessed in hospital or even looked at only from the point of view of the ward staff, it lacks information, it's minimal at times, needs more on treatment, diagnosis and when to be seen again by the hospital.'

(Community Nurse, A39. 5th February 1993, interview transcript)

'The intention is to have a needs led service but at present it is service led and there is a misunderstanding, a mismatch by what is offered by Social Services, the hospital team give a false expectation to patients and carers of what can be provided and inappropriately assess needs due to hospital's perspective, consistently the community reality is different, so particular medics give a false impression of what can be provided, clearly demonstrating a poor understanding of roles and service provision. The assessments from acute tend to be either too low or high in appreciation of patients' needs. At home, therefore, the suitability of assessments by wards is suspect.'

(Community Social Worker, A59. 23rd February 1993, interview transcript)

'Referrals for equipment, late or inappropriate expectations of services and a lack of comprehension of what services are available.'

(Community Occupational Therapist, A42. 8th February 1993, interview notes)

'The geriatric service is very good but with Medical and Surgical no information and late/short notice discharges, surgical is the worst. Acute staff do not know about home conditions therefore do not realise what is required what abilities are in hospital may not be reflected in the home such as ADL's. Lack of understanding of the community role and the input of District Nurses, lack of understanding of community situation that is no care for 24 hours a day.'

(Community Nurse, A39. 5th February 1993, interview notes)

However, it should not be thought that this perceived failure to appreciate roles was only one way, as some of the ward based MDT also felt that members of the PHCT did not understand their reality either.

'Not much coordination could be improved – liaison, no information from community on admission or after, its all pretty poor, there are some instances when community nurses come in or phone and there is coordination such as in a terminal case but in general there's not much dialogue between community and ward.'

(Staff Nurse, E9. 24th March 1993, interview notes)

'MDT can become fraught quite easily, a 'delicate area'. In multi-agency collaboration, community workers don't understand how little notice given i.e. discharge and how much medical condition can change quickly and the power of consultants to discharge quickly for beds.'

(Social Worker, D3. 8th March 1993, interview transcript)

There were occasional examples of good communication but this seemed to happen either when certain individuals got on well together, or when someone made a particular effort to 'keep in touch':

'I have a good relationship with Sister xxxxxx (community nurse) she's really good and with difficult discharges like terminal cases she'll liaise and knows her stuff. Sister xxxxx is outstanding comes in and phones-close liaison even post discharge if problems arise at home such as with colostomy or ileostomy.'

(Staff Nurse, B4. 6th March 1993, interview notes)

As noted earlier, there tended to be fewer problems when a specialist nurse had been involved, and the vascular unit was often 'singled out' for special praise.

The main emphasis in this account so far has been on the tensions between pace (the need to ensure a speedy discharge), with the tendency to focus primarily on the medical condition, and to 'push' the discharge as much as possible, and complexity, with due recognition being given to a range of factors other than the diagnosis. Difficulties on the Medical/Surgical Unit were compounded by the limited formal structure and the

absence of a full MDT on the ward rounds. Nurses were therefore involved in several 'fixing' activities which help to pull the discharge together. They are also involved in 'informing' patients due to the relative failure to fully involve them, the intimidating nature of the ward round, and the failure fully to ensure that patients understand the information that they have been given. The overall effect is that the emphasis is on 'processing patients' with older individuals being seen mainly in terms of their presenting condition. As noted earlier, a triumph of pace over complexity. The following two case studies provide contrasting illustrations of the above points.

4.8: Case Study One: Surgical Unit

Mr. Evans, aged 69 years was admitted for further treatment of a malignant growth in his bowel. He had been an in-patient on numerous occasions during the last year and had a colostomy in place. Prior to his recent discharge, he did not feel fully ready to go home but considered that the professional team knew best:

'Well they said I would be ready for home the following day when they saw me on the ward round (pause) they were in charge and I thought, well they knew best really. I wanted to go home and didn't want to stay in any longer if didn't have to. I still felt weak and my appetite was poor but I thought I would be better once I would be home. That wasn't the case when I did come home (pause) but I thought at the time I'd be alright.'

(Patient, B27. 17th July 1993, interview transcript)

Mr. Evans desperately wanted to return home: "I felt like a burden" and his wife noted that he put on a 'sham face' to the doctors and nurses so that he could be discharged

sooner. However, despite his several previous admissions, the discharge was not adequately planned and his home circumstances, and the availability of supplies, were not checked prior to the decision to allow Mr. Evans home.

As a result Mr. Evans did not have adequate supplies for his return home, having used his own supply of stoma bags whilst in hospital, (the type he needed were unavailable in the hospital). The time lapse involved in receiving a new supply from the community chemist resulted in some distressing problems in maintaining personal hygiene:

'While I was in the hospital I had used up my own supply (of stoma bags) and I ran out as soon as I got home and there was terrible problems managing it all while I organized to get some new ones and my wife had to go and get them for me. (pause) I was much weaker than I thought once I got home and couldn't get up the stairs.'

(Patient, B27. 12th July 1993, interview transcript)

As a consequence, Mrs. Evans had to struggle to move her husband's bed downstairs and arrange for a fold-up bed for herself so that she could assist him with toileting during the night due to his poor mobility. Furthermore, Mr. Evans had a tendency to fall and did so numerous times following discharge, mobilizing by using the furniture, as he was not competent to use his Zimmer frame, due to a lack of understanding as to its purpose. It transpired that whilst Mr. Evans had received some treatment from the physiotherapist whilst in hospital, this had been when he felt most unwell and was squeezed in during the 'resting time' he had been allocated between nursing and medical care. Consequently, he failed to get much benefit.

Mrs. Evans felt that her husband had been discharged too early as he had only been eating for 3/4 days prior to coming home and was unable to tolerate solids, suffering

continual coughing, which resulted in him vomiting his food. The dietician was considered to have been rather unhelpful, simply telling him to eat more protein, without an indication of which food was suitable. As his carer, Mrs. Evans was angry that she had not been involved in the decision-making process, particularly the timing of the discharge:

'I'm left out and I do the work, no one talked to me about it – I came in to visit in the evening and he said I'm coming home tomorrow and it was a nightmare having to sort things out at the house, I wasn't expecting him to be home so quick and his appetite was still bad and he was weak. No-one talked to me and I'm the one who looks after him not anyone else.'

(Carer, B27. 12th July 1993, interview transcript)

The couple managed at home by arranging their own routine, and also arranging their own aftercare. They asked for meals on wheels from the community social service department but were informed that this was not possible because of where they lived. Whilst they received DN support to change Mr. Evans' wound dressing, this required much more attention than a visit by the DN due to it 'weeping' with excaudate and the dressing was therefore changed several times a day by his wife. She had learnt technical procedures and practical skills, such as lifting, by trial and error, having received little or no instruction and advice.

As Mr. Evans had been an in-patient several times in the last year and was well known to ward staff, it might be anticipated that they would be well acquainted with his needs, had established a good liaison with the community services, and that discharge planning should have caused no difficulties. However, quite the reverse seems to have occurred and the focus while in hospital was confined to stabilizing his condition so that he could

be discharged home. No account seems to have been taken of the surrounding context, his overall frailty, and what this might mean in terms of his ability to manage at home, and the demands that might be placed on his wife. The 'case' was seen as being straightforward and the underlying complexities completely overlooked. This was a classic case of 'processing the patient'. The following case study on the Vascular Unit stands in marked contrast.

4.9: Case Study Two: Vascular Unit

Mr. Graham was a 70 year old man admitted as an emergency with recurrent vascular related foot problems. He also suffered from diabetes. On admission, the vascular specialist nurse and the ward staff assessed him. During the course of his treatment at both the pre- and post-operative stage, he was given information which was easily understood, including a diagram to illustrate the nature and position of the vascular bypass required in his leg:

'The specialist nurse xxxxx (vascular) came to see me and described the operation and what was going to happen after it, and what I shouldn't do and what I could do when I went home. She also said roughly how long I would be in under Mr. xxxxx (consultant). She was very good and the nurses were all very nice, but the specialist nurse seemed higher and she was in charge me of (pause) or seemed to be anyhow.'

(Patient, C16. 27th May 1993, interview transcript)

Mr. Graham's home circumstances were assessed and preparation for discharge made in advance of returning home, with a plan of support on discharge, including mobility and the post-operative condition of the wound and the limb. His wife was also involved and

given a thorough explanation of what to observe. Reassurance was given that help would be available if needed:

'I was asked about what things were like at home and who would be around to look after me once I was home. It was all quite thorough really and xxxxx (specialist nurse) wrote everything down. My wife as well was told about it and the important things to look out for afterwards and they said to give them a ring straightway if there was a problem and contact xxxxx (specialist nurse).'

(Patient, C16. 28th May 1993, interview transcript)

Liaison and continuity were provided by the specialist nurse and other members of the ward staff. The specialist nurse was the chief contact point and took the main responsibility for the discharge plan by providing co-ordination between the medical, nursing, social work, physiotherapy and occupational therapy staff. This was recognized and appreciated by Mr. Graham:

'The other nurses helped me with washing and dressing after the operation but it was xxxxx (specialist nurse) who was the one that organized everything about going home and talked to Mr. xxxxx (consultant) on and after the ward round and to my wife and she was the one that phoned the District Nurse and sorted out coming to see me afterwards.'

(Patient, C16. 28th May 1993, interview transcript)

A complete walking assessment was completed by the physiotherapist and the timing of the discharge was delayed by the nursing staff to ensure adequate support at home:

'Some of the arrangements weren't quite ready for me to go home so xxxxx (specialist nurse) discussed it with the other nurses and I went home a couple of days afterwards when xxxxx (specialist nurse) felt happy that everything was in place for me.'

(Patient, C16. 28th May 1993, interview transcript)

On the day of discharge, the wound was checked, clean dressings applied, a supply of new medications provided and explanations given by the medical staff as to when and why they should be taken.

Mr. Graham felt confident on leaving the ward because the staff assured him in the event of any problem '... don't hesitate to come back straight here'. A community nurse attended on his return home to change the wound dressing and there was initial follow-up by the specialist nurse, followed by regular clinical check-ups for a few weeks after his return home.

The contrast between these two cases is quite startling with it being apparent that the full complexity of Mr. Graham's situation was taken into account and, under the lead of the specialist nurse, a comprehensive discharge plan produced. Pace was sacrificed in order to address complexity (the discharge was delayed until support at home was ready), all members of the MDT were involved and, importantly, Mr. Graham and his wife, were not only informed but meaningfully involved. Here was a prime example of 'processing people' in the best sense of the word.

The above two cases have of course been selected especially for their contrasting nature and are best viewed as 'ideal types' (in the Weberian sense). One was a clear example of 'processing patients' with pace and a focus on the condition alone being the driving force, while the second was an example of 'processing people' where the focus was on the complexity of the issues involved and a full consideration was given to context and

background. Most of the discharges examined were not so clear cut, but the majority, other than in a few cases such as Mr. Graham's where there was usually a specialist nurse involved, were much closer to the 'processing patients' end of the spectrum. The reverse might be said to be true in the Care of the Elderly Unit, as the following section illustrates.

4.10: Processing People: A Case of Complexity over Pace

This section considers the way in which the discharge process was managed on the Care of the Elderly Unit in order to try and identify the similarities and differences between practice here and that on the Medical/Surgical Unit. As will become apparent, differences did emerge, particularly between the espoused emphasis on holistic care and multidisciplinary team working. While such differences did impact on the discharge experience it was nevertheless apparent that both areas expressed similar problems and challenges, especially with respect to community liaison.

It is suggested that the differences between the areas, in part at least, are best understood as a function of the relative emphasis given to complexity and pace, in that on the Care of the Elderly Unit, complexity was almost a given. That is, because of the evolution of geriatric medicine and its claims to holism and multidisciplinary it was expected that the majority of cases would be complex and therefore de facto require the skills of the MDT. Because of the anticipated complexity the main focus of activity was not on the pace of the discharge (i.e. making it as speedy as possible), but rather in seeking to address the multiple needs of the older person. Underpinning such a belief was that the assessment of need should not be primarily on the condition but rather on

the person in context. Nevertheless, despite the widespread acceptance of such values the extent to which genuine multidisciplinary was achieved was probably not as great as was claimed. This is perhaps best exemplified by examining the ward round.

As was the case on the Medical/Surgical Unit, the ward round was the main 'formal' mechanism for conducting business and, in principle at least, this was where decisions regarding discharge occurred. However, there were differences between the two rounds in the two areas. The ward round on the Care of the Elderly Unit was explicitly and avowedly multidisciplinary in nature and was intended to provide a forum for debate. Secondly, the ward round was not the only formal mechanism for discussing discharge, as in recognition of the degree of complexity that older people presented, case conferences were also organised. Thirdly, there were a number of less formal but nevertheless explicitly acknowledged types of work, such as the pre-ward round 'mini conference' in which some of the initial decisions were made:

'Nurses and doctors liaise, there is discussion prior to the ward rounds before the consultant arrives to prioritise patients.'

(Staff Nurse, E10. 26th March 1993, interview notes)

Interestingly, while this may have been an effective way of using time it was really counter to the ethos of the MDT in that unless they happened to be there, other disciplines were effectively excluded from the start of the decision making process. Difficulties were compounded in that if the pre-ward round conference finished early then there was a tendency to start the round proper, even if this was before the agreed time. This also limited the full participation of the MDT. Moreover, even though the

ward round was supposed to be fully participative it was nevertheless considered to be medically dominated:

'Dr. (names consultant) tends to presume too much on ward round due to poor planning, too much emphasis on Consultant led not enough delegating, more collaborative working required with shifts in locus of responsibility, currently medical issues predominate.'

(Staff Nurse, E9. 24th March 1993, interview notes)

'Planning questions and input consultant based not by other members of the multidisciplinary team, should be led by other members of the multidisciplinary team with collaborative working as required.'

(Staff Nurse, D6. 10th March 1993, interview notes)

'...the ward round is not collaborative but consultant centred ward rounds are hit and miss in terms of multidisciplinary team working.'

(Senior Nurse, C4. 11th April 1993, interview transcript)

Ward rounds were, however, valued highly by the consultant medical staff who saw them not only as the forum within which decisions were made, but also as the only real opportunity to 'meet' the team as a whole. As a result though the patient was sometimes excluded:

'Ward rounds decide timing of discharge following consultant examination, only time you see people together – important, required for liaison re patients and team, usually between consultant and team really, the patient is rather excluded.'

(Consultant, E2. 3rd March 1993, interview notes)

This perception was confirmed by the other disciplines and patients themselves, with it often being the nurse who acted on the patients' behalf, either to let their opinion be known or to ensure that they understood what had been discussed:

'Relatives / patients opinions are represented but never are they formally participants in MDT discussions. Usually their views are represented or presented by the nurses, Social Worker or others at times.'

(Social Worker, D3. 8th March 1993, interview transcript)

'Nurses have broad feel for issues of all MDT members and patients and carers. So the ward round decision-making is effective due to nursing input as mediator and translator for patients and carers.'

(Ward Sister, E5. 14th March 1993, interview notes)

'The doctor did not involve me in discussions, nurse came to explain on occasions, you're not listened to as an individual they come round and talk about you then off they go to the next patient with a bit of an explanation and that's it really.'

(Patient, D23. 21st June 1993, interview notes)

'...there's not enough information given they 'chatter among themselves' nurses explained but would have liked more information from doctor – to be told face to face what's going on and what's going to happen, that sort of thing, its worrying not knowing what's going on, there's lots to sort out to go home and my wife needs to know.'

(Patient, E14. 11th May 1993, interview transcript)

Indeed it was clear that the nurses saw themselves as the fulcrum of the ward round, which whilst potentially medical-led was nevertheless influenced significantly by the nurses. Sometimes nurses felt that they needed to be assertive in ensuring that the patients' best interests were at the top of the agenda:

'The ward round is not a good place for discussion or talk about people's problems, it's a medical round, made ineffective as MDT meeting by the team being 'meek and feeble.'

(Staff Nurse, B4. 6th March 1993, interview notes)

'Nurses role is important, we determine support. Marginal patients do not get discharged because of nursing intervention.'

(Staff Nurse, B6. 8th March 1993, interview notes)

'Patients with problems are not pushed out, and patient wishes are respected, especially if problem with relatives.'

(Staff Nurse, D15. 25th April 1993, interview notes)

Interestingly the nursing staff were also sensitive to the fact that their multidisciplinary colleagues could not always attend the ward rounds:

'If the team members aren't on the ward round we chase them up before – such as the Social Worker typically, to be able to make best use of time. Time prior to ward round is used by nurses to discuss matters then the decision making at the ward round and after is better.'

(Staff Nurse. D13. 11th April 1993, interview notes)

The above quote would suggest that although the doctors believed that they were the key decision-makers, that there was 'hidden' work that went on behind the scenes to ensure that other perspectives also exerted an influence.

Therefore, although the ward rounds on both the Medical/Surgical and Care of the Elderly Units were often seen primarily as a medical 'show', in reality the two were

quite different, due mainly to the differing roles of the nurse. On the Medical/Surgical Unit more often than not the nurse 'serviced' the round in order to facilitate its smooth running and to complete it as quickly as possible. The main focus was on the patient's medical condition and other issues often did not feed in. Indeed, as one nurse noted, she was scolded by the sister for 'fussing' when she attempted to introduce other issues. This can be seen as another manifestation of the emphasis on pace (finishing the ward round as quickly as possible) and 'processing patients' (emphasis on the medical condition). In contrast on the Care of the Elderly Unit the nurse often acted as an 'orchestrator' of the round, interjecting key issues and other perspectives to ensure that maximum attention was given to complexity, and if necessary at the expense of pace, with the ward rounds often taking significantly longer on the Care of the Elderly Unit.

As the second analysis continued it became increasingly apparent that despite the importance that the medical staff attached to the ward round as the main focus of discharge planning, other members of the MDT considered that the 'real' work was completed elsewhere and that the majority of this work was undertaken by nurses. Indeed, even one of the consultants recognised this:

'Real issues about discharge are dealt with after the (ward) round – its better, real issues not addressed on ward round, practical aspects of discharge are done after such as 'housekeeping' and tie up loose ends. The ward round brings together information – expressing opinions, collecting information, the medical – nursing relationship is the key to the quality of discharge.'

(Consultant, E2. 16th March 1993, interview notes)

This role was widely accepted, and indeed welcomed by the other members of the MDT who acknowledged that they often did have the time. More often than not this was not

seen as 'interfering' but rather as a way of ensuring that their voices were heard, albeit indirectly. This 'alerting' activity was far more commonplace and far more explicit on the Care of the Elderly Unit:

'I would like to have greater interaction with all families but in reality only possible to see referrals, assessing nurses usually pick these up and they are appropriate referrals for those needed.'

(Social Worker, D3. 8th March 1993, interview transcript)

'Informed consultation works well. I'm part time and only work mornings, nurses provide me with information from carers and information about timing of discharge. I can arrange everything in advance if I know the timing, not rushed then.'

(Occupational Therapist, D1. 2nd March 1993, interview notes)

'Staff nurse takes responsibility for discharges informally, people are aware of this, the MDT does not have defined responsibility, among team the roles are unstructured.'

(Social Worker, D3. 8th March 1993, interview transcript)

While as the above quotes suggest much of this informal work was explicitly recognised and indeed welcomed, other activities occurred that were possibly more covert but seen as necessary to the creation of a smooth and holistic discharge:

'Nobody likes to make decisions. Dr. (names Consultant) thinks he does but a lot goes on that he doesn't know about, initiatives taken by others, we don't wait for the nod, preliminary arrangements are done – even without SHO (Senior House Officer), nurses see the possibilities and make appropriate arrangements, speed things up.'

(Senior Staff Nurse, E7. 15th March 1993, interview transcript)

This can be seen as a fascinating variation on the theme of 'pushing' noted on the Medical/Surgical Unit, but with an entirely different purpose. On the Medical/Surgical Unit pushing was instigated in order to ensure that the medical directives were met as quickly as possible and the discharge completed. In the above instance, while the aim was to get as speedy a discharge as possible, the onus is on complexity so that the aim was to ensure that issues and decisions which might not occur to doctors were acted upon. As they knew the patients best, nurses believed that they were in the most advantageous position to 'see the possibilities'.

However, most of the informal work was recognised by the remainder of the MDT and comprised of similar but more diverse activities as had been apparent on the Medical/Surgical Unit. These were fixing, informing and brokering.

Fixing, as will be recalled, relates to activities which are intended to 'arrange, organise, or prepare' for the discharge process. Although these activities had been evident on the Medical/Surgical Unit they were far more apparent, more overt, and more widely recognised on the Care of the Elderly Unit. Therefore, while they were not part of the formal work, and indeed as the quote above suggests, were occasionally covert and hidden from some members of the MDT, they formed a major part of the nurses role in relation to discharges.

The nature of 'fixing' is captured eloquently and appropriately by a staff nurse in the quote below:

'The nurses team as part of informal working co-ordinated and 'glue' together the discharge planning process and things are "fixed" by the nurses, it depends on us to pull things together and run around making sure things are fixed for discharge.'

(Staff Nurse, E4. 9th March 1993, interview notes)

Fixing can be seen to comprise three main types of activity, 'housekeeping', 'connecting' and 'alerting'. Housekeeping, as noted by the consultant in the quote cited earlier, is primarily about 'keeping the books' in order and ensuring that the necessary paperwork and other process issues, such as transport and medication, are completed. As was highlighted in the last chapter, at the time of the study on the Care of the Elderly Unit there was no central record of the discharge process that could be referred to by all members of the MDT, and this was seen as a deficit. Indeed the introduction of the 'discharge checklist' as part of the new discharge procedure was intended to rectify this omission. In the absence of a multidisciplinary record the nursing kardex constituted the main record of the progress of discharge. While housekeeping activities were fairly mundane they were nevertheless essential as a failure to book transport for example could cause unnecessary delays to the proceedings.

'Connecting' describes the nurses' role as a form of relaying information via which most other members of the MDT, PHCT and patients/carers are put in touch. One staff nurse captured the nature of connecting thus:

'...the activities or tasks identified by the consultant, team members and doctors on the ward round relies on us as nurses to be referral agents and contact other team members or teams in the community to get things ready for the discharge to take place.'

(Staff Nurse, D9. 15th March 1993, interview notes)

Altering refers to activities in which nurses bring issues of concern to the attention of other disciplines, as noted in the earlier quotes. 'Connecting' and 'alerting' activities were much appreciated by members of the MDT as the early quotes from the SW and

occupational therapists testify, but also extend to include the PHCT and patients/carers, and could comprise multiple links:

'The role of the nursing staff caring for the patient is crucial, nursing role is management of patient and discussion with team, liaison with physio re: ability to cope with rehabilitation, interaction with carers, for example, on a late shift informal information obtained, sensitivity to the issues by nurse then refer to social work based on information.'

(Staff Nurse, C5. 12th April 1993, interview notes)

Nurses were seen to be well suited to this sort of work as doctors were not perceived to be interested, and the other team members were usually not available at crucial times, for example, evening visiting:

'When needed to liaison with District Nurse its part of the nursing role. Doctors do not take account of weekends or bank holidays, nurses are referral agents for the doctors you see, nurses tend to pick up things prior to timing of discharge and its left to the nurses to liaison with patients and relatives. MDT can't liaison effectively with relatives (pause) timing, the nurses see the relatives on a late shift.'

(Staff Nurse, D15. 23rd April 1993, interview transcript)

This important role was also appreciated by carers, as illustrated below:

'The nurses were the ones to ask and they said as much as they could and organised a meeting with Dr. xxxxx and the Social Worker (pause) the nurse, you know xxxxx said what Dr. xxxxx had said in the ward round and I thought it was better to see him on his own to discuss my mum's care and what the plans would be for going home and how she would be in the long run.'

(Carer, D20. 27th March 1993, interview transcript)

'Connecting' can be seen as a largely passive process in which the nurse acts primarily as the link, and does not shape or influence the message. This is in contrast to 'brokering' activities, which it will be recalled involve the nurse as a much more of an active 'middleman' in setting up 'deals' of one sort or another. There were relatively few examples of 'brokering' on the Medical/Surgical Unit with most discharge related activity being 'pushing' and 'fixing'. Brokering was much more evident on the Care of the Elderly Unit and, as with fixing, comprised more than one form. Brokering is conceptually similar to fixing, as the quote below suggests:

'After the ward round, with registrar or, and the consultants round it's the nurses that are the ones that broker the discharge, they have to liaise with family and all the team members, nobody else has to or can pull all the different bits to the discharge together, it's the nurses.'

(Staff Nurse, E6. 15th March 1993, interview notes)

However, as noted above, brokering involves the nurse as a much more active agent and consequently is a more highly skilled activity requiring well developed interpersonal skills, as well as tact and diplomacy.

Brokering comprises three main types of activity: mediating, as in 'be the medium for bringing about' (Compact Oxford Dictionary, 1996); negotiating, as in 'find a way over or through a difficulty or obstacle' (Compact Oxford Dictionary, 1996); and advocating, as in 'a person who speaks in favour (of another)' (Compact Oxford Dictionary, 1996).

The nurses' role in mediating therefore was to bring together two parties so that they could begin to air any potential differences of opinion. The skill here was to actually

get the parties 'to the table', and once there to remain neutral. This most often involved mediating in disagreements between patients and carers:

'Sometimes its difficult if a patient wants to go home and the relatives aren't too happy about it. Nurses get patients and relatives together, MDT do not see relatives unless specific issue, nurse see them on the late shift.'

(Staff Nurse, D5. 8th March 1993, interview notes)

As suggested above, negotiation involved a similar process but here the nurse took a more active role in actually 'negotiating' with the various parties involved. This was mainly about resolving communication difficulties and, if needed, 'buying time' so that there was potential for resolution. Nurses perceived that this role was recognised and valued by the MDT, especially senior medical staff:

'Discharge can miss the point about the communication issues, by focusing on the medical. Nursing staff work is 50% liaison and 50% requests for assessment, referral, re-assessment, delay the discharge for more liaison with family because there's a problem and so on, nurses negotiate and run around between the team and family and patients. There is recognition of the importance of this type of nursing by the consultant.'

(Staff Nurse, E10. 24th March 1993, interview notes)

Advocacy was a more active role still, and was concerned with 'sticking up, or speaking for, others'. This most obviously involved patients and carers but also other disciplines. This type of advocacy has already been noted in relation to the ward round (see earlier). This is succinctly captured in the quotation below:

'Nurses speak for Social Workers and physio and patient and carer to the medics. There's still lack of communication on MDT working, though better here than most wards. The ward round is the place you have to say your view or those of others about the patient but if the opportunity is not taken – if held back, lost the chance, the opportunity needs to be taken but it depends how its presented if its to be accepted.'

(Staff Nurse, E9. 24th March 1993, interview notes)

Also implicit in this quote is the need not only to 'take the opportunity', but also to do so tactfully, in that too belligerent or clumsy an attempt might be misconstrued. Not all staff had the skill or experience to successfully 'broker' the discharge.

While the ward round provided the main opportunity for advocacy, nurses were alert throughout the discharge process and, for example, would ensure that the patient was 'fit' for discharge prior to going home and, if necessary, intercede on their behalf:

'Doctors check the patients before they go home, but if nurses aren't happy that everything is okay nurses ensure the discharge is delayed and liaise within the team and with the family.'

(Staff Nurse, B5. 6th March 1993, interview notes)

'Brokering' can therefore be viewed as a skilled interpersonal process comprising three types of activity involving the nurse in a progressively more proactive role from mediating through negotiating to advocating. As suggested, some nurses were better at brokering than others, a point not lost on other members of the MDT:

'...nursing team do not only direct but also indirect co-ordination. They are the ones that glue it all together, some are better than others they

know what's going on and liaise between different team members and Dr. xxxxx (consultant Geriatrician).'

(Social Worker, D3. 8th March 1993, interview transcript)

The last main type of activity that could be identified from the data was informing. As was noted in the evaluations, the provision of information to patients and carers, as well as to the community, was often seen as being deficient on both the Medical/Surgical Unit and the Care of the Elderly Unit. Indeed the outcome of the shared negotiations on the Care of the Elderly Unit was the production of an information booklet (Homeward Bound) that contained both general information of potential use to all older people, and individualised information for particular patients (see Lundh and Williams, 1997).

The evaluation on the Medical/Surgical Unit identified serious problems with information given to patients and carers, other than in cases where a specialist nurse had been involved. There were no specialist nurses on the Care of the Elderly Unit, and there were problems with information, as is apparent below:

Patient: 'The tablet does something to my blood, keeps it thin and that's what they said when I left the ward that had something to do with the clot, isn't it xxxxx (carer)?'

Carer: 'Yes that's right the warfarin is important to take but I don't know for how long he's going to be on it.'

Interviewer: 'Did you have any advice about what look out for – precautions and so on to look out for when you are home because xxxxx (patient) is on the warfarin?'

Carer: 'No nothing like that, it was a bit of a rush we had the tablets as we left the ward, it would have been useful to have a bit more information you know about the clot and what's going to happen with the warfarin and everything.'

(Patient and Carer, A34. 3rd November 1992, interview transcript)

However, such instances were by no means as frequent, as the nurses took their information giving role seriously. Two main types of information processes could be identified, termed here: 'conveying' as in 'to transmit' (Compact Oxford Dictionary, 1996); and 'interpreting', as in 'explain the meaning of' (Compact Oxford Dictionary, 1996).

These terms are fairly self-explanatory with conveying involving nurses acting mainly as a messenger to relay information from one source, usually a doctor, to the patient and/or carer. Often, however, the type of information given was of a technical or sensitive nature and there was a need to help the patient/carer to interpret its meaning. In comparison to the Medical/Surgical Unit doctors were far more active in giving information on the Care of the Elderly Unit, and took more time and trouble to ensure that the patient understood. Ironically, given the fact that it must have been a far more common event on the Medical/Surgical Unit, the doctors on the Care of the Elderly Unit were also seen as far more skilful in relaying difficult information, often in partnership with nurses, as the following quote from a patient with terminal cancer tellingly illustrates this:

'Felt very tired (pause) looking forward to going home, the three doctors had been very truthful in hospital and for going home, family had a discussion – my son – with the doctors about their suspicions. The nurses, the staff nurses showed an interest and before going home, after the doctors had finished, I was seen by the nurse (long pause) had a comforting discussion 'lifted a burden off my shoulders.'

(Patient, A24. 15th October 1992, interview transcript)

This partnership between doctors and nurses seemed to work well in many cases, not just those involving bad news:

'Dr. (names consultant) spoke to my mother about her condition, she asked why she had passed out and he said her heart hadn't been working properly.'

(Carer, A32. 29th October 1992, interview transcript)

The level of commitment by doctors to this aspect of their role stood in stark contrast to that on the Medical/Surgical Unit and provides another indication of the recognition and importance of 'complexity' as opposed to 'pace'. Nevertheless, despite this there were cases when nurses considered that doctors had not been as effective as they might in informing patients/carers, and in such instances many nurses took this role upon themselves, especially following the ward round:

'Communication happens informally, the nurses with the doctors, OTs and team. Tendency to inform / involve relatives rather than patients. Ward round is consultant led generally, not always, more shared responsibility required – collaborative working. Nurses tackle information – patients don't get enough, nurses, after the doctors have finished, explain things from the round, they outline things about the discharge and their condition.'

(Staff Nurse, A8. 31st September 1992, interview notes)

This role was also recognised and valued by patients:

'In terms of discharge planning the most contact was with the nurses. Most information was from the nurses as well. There was very good explanation about condition and treatment by nurses and doctors, also with my daughter.'

(Patient, A36. 6th November 1992, interview transcript)

Another fascinating aspect of information giving emerged from the interviews with patients and carers. Although generally there were high levels of satisfaction with their discharge from the Unit, one of the most frequent complaints was that they hadn't been given sufficient information. However, it was apparent that in several cases that the information had actually been given to the patient or carer but that they had been selective in what they chose to pass on to others:

'Well I made sure I found out what was going on and told the family what they needed to know so that they could get things ready for me leaving to come home. I had a good chat with Dr. xxxxx, he was very helpful.'

(Patient, A25. 15th October 1992, interview transcript)

'It was better for me to see Dr. xxxxx and the nurse kept me informed since I couldn't make it to the ward round, so xxxxx (nurse) had a chat with me and the I said some of the basics to my father, just the minimum, there's no need to worry him about all that.'

(Carer, A34. 3rd November 1992, interview transcript)

It was therefore clear that despite the best efforts of nurses to convey and interpret information these could be undone by factors outside their control.

The other major aspect of communication and information giving that emerged from both evaluations was that between the MDT and the PHCT. As described earlier, this was a major bone of contention on the Medical/Surgical Unit, but was generally seen as being 'far better' on the Care of the Elderly Unit. However, on occasions similar problems did surface about misunderstanding others' roles and not appreciating the realities of life either 'in the hospital' or 'out in the community':

'Hospital context not understood and no appreciation of workload – by community staff, documentation not good, no form of communication and there's no real face to face contact or conversation between community and the ward, with the letters from GPs being poor in quality and occasional phone calls from District Nurses.'

(Staff Nurse, A6. 30th September 1992, interview notes)

'Discharge planners do not know about home activities, for instance do not realise what patients can do in hospital is not the same at home therefore the decisions based on hospital assessment on the wards have little relevance following discharge home back into the community.'

(GP, A62. 27th February 1993, interview notes)

However, there was recognition that a failure to communicate was not always the ward's fault and that patients could present an 'image' in order to be discharged early.

But in such cases the DNs thought that their involvement would have helped:

'Patients say that they are better to get out therefore lie to get out – say that carers are there but carers not really a legitimate role, such as neighbours, that's why District Nurses should be involved.'

(Community Nurse. A39. 5th February 1993, interview notes)

On the whole, however, there were far fewer problems between the MDT on the ward and the PHCT with regard to the Care of the Elderly Unit. In particular it was felt that fewer unrealistic promises about services in the community were made and the PHCT generally considered that there was an appreciation of the 'complexity' of the issues involved.

Sometimes, however, things fell down and these were usually in circumstances when despite best intentions, 'pace' dominated over 'complexity'. This occurred when there was a 'bed crisis' and it was acknowledged by both the MDT and the PHCT that it was on such occasions that things started to go awry. It was here that 'pushing' exerted an influence:

'When there is a bed crisis and a push for beds from the medical area, discharges are rushed and there are forced discharges.'

(Staff Nurse, A7. 31st September 1992, interview notes.)

'Quality goes down with bed crises, nurses have bulk of stress due to being the liaising person in the ward, a focus on nurses in the scheme of things.'

(Staff Nurse, A11. 2nd October 1992, interview notes)

'Ejected on Friday afternoon home due to the push for beds with no communication, planning or involvement with the community team even if the patient's got difficult problems and needs support from social care or District Nurses over the weekend or bank holiday.'

(Staff Nurse, A8. 31st September 1992, interview notes)

Fortunately, in contrast to the Medical/Surgical Unit, such events were the exception rather than the rule on the Care of the Elderly Unit, illustrating the benefits of attention to complexity rather than pace.

4.11: Summary

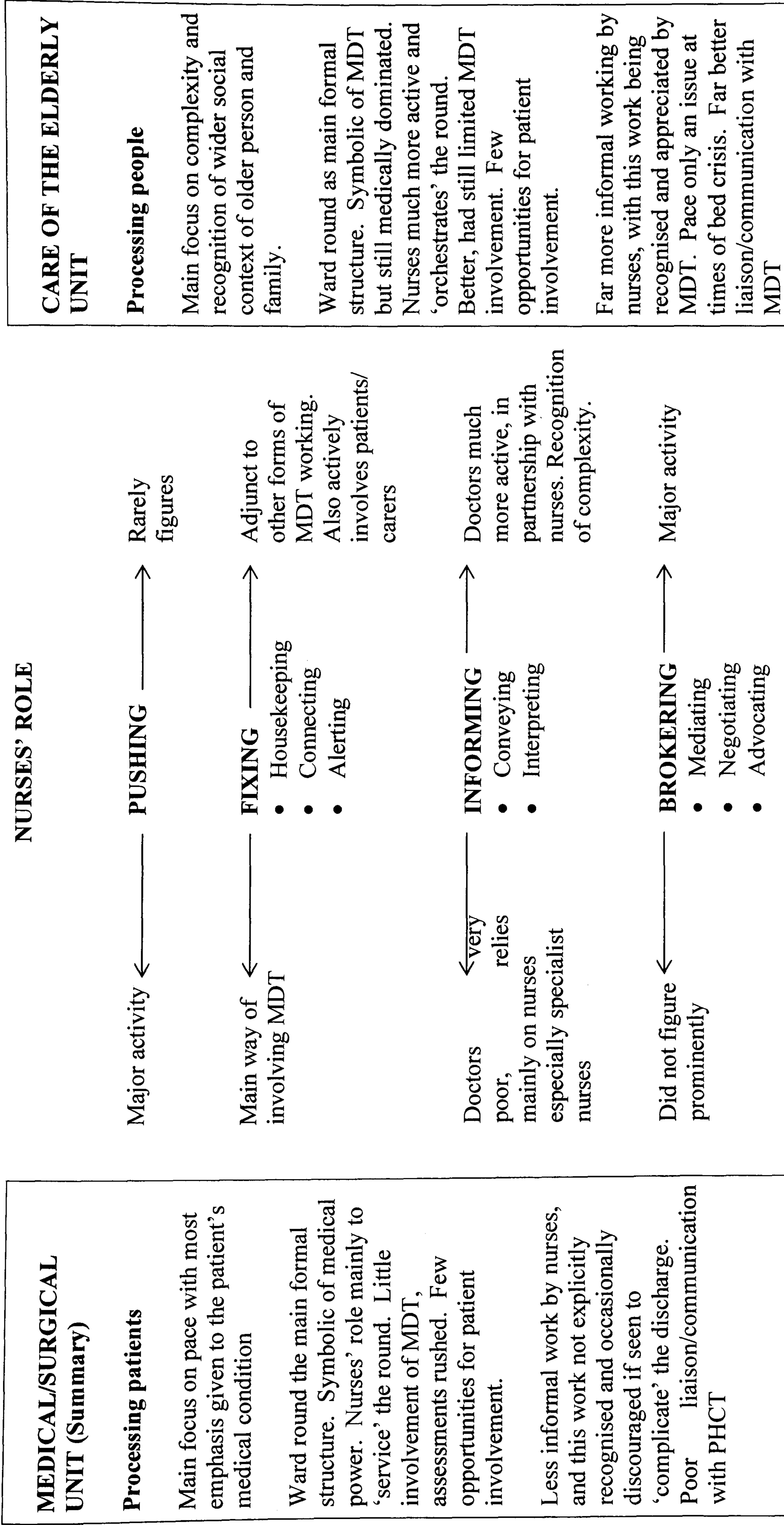
As its title suggested, the purpose of this chapter was to move beyond evaluation and towards explanation. The account provided in the previous chapter had been compiled as a case report, the intention of which was to facilitate a negotiated set of constructions as a basis for local action and change. The form of the account reflected this. It had served this purpose well, although as noted, it was not possible to reach a consensus.

Due to the enforced gap between the initial evaluation and my return to this thesis, and informed by the writings of Rodwell (1998) and Charmaz (2000), the intention in this chapter was to develop a grounded theory, still firmly located within a constructivist paradigm, that might illuminate the differing experiences of discharge on the Medical/Surgical and Care of the Elderly Units.

It was Armitage (1981) who highlighted the complexity of discharge and argued that it should be conceived of as a 'process' that has temporal dimensions. Based on a second analysis of the data two core categories emerged which were termed 'pace' and 'complexity'. Pace is to do with the speed of the discharge, getting as many people through the system as quickly as possible. Where pace predominated it was suggested that the discharge is best seen as 'processing patients' where the overriding emphasis is given to the medical condition and other issues of context which might 'complicate' events are given relatively short shrift. 'Complexity' is concerned with explicitly recognising that attention to the medical condition alone is not adequate, especially in relation to older people, and that good care requires attention to not only a complex set of medical factors, but also the social context within which the 'care' is inextricably embedded. When complexity is acknowledged and addressed then discharge is better seen as 'processing people'.

Both formal and informal working were identified on the Medical/Surgical and Care of the Elderly Units, with shared formal structures in the form of the ward round, albeit with a differing emphasis. The formal structure of the ward round was high on 'symbolism' but much of the 'real work' of discharge was undertaken informally with the nurse at the centre. However, while there were certain shared forms of informal working, especially fixing, there was markedly differing emphasis on the units which largely reflected the relative importance given to pace and complexity. These are illustrated in Figure Seven (see next page) which comprises a summary of the main components of the grounded theory.

Having in this chapter delineated the theory the thesis concludes with a consideration of its adequacy in light of the limitation of the study and an outline of the implications of the theory in the context of existing literature and current policy and practice.



CHAPTER FIVE

FIT FOR PURPOSE?

5.1: Introduction

Much is made of the idea of ‘fitness for purpose’ in the health care world and the intention of this chapter is to consider the extent to which the results of the studies on which this thesis is based can be seen to be ‘fit for purpose’. In addressing this issue the chapter comprises several sections which consider the differing ways in which ‘fitness’ might be judged.

Firstly attention is given to the results of the two studies and the ‘products’ that emerged. For if these are not ‘fit’ then whatever follows is compromised. The ‘fitness’ of the results is based on the premise that there are two main products in this thesis, the case reports of the Fourth Generation evaluation and the grounded theory. Although some of the canons by which these products can be judged to be ‘fit’ or otherwise are shared, others differ. Therefore the evaluations described in Chapter 3 and the grounded theory presented in Chapter 4 will be considered separately. In addressing the idea of ‘fitness for purpose’ it is obviously essential that ‘purpose’ itself is defined and that fitness is considered in relation to appropriate criteria. I also believe that it is important to consider fitness across a number of fronts and the ones that I will address in relation to the two studies are:

Process – where the studies conducted in a manner that can be seen as being ‘fit for purpose’.

Presentation – where the results presented in a way that was ‘fit for purpose’.

Product – where the results themselves ‘fit for purpose’.

In addressing the above three areas both the strengths and limitations of the study will be considered.

The subsequent section will consider the grounded theory in the context of the existing literature in the field underpinned by the four processes suggested by Morse (1994). Morse (1994) contends that despite the diversity of qualitative research approaches that now exist, these share four common processes. She terms these comprehension, synthesis, theorising and recontextualisation, arguing that these processes are sequential. Thus comprehension precedes synthesis, synthesis is followed by theorising, and finally, efforts should be made to ‘recontextualise’ the theory. For Morse (1994) comprehension is said to be complete when there are enough data ‘to be able to write a complete, detailed, coherent and rich description’ (p27). I would argue that comprehension was demonstrated in Chapter 3 as illustrated by the case reports that were fed back to the various participants. Synthesis, for Morse (1994) is the merging of stories to describe ‘a typical, composite pattern of behaviour or response’ (p30) in order to identify ‘critical factors’ that help to explain variation in the data. These factors are then related by the process of theorising, which Morse (1994) contends is essential to provide both structure and application in qualitative research. Theory, however, does not provide a ‘true’ answer but rather is a ‘best fit explanation’ that accounts for the

data most simply. I would argue that synthesis and theorising occurred in Chapter Four, with the identification of a range of ‘critical factors’ which were then related to help illuminate differences in the discharge processes on the Medical/Surgical and Care of the Elderly Units. The extent to which this ‘theorising’ can be considered adequate will be addressed later.

Although all of the above processes are essential Morse (1994) contends that the ‘real power’ of qualitative research lies in ‘recontextualising’ the results by holding them up to existing theory and the work of other researchers in order to place the results ‘in the context of established knowledge’. This enhances their application and provides an indication of whether they can be related to other contexts and settings. The extent to which the results of this thesis, and the grounded theory can be recontextualised is considered later in this chapter.

Following this the thesis will conclude with a consideration of the implications of the studies in the context of current policy and practice.

5.2: Fit for purpose: A consideration of the Fourth Generation evaluation

The original intention of the studies upon which this thesis is based was to evaluate the way in which discharge was experienced on a Care of the Elderly Unit in a DGH from the perspective of all the major stakeholders involved. A Care of the Elderly Unit was selected largely for pragmatic reasons and in the context of opportunities that presented themselves at that time. However, evaluating the discharge process on such a unit is theoretically interesting, as the literature would suggest that, notwithstanding a number of generic problems in relation to discharge planning, the process on a Care of the

Elderly Unit is likely to be better coordinated than elsewhere due to the attention given to multidisciplinary working and the focus on the multiple needs of older people. Subsequent to this initial evaluation the opportunity arose to conduct a similar study on the Medical/Surgical Unit in the same DGH at a time when a new discharge policy was being introduced. This provided an opportunity to compare the ways in which discharge planning operated in the varying units.

The rationale for using a Fourth Generation evaluation was presented in Chapter Two, and in judging the 'fitness' of the work it is therefore important to apply the criteria appropriate for a Fourth Generation evaluation in respect of the process of constructing the research, the presentation of the results, and the product itself. That is the purpose of this section.

In terms of the process of undertaking a Fourth Generation evaluation the essential criteria are that it must be: participative; acknowledge and account for the existence of multiple realities; be conducted in a natural setting; and use the 'human instrument' as the primary method of data collection. In keeping with this participative approach, the criteria against which the service to be evaluated is to be judged should not be decided a-priori, but rather emerge following negotiation with the participants themselves. However, literature 'analects' may be used to identify potentially important issues which are fed into these negotiations. Once the initial negotiation has taken place then the views of multiple stakeholders should be sought, and a hermeneutic cycle developed, with data being analysed by a process of constant comparative analysis until consensus begins to emerge. The hermeneutic cycle can be augmented by inputs from other cycles, by other forms of data collection (e.g. documentary analyses and observation) and the 'etic' or outsider views of the evaluator.

I would contend that most of the above criteria were met in the evaluations in this thesis, but that limitations can also be identified. In the context of the initial study in this thesis an 'etic' view was not possible as I was already working on the unit under consideration. Such a possibility is not really addressed in the Fourth Generation literature as it is assumed that the evaluator is external to the service. The fact that I was already familiar with the unit might therefore be seen as a limitation of the study. Indeed, in the context of qualitative research generally, Morse (1994) contends that optimal comprehension is hindered if the researcher is not a 'stranger' to the setting, believing that familiarity 'dulls the researchers' ability to view the setting with sensitivity. On the other hand, Carter (1981) argues that familiarity with the culture of a setting provides easier access to 'backstage' information that might be hidden from someone not familiar with the ways in which people go about their business. In the context of the study on the Care of the Elderly Unit I believe the latter to be more relevant and would argue that my knowledge of individuals and their personalities allowed me to establish rapport and to put people at their ease more readily than would have been the case had I been a stranger.

The same consideration did not apply to quite such an extent on the Medical/Surgical Unit, as although I was known in the setting I was not as familiar as I was on the Care of the Elderly Unit. It therefore took a little longer to convince participants that the evaluation was more than a 'management' exercise. Indeed for certain groups, notably the doctors, this perception endured throughout the study, and was exacerbated by the fact that the aims of the study and the criteria for the evaluation were not negotiated to the extent that they had been on the Care of the Elderly Unit as they were explicitly linked to the new discharge policy.

However, in neither Unit did I feel that there was overt antagonism to the study, apart from the reactions of a few medical colleagues who tolerated rather than facilitated the process. This was most obviously the case in the Medical/Surgical Unit, particularly, as noted earlier, when the time came to agree the results and to discuss potential changes to practice. This apart, I would argue that the participative elements of a Fourth Generation evaluation were followed as closely as possible in these studies.

The authenticity criteria were introduced in Chapter 2 and it is with respect to the process of conducting a Fourth Generation evaluation that these apply. I will begin here with the fairness criterion. Indeed consideration was given to these criteria in Chapter Three, and in synthesising the results of the two studies I believe that at the time I genuinely considered that the fairness criterion had been met and that I had made every effort to involve all the major stakeholders in the two settings. This was less obvious with respect to the negotiation stage as patients and carers did not contribute to this phase. However, this would have been difficult to organise and there were insufficient funds to allow for the extensive additional travel that would have been involved in rural North Wales. However, with hindsight it may have been possible to post a summary to patients and carers and solicit their views in this way.

On the other hand, as the main purpose of the negotiation phase is to agree an agenda for change and patients/carers would not in any event have been involved personally in the change process, I do not consider that their omission from the negotiations compromised the fairness criterion.

A more serious threat was posed by my failure to involve nursing auxiliaries and ward clerks in the studies. At the time this did not seem particularly appropriate, but again in retrospect their inclusion would have added an extra dimension and would have been

more in keeping with the emancipatory character of Fourth Generation evaluation. Their absence should be seen as a limitation of the studies.

Ontological authenticity, it will be recalled, addresses the degree to which participation in a Fourth Generation evaluation results in an enhanced emic construction. That is, following the study, do individuals or groups better understand their own situation? The most obvious example of this occurred amongst the staff nurse/enrolled nurse group on the Care of the Elderly Unit who began more fully to appreciate the key role that they played in the discharge process. For many this was an enlightening and potentially empowering experience, consistent with the aims of a constructivist inquiry. There was less evidence of ontological authenticity among other groups, and indeed there was marked resistance to some of the challenges that the study raised, particularly among medics. So, for example, one of the consultants on the Care of the Elderly Unit did see that the difficulties with the MDT, which had been identified by several other participants, were in part a result of his own working style. This might have been perceived as a personal threat by the individual involved. There was a more widespread failure to accept the issues that the study raised on the Medical/Surgical Unit, with the medical establishment as a whole not playing any meaningful part in the negotiation process.

It would be conjecture to hazard a guess as to why the medics failed to participate, but it seemed to me that their 'excuse' was that the study had not been rigorous enough methodologically, and that consequently the results were not valid. However, another potential explanation was that the results were seen as a threat to their traditional power base, as they highlighted shortcomings in the way that the formal structures worked.

These results may have been unpalatable to those concerned. It might therefore have been easier to reject the results rather than to accept personal or professional limitations.

Educative authenticity is based on the belief that participation in a Fourth Generation evaluation presents an opportunity to gain new insights into the perceptions of others.

So, for example, in the present study the MDT on the Care of the Elderly Unit had the opportunity to explore the ways in which they worked more openly than had previously been the case. This could, to a limited extent, be said to have provided new insights.

However, probably the most telling form of educative authenticity was the increased awareness amongst the MDT on the Care of the Elderly Unit of the limited opportunities for the participation of patients/carers in the discharge process and the deficits in the information that they received. There was also, to some extent, a greater appreciation of the views of the PHCT amongst the ward MDT, and vice versa.

While ontological and educative authenticity are important consequences of the process of a Fourth Generation evaluation, they are not of themselves seen as sufficient.

According to Guba and Lincoln (1989), the purpose of an evaluation is to stimulate some form of action so that 'no Fourth Generation evaluation is complete without action being prompted on the part of participants' (p249). Catalytic authenticity (is action stimulated) and tactical authenticity (is action empowered) are therefore prime considerations.

However, difficulties in respect of these criteria emerged in the present studies because in order to stimulate and empower action there has to be both consensus and acceptance, in principle at least, of a) the need for change, and b) that the results provide some useful indicators of the type of change required. This provided very difficult in the present study due to the failure fully to accept the results by one of the

most powerful, if not the most powerful of groups, the senior medical staff. Consequently, the result on the Care of the Elderly Unit was a partial resolution, for while most members of the MDT wanted to discuss and introduce changes to the way that the team functioned, this could not be agreed upon. Instead efforts were focussed on the transmission of information to patients/carers and efforts were made to introduce a more structured approach in the form of an information booklet, '*Homeward Bound*'. However, despite the investment of considerable effort this was not as successful as it might have been, probably due to the failure to address the more fundamental issue of MDT working (see Lundh and Williams, 1997).

Even less progress was made on the Medical/Surgical Unit due to the failure of senior medical staff to engage in any meaningful way with the negotiation process. Despite invitations to all the events no medics attended, and my own efforts to feedback the results to the surgical audit group were effectively rendered useless by the response of one of the most senior surgeons (see Chapter Three).

The potential for change to the ways in which information was transferred to the PHCT was stimulated by the evaluation on the Care of the Elderly Unit, with an agreement in principle to look at the role of the sector office. However, in the event the introduction of the new discharge policy rendered this redundant before it had started.

On the basis of the above it could be argued that the evaluation studies had only limited success in relation to the authenticity criteria, and this seems a reasonable conclusion to draw. However, questions need to be asked about the degree to which the authenticity criteria are realistically achievable. While few would argue with the principles of education and empowerment upon which they are based, the criteria themselves may be rather naïve in some contexts and/or potentially threatening to some individuals. For

some people the sort of ontological authenticity proposed might not be welcome and could pose a real threat to their self-image. Moreover, the translation of new insights into actual change requires consensus if change is not to be imposed and, as the present study illustrated, even if consensus is apparent amongst the majority, change will not occur if the most powerful group does not 'sign up' to it. Guba and Lincoln (1989) recognise that Fourth Generation evaluation does potentially threaten power bases but offer little in the way of practical advice as to how resistance might be overcome.

If care is not exercised therefore a Fourth Generation evaluation could destabilise existing structures and/or raise expectations and cause frustrations. For some, therefore, the easiest way to resolve or avoid addressing difficult issues is to reject the results. This, in part, is what happened in the present studies.

As will be apparent, the authenticity criteria present a number of challenges, but Guba and Lincoln (1989) themselves recognise that these criteria are still in their infancy, and in later writings suggest the need for their further development (Lincoln and Guba, 2000). This point is also made by Rodwell (1998). Interestingly, very little debate about the authentic criteria is apparent in the wider literature, certainly not the nursing literature, where it is the trustworthiness criteria that receive far more attention. Indeed these are often promoted as canons for qualitative research in general. However, Guba and Lincoln (1989) question the extent to which these parallel criteria are entirely consistent with the beliefs that underpin a constructivist inquiry and I would argue that greater attention to the authenticity criteria would add to debate within the methodological literature.

5.3: Fitness for purpose: Presentation of a Fourth Generation evaluation

The presentation of a Fourth Generation evaluation takes the form of a case report and this plays a key role in the negotiation process. Following negotiation, the final case report should be a joint construction based on a consensus among the various interest groups involved. The way that the case report is presented is therefore of great importance. Guba and Lincoln (1989) suggest four criteria upon which judgements about the quality of case report presentations can be made. These are:

Axiomatic criteria – that is, does the product (the case report) reflect the values upon which a Fourth Generation evaluation is based – namely, is the case report the result of a negotiation, and does it reflect multiple realities.

Rhetorical criteria – is the report concise, simple and clear, and is it accessible conceptually to all the stakeholder groups it is intended to address.

Action criteria – does the case report identify areas for action.

Application or transferability criteria – does the report provide information that an interested reader might find useful in applying the results to their own setting or context.

In large measure the above judgements have to be made by the readers of the report. Certainly the case reports, as presented to the participants in the two study areas in the present study, can, I believe, be seen to have met the above criteria. However, as the studies are also part of a PhD thesis, the judgements of another set of audiences also have to be considered. It is for this reason that Chapter Three is presented in a form as

close as possible to the case reports as they were viewed by the participants in the evaluations. Some minor changes have been made and more detail has been included (as readers of this thesis do not have the benefit of the negotiations that occurred during the evaluations) but the overall style and content are very similar. The readers of this thesis should therefore bear the above four criteria in mind when reading Chapter Three and draw their own conclusions as to whether the case reports can be seen to have met them.

5.4: Fitness for purpose: The product

Over and above the way that the results of a Fourth Generation evaluation are presented, Guba and Lincoln (1989) provide two sets of criteria upon which judgements as to the quality (or, as they term it, adequacy) of the results themselves can be made. There are the trustworthiness criteria (see Chapter Two) and those used by Glaser and Strauss (1967) in respect of grounded theory, namely fit, work, relevance and modifiability. The trustworthiness criteria were considered in Chapter Two and will not be addressed again here. Rather attention is briefly turned to the criteria of fit, work, relevance and modifiability.

Charmaz (2000) applies the same quality criteria to a constructivist grounded theory, as will be discussed in greater detail shortly, and this again highlights the similarities between Fourth Generation evaluation and several elements of grounded theory. Moreover, the interpretation of these criteria is broadly similar. Briefly, Guba and Lincoln (1989) take the above criteria to mean:

Fit – are the results supported by the data?

Work – do the results provide a level of understanding that is accepted by, and credible to, the participants?

Relevance – do the results deal with important issues in the context of the service or innovation that is being evaluated?

Modifiability – are the results open to change in order to accommodate new information?

To a large extent the degree to which the above criteria will be met depends upon whether the study has been conducted according to the canons of a Fourth Generation evaluation and whether or not a consensus has been reached. So, for example, the results will only really work (and be seen as acceptable and credible) if there has been a full resolution. Similarly, relevance can only really be judged by the participants, as their agreement is needed as to what are seen as ‘important’ issues. Therefore, the caveats previously discussed in respect of this thesis also apply here, and bearing these in mind I would argue that the results can be seen to have met the above criteria as well as they could in the circumstances in which the study was undertaken.

Having considered the fitness for purpose of the Fourth Generation evaluation, attention is now turned to the second element of the thesis, that is the generation of the grounded theory.

5.5: Fitness for purpose: A consideration of the grounded theory

Before discussing the degree to which the grounded theory which emerged from the study can be seen as being ‘fit for purpose’, it is necessary once again to highlight an important caveat: that is that the theory in this thesis was developed several years after the original data were collected. It was therefore informed by later methodological writings, especially those of Rodwell (1998) and Charmaz (2000). However, these authors draw explicitly upon a constructivist paradigm and their arguments are entirely consistent with the ways in which the data for the present study were collected. Therefore whilst the data were not originally collected with the purpose of developing a grounded theory per se, the manner in which they were collected, with attention to constant comparative method, is congruent with a grounded theory. Indeed the rigour with which the various hermeneutic cycles were developed provides confidence that the important tenets of a constructivist grounded theory were met (Charmaz, 2000). The purpose of this section is to demonstrate this. As the process of data collection and analysis have already been addressed, most attention here is given to the presentation of the theory and whether it meets the criteria for a ‘good’ constructivist grounded theory, as described by Charmaz (2000).

Both Rodwell (1998), in respect of reporting constructivist research more generally, and Charmaz (2000), who deals specifically with a constructivist grounded theory, make similar suggestions about the ways in which such results should be presented. Rodwell (1998) believes that results should be transparent, easy to understand, and ‘intellectually accessible’, so that readers feel that they can clearly ‘follow the story’. Similarly, for Charmaz (2000), a constructivist grounded theory should not use ‘awkward scientific terms’ or rely on ‘overly complex conceptual constructions’. However, it does need to

be presented with depth and clarity, while at the same time highlighting the 'basic processes' that are at work. Therefore, for Charmaz (2000) 'simple language and straightforward ideas make theory readable' (p527).

Once again it is largely for the reader to judge whether or not Chapter Four is presented in a way which fulfils the above criteria. However, it should be noted that whenever possible the main categories were named using terms taken directly from the data. So, for example, 'fixing', 'brokering' and 'housekeeping' were all phrases used by the respondents themselves. In other instances terms were based on colloquial meanings which captured the essence of the themes. On this basis I believe that if any of the original participants were to read the theory that they would be able to follow its logic and understand its message. Unfortunately, due to the time differential, it was not possible to return to the original participants and ask them to comment on the way in which the theory was written. This must be recognised as a limitation of this thesis.

Over and above the manner of its presentation the criteria for a good constructivist grounded theory as defined by Charmaz (2000) are the same as those identified for grounded theory in general and also applied to a Fourth Generation evaluation, that is: fit; work; relevance and modifiability. However, there are some important differences in emphasis and these relate mainly to the way that the theory is generated and structured. For Charmaz (2000) traditional grounded theory is too dominated by the voice of the researcher, who she sees as making the key decisions about what is to be included or not. In contrast, a constructivist grounded theory is intended to be empowering and to engage the respondents in a more active way. It could legitimately be argued that the theory presented here would fail on this criterion as it was developed retrospectively without any involvement of the respondents. However, the data were

collected in a manner entirely consistent with a constructivist approach to grounded theory, which Charmaz (2000) describes as follows:

'A constructivist approach necessitates a relationship with respondents in which they can cast their stories in their terms. It means listening to their stories with openness to feeling and experience.'

(Charmaz, 2000, p525)

In order to 'capture' such experience, it is, as noted above, essential to avoid the use of 'awkward scientific terms'. For Charmaz (2000) what she terms 'objectivist' (i.e. traditional grounded theory) places too much emphasis on the scientific at the expense of the experiential. Once again it is to be hoped that the theory as presented here captures experience meaningfully.

Notwithstanding the fact that the original respondents cannot comment on the results, the idea of 'vicarious experience' (Guba and Lincoln, 1989; Rodwell, 1998) holds a key position in any constructivist inquiry. In other words, when reading the text or theory the reader (whether they were involved in the study or not) should feel 'as if' he or she had been there. Charmaz (2000) contends that the way in which the theory is presented can either 'bring experience to life', or 'wholly obscure it', and for her a well written theory 'pulls readers in'. Once again the extent to which theory, as presented here, achieves this is for the reader to judge. This emphasis on an experiential rather than a scientific view of the world for Charmaz (2000) marks a constructivist grounded theory out as different from the approach as advocated by Glaser and Strauss (1967).

Another difference is that, for Charmaz (2000), it is neither desirable nor possible to identify a single 'core category' or to limit the number of 'basic social processes' that

emerge. The identification of a 'core category' is central to a good 'objectivist' grounded theory, but Charmaz (2000) believes it represents attempts by science to reduce the social world. Therefore, while Charmaz (2000) contends that any theory should be as 'simple and concise' as possible, it is likely to contain a number of important categories and processes. This was the case with respect to the present theory.

Therefore with the important caveat regarding the time lapse between data generation and the second analysis, I would contend that the grounded theory as presented in this thesis meets the above criteria. Having considered the quality or otherwise of the results of the studies upon which the thesis is based, attention is now turned to the extent to which they can be recontextualised.

5.6: Recontextualisation: The 'real' power of qualitative research?

Generalisation, particularly in a statistical sense, is inconsistent with qualitative research. However, Morse (1994) argues that recontextualising results and theory are essential if qualitative research is to be optimally effective in helping us to understand the social world. Similar arguments have been made with respect to constructivist inquiry and Fourth Generation evaluation (Guba and Lincoln, 1989; Rodwell, 1998) using the concept of 'transferability'. Morse (1994) contends that recontextualisation is achieved by holding results/theory up to existing knowledge and making systematic comparisons. That is the purpose of this section of the thesis which compares the current results/theory with existing knowledge at several levels, each with an increasing level of 'abstraction'. Initially, therefore, the empirical 'results' themselves are

compared with other studies of discharge planning, particularly that reported by Tierney (1993). Comparisons with these results are seen as particularly appropriate as Tierney's study was conducted and reported almost contemporaneously with the studies in this thesis and they therefore reflect a similar context, making comparison more valid and meaningful.

Subsequently the grounded theory, which attempts to provide an account of the processes underpinning discharge in the two areas, is compared with similar attempts to explain the phenomenon of discharge, notably those of Jackson (1994) and Bull and Roberts (2001). It will be argued that the theory presented here goes beyond these accounts and provides a more elegant and complete understanding of discharge, particularly the key role played by the nurse.

Following this it will be suggested that a consideration of discharge planning can help to illuminate some of the difficulties seemingly inherent in team working more generally and therefore that the theory, as developed here, provides insights into the literature on team working. This section will draw in particular on the work of Qualls and Czirr (1988) cited in Chapter Two, and the more recent 'integrative review' of McIntosh and McCormack (2001). This 'inferential leap' from discharge planning as a specific example of team working (or not as the case might be) to a consideration of discharge as an example of more generic team working issues is consistent with the shift from a 'substantive' to a 'formal' grounded theory. This was noted by Glaser and Strauss (1967) in the following way:

'By substantive theory, we mean that developed for a substantive or empirical, area of sociological inquiry, such as patient care, race relations (or discharge planning – my addition)... By formal theory, we mean that developed for a formal, or conceptual area of sociological inquiry such as stigma, deviant behaviour (or team working – my addition)...' (p32).

Finally in this section I will argue that the results of this thesis can also be used to explore the nursing role more widely and in order to do this I will draw upon the work of Liaschenko and Fisher (1999) and their formulation of the types of knowledge that nurses use in their work. I will suggest that the pushing, fixing, informing and brokering roles described here make an addition to understanding the role of the nurse in a wider context than either discharge planning or team working.

5.7: Comparing the empirical results

As was highlighted in the introduction and Chapter 1, the studies upon which this thesis is based were completed at a particular 'historical' moment which coincided with a renewed emphasis on discharge planning and a focus on the needs of frail older people in the context of the impending introduction of community care legislation. In considering whether the empirical results were simply an artefact of the local situation, or if they reflected more widespread issues, it is important that comparisons are drawn with the results of other studies which were as contemporaneous as possible with those in the thesis. It is for this reason that comparisons are made with the extensive study of discharge undertaken in Scotland by Tierney (1993). Although this study was far more comprehensive than my own it is nevertheless useful as a comparator as the survey was completed at approximately the same time as the studies in this thesis.

Tierney (1993) argued that at the time of their study that we lacked a comprehensive understanding of the discharge planning process and that, with the ever-shorter lengths of stay in acute hospital settings, a complete account was needed in order to help staff deal with the 'formidable challenges' that good discharge presented.

In order to facilitate comparison between the present results and those of Tierney (1993), attention is turned to three broad areas considering, as did the evaluation upon which this thesis is based, the role of the MDT, the involvement of patients and carers, and the communication between the MDT and the PHCT. It is instructive to note that in all these areas the similarities between my results and those of Tierney (1993) are striking.

Therefore Tierney (1993) note that whilst over 90% of their respondents (on 319 wards) agreed the discharge planning was a multidisciplinary process and that good communication is a key element, the actual involvement of the MDT, other than on geriatric assessment units, was limited. This was particularly the case on surgical units, which were also far less likely to have a written discharge policy. In the Scottish study 75% of surgical units did not have a written policy, with this figure being 53% on general medical wards and 35% on 'geriatric' wards. This relative lack of emphasis given to discharge planning on the more acute wards is broadly reflective of that described in this thesis and confirms that greater attention is given to the importance of discharge on care of the elderly units. Furthermore, even in situations where there was a written discharge policy, the least commonly addressed issue was the respective roles and responsibilities of various members of the MDT (Tierney, 1993). This again is similar to the findings reported here where the role of the MDT were often implicit and indeed had it not been for nurses, then involvement of other members of the MDT on

the Medical/Surgical Unit would have been minimal. As a result of their investigation Tierney (1993) concluded that 'the multidisciplinary approach to discharge planning is a generally held principle but, in practice, it is not widely developed' (p15). This conclusion could just as easily have been written for the present study, and this is an issue that will be addressed in more detail shortly.

If attention is now turned to the involvement of patients and carers the congruence between the Scottish study and the Welsh one is once again quite apparent. So, for example, Tierney (1993) note that one of the aims of the discharge policies they considered was that the patient should lie at the heart of the planning process. However, they discovered that this was frequently not the case, with only about 30% of units actively involving patients, and about 50% actively involving the family. As with MDT working, patients and carers were less involved in the Medical and Surgical Units than in the Care of the Elderly settings. Further reinforcing the findings reported here is the fact that although 90% of ward managers stressed the important of providing patients with adequate information about their treatment, medication and follow-up arrangements, large numbers of patients reported that they did not feel well informed about these issues.

Interestingly, Tierney (1993) found that ward managers generally acknowledged the vulnerability of older patients, and agreed that the incidence of chronic illness and their complex social arrangements which marked them out for 'special consideration'. However, the study also concluded that, apart from on the geriatric units, there was only limited awareness of the nature of gerontological nursing and consequently much of the espoused 'specialist care' was not received. Consistent with the conclusions from the current studies, this suggests that 'complexity' is often overlooked, especially in acute

surgical/medical areas, and that attention is given primarily to the medical needs of older patients. Further reinforcing the important role of the nurse Tierney (1993) note that 'in practice much of the responsibility for discharge planning rests with nurses' (p16). The similarity between the conclusions of Tierney (1993) and my own also extend to the quality of communication between the MDT and the PHCT.

Tierney (1993) describe the limited involvement of the PHCT, with GPs and DN's rarely being actively involved in decisions around discharge planning and often receiving inadequate information. Members of the PHCT generally considered that hospital staff did not appreciate their roles and that if information was sent at all it was frequently late and/or lacking in important detail. The initial discharge summary was felt to be too brief to be helpful and the subsequent discharge letter was often too late. Despite widespread dissatisfaction with current arrangements Tierney (1993) suggested that this was not 'fully appreciated' by hospital staff, and that there was an urgent need to address the distance between hospital and community teams, particularly regarding the preparedness of patients for discharge.

As a result of their extensive investigations Tierney (1993) concluded that there was considerable variability in the quality of discharge planning across units, hospitals and health authorities, and that, despite widespread acceptance of the principles of good discharge planning, there was far less evidence of these being applied in reality. Consistent with the present studies, therefore, it is clear that the existence of a discharge policy per se does not guarantee that the discharge experience will be improved. Rather it seems that variability is more related to the ways of working and that, in settings where there are better MDT relationships, discharge itself is likely to be better. This is more often the case on Care of the Elderly Units than in Medicine and Surgery.

The congruence between the Scottish study and those reported here is readily apparent and it seems that the 'results' can therefore be 'recontextualised' from one setting to another. Moreover, it also emerges that this congruence does not just relate to these two studies, nor indeed is it simply a product of the context in which the studies were completed.

To illustrate this point Marks (1994) completed an extensive review of the research on discharge planning and came to the following conclusions:

'...discharge planning and practice in the UK are remarkable in at least two ways. First is the consideration of research findings stretching back at least 20 years, which document the breakdown of routine discharge procedures. Second is continuing evidence of major gaps in the discharge planning process despite government guidance and a host of initiatives at local levels' (p6).

On the basis of the above it would seem reasonable to conclude that problems with discharge planning are longstanding and enduring despite both national and local initiatives extending back over two decades. It is therefore important to seek some theoretical explanation that might, in part at least, help to identify, and potentially overcome, existing barriers to better practice. Two such theoretical explanations are considered here and discussed with respect to the theory advanced in this thesis. In order to assist in this process the two explanations advocated by Jackson (1994) and Bull and Roberts (2001) are discussed first, and then comparisons made with the present theory.

Jackson's (1994) work is based on an extensive consideration of the discharge literature between 1978-1992 and its analysis using a theoretical model proposed by McKeenon

and Coulton (1985). In providing a context for her work Jackson notes that the term 'quicker and sicker' provide an accurate reflection of the impact on health care practices with older people in the early 1990's, with there being explicit tensions between ever more complex needs of older people and the emphasis on faster patient throughput and reduced length of hospital stay. In this context Jackson (1994) argues that the pejorative term 'bed blocker' resurfaced to focus attention on the problem of older patients 'silting up' valuable hospital beds. This, in part, she believes, accounts for the emphasis given to discharge planning which the literature review suggested is underpinned by three sets of beliefs:

1. That discharge planning is cost effective;
2. It enhances continuity of care; and
3. It improves the quality of life of older people and their carers

In order to examine these beliefs she applied the organisational framework proposed by McKeehan and Coulton (1985), which argues that organisations have both formal and informal structures, with the formal structures being explicit and underpinned by documented evidence and well defined roles, whereas informal structures lack clear guidance and well established procedures. Jackson (1994) argues that discharge planning is more effective if there are explicit formal procedures in place. However, both the work of Tierney (1993) and the conclusions of the present study would not support such an argument as in both cases the existence of a formal policy was less important than ways of working. Indeed in the present study on the Care of the Elderly Unit it was the 'informal' system that accounted for the 'real' work of discharge, with

the formal structures being largely symbolic of medical power bases. It could of course be argued that the formal structures in place were dysfunctional and that if they were replaced with better formal structures then the discharge planning experience would improve. To an extent this might be true but what emerged from the Care of the Elderly Unit was that much of the 'real' work was invisible. Indeed at times it was deliberately hidden from medical colleagues. If such tacit work were to be made fully explicit it might be that this would threaten traditional roles and therefore would be rejected. Notwithstanding this, as will be discussed later, the important role of the nurse needs to be more fully acknowledged if it is to receive the recognition it deserves, and if practitioners are going to be equipped with the necessary skills and knowledge.

The second element of the McKeenon and Coulton (1985) model that Jackson (1994) applies is that of the processes of discharge planning which she divides into: the assessment; the plan and its implementation. For Jackson (1994) assessment addresses **what** and **when** issues, and she argues that assessment should be comprehensive and cover at least five areas (physical, cognitive, social/family, environmental, access to care) and that it should begin as early as possible. However, while this might represent the ideal situation the literature clearly attests to the fact that such practice is the exception rather than the rule. The results of the present study indicate that the quality and depth of the assessment is influenced mainly by the relative importance accorded to either pace or complexity. In the context of acute care, especially with the perceived emphasis on early discharge, pace tends to take priority over complexity and unless this problem is readdressed than discharge planning is unlikely to improve significantly.

Jackson (1994) contends that 'planning' turns largely on **who** is seen as being responsible with a continuum being apparent in the literature. At one extreme the consultant physician takes responsibility for all aspects of discharge planning, acting as the gatekeeper to all other services. At the opposite end is true multidisciplinary working in which each team member plays an important role. Jackson (1994) contends that most of the literature sees the nurse as playing a major part. Furthermore, she argues that to be effective the plan must be adequately communicated and that it should be accessible to all members of the team. The present study certainly reinforces the major contribution made by nurses on both the Medical/Surgical Unit and the Care of the Elderly Unit. However, there are important differences in emphasis, broadly reflecting the 'culture' of the units and the relative importance given to 'pace' and 'complexity'. Therefore, while Jackson (1994) argues that the literature identifies an important role for the nurse, she sees this as being confined largely to informing patients and educating them about their medication and so on. The present study provided a far more detailed, complete and sophisticated description of the role of the nurse, which identifies a variety of activities, serving different purposes at differing stages of the discharge process.

The final phase of the discharge processes is the implementation of the plan which Jackson (1994) believes requires good working relationships, and involvement of the patient/family, suitable administrative support, a degree of flexibility, as well as strong liaison with the community. The theory presented in this thesis again illustrates the essential contribution of the nurse in 'making things happen'. Therefore in addition to 'fixing' the plan it is also suggested that the plan itself, especially on the Care of the Elderly Unit, relied heavily on the several 'brokering' activities of the most skilful nurses, who might variously need to mediate, negotiate or advocate, depending on

circumstances and situations. The quality of the discharge often turned on these subtle and diffuse activities. Moreover, the degree to which patients/family were actively involved also hinged largely on whether the emphasis was placed simply on informing them (the norm on Medical/Surgical Units, other than when a specialist nurse was involved), or more actively involving them by helping to convey and interpret information. The nurse therefore seems highly influential in ensuring that the discharge process was as flexible as possible.

Within Jackson's (1994) analysis of the literature the final elements of discharge are the outcomes of the process in terms of the impact on patients and carers. Jackson (1994) contends that most of the literature has focussed on a narrow set of outcomes, confining these largely to length of stay, reduced readmission rates and patient/carer satisfaction. In many ways these reinforce the priority given to 'pace' and the onus placed on the 'costs' to the health care system. There is a need to extend a consideration of outcomes to include a more sensitive and expansive set of indicators. As will be noted later, the current emphasis on the patients' experience of health care is a welcome move in this direction.

As a result of her analysis Jackson (1994) contends that despite the extensive literature in the area of discharge planning that several questions remain unanswered. I would argue that a key consideration is a greater understanding of the role of the nurse and that the present study has made an important contribution to explicating the nature and extent of this role.

Such a contention is reinforced by the more recent work of Bull and Roberts (2001) who propose that despite the considerable emphasis given to discharge planning, few studies have actually clearly identified the processes that are involved in what they term

a 'proper' discharge. These authors see the explication of these processes as essential, and describe this in the following way:

'Recognition of the components of an effective discharge can facilitate organisations in designing care delivery and orientating staff to discharge planning' (p578).

Based on their small-scale study these authors highlight the central role of communication in discharge planning and they identify three areas that they see as needing improvement. These are communication processes within and between the MDT, communication between MDT and patients/carers, and communication between the MDT and PHCT. Based on their data they conclude that professionals see the MDT as being absolutely essential and that in order to function adequately, there needs to be time, trust and a blurring of boundaries, and that someone needs to take responsibility for coordinating the efforts of the team. They take a temporal approach to discharge and identify four stages:

- 1 getting to know the patient and gathering complex information on a range of fronts. Similar to those proposed by Jackson (1994);
- 2 planning a discharge date;
- 3 getting ready for going home; and
- 4 making the transition.

They argue that in order to be effective ‘three cycles’ of communication need to work effectively, and these are as noted above (i.e. within MDT, MDT ↔ patient and carer, MDT ↔ PHCT). The essence of a good discharge is, they propose, ‘open, honest, continuous and timely’ communication. Interestingly, the three cycles of communication that they identify mirror the three main hermeneutic cycles used in the present study. This reinforces the pivotal part of communication and the central role of the nurse in facilitating communication within all three cycles.

Bull and Roberts (2001) conclude that whilst their study has begun to identify the components of what they term a ‘proper’ discharge, that several questions remain unanswered. These include the mechanisms that facilitate communication between the three cycles that they identify, how health care professionals interact with older patients and their families, and how these groups are involved in the discharge planning process.

The role of the nurse in ‘pushing’, ‘fixing’, ‘informing’ and ‘brokering’ as described in this thesis represent an important step towards a fuller and more complete understanding of crucial, but often implicit, elements of a ‘proper’ discharge. However, further work is needed to study in more detail the impact that such processes have on outcomes for patients and carers beyond those described in this thesis.

On the basis of the above I would argue that the results of the studies in this thesis can indeed be recontextualised, and that the theory suggested here also identifies important elements of the discharge process that can help to explain the differences between discharge in various settings and contexts. Consideration is now given as to whether the insights gained can also be applied to team working more generally.

5.8: Towards a more formal theory

As noted earlier, one of the markers of a 'good' grounded theory is that it can potentially be 'modifiable' in light of new data and that it may move from a substantive to a formal theory. Substantive theories, it will be recalled, deal with specific and fairly circumscribed issues, in this instance discharge planning. However, the argument is made that the insights from such specific issues might also be relevant to other more general concerns. Thus whilst both substantive and formal theories are 'mid-range', a formal theory is usually broader in scope than a substantive theory.

I would suggest that several of the insights which have arisen in relation to discharge planning might also be usefully applied to team working more generally, and this possibility was also noted by Marks (1994), who commented that:

'Discharge is a cipher for the organisational integrity of the NHS and indicates the difficulties involved in implementing policies which span both hospital and community sectors.' (p7)

As many of the difficulties inherent in working across hospital and community sectors also surface in relation to multidisciplinary working, it is also reasonable to argue that discharge might be used as a 'cipher' for considering how some of these tensions might be addressed. In this section I consider what the studies in this thesis might have to say about MDT's within the context of acute care, using work of Qualls and Czirr (1988) as a starting point. Subsequently, the scope is broadened to consider the issue of partnerships more generally, this time in the wider context of Primary Health Care, drawing on the recent integrative review of MacIntosh and McCormack (2001).

The work of Qualls and Czirr (1988) was outlined in Chapter Two and provides an elegant model for considering many of the issues around MDT working. This model was based on several years' observation by the authors of the problems around team working in their clinical practice. Essentially, they argue that many of the difficulties they encountered were due to the implicit and unexplored or acknowledged assumptions that team members bring to their day-to-day work. They believe that if these assumptions were to be made more explicit and discussed openly then more energy could be given to patient care. However, they also note that:

'Professionals who do not recognise that a range of models exist, and who judge others within their own model, tended to believe that they are acting professionally, and that others are acting unprofessionally.'

(Qualls and Czirr, 1988, p373)

In order to reconcile and work through such differences there is a need both to acknowledge the existence of various models and to have a framework within which to discuss differences. Qualls and Czirr (1988) suggest that there are two broad areas and seven continua by which team working within 'geriatric' care can be considered. The two broad areas are to do with the interactions between professionals and patients/carers, and the interactions within the team.

As will be recalled from Chapter Two, the four continua within the first broad area are differentiated by the extent to which an acute or chronic disease orientation is dominant, with the following consequences (Figure Eight):

Figure Eight

Models of MDT Working Professional ↔ Patient Interactions

Acute orientation

Chronic orientation

Rule 'out' problems ← Logic of assessment → Rule 'in' problems

Narrow focus

Holistic focus

Medical condition ← Focus of effort → Wider social context

Professional as executive ← Locus of responsibility → Professional as paid adviser

Immediate issues predominate ← Pace of action → Longer term issues to the fore

The work on this thesis provides further empirical validation for the above model as reflected in the 'processing patients' or 'processing people' model suggested. The former relates to the acute focus and the latter to the chronic focus in the model of Qualls and Czirr (1988). Moreover, the emphasis on 'pace' as opposed to 'complexity', or vice versa, is also consistent with the earlier work. I would also agree with the suggestion of Qualls and Czirr (1988) that neither model is necessarily right or wrong, and that each is either more or less appropriate in differing circumstances. However, in the context of discharge of older people from hospital it is the 'complexity' of the situation that should be to the fore, with a greater relative emphasis on 'processing

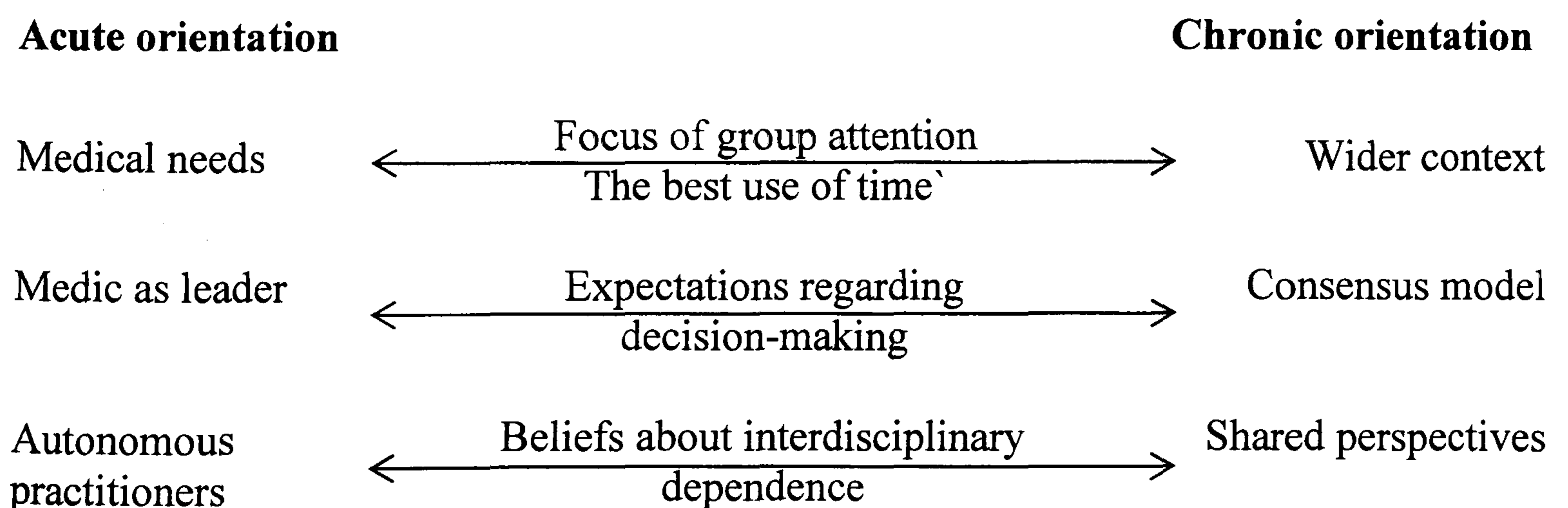
people'. Indeed as Qualls and Czirr (1988) note, the greatest potential for conflict occurs when discharge from an acute setting is considered. Also consistent with Qualls and Czirr (1988) is the conclusion from the present study that when differences are ignored, as was the case on the Medical/Surgical Unit, then discharge is less effective and driven primarily by professional (medical) agendas. However, the present study also suggests that the nurse can play an important role in redressing this balance by seeking more fully to involve the MDT, using the 'fixing' tactics of 'connecting' and 'alerting'.

It requires further study to see if the nursing roles defined here (fixing, informing and brokering) can also be applied to other aspects of team functioning, or indeed if they can be fulfilled by other team members in differing contexts.

The second main area to which Qualls and Czirr (1988) turn their attention is ways of working within the MDT. These are seen to be influenced by the orientation within the professional – patient domain and include three continua, as illustrated below in Figure Nine:

Figure Nine

**Models of MDT Working
Interactions within the Team**



Once again Qualls and Czirr (1988) argue that neither end of the above continua are inherently better or worse but rather more or less useful in certain circumstances. However, in the context of the discharge of older people, 'best practice' would seem to be located more towards the chronicity end. The current study would indicate that this is often not the case and in terms of decision-making and the focus of attention (particularly on Medical/Surgical Units) that the medical influence remains dominant. Even on the Care of the Elderly Unit where there was more explicit attention to the role of the MDT, the formal structures were seen to be dominated by a medical perspective. However, Qualls and Czirr (1988) argue that the best functioning teams are able to move flexibly through the various continua, and the present study would suggest that a major part of the nurses' role is to facilitate flexibility and the greater involvement of the MDT. This is especially evident in their 'connecting' and 'alerting' functions, which on the Medical/Surgical Unit were often the only way of bringing the wider perspective of the MDT to bear. Even on the Care of the Elderly Unit these tactics are important ways of expanding the focus of the teams' efforts.

Therefore, I would argue that the present studies provide further empirical support for the framework suggested by Qualls and Czirr (1988), but that in elaborating upon the work of the nurse, new insights have been provided into the ways in which 'complexity' can be given a greater focus is in effect to move beyond the rather limited attention given to the needs of older people when most attention is concentrated on 'pace'.

Broadening the context yet further, MacIntosh and McCormack (2001) argue that rhetoric has now moved beyond the notion of teamwork to a more holistic focus on partnerships. In undertaking an integrative review of the literature on partnerships in primary care they identify 3 orientations.

- ‘Multi’ partnerships** - in which contributors work independently towards a common goal.
- ‘Inter’ partnerships** - in which differing types of partners work collaboratively towards a common goal.
- ‘Intra’ partnerships** - in which similar groups of partners work together towards a common goal.

Underpinning all of the above is the idea of a ‘common goal’, and as Qualls and Czirr (1988) contend this is what is often lacking or not made explicit. However, MacIntosh and McCormack (2001) argue that in terms of a true partnership ‘multi’ working is not appropriate and that ‘inter’ or ‘intra’ partnerships should now be the benchmark. They also contend that partnerships can involve either a largely passive, or a more active role. These notions mirror those suggested in the present study in respect of older people and their carers, when it was argued that they could either be informed (passive) or involved (active) in their own care and discharge planning.

MacIntosh and McCormack (2001) believe that if patients/carers are to be involved as partners then the emphasis should be on active involvement in which the goal is to facilitate self-reliance and self-determination. This, as will be noted briefly later, is consistent with the recent discussion about the role of the ‘expert patient’ (Department of Health, 2001a). For MacIntosh and McCormack (2001) this means looking at new ways of working which challenge prevalent notions of expertise, and also raise important questions about different forms of knowledge and differing ways of knowing. This will be discussed shortly in relation to the work of Liaschenko and Fisher (1999).

Again in the context of primary care Poulton and West (1999) have undertaken a detailed evaluation of what determines successful team working and concluded that it is the processes rather than the structures that are most influential. Interestingly, Davies (1998) argues that in collaborative teams there is a feeling of 'connectedness' rather than individuals being bounded by disciplinary beliefs. Similarly, Finlay (2000) contends that multidisciplinary teams tend to be hierarchical, and largely concentrate on formal structures which are task-focussed. In contrast collaboration teams are more likely to be interdisciplinary with less formal structures and more open and collegiate relationships.

Although the teams in this study approximate more closely to a multidisciplinary rather than an interdisciplinary team, many of the activities undertaken by the nurses can be seen to have a decidedly interdisciplinary orientation. Therefore, the process of 'connecting' was identified as a key component of 'fixing', as was the similar activity of 'alerting'. Both of these processes actively sought to involve the wider team and to in some way circumvent the medical dominance. Similarly, in respect of the more active involvement of patients/carers elements of informing (especially interpreting) and 'brokering' can be seen to have a similar goal in mind. I would argue therefore that the nurses role within an inter/intra partnership model of working might in part be explained by the processes identified in this study and that this is an area of research which would benefit from greater attention.

The above would suggest that the processes identified in the substantive grounded theory can help not only to illuminate the experience of discharge planning, but also provide insights into the area of teamwork and partnerships. However, the work of

Liaschenko and Fisher (1999) also indicates that the results may have even greater significance and can feed into debates about the role of nursing more generally.

Liaschenko and Fisher (1999) are concerned with the type of knowledge that they believe should underpin nursing practice and their aim is to theorise knowledge that makes sense to practitioners and provides a firm basis for action. They believe, as does Charmaz (2000), about theory more generally, that nurses rarely draw on nursing theory as it is too distant from the reality of their working life. Consequently, Liaschenko and Fisher (1999) contend that neither scientific nor everyday language is fully appropriate as a basis for nursing care but that there is a need for a form of knowledge that is intermediate between the two. For these authors one of the main goals of nursing is to help people to manage illness trajectories, and to achieve this nurses must use more than 'case' knowledge' (that is an understanding of the biomedical basis of a condition or 'case'), and also 'know' how to 'get things done'. Essentially Liaschenko and Fisher (1999) suggest that one of the key nursing functions is to help patients navigate their way around the health care system effectively and to connect patients to resources. They view this 'coordinating' function as being an extremely important, but largely unacknowledged, role that is generally not seen as a vital part of the nursing contribution to the health care system. This role was termed 'orchestrating' within the MDT on the Care of the Elderly Unit and contrasted with the more basic 'servicing role' of the nurse on the Medical/Surgical Unit. 'Orchestrating' seems a more appropriate metaphor than coordinating, for this is a difficult and delicate role and is consistent with Nolan et al's (1997) vision of the nurse as orchestrating rehabilitation.

Building on these arguments Liaschenko and Fisher (1999) suggest that 'knowing the patient' has been a major theme in the nursing literature for many years but that what

this means is less clear. They contend that case knowledge, based on a biomedical view of the world, is the main way of understanding patients' needs but that there is also a need for both person knowledge and patient knowledge. Person knowledge provides the biographical context and background from which an individual comes and are details which mark them out as unique. Nurses need some of this knowledge to 'envision' the everyday world of the care recipient in order to help them to adjust to their new reality and understand the likely impact of the disease process. In bringing together case and person knowledge, in conjunction with the care recipient, nurses jointly create 'patient knowledge' which enables the 'patient' to navigate their way around the health care system more effectively. Patient knowledge is not simply knowledge of the patient, but actually **defines** the patient in the context of the health care system. The type and diversity of 'patient knowledge' required depends on the complexity of the individual's condition and their length of contact with health care. This knowledge is therefore temporally and spatially created and differs, for example, in an acute condition where cure is the aim and contact with the health care system is limited as opposed to a chronic condition when cure is not possible and contact with the system is likely to be more prolonged.

Liaschenko and Fisher (1999) contend that we need to better understand the nurses' role in relation to 'knowing the patient' and the variety of functions that they fulfil in this regard.

On this basis I would argue that the processes identified in this thesis, especially 'fixing', 'informing' and 'brokering', begin to illuminate the differing ways in which nurses help people to negotiate their way around the health care system, and as such,

adds to our understanding of the essential role of the nurse, not only within the discharge process and the MDT, but also in the wider context of the health care system.

5.9: What are the implications? Grasping the policy and practice ‘nettle’

‘The era of the patient as a passive recipient of care is changing and being replaced by a new emphasis on the relationship between the NHS and the people it serves - one in which health professionals and patients are genuine partners seeking together the best solutions to each patient’s problems- one in which patients are empowered with information and contribute ideas to help in their treatment and care.’

(Department of Health 2001a, p9)

It is almost a decade since the studies on which this thesis is based began, and in many ways the health care world has changed in quite fundamental ways in the intervening period. Bernard and Phillips (2000) argue that the 1990’s witnessed the emergence of a new language of health and social care policy underpinned by notions of empowerment and participation. The quotation above, taken from a recent Department of Health report (Department of Health, 2001a) on the ‘expert patient’, is one manifestation of this trend which, according to the Government, points the way towards a vision of a health service based on partnership between providers and users, particularly those users with chronic illness and disability. It might therefore be legitimate to ask what contribution this thesis makes to such new agendas and to query if the insights which emerged have relevance and currency. That briefly is the purpose of this final section.

So far in this concluding chapter I have considered whether the thesis and the results upon which it is based can be seen to be ‘fit for purpose’. I defined fitness in three main ways, in terms of the processes or how the studies were conducted, how the results were presented and the product, that is the results themselves. As already argued, and

acknowledging the limitations that were identified, I believe that overall the thesis can be viewed as meeting the appropriate 'fitness' criteria as they relate both to Fourth Generation evaluation and constructivist grounded theory.

Subsequently attention was turned to whether or not the results of the thesis could be recontextualised. Based on a consideration of the wider empirical and theoretical literature on discharge planning, the literature in the more formal area of MDT working and some of the literature relating to the wider role of the nurse it was argued that the results do indeed provide new insights which help better to illuminate a number of key processes, especially as they relate to the role of the nurse in 'orchestrating' several elements of the health care system.

The question now is whether the results have relevance for the emerging policy and practice agendas and if they say anything about future research or the preparation of practitioners? Or rather is the knowledge in this thesis now 'past its sell by date' and redundant in the light of new trends and developments. I would argue that this is far from the case, as the substantive topic of discharge planning is still of great interest and the more formal area of partnership is of even greater import. I will now consider the role of the 'product' of the thesis in 'grasping the nettle' of improving current practice in a new era of policy initiatives. In order to consider the implications of the thesis in informing emerging policy and practice debates, I will briefly describe the current policy landscape.

5.9.1 The recent policy context: What are the challenges ahead?

“In looking at assessment and discharge planning, one of the factors that stands out is the number of different people who have to work together within the hospital to ensure a quality outcome for the user”.

(Department of Health, 1993, p23)

The recognition that ‘different people’ have to ‘work together’ to ensure a ‘quality outcome for the user’, described in the *Community Care Monitoring and Development Special Study* (Department of Health, 1993), is as pertinent today as it was then. Though it is almost a decade since the studies on which this thesis is based began, and the health care world has indeed changed, there is also a great deal of continuity in the focus of reforms, with the notions of empowerment and participation being seen as paramount (Department of Health, 2001a). Whilst the rhetoric of partnership is not in any sense ‘new’, the emphasis has changed from a focus on inter-professional and inter-agency partnership, to a vision which more explicitly includes patients and carers, as evidenced for example in the notion of the ‘expert patient’ (Department of Health, 2001a).

In 1997 Labour proposed a ‘new vision’ for modernising health and social care (Means and Smith, 1998) and this ‘vision’ continues to be elaborated upon and developed as the reform programme is ‘rolled out’. This ‘new vision’ has become clearer as successive documents have mapped out the nuts and bolts of the reforms. Central to the modernisation agenda is the development of professional skills, whilst at the same time dismantling professional and service boundaries in order to produce more cost-effective and efficient services and reduce existing health inequalities (Department of Health,

1998a, Department of Health, 2000a). The NHS Plan (Department of Health, 2000a) specifically targets the divisions between health and social care and also places particular emphasis on services for older people (Masterson, 2002). Further reinforcing this point the Department of Health *Modernising Health and Social Services, National Priorities Guidance* (2000b) from 2000 to 2003 reiterates the need for ‘fast, fair, convenient services’, whilst also “increasing satisfaction by involving and responding to patients and the public” (Department of Health, 2000b).

The balance between ‘fast’ and ‘fair’ services has in the past been difficult to achieve as it hinges on a complex range of issues (Means and Smith, 1998). Yet despite the rhetoric there seems to be a relative lack of attention to the process of **how** to ‘make it (the reforms) happen’, and it could be argued that the reform programme has focused too much on the ‘what’ and paid insufficient attention to the ‘how’. As Garside (1998) notes “It could be said that much of change management really lies in the ‘motherhood and apple pie’ domain – nice words, but how practical are they?” (p14). This is particularly important in the context of services for older people.

The National Service Framework (NSF) for Older People (Department of Health, 2001b) promotes an integrated view of how care for older people should be developed through forging closer partnerships between health and social care, professionals and older people. The national standards provide the benchmarks against which care will be judged by the UK government and such standards recognise the importance of the views of older people and their carers (Hutton, 1999). Meeting these standards poses fundamental questions about the ways in which services are currently delivered. As Masterson (2002), in a recent review of the ‘macro-politics’ of cross boundary working, has noted “cross boundary-working is shown to pose many challenges to existing

professions, services and structures” (p337). In particular, the reform programme, especially the NSF, impacts on nursing as the largest occupational group in the NHS. Marks (1994) suggest that discharge planning acts as a ‘cipher’ for many of the challenges that health care systems face, and this is equally true now as it was then.

The NSF for Older People promotes the need for “co-ordinated and integrated service responses” which provide person-centred care for older people (Department of Health, 2001b, p23). In many ways this is exactly what this thesis has identified as being missing in discharge planning. The core standard of ‘person centred care’ in the NSF (Department of Health, 2001b) clearly suggests the need for ‘people’ orientated approaches and envisages this being achieved through the single assessment process and the provision of integrated services. I would suggest that the theory produced in the thesis has implications for achieving these aims by illuminating the ‘micro-processes’, which influence not only discharge planning, but the ways in which professionals and services relate to themselves and older people and their carers.

A comprehensive single assessment process underpins the NSF, and I would suggest that ‘brokering’ and ‘informing’ roles, and related activity, are essential prerequisites of such an approach. Some specific examples from the NSF may help to illustrate this. The NSF (Department of Health, 2000b) notes that “In order to make decisions about their care older people need: the opportunity to ask questions including about their medicines, why they have been prescribed, and any possible side effects” (section 2.14, p28). Yet this thesis would suggest that the provision of ‘opportunities to ask questions’ are often insufficient to promote genuine ‘person centred care’ which is likely to rely on activities such as ‘conveying’ and ‘interpreting’, which are all too often ignored.

However, little is likely to change unless agencies, professionals and users can begin to forge shared understandings.

5.9.2 Towards a shared understanding

“Collaboration and co-operation cannot be taken for granted when changes are imposed. They are by products of wider systems in which people find that it is worthwhile and possible to work with others. Trust is an essential element in such relationships but it cannot be decreed or demanded by manager; it grows from common commitments and understandings, and from experience”.

(Hadley and Clough, 2001, p309)

Possibly one of the most important messages to emerge from this thesis is reflected in the above quotation, that is, trust cannot be decreed but requires a common understanding. This is the very basis of constructivist research, yet as the research reported here has demonstrated, the continued dominance of the biomedical view of the world does little to promote a shared or common understanding. Yet it is increasingly apparent that the success of initiatives, such as the NSF for older people (Department of Health, 2001b), which requires the dismantling of traditional boundaries, will not, indeed cannot, work until a more common understanding is reached. Many of these tensions are exemplified in the current debates about ‘intermediate care’.

The canons of intermediate care, as described by Steiner (2001) below, resonate closely with tensions noted in this thesis between ‘processing patients’ and ‘processing people’.

“These (the bases of intermediate care) are holistic assessment, timely re-assessment, flexible input from a multi-professional team and,

significantly, a plan either to send the patient home as quickly as possible or to keep the patient out of hospital in the first place.”

(Steiner, 2001, p33)

One of the most striking features of intermediate care is the renewed call for MDT working, which is not only ‘flexible’ but also timely. The need for ‘holistic assessment’ and the use of comprehensive geriatric assessment mandates close ‘inter’ partnership working (McIntosh and McCormack, 2001). Much of what this thesis says is clearly of relevance to such current debates.

For example, Steiner (2001) argues that there are key challenges facing intermediate care which focus on the composition of the professional team, their training needs and the ‘matter of professional turf’. These are the same issues identified in relation to discharge planning at the start of this thesis. The results therefore can add to contemporary and wider debates.

As a further illustration, the studies on the Care of the Elderly Unit, Medicine and Surgery identified a lack of ‘teamness’ (Freeman *et al.*, 2000), with little open communication, fragmented MDT working, and a poor team culture, even on the Care of the Elderly Unit where despite a ‘rhetoric’ of collaboration which did not match the ‘reality’. It is clear that greater attention needs to be turned to the ‘informal’ methods of working identified in this thesis if many implicit and latent tensions are to be identified and addressed. This relates to all facets of health and social care that involve the movement of frail older people across service boundaries.

I would therefore argue that the findings from the thesis may well be useful in informing practice, not only in terms of intermediate care but also at the interface

between hospital care and the transfer of patients to care homes. At such times the importance of 'brokering' and 'informing' roles are obvious if older people and their families are to be enabled to make the informed choice that eludes so many older people entering care (Davies, 2001). The interface between hospital and care homes provide an exciting arena in which to further elaborate upon the 'fixing', 'informing' and 'brokering' roles described here, especially as many decisions to place an older person in care are made at a time of crisis (Davies, 2001). As Reed and Morgan (1999) state:

"The discharge of older people to nursing and residential homes (care homes) represents a major life change for older people. It has, however, received less attention in the nursing research and policy literature than discharge to the patient's own home. This may be because managing the discharge of patients to their own home presents nurses with responsibilities for organising and co-ordinating a range of professionals, carers and agencies, and therefore constitutes an obvious set of activities for nurses to engage in. Older people moving into nursing or residential care homes, however, present a different set of responsibilities which may not be quite so obvious, or appear so pressing, yet which correspond with many of the definitions and models of nursing which emphasise the role of the nurse in supporting patients through processes of loss and change." (p819).

The points made by Reed and Morgan (1999) are particularly relevant in considering how the theory outlined here may be useful in investigating the nurses' role in the transition to care homes. For example, the thesis has highlighted the important contribution of the 'brokering' role in 'processing people', especially 'mediating', 'negotiating' and 'advocating'. I would suggest that these activities are of relevance to the area of transition from hospital to care homes. However, further research would be required to judge the 'modifiability' of these roles as currently described.

The above sections have outlined many of the recent policy developments relating to older people and suggested that the results in this thesis have important implications. It

is obvious that traditional ways of working will need to change and this suggests that educational preparation must change also.

5.9.3 Preparing practitioners for partnership

Bull and Roberts (2001) argue that discharge planning is now a global concern given both demographic trends and the findings from several different countries that the challenges faced in discharging frail older people from hospital, and the barriers to good practice are remarkably similar. They contend that there is a pressing need for studies which identify the components of effective discharge planning in order that they can be replicated elsewhere. Although it would be premature to suggest that this study can define what these components are I believe that important new insights have been provided which help to explicate the complex and subtle ways in which nurses exert an influence on the health care system. However, many of these actions are implicit and not necessary fully acknowledged by the MDT. Indeed in some cases team members may not even be aware of the nurse's role. Clearly there is a need for further study which elaborates upon and helps to explicate the effects of the nurses' role in order both that other members of the team can be aware of what is happening and that nurses can be trained to hone the skills that they need. Qualls and Czirr (1988) highlight the pernicious effects of a failure openly to acknowledge different roles and until this acknowledgement occurs, any moves towards greater partnerships, especially with the 'expert patient' are likely to flounder.

Moreover, as the present studies demonstrated not all nurse naturally adopt 'fixing' and 'brokering' roles, and of those that do some are more adept than others. Bull and

Roberts (2001) argue that nurse training should pay more attention to the development of communication skills and also prepare nurses for a leadership role within the MDT. The UK Government has recently announced a 6 year plan to move towards developing and testing models which promote the role of the expert (Department of Health, 2001a) patient and they argue that this will require a fundamental shift in the ways that health care professionals relate to patients. I would argue that many of the skills identified in this thesis will be essential if this shift is to occur. As Liashenko and Fisher (1999) contend 'knowing the patient' requires the ability to seek and relate differing 'forms of knowing' which help to construct the patient role. If the new patient role is to be one of 'expert' then the forms of knowing required will indeed be different. As the Department of Health (2001a) report suggests, the real challenge for the future is the rise in the incidence of chronic illness and I would argue that addressing this challenge mandates a shift in emphasis from 'pace' to a greater acknowledgement of 'complexity'. Only in this way will the relationships which need to be forged in order to tap into the stores of knowledge held by the expert patient be created (Department of Health, 2001a). This is likely to require new ways of professional working, which need to build on new systems of professional education.

5.9.4 An agenda for education and training: Discharge planning and developing 'basic learnings'

Many issues relevant to contemporary policy and practice are not in any sense 'new'. For example, collaboration as a 'key component' was identified in Chapter One and is equally current today, indeed collaboration underpins much contemporary policy. Given this I believe that the insights provided in the thesis have particular implications

for contemporary education and training for both nurses and the MDT if the reform agenda is to be realised.

The challenge of implementing the NSF for Older People (Department of Health, 2001b) pivots on developing differing modes of working that are concerned primarily with 'intra' and 'inter' partnership (MacIntosh and McCormack, 2001). This will require reconsideration of the learning environment, and the goals of education. As a recent major evaluation of nurse education has suggested, much more attention needs to be given to the nature of relationships (Nolan *et al.*, 2002). A better understanding of relationships is unlikely to occur while professional education itself is unidisciplinary.

A good example of a way forward is that provided in the report by Fowler, Hannigan and Northway (2000), highlighting the benefits of 'shared learning' between community nurses and social workers as part of an initiative in South Wales. In this programme community nurses and social workers followed a structured post qualifying course and the evaluation of the programmes indicated the benefits of such an approach and the efficacy of using client centred case studies as triggers for inter professional learning.

Similarly, Scholes and Vaughan (2002) use data collected from a Department of Health study *Evaluating New Roles in Practice* to highlight the need for shared learning to occur not only in higher educational settings but also "centre on learning from one another in practice if it is to be most effective" (p406). The case for a focus on learning based on working 'in practice' was reinforced by McCallin (2001) in her study of interdisciplinary practice that highlights the complexities of the social processes of collaboration. McCallin (2001) observes that the determinants of team practice need to be understood within particular cultural and contextual conditions. Nolan *et al.*'s (2002)

study of nurse education clearly demonstrated that the major influences of the ways in which nurses learn occur during their clinical placements. It argues for a major reconsideration of both basic and post-basic education.

The Audit Commission report *Talents: Education, training and development for healthcare staff in NHS Trusts* (2001) provides a blueprint for how they believe that education and training should be organised in the future. It highlights the importance of targeting 'front line' staff and of addressing training in a multidisciplinary manner. It criticises the uni-professional approach of much continuing professional development which ignores the fact that staff work in multi-professional teams. Making explicit many of the implicit processes identified in this thesis and incorporating them into the educational preparation of practice would do much to move things forward.

The thesis has highlighted the importance of good communication, not only within the MDT, but also between the MDT and patients/carers. The activities 'brokering' and 'fixing' typified the complex, but often hidden, processes involved in clinical work and their importance for the MDT and patients and their carers. It would seem that such social processes are of great importance in discharge planning and in the wider context of the numerous 'partnerships' involved in professional and patient/carer interactions in both health and social care. The 'processing patients – processing people' model identifies a number of key skills required. Others have reached similar conclusions.

MacIntosh and McCormack (2001) advocate that the preparation of practitioners should be based on fostering inter-dependence and equip practitioners with the strategic skills of networking, negotiating, sharing power and critiquing partnership, all of which they contend should be core skills in the curriculum. The present study would suggest that many nurses already have such skills and apply them in subtle ways. However, there is

clearly a need for further study in order that we can more readily identify how the skills required can be learned and improved. Moreover, it seems likely that if 'inter' partnerships are to be developed (MacIntosh and McCormack, 2001) then training too should reflect such a philosophy and itself be interdisciplinary and actively involve both expert patients and expert family carers in the training of their partners in care, the future professionals.

5.9.5 Developing research and practice: The role of a constructivist inquiry

Another important part of the recent health and social care rhetoric is the notion that the patient's experience should inform the ways in which 'quality' in health and social care is defined. Indeed the NSF for Older People is predicated upon just such a belief (Department of Health, 2001b). However, to capture this experience adequately will require differing ways of understanding the world which go beyond those beliefs underpinning the current 'gold standard' evidence produced by the Randomised Controlled Trial (RCT). While qualitative methods have been more widely recognised of late, they are still not viewed as being of equal status to more traditional quantitative approaches. Thorsteinsson (2002) provides a good example in her work on the 'magical touch of nursing' in the care of individuals with a chronic illness. Such a phenomenological approach provides important insights into the dynamics of nurse-patient interactions and support the crucial role of 'professional caring' behaviours for individuals with chronic illness. Such in-depth understandings are also required if progress is to be made in relation to discharge planning in particular, and partnerships more generally.

For example, Procter, Wilrockson, Pearson and Allgar (2001) noted in their study that an in-depth understanding of the process of hospital discharge experienced by patients

and carers was important in responding appropriately to those 'at risk'. As they suggested "*the concept of unsuccessful discharge is in itself problematic as it immediately raises the question unsuccessful for whom?*" (p214). This study highlights the benefits of a broader methodological canvas underpinning the research used to develop policy and practice.

Such benefits were further demonstrated by Reed, Pearson, Douglas, Swinburne and Wilding (2002) who utilised an Appreciative Inquiry (AI) methodology to examine going home from hospital. Such an approach has roots in action research and organisational development, but is also linked to social constructivism and focuses on exploring a social world that is created and constructed 'by the debates we have about it'. The research process is directed towards "appreciating what it is about the social world that is positive and exploring this" (Reed *et al.*, 2002, p38). This moves the dialogue away from the more positivist assumptions of action research about a "world 'out there' that can be described objectively and engineered effectively" (Reed *et al.*, 2002, p38). The dialogue between different stakeholders in 'going home from hospital' (including older people and their carers) generated some interesting findings. This inclusive process revealed a number of key themes, of particular note was developing understanding of the 'whole system' and empowerment. The benefits of qualitative approaches is clearly demonstrated in these two studies, and was, I believe, reaffirmed in the current project.

In the thesis I have argued that a constructivist approach provides one way forward in not only understanding the social world of clinical practice, but also in enabling change to occur. In particular the use of negotiation as part of the framework for evaluation presents a powerful model for social change in a situational setting, enabling

stakeholders to negotiate 'new' joint constructions as part of the research process. Similarly, Eyk and Baum (2002) in the findings from their evaluation of collaborative interagency projects, emphasised the importance of 'constructivist-like' values and learning process:

"The development of partnerships which are either based on trust, or on open negotiation of power differences and professional territories, and the management of mistrust are found to be important foundations for achieving greater genuine collaboration between primary and tertiary healthcare" (p262).

Moreover, constructivism involves consensus-based decision making by addressing multiple perspectives, and this would seem to be consistent with the assumptions underpinning policy in health and social care, as described earlier. Furthermore, the agenda established in current policy requires better understanding of the multiple perspectives of stakeholders engaged in what Reed *et al.* (2002) described in their study as the 'whole system'. Clearly, making current policy work requires a collaborative approach that is based on a range of 'partnership' skills and sources/forms of knowledge.

Notwithstanding some of the challenges I encountered in using a constructivist approach, I would contend that it has much to offer especially as it questions taken-for-granted assumptions about who defines knowledge and illustrates how consensus may be negotiated given the will and the time. In moving towards true collaborative working Finlay (2000) throws down the following challenge:

'It (collaborative working) requires a willingness to listen and a desire to hear what others are saying. It requires the courage to let go of one's own perspective and actively to value the contribution of others. Are we ready for the challenge?' (p185)

Working from within a constructivist perspective is one way of at least acknowledging the challenge and as, Rodwell (1998), contends it potentially provides a way of framing both research and practice so that the two are more closely related. If this thesis has made progress in this direction then it will have achieved its aim and the journey will have been worth the effort.

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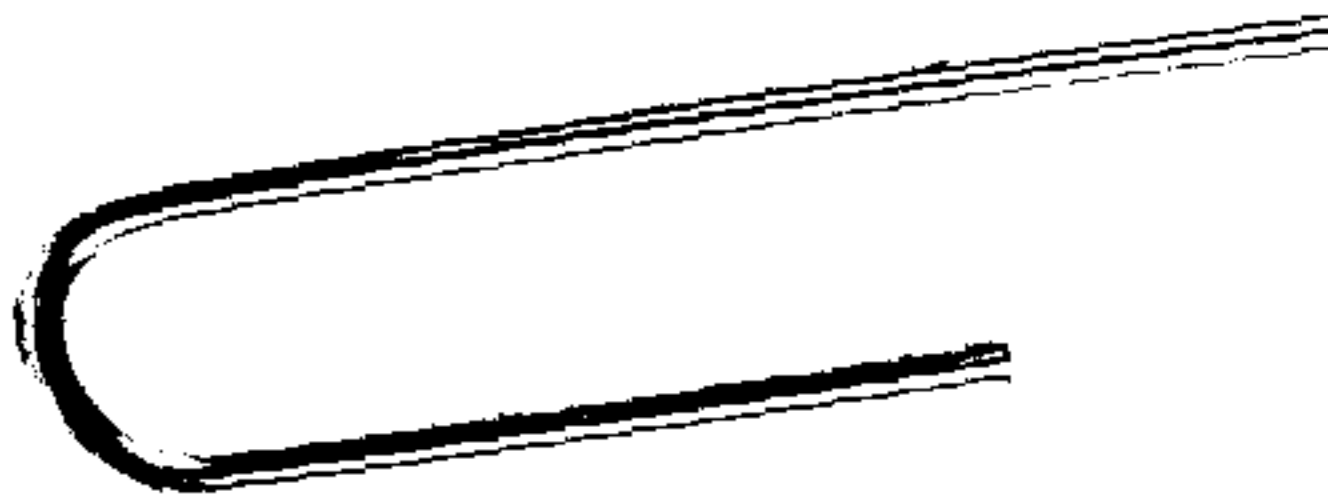
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APPENDIX ONE
ETHICAL SUBMISSION

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APPENDIX TWO

PATIENT LETTERS AND PATIENT CONSENT FORM

HEALTH STUDIES RESEARCH DIVISION
Upper School
St. David's Hospital
BANGOR
Gwynedd LL57 4SL

Tel: 0248 37089
Fax: 0248 355830

Mr. Sion Williams BA (Hons) RGN

Our Ref.: SW/MR

XXXXXX
XXXXXX
XXXXXX

Dear XXX

I am writing to ask whether you would consider participating in a study of discharge arrangements from Ysbyty Gwynedd. As a recently discharged patient your views and those of your relatives/carers involved with your care, would be invaluable. The study is based on XXX ward where you were recently an inpatient, and the aims of the study are to assess the strengths and weaknesses of discharge planning on the ward. The results of the study will help to outline possible areas for improvements.

I would be grateful if it were possible for us to meet at your home on ... at ... ; if this is inconvenient I would be happy to arrange an alternative time that would suit you better. The interview will be about an hour long at the most and all information will be strictly confidential.

I enclose a stamped addressed envelope for your reply. If an alternative day or time is preferred, please write it on the reply.

Thank you for your assistance and I look forward to hearing from you.

Yours sincerely

Sion Williams

Consent to Participate in the Evaluation of XXXX Ward study on the discharge of older people from hospital

The aims of the above study have been explained to me and I have had an opportunity to discuss the project and clarify my understanding.

I consent on the understanding that any information will be CONFIDENTIAL and ANONYMOUS, and that on no account will my identity be revealed.

Signed:

Date:

APPENDIX THREE

SEMI-STRUCTURED INTERVIEW SCHEDULES

SEMI-STRUCTURED INTERVIEW GUIDE: HOSPITAL-BASED STAFF

OPENING STATEMENT

Thank you for agreeing to take part in this study, the objective of which is to examine the current discharge process from a variety of perspectives, including those of all the multidisciplinary team members. The patients of Dr. have been selected as a sample, and the views of patients and their carers will also be sought.

Our discussion will be treated in strictest confidence. However, it would help me greatly if I could tape-record the interview. I have a tape recorder but will only use it if you are willing for me to do so (the information will be erased once the interview has been analysed). The interview involves a series of questions and a brief questionnaire, but please feel free to raise issues which you consider important as we go along, if they have not been touched upon.

INTRODUCTORY QUESTIONS/TOPICS

1. Respondent's opinion of what represents a 'good' discharge.
2. Respondent's opinion of what they consider to be the main obstacles to a successful discharge.
3. Respondent's opinion of what they consider to represent an unsafe discharge.
4. Are efforts made to identify patients 'at risk' of poor discharge? If so, what criteria are used?
5. Respondent's opinion of how they feel the patient's transition from hospital to home can be improved?
6. Respondent's opinion of the advantages and disadvantages of patient and carer participation in the discharge planning process.

COMPLETE DISCHARGE PLANNING EVALUATION QUESTIONNAIRE

I will now read out to you a list of criteria which are said to represent a good discharge. Could you please tell me how well you think these criteria are currently met on this ward using the following code- Always, Mostly, Sometimes, Rarely, Never.

CRITERION	Always	Mostly	Sometimes	Rarely	Never
Discharge planning begins prior to (elective admissions) or immediately on (emergencies) admission.					
If patient is already in receipt of community services, the ward is promptly informed of these by the relevant staff.					
Community based staff are fully involved and consulted in the discharge planning process.					
All staff are fully aware of their defined responsibilities in relation to the discharge process.					
There is a named individual with responsibility for co-ordinating the discharge of each patient.					
The patient is fully involved and informed at every stage of the discharge process.					
Where relevant, patient's carers/relatives are involved/informed at every stage.					
If required there is a full assessment of each patient's: Home circumstances Existing levels of support Functional abilities Anticipated future support Aids/adaptations required Each carer's willingness and ability to care.					
Patients receive full instruction/tuition in all relevant areas of need.					
Patients' carers receive full instruction in all relevant areas of need.					
Efforts are made to ensure that such instruction is fully understood.					
Instruction/tuition is accompanied by written advice.					
Full multi-disciplinary discussion involving patient occurs before the decision to discharge is made.					

Full multi-disciplinary discussion involving patients' carers occurs before the decision to discharge is made.					
48 hours notice of discharge is given to: Patients/carers All community services involved.					
The patient's fitness for discharge is re-assessed on the day of discharge.					
Every effort is made to avoid discharge prior to weekends/Bank Holidays.					
Patients are provided with: Full details of their after care arrangements Sufficient supplies of dressing, medication etc. Any aids they require.					
All phases of the discharge process are fully documented and kept in a central reference point.					
Transfer of medical, nursing and other care occurs on the day of discharge.					

MULTIDISCIPLINARY ASPECTS OF DISCHARGE PLANNING

TOPICS

1. Where does the responsibility lie for initiating discharge arrangements and decision making regarding the discharge of patients from the ward?

2. What role do case conferences have to play in decision planning and decision making?

Probe:

Would you describe the case conference at present as being effective or ineffective?

If it is ineffective, why?

How would you improve the situation?

3. What role do ward rounds have to play in discharge planning and decision making?

Probe:

Do you consider ward rounds to be effective in terms of:

- i) Multidisciplinary Teamwork?
- ii) Decision making re discharge?
- iii) Liaison between key members of the multidisciplinary team and the patients?

If not covered sufficiently when completing evaluation questionnaire, then ask:

4. Is sufficient information given to patients and carers concerning diagnosis and treatment during hospitalisation / on discharge? Is the subject of medication given attention; prior to discharge does a member of staff or the pharmacist inform patients about the tablets they are to take at home?

Probe:

Is there a tendency to focus information giving towards the relatives/carers to the detriment of the patient?

5. Do you consider that enough time and priority is given to discharge and its planning?

6. How would you describe the role of home assessments/visits in the discharge planning process?

Probe:

Perceptions as to their value.

Perceptions as to whether assessments are under utilised or used appropriately.

7. Any other difficulties patients may experience on the day of discharge?

MULTI AGENCY ASPECTS OF DISCHARGE PLANNING

1. Perceptions of the relationship between the ward and the community services who are involved with discharge planning.

Probe:

- a) Current strengths.
- b) Do problems exist? If so, what are the main areas of conflict or contention?
- c) Why does the respondent think these have evolved into problem areas?
- d) How can the situation be improved and how likely is it that improvement will occur?

2. Perceptions re adequacy of information contained on current Transfer of Care Forms.

3. Perceptions of adequacy of transport arrangements for patients to return home.

Strengths of current system

Any problems associated with the timing of transport?

Any problems in obtaining transport at short notice?

Any problems in organising transport and liaising with the ambulance office?

4. Perceptions re the potential impact of Community Care legislation on discharge planning in the Acute Unit.

ANY OTHER COMMENTS RESPONDENT WOULD LIKE TO MAKE REGARDING THE DISCHARGE PROCESS?

THANK YOU VERY MUCH FOR YOUR CO-OPERATION AND TIME

SEMI-STRUCTURED INTERVIEW GUIDE AND PATIENT/CARER QUESTIONNAIRES

OPENING STATEMENT

Thank you very much for agreeing to take part in this study which is examining the current discharge arrangements from The XXXXX Care of the Elderly Unit at Ysbyty Gwynedd.

As someone recently discharged from hospital, I would like to ask you some questions about the way in which your return home was arranged and discuss a few issues related to your discharge.

The interview is strictly confidential and I would value your candid opinion. I have a tape recorder for my own convenience and reference but will only use it if you are willing for me to do so. If you would prefer me not to use the tape-recorder then I can make some notes as we go along instead.

OVERALL PERCEPTIONS OF DISCHARGE PROCESS

Perhaps we could begin with your overall opinion of the way your return home was arranged?

Include the following if not raised spontaneously:

- a) Were you given an idea of how long your stay in hospital would be? If so, when was this given to you?

Before admission

1st day

2 - 3 days

4 - 5 days

Longer

- b) When were the arrangements for your return home first discussed with you?

Before admission

1st day

2 - 3 days

4 - 5 days

Longer

- c) Do you remember how much warning you had before being discharged from hospital?

Less than 24 hours

1 - 2 days

Over 2 days

Don't know

- d) Do you feel this was enough notice?

If this was insufficient notice, how much time would you have needed/liked?

e) Was the date and time of discharge convenient?

Probe:

If not convenient - why?

Home not ready

Carer not ready

Any other

f) Were you sent home immediately before a weekend?

Probe:

If sent home at a weekend did this present any potential problem or difficulties? Did you raise these with someone on the ward before your discharge home?

g) Did you feel you were ready to go home?

h) Thinking back, do you feel you were discharged from hospital:

Too soon

About right

Could have been sooner

Don't know

PERCEPTIONS OF DETAILED DISCHARGE PLANNING

TOPICS

- a) Did anyone at the hospital discuss the arrangements for your return home?

Include:

Was your return home fully discussed with you? Were you involved or informed in decision making, did you have enough say in arranging your return home?

- b) Whilst in hospital were you presented with any new medicines to take, which you were not taking before your admission?

Probe:

Were you given advice/instructions about your medication prior to going home?

Did you understand the advice you were given?

Can you remember what advice you were given?

When was it given?

By whom was it given?

What form did it take - verbal, written, demonstration or participation?

- c) Were you given information/advice about your condition and its treatment whilst in hospital?

Probe:

Did you understand the advice you were given?

Did you remember the information you were given?

Can you remember who gave it to you and when?

In what form was it given? Probe as above.

Did your family/carers have the same information as you?

- d) Was there any other advice/information you would have liked but did not receive? If so, what?

- e) Were your needs for any extra help on return home fully discussed with you?

- f) Do you remember what type of assessments, if any, you had before being sent home?

Probe:

What assessment do you remember?

Were these carried out by:

Nurses

Occupational therapist

Physiotherapist

Speech therapist

Doctors

Any others

- g) Did you have an opportunity to discuss any concerns you had about your discharge home during the visit by the consultant and team on the ward rounds?

Probe:

Were the opportunities available sufficient?

Would you have preferred private discussions?

If no opportunity was available, would you have wanted one?

- h) Which members of staff did you have most contact with whilst in hospital?

- i) Do you think that your carer's needs were met by the ward staff? (If carer present, obtain their perspective).

PERCEPTIONS OF THE DAY OF DISCHARGE

- a) On the day of discharge did you feel ready to go home?

Probe:

Did a member of the medical staff check this with you?

Were your possessions ready for you?

Were you appropriately dressed to go home?

- b) What was your experience of the transport for your return home?

Probe:

Were there any difficulties experienced; such as a long wait before setting off in the transport; did the time to depart coincide with mealtimes or washing/dressing; did you feel that you needed more time to get ready; did you have an opportunity to go to the toilet before setting off?

- c) If transport was by other than ambulance - did this cause any difficulties?

PERCEPTIONS OF RETURN HOME AND AFTERCARE

- a) Was your home ready for you on your arrival from hospital?

Probe:

Was access to the house arranged, food and heating? What time did you arrive at home and was there anyone to meet you?

- b) Did the services arranged for you arrive as promised?

Probe:

What were they?

How satisfied are you with the services arranged?

- c) Are there any services that could have been arranged to help you on your return home that you are currently not receiving?

(Probe the carer, if present, during or after interview)

- d) I would now like to ask you some questions about the services you had before going into hospital and how they may have changed since you came home. For each service I read out could you tell me if you received it before you went into hospital and how often, also if you receive such a service now and how often?

Services received:

District nurse

Home-help

Meals on wheels

Night sitters

Voluntary services (Probe which)

Day Care/Day Hospital

Any other service

- e) Did you have help from family or friends before going into hospital?

Probe:

What help was received?

Has your need for such help increased following your return home?

- f) How would you describe your general health now, as compared with before you went into hospital?

- g) Compared to before you went into hospital, are you able to do more or less for yourself now?

I would like to ask you in rather more detail about how much you are able to do for yourself, firstly, if you can remember before the admission to hospital and secondly, your present abilities since your return home.

COMPLETE SELF-CARE ASSESSMENT QUESTIONNAIRE

Insert **B** for abilities before and **A** for abilities after.

Tasks	Unable/Needs help	Alone with difficulty	Alone no difficulty	Who provides help
Shop				
Walk down road				
Cut own toe nails				
Climb up/down stairs/steps				
Prepare meals				
Light housework				
Bath/shower wash all over				
Put on shoes				
Stand				
Make a cup of tea				
Hold a pen				
Eat/drink				
Dress/undress				
Get around the house				
Turn taps				
Wash/shave				
Get in/out of bed				
Comb hair				
Attend to own toileting needs				

For each task with which help is needed, probe to see who provides such help.

ANYTHING ELSE YOU WOULD LIKE TO RAISE/DISCUSS, regarding any of the points we have brought up, or any additional issues which you would like to address?

Thank you very much for your co-operation and time, and I would like to emphasise again that all information will be treated confidentially and the tape (if used) will be erased after analysing your comments. Your contribution is valued and will form the basis of a constructive review of current discharge practice.

THANK YOU

APPENDIX FOUR
DISCHARGE PLANNING QUESTIONNAIRE

DISCHARGE PLANNING EVALUATION QUESTIONNAIRE

Ward A: MDT respondents

	CRITERION	Always	Mostly	Some- times	Rarely	Never Applied
1	Discharge planning begins prior to (elective admissions) or immediately on (emergencies) admission.	5	5	6	2	
2	If patient is already in receipt of community services, the ward is promptly informed of these by the relevant community staff.		1		6	7
3	Community based staff are fully involved and consulted in the discharge planning process.			3	12	1
4	All staff are fully aware of their defined responsibilities in relation to the discharge process.	6	9	1	2	
5	There is a named individual with responsibility for co-ordinating the discharge of each patient.	2	4	3	2	4
6	The patient is fully involved and informed at every stage of the discharge process.	6	8	3	1	
7	Where relevant, patient's carers/relatives are involved/informed at every stage	10	6	1		
8	If required there is a full assessment of each patient's: a) Home circumstances b) Existing levels of support c) Functional disabilities d) Anticipated future support e) Aids / adaptations required f) Each carer's willingness and ability to care.	8 11 11 8 9 5	6 7 5 2 2 7	1 1 2 2 2	1 1 2	 1 1
9	Patients receive full instruction / tuition in all relevant areas of need.		9	10	3	
10	Patient's carers receive full instruction / tuition in all relevant areas of need		9	10	3	

	CRITERION	Always	Mostly	Some- times	Rarely	Never Applied
11	Efforts are made to ensure that such instruction is fully understood.	2	4	5	1	1
12	Instruction / tuition is accompanied by written advice.			4	8	3
13	Full multidisciplinary discussion involving patient occurs before the decision to discharge is made.	2	3	4	5	3
14	48 hours notice of discharge is given to: a) patients / carers b) all community services involved	3	7	6	2	
15	The patient's fitness for discharge is re-assessed on the day of discharge	5	7	3		
16	Every effort is made to avoid discharge prior to weekends / Bank Holidays	3	5	2	2	2
17	Patients are provided with: a) Full details of their after care arrangements b) Sufficient supplies of dressing, medication etc., c) Any aids they require	5	2	2	3	
18	All phases of the discharge process are fully documented and kept in a central reference point.	3	1	2	4	1
19	Transfer of medical, nursing and other care occurs on the day of discharge.	3	4		2	

APPENDIX FIVE
WARD A: CASE REPORT

**DISCHARGE
AND
THE ELDERLY**

**Sion Williams
February 1993**

DISCHARGE AND THE ELDERLY:

A Report on the study of Discharge on XXXX Ward

Introduction

This brief report brings together the main results of the study on XXXX Ward, which examined the issue of discharge. As you know, this involved interviews with all members of the multidisciplinary team (MDT), patients, carers and members of the Primary Health Care Team (PHCT) including social workers, occupational therapists and physiotherapists.

It was clear from the interviews that the patients and carers interviewed were in general satisfied with their care and reported that their needs were met attentively and compassionately by the ward team. The community staff were also satisfied with the service provided by the ward and the Care of the Elderly Unit in general. However certain issues emerged which suggested that there were areas in which improvements might be made.

The report is divided into the following sections representing the perspectives of:

- the multidisciplinary ward team,
- the patient and carers,
- the community team.

At the end of each section a series of suggestions are outlined, developed from the main body of data obtained in the interviews. These form a framework for discussion of possible changes to current practice.

Multidisciplinary Ward Team Perspective

Teamwork seemed to be the basis of ward functioning and worked well in general. During the interviews it became apparent that there were three main areas which represent opportunities for improvement. These are examined under the sub headings of:

- Information and the MDT
- Community liaison
- Information giving and patient/carers.

Information exchange was consistently identified as a key component in all these areas.

Information and the MDT

Information flow between team members was seen as problematical, with a perceived need for improved communication and enhanced collaboration.

The organisation of the MDT did not allow for full discussion of shared concerns. Timing of the ward rounds and case conferences was seen as crucial and dictated the attendance of team members.

The formal involvement of specialists in the team was limited e.g. speech therapists, dietician. A need was identified for greater involvement (when appropriate) so as to provide input in organised meetings, such as case conferences.

Poorly defined responsibilities for co-ordinating/managing discharge caused concern. An informal organisational network seemed to exist focused on the nursing staff.

The recording of discharge plans was seen as fragmented due to the ill-defined parameters of responsibility.

The short notice of discharge hampered the ability of some team members to liaise effectively with the MDT on the ward and in the community e.g. physiotherapy staff. Discharge planning was felt to be adversely affected when a 'bed crisis' existed.

Community Liaison

Liaison between the ward and community team was negatively affected by poor information flow; there was limited involvement by the PHCT in discharge planning.

A dual system of transferring nursing care existed and the use of the transfer of care book was consistently criticised by all staff. The transfer sheet also needed modification with a view to increasing the scope for more detail.

Information from the community staff on admission was seen as inadequate, especially from the District Nurses. Often information was given by patients and carers which proved problematical and inaccurate; staff felt that more direct liaison should be established with the community team.

Information Giving and Patients/Carers

It was clear from all perspectives that more information should be given to patients and carers. The information was seen to be deficient in terms of:

- quality
- consistency
- format

The quality of information giving was problematical, generally too sparse, basic or technical, with information not gauged to the recipients' level of understanding.

The quality of information giving seemed to be affected by the variable workload. However the periods identified as enabling information giving produced only partial success, since the process was too brief, unstructured and consisted of little written information with limited attempts to ensure comprehension.

The quality of information regarding the patients condition and their medication was seen as requiring improvement; a knowledge of the patient's condition was perceived as a prerequisite for meaningful involvement in decision making by both patient and carer. It was acknowledged that information re- medication facilitated drug compliance.

Information was not consistently given in a co-ordinated manner to patients and carers; this led to fragmentation of the team efforts. The format of information giving was rarely structured and therefore consistency was difficult to achieve.

Written material was rarely given unless there was a particularly difficult discharge and it was recognised by the majority of team members that it would be beneficial for patients and carers. This was felt to be significant with medication and information relating to the patient's condition and backup details.

It was felt that a scarcity of organised written information hampered information giving, even though there was potentially a variety of leaflets and booklets available.

Suggestions

Further development of the multidisciplinary team, fostered by a re-structuring of the operation of the ward round and case conference. For instance, the commencement of the round earlier in the day and a case conference held on its completion with all the team members attending the conference. Both meetings would need to commence at specified times to allow team members to arrange their work effectively.

The clarification of roles and responsibilities regarding discharge. (This has in part, been addressed by the Acute Unit Discharge policy).

Greater involvement of specialist team members in meetings - specifically the case conference, which could be utilised on a 'drop in' basis, if the conference was clearly timetabled.

Increased collaboration/co-ordination in documenting discharge arrangements among team members. (This has been addressed in part by the checklist in the Discharge Policy).

Modification of the transfer of nursing care documentation was consistently advocated and the discontinuation of the book format.

There was a clear need seen for greater liaison with the community staff, perhaps by-passing the Sector Office.

The development of information giving in particular to patients and also carers, with greater use of written material.

Community Perspective

There was a general need acknowledged for improved liaison between the Acute and Community sectors and a movement away from a "them and us" situation. Though the elderly ward was included in this statement it was clear that a closer relationship existed between the elderly and community staff than in other clinical areas. Both general practitioners and District Nurses felt that in general a good service was received by the ward.

The main issues raised were:

Assessments

There was a general anxiety about ward-based staff promising services for patients/carers on discharge and the commitment of resources was felt to be the responsibility of the community staff following assessment. Difficulties were caused with carers in particular, when community staff had to withdraw or reduce their input following discharge home.

The community staff felt that ward-based assessments of patients did not reflect accurately their abilities or anticipate problems in the home environment.

It was felt that there existed a general misconception about the nature and volume of community work. This was reflected at times by inappropriate requests and general problems such as short notice referrals and the discharging of patients with dressings unavailable in the community.

Information Exchange

This was identified as a crucial issue by the PHCT and centred on timing and the quality/content of information given.

There was some delay in GPs receiving notice of discharge but it was felt that the fax had made a very positive contribution, though a few days delay in transferring information still occurred at times.

The discharge report took some weeks to arrive but this was acceptable if the preliminary summary had been received, the format was well liked by the majority of practices.

Information was transferred to the nursing staff prior to discharge, even if at short notice, the District Nurses were aware of discharges before the GPs.

Information flow within the PHCT was in some areas problematical, especially with reference to admissions. In some areas it took 3 or 4 days for nurses to know of an admission, this proved to be an obstacle in providing the ward with additional information.

It was recognised that improved liaison was required between the community and ward nursing staff to plan the discharge of patients in need of community care.

Community nursing staff had information that was invaluable for planning future care and often had "insider" knowledge of the carer - patient relationships.

The transfer of nursing care document required improving in both detail and format, with ADL information related to applied function.

It was felt that more information could be given to the patients and carers regarding their condition and their medication.

Resources

The supply of drugs on discharge was felt to be satisfactory, though some problems were caused by the need for specific dressings/lotions to be given which were unavailable in the community.

The resources available for discharged patients differed in Arfon and Mon, in particular the availability of occupational and physiotherapy staff. The PHCT is at present being re-organised to facilitate greater information flow and liaison, in particular Arfon.

2.4 Notice

At times short notice was given for discharges and this resulted in problems for some members of the PHCT, in particular the nursing and social work staff.

Short notice discharges presented few difficulties for the GPs, though patients on occasions complained of being 'rushed'.

Suggestions

Greater liaison with ward staff was seen as a priority, and involvement in planning discharges requiring complex or significant community input.

Contacting the PHCT or nursing staff directly and not through the present channels, particularly in Mon.

Further development in the use of the fax machine in transferring information between the ward team and the PHCT.

The development of the nursing transfer of care form and the modification of its content to the requirements of the PHCT.

Patient and Carer Perspective

Contrary to the literature the notice of discharge did not present any difficulties for patients or carers, the nursing and medical staff on the ward providing provisional dates so as to prepare carers adequately. Significantly the study noted that dependency did consistently increase following discharge for a period of some weeks.

During the interviews with patients and their carers two main issues were identified as being of particular importance:

- involvement in the discharge process
- information giving (in particular re- medication and condition).

Involvement

Involvement in the discharge process was problematical and centred on the definition of 'involvement'; it was taken to represent 'being informed'. The perceptions of staff, patients and carers differed from the definition of involvement as *participation* in the decision making process (Department of Health, 1990; Welsh Office, 1989).

Involvement during ward rounds was seen as particularly difficult leading to a feeling of exclusion by patients. Great importance was attached to the round by patients (and carers) and the visit of the consultant, however patients rarely felt that they were involved, with the discussion focusing on the attending team.

A central part of patient/carer and team interaction was the role of relatives or carers. They could legitimately enquire on behalf of the patient without compromising what seemed to be a valued passive role. It was apparent though that information was *filtered* by carers, and patients only received partial explanations.

Information

Information was a key issue for patients and carers and the nursing staff was identified as the main contact for information. The interviews held with relatives was felt to be valuable and the medical staff during such meetings were helpful and approachable, in particular the consultant.

Three key issues were identified:

1. Health problems
2. Treatment and medication
3. Health education/skills.

Health problems were poorly understood by patients and carers, in particular the relationship between the medical condition and treatment.

Information was given prior to discharge but was episodic, unstructured and rarely reinforced with written information.

Medication proved problematical with some confusion over tablets once discharged. Patients/carers were unaware of side effects/contra-indications e.g. with Warfarin, and were often uncertain about when to take the drugs prescribed.

Health education or tuition of appropriate skills was problematical, with patients and carers. However, patients with complex discharge needs were prioritised.

Suggestions

The problems of information giving could be tackled specifically by the development of an *information package* with the incorporation of an individual patient profile. This would contribute to the quality, consistency and delivery of information, providing a standard structure for the process of information giving and a written format which patients could relate to once discharged. The development of such a package would have to involve members of the multidisciplinary team so as to produce a holistic document. Any package developed for patients would be a resource to facilitate improved information giving and not a substitute for discussion.

Greater emphasis on patient/carer education by team members, with information given regarding the medical condition, medication, benefits and patient handling skills.

The involvement of patients in the decision making process e.g. during ward rounds and informally whilst an inpatient on the ward.

CONCLUSION

It is hoped that the feedback of information from the study will form the basis for further improvements in caring for the elderly on XXXXX ward and will structure developments in the management of discharge. The study will be formally repeated later in the year to evaluate the progress of developments in the practice area and it is anticipated that an on-going audit mechanism will be established.

The project is firmly embedded in an interactive/action research approach and it is hoped that the report will form the basis for discussion resulting in an action plan, which will address the areas outlined, particularly information.

APPENDIX SIX

SECOND PHASE: THE W.A.G.N.A PROPOSAL

PROPOSAL: FUNDING FOR NURSING AND MIDWIFERY DEVELOPMENT
SITE AT YSBYTY GWYNEDD, BANGOR

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APPENDIX SEVEN
SECOND PHASE REPORT

Grasping the Nettle

An Audit of Discharge Management

in the

Acute Setting of Ysbyty Gwynedd

Mr. Sion Williams

Project Manager

WAGNA

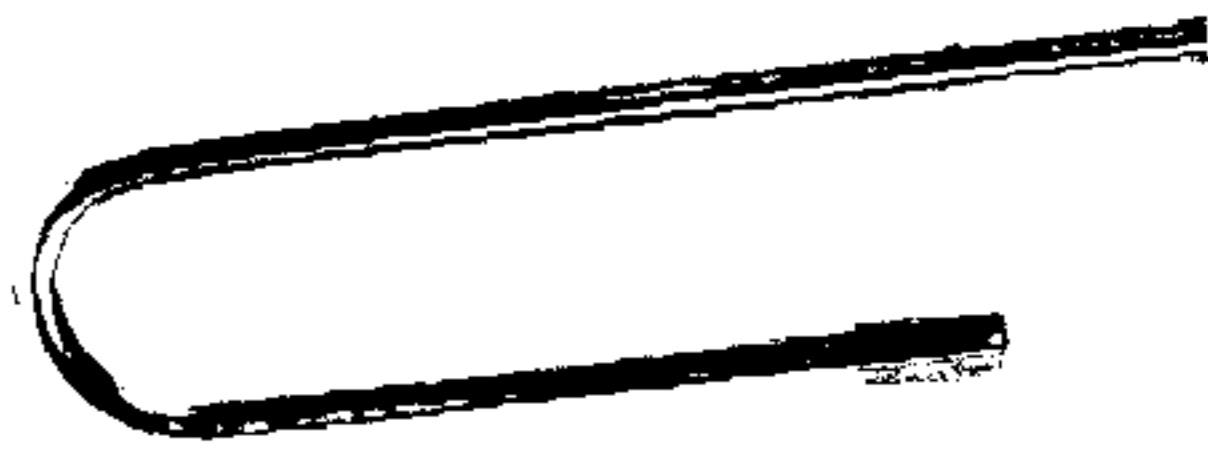
Dr. Mike Nolan

Senior Lecturer in Nursing Research

Health Studies Research Division

University of Wales, Bangor

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APPENDIX EIGHT
EXAMPLE CHECKLIST

Discharge Checklist

Ward D

Name:

Next of Kin:

Address:

Address:

Tel No:

Tel No:

Date of admission:

Discharge address:

Date of discharge

			Not required	Signed
Pre admission				
Discuss details of admission / discharge requirements				
Refer to Hospital Social Worker if needed				
On admission				
Named nurse				
Admitting Nurse				
Discuss discharge requirements / determine levels of existing community support				
Information received from Community Services				
Details of assessments ordered	Date referred	Date seen		
Family interviewed by Doctor	Date family asked to see	Date family seen by Doctor		

			Not required	Signed
Discharge arrangements services planned				
Planned date of discharge with MDT, patient and carer agree				
Next of kin informed				
Transport arrangements				
Ambulance ordered				
Escort arranged				
Supplies / instructions given on discharge				
Patient / instructions given on discharge	Date referred	Date transferred		
Patients property returned				
Patient suitably clothed				
Patient fit for discharge				
Transfer medical care				
Transfer nursing care				
Inform Medical Records of discharge				

Additional information:

Ward E: Amended discharge checklist

Discharge checklist and records of discharge planning process

Name No. Hospital Ward

Discharge address Next of Kin

Tel No. Tel No.

Date of admission Informed of discharge

Date discharged

Action required / date ordered	Action undertaken (include date completed and location of results if relevant)	Not required	Signed
Pre-admission			
Discuss details of admission discharge requirements			
Inform hospital social worker if needed			
On admission			
Discuss admission / discharge requirements			
Allocate named nurse			
Determine levels of existing community support			
Information received from community services			
During admission / prior to discharge			
Details of assessment ordered with dates			
Discharge arrangements agreed with MDT and patient / carer			

Action required / date ordered	Action undertaken (include date completed and location of results if relevant)	Not required	Signed
Details of instructions / advice to patient / carer			
Community services ordered / preparation of home / receiving hospital etc., informed			
Follow up arrangements made			
Transport arrangements			
Ambulance authorised			
Ambulance ordered / confirmed			
Cost implications noted			
Escort arranged			
Supplied given to patient			
Patient fit for discharge			
Patient's property returned			
Patient suitably clothed			
Discharge details forwarded to community services			
Transfer medical care			
Transfer nursing care			
Other			
Inform Medical Records of discharge			
Any other details			

APPENDIX NINE

WELSH OFFICE WORKING GROUP

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APPENDIX TEN
INTERVIEW LOG

Interview Log																				
Phase One Interview Cycle																				
Interview	Code	Person Interviewed	Age	Gender	Place of interview	Date of interview	Length of interview	Transcription completed	Other comments											
Professional Interviews																				
Ward A	A1	Ward Manager	N/A	F	Ward Area	29.9.92	1.5 Hour	Yes	Fieldwork notes completed and taped											
Ward A	A2	Senior Nurse	N/A	F	Ward Office	29.9.92	1.5 Hour	Yes	Fieldwork notes completed and tape poor quality											
Ward A	A3	F Grade Nurse	N/A	F	Ward Area	30.9.92	1 Hour	Yes	Fieldwork notes completed and taped											
Ward A	A4	Staff Nurse	N/A	F	Ward Area	30.9.92	1 Hour	No	Fieldwork notes completed and taped											

Ward A	A5	Staff Nurse	N/A	F	Ward Area	30.9.92	1 Hour	No	Fieldwork notes completed and taped
Ward A	A6	Staff Nurse	N/A	F	Ward Area	30.9.92	1 Hour	No	Fieldwork notes completed and taped
Ward A	A7	Staff Nurse	N/A	F	Ward Area	31.9.92	1 Hour	Yes	Fieldwork notes completed and taped
Ward A	A8	Staff Nurse	N/A	F	Ward Area	31.9.92	1 Hour	Yes	Fieldwork notes completed and taped
Ward A	A9	Staff Nurse	N/A	F	Ward Area	31.9.92	1 Hour	Yes	Fieldwork notes completed and taped
Ward A	A10	Enrolled nurse	N/A	F	Ward Area	2.10.92	1 Hour	No	Fieldwork notes completed and taped
Ward A	A11	Enrolled Nurse	N/A	F	Ward Area	2.10.92	1 Hour	No	Fieldwork notes completed and taped

Ward A	A12	Enrolled Nurse	N/A	F	Ward Area	2.10.92	45 Minutes	No	Fieldwork notes completed and taped
Ward A	A13	Social Worker	N/A	F	Ward Office	2.10.92	1.5 Hours	Refused taping	Fieldwork notes completed
Ward A	A14	Occupational Therapist	N/A	F	Ward Office	6.10.92	1 Hour	No	Fieldwork notes completed and tape poor quality
Ward A	A15	Physiotherapist	N/A	F	Ward Office	6.10.92	1 Hour	No	Fieldwork notes completed and tape poor quality
Ward A	A16	Physiotherapist	N/A	F	Ward Office	6.10.92	1 Hour	No	Fieldwork notes completed and tape poor quality
Ward A	A17	Doctor	N/A	M	Ward Office	2.11.92	1 Hour	Refused taping	Fieldwork notes completed
Ward A	A18	Doctor	N/A	M	Ward Office	3.11.92	1 Hour	Refused taping	Fieldwork notes completed
Ward A	A19	Doctor	N/A	M	Ward Office	4.11.92	45 Minutes	Refused taping	Fieldwork notes completed

Ward A	A20	Doctor	N/A	M	Ward Office	4.11.92	45 Minutes	Refused taping	Fieldwork notes completed
Ward A	A21	S.L.T	N/A	F	Ward Office	8.11.92	1 Hour	No	Fieldwork notes completed and taped
Patient and carers Interviews									
Ward A	A22	Patient	75 years	M	Home	13.10.92	1.5 Hours	Yes	Fieldwork notes completed and taped
Ward A	A23	Carer and Patient	73 years	F	Home	13.10.92	1.5 Hours	Yes	Fieldwork notes completed and taped
Ward A	A24	Patient	71 years	F	Home	15.10.92	1.5 Hours	No	Fieldwork notes completed and taped
Ward A	A25	Patient	78 years	F	Home	15.10.92	1.5 Hours	No	Fieldwork notes completed and taped

Ward A	A26	Patient	82 years	M	Home	16.10.92	1.5 Hours	No	Fieldwork notes completed and taped
Ward A	A27	Patient	88 years	M	Home	20.10.92	2 Hours	No	Fieldwork notes completed and tape poor quality
Ward A	A28	Patient	72 years	F	Home	21.10.92	1.5 Hours	No	Fieldwork notes completed and tape poor quality
Ward A	A29	Patient	86 years	F	Home	22.10.92	1 Hour	Spoilt tape	Fieldwork notes completed
Ward A	A30	Patient	71 years	M	Home	27.10.92	1.5 Hours	Yes	Fieldwork notes completed and taped
Ward A	A31	Patient	81 years	M	Home	28.10.92	1 Hour	No	Fieldwork notes completed and taped
Ward A	A32	Carer Alone	62 years	M	Home	29.10.92	1.5 Hour	No	Fieldwork notes completed and taped

Ward A	A33	Carer and Patient	68 yrs and 86 yrs	F F	Home	29.10.92	1.5 Hours	Refused taping	Fieldwork notes completed and tape poor quality
Ward A	A34	Carer and Patient	84 years	F	Home	3.11.92	1.5 Hours	No	Fieldwork notes completed and tape poor quality
Ward A	A35	Carer and Patient	88 years	F	Home	4.11.92	1.5 Hours	No	Fieldwork notes completed and taped
Ward A	A36	Patient	75 years	F	Home	6.11.92	1 Hour	No	Fieldwork notes completed and taped
Ward A	A37	Patient	70 years	M	Home	6.11.92	1.5 Hours	No	Fieldwork notes completed and taped
Community Team Interviews									
Community	A38	Community Nurse	N/A	F	Health Centre	3.2.93	1 Hours	No	Fieldwork notes completed and taped

Community	A39	Community Nurse	N/A	F	Surgery	5.2.93	1 Hours	No	Fieldwork notes completed and taped
Community	A40	Community Nurse	N/A	F	Surgery	8.2.93	1 Hours	No	Fieldwork notes completed and taped
Community	A41	Community Nurse	N/A	F	Surgery	8.2.93	1 Hours	No	Fieldwork notes completed and taped
Community	A42	Community OT	N/A	F	Community Hospital	8.2.93	1 Hours	No	Fieldwork notes completed
Community	A43	Community Nurse	N/A	F	Surgery	9.2.93	1 Hours	No	Fieldwork notes completed
Community	A44	Community Nurse	N/A	F	Community hospital	9.2.93	1 Hours	No	Fieldwork notes completed
Liaison	A45	Ambulance Liaison Officer	N/A	M	District General Hospital	9.2.93	45 minutes	Taping refused	Fieldwork notes completed
Community	A46	Physiotherapist	N/A	F	Community Hospital	10.2.93	1 Hour	No	Fieldwork notes completed

Community	A47	GP		N/A	M	Surgery	15.2.93	1 Hour	Refused taping	Fieldwork notes completed
Community	A48	GP		N/A	M	Surgery	15.2.93	1 Hour	Refused taping	Fieldwork notes completed
Community	A49	GP		N/A	M	Surgery	15.2.93	1 Hour	Refused taping	Fieldwork notes completed
Community	A50	GP		N/A	M	Surgery	17.2.93	1 Hour	Refused taping	Fieldwork notes completed
Community	A51	GP		N/A	M	Surgery	17.2.93	1.5 Hours	No	Fieldwork notes completed and taped
Community	A52	GP		N/A	M	Surgery	18.2.93	1 Hour	No	Fieldwork notes completed and taped
Community	A53	GP		N/A	M	Surgery	18.2.93	1 Hour	No	Fieldwork notes completed and tape poor quality
Community	A54	GP		N/A	M	Surgery	19.2.93	1 Hour	Spoilt tape	Fieldwork notes completed

Community	A55	GP		N/A	M	Surgery	19.2.93	1 Hour	No	Fieldwork notes completed and taped
Community	A56	GP		N/A	M	Surgery	19.2.93	1 Hour	No	Fieldwork notes completed and taped
Community	A57	GP		N/A	M	Surgery	22.2.93	1 Hour	No	Fieldwork notes completed and taped
Community	A58	Social Worker		N/A	F	Office	23.2.93	1.5 Hours	Refused taping	Fieldwork notes completed
Community	A59	Social Worker		N/A	F	Surgery Office	23.2.93	1.5 Hours	Refused taping	Fieldwork notes completed
Community	A60	Community Nurse		N/A	F	Health Centre	24.2.93	1.5 Hours	Yes	Fieldwork notes completed and tape not recorded
Community	A61	Community Nurse		N/A	F	Health Centre	24.2.93	1 Hours	No	Fieldwork notes completed and poor quality tape

Community	A62	GP		N/A	F	Surgery	27.2.93	1 Hour	No	Fieldwork notes completed and taped
Community	A63	GP		N/A	M	Surgery	27.2.93	1 Hour	No	Fieldwork notes completed and taped
Community	A64	GP		N/A	M	Surgery	27.2.93	1 Hour	No	Fieldwork notes completed and taped

Phase Two Interview Cycles	Code	Person Interviewed	Age	Gender	Place of interview	Date of interview	Length of interview	Transcription undertaken	Other comments
Professional Interviews									
Ward B Interviews									
Ward B	B1	Ward Manager	N/A	F	Ward Office	4.3.93	1 Hour	No	Fieldwork notes completed and taped
Ward B	B2	Ward Manager	N/A	F	Ward Area	4.3.93	1 Hour	No	Fieldwork notes completed and taped
Ward B	B3	Staff Nurse	N/A	F	Ward Office	4.3.93	1.5 Hour	Yes	Fieldwork notes completed and taped

Ward B	B4	Staff Nurse	N/A	F	Ward Area	6.3.93	1 Hour	Yes	Fieldwork notes completed and taped
Ward B	B5	Staff Nurse	N/A	F	Ward Area	6.3.93	1 Hour	No	Fieldwork notes completed and taped
Ward B	B6	Senior Nurse	N/A	F	Ward Area	8.3.93	1 Hour	Refused taping	Fieldwork notes completed
Ward B	B7	Staff Nurse	N/A	F	Ward Area	8.3.93	1 Hour	Refused taping	Fieldwork notes completed
Ward B	B8	Occupational Therapist	N/A	F	Ward Office	10.3.93	1 Hour	No	Fieldwork notes completed and taped
Ward B	B9	Social worker	N/A	F	Office	12.3.93	1.5 Hours	Yes	Fieldwork notes completed and taped
Ward B	B10	Staff Nurse	N/A	F	Ward Area	15.3.93	1 Hour	Refused Taping	Fieldwork notes completed

Ward B	B11	Staff Nurse	N/A	F	Ward Area	15.3.93	1 Hour	No	Fieldwork notes completed and tape poor quality
Ward B	B12	Doctor	N/A	M	Ward Area	16.3.93	1 hour	Refused taping	Fieldwork notes completed
Ward B	B13	Doctor	N/A	M	Ward Area	16.3.93	1 Hour	Refused taping	Fieldwork notes completed
Ward B	B14	Doctor	N/A	M	Ward Area	16.3.93	45 Minutes	Refused taping	Fieldwork notes completed
Ward B	B15	Physiotherapist	N/A	F	Ward Office	16.3.93	1 Hour	No	Fieldwork notes completed and taped
Ward B	B16	Specialist Nurse	N/A	F	Ward Office	23.3.93	1.5 hours	No	Fieldwork notes completed and taped
Ward B	B17	Doctor	N/A	M	Ward Area	23.3.93	1 Hour	Refused taping	Fieldwork notes completed

Ward C Interviews												
Ward C	C1	Staff Nurse	N/A	F	Ward Area	5.4.93	1 Hour	No	Fieldwork notes completed and taped			
Ward C	C2	Staff Nurse	N/A	F	Ward Area	8.4.93	1 Hour	No	Fieldwork notes completed and taped			
Ward C	C3	Ward Manager	N/A	F	Ward Office	11.4.93	1.5 Hour	No	Fieldwork notes completed and taped			
Ward C	C4	Senior Nurse	N/A	F	Ward Office	11.4.93	1.5 Hour	No	Fieldwork notes completed and taped			
Ward C	C5	Staff nurse	N/A	F	Ward Area	12.4.93	1 Hour	Yes	Fieldwork notes completed and taped			
Ward C	C6	Staff Nurse	N/A	F	Ward Area	12.4.93	1 Hour	No	Fieldwork notes completed and taped			
Ward C	C7	Ward manager	N/A	F	Ward Area	14.4.93	1.5 Hours	Refused taping	Fieldwork notes completed			
Ward C	C8	Staff Nurse	N/A	F	Ward Area	20.4.93	1 Hour	No	Fieldwork notes completed and taped			

Ward C	C9	Staff Nurse	N/A	F	Ward Area	20.4.93	1.5 Hours	No	Fieldwork notes completed and tape
Ward C	C10	Staff Nurse	N/A	F	Ward Area	23.4.93	1 Hour	No	Fieldwork notes completed and taped
Ward C	C11	Specialist Nurse	N/A	F	Ward Area	24.4.93	1.5 hours	Spoilt tape	Fieldwork notes completed
Ward C	C12	Specialist Nurse	N/A	F	Ward Area	24.4.93	1 Hour	Yes	Fieldwork notes completed and taped
Ward C	C13	Doctor	N/A	F	Ward Area	25.4.93	1 Hour	Taping refused	Fieldwork notes completed
Ward C	C14	Doctor	N/A	F	Ward Area	25.4.93	1 Hour	Taping refused	Fieldwork notes completed
Ward D Interviews									
Ward D	D1	Occupational Therapist	N/A	F	Ward office	2.3.93	1 Hour	No	Fieldwork notes completed
Ward D	D2	Physiotherapist	N/A	F	Ward Office	4.3.93	1 Hour	No	Fieldwork notes completed and taped

Ward D	D3	Social Worker	N/A	F	Ward Office	8.3.93	2 Hours	No	Fieldwork notes completed and taped
Ward D	D4	Ward Manager	N/A	F	Ward Area	8.3.93	1 Hour	Spoilt tape	Fieldwork notes completed
Ward D	D5	Staff nurse	N/A	F	Ward Area	9.3.93	1 Hour	No	Fieldwork notes completed and taped
Ward D	D6	Staff Nurse	N/A	F	Ward Area	10.3.93	1 Hour	No	Fieldwork notes completed and taped
Ward D	D7	Doctor	N/A	M	Ward Area	10.3.93	1 Hour	Refused taping	Fieldwork notes completed
Ward D	D8	Doctor	N/A	M	Ward Area	10.3.93	1 Hour	No	Fieldwork notes completed and taped
Ward D	D9	Staff Nurse	N/A	F	Ward Area	15.3.93	1 Hour	Refused taping	Fieldwork notes completed
Ward D	D10	Staff Nurse	N/A	F	Ward Area	15.3.93	1 Hour	Refused taping	Fieldwork notes completed
Ward D	D11	Doctor	N/A	M	Ward Area	25.3.93	1 Hour	Refused taping	Fieldwork notes completed

Ward D	D12	Staff nurse	N/A	F	Ward Area	27.3.93	1 Hour	No	Fieldwork notes completed and taped
Ward D	D13	Staff Nurse	N/A	F	Ward Area	11.4.93	1 Hour	Refused taping	Fieldwork notes completed
Ward D	D14	Doctor	N/A	M	Ward Area	25.4.93	1 Hour	Refused taping	Fieldwork notes completed
Ward D	D15	Staff Nurse	N/A	F	Ward Area	25.4.93	1 Hour	No	Fieldwork notes completed and tape poor quality
Ward E Interviews									
Ward E	E1	Staff Nurse	N/A	F	Ward Area	3.3.93	1 Hour	No	Fieldwork notes completed and taped
Ward E	E2	Doctor	N/A	M	Ward Area	3.3.93	1 Hour	Refused taping	Fieldwork notes completed
Ward E	E3	Staff Nurse	N/A	F	Ward Area	9.3.93	1 Hour	Refused taping	Fieldwork notes completed
Ward E	E4	Staff nurse	N/A	F	Ward Area	9.3.93	1 Hour	No	Fieldwork notes completed and taped

Ward E	E5	Ward Manager	N/A	F	Ward Office	14.3.93	1.5 Hour	No	Fieldwork notes completed and taped
Ward E	E6	Staff Nurse	N/A	M	Ward Area	15.3.93	1 Hour	Yes	Fieldwork notes completed and taped
Ward E	E7	Staff Nurse	N/A	F	Ward Area	15.3.93	1 Hour	No	Fieldwork notes completed and taped
Ward E	E8	Doctor	N/A		Ward Area	16.3.93	1 Hour	Refused taping	Fieldwork notes completed
Ward E	E9	Staff Nurse	N/A	F	Ward Area	24.3.93	1 Hour	Refused taping	Fieldwork notes completed
Ward E	E10	Staff Nurse	N/A	F	Ward Area	26.3.93	1 Hour	Refused taping	Fieldwork notes completed
Ward E	E11	Doctor	N/A	M	Ward Area	26.3.93	1 Hour	Refused taping	Fieldwork notes completed
Ward E	E12	Doctor	N/A	M	Ward Area	26.3.93	1 Hour	Refused taping	Fieldwork notes completed

Patients and carers Interviews																			
Ward B Interviews																			
Ward B	B18	Patient	80 years	F	Home	26.5.93	1 Hour	No	Fieldwork notes completed and taped										
Ward B	B19	Patient	82 years	M	Home	2.6.93	1 Hour	No	Fieldwork notes completed and taped										
Ward B	B20	Patient	76 years	F	Home	4.6.93	1 Hour	No	Fieldwork notes completed and tape poor quality										
Ward B	B21	Patient	81 years	F	Home	7.6.93	1 Hour	No	Fieldwork notes completed and tape poor quality										
Ward B	B22	Patient	71 years	M	Home	8.6.93	1 Hour	No	Fieldwork notes completed and taped										

Ward B	B23	Patient	68 years	M	Home	21.6.93	1 Hour	No	Fieldwork notes completed
Ward B	B24	Patient	72 years	M	Home	21.6.93	1 Hour	Yes	Fieldwork notes completed and taped
Ward B	B25	Patient	75 years	M	Home	21.6.93	1.5 Hour	No	Fieldwork notes completed and taped
Ward B	B26	Patient	71 years	F	Home	2.7.93	1 Hour	Yes	Fieldwork notes completed and taped
Ward B	B27	Patient and carer	69 years	M	Home	12.7.93	1 Hour	No	Fieldwork notes completed and taped
Ward C									
Interviews									
Ward C	C15	Patient	81 years	M	Home	26.5.93	1 Hour	Yes	Fieldwork notes completed and taped
Ward C	C16	Patient	70 years	M	Home	28.5.93	1 hour	Yes	Fieldwork notes completed and taped
Ward C	C17	Patient	68 years	F	Home	3.6.93	1 Hour	No	Fieldwork notes completed and taped

Ward C	C18	Patient	73 years	M	Home	3.6.93	1 Hour	Refused taping	Fieldwork notes completed
Ward C	C19	Patient	69 years	F	Home	4.6.93	1 Hour	Refused taping	Fieldwork notes completed
Ward C	C20	Patient	83 years	M	Home	7.6.93	1 Hour	Spoilt tape	Fieldwork notes completed
Ward C	C21	Patient	86 years	M	Home	8.6.92	1 Hour	Spoilt Tape	Fieldwork notes completed
Ward C	C22	Patient	84 years	F	Home	8.6.92	1 Hour	Refused taping	Fieldwork notes completed
Ward C	C23	Patient	75 years	F	Home	29.6.93	1 Hour	Refused taping	Fieldwork notes completed
Ward C	C24	Patient	68 years	M	Home	2.7.93	1 Hour	No	Fieldwork notes completed and taped
Ward D Interviews									
Ward D	D16	Patient	68 years	M	Home	25.5.93	1 Hour	No	Fieldwork notes completed and taped

Ward D	D17	Patient	67 years	M	Home	25.5.93	1.5 Hours	No	Fieldwork notes completed
Ward D	D18	Patient	74 years	F	Home	28.5.93	1 Hour	No	Fieldwork notes completed and taping
Ward D	D19	Patient	68 years	F	Home	31.5.93	1 Hour	Yes	Fieldwork notes completed and taping
Ward D	D20	Carer alone (Patient)	N/A 73 years	F F	Home	31.5.93	1.5 Hours	Yes	Fieldwork notes completed and taping
Ward D	D21	Patient	69 years	F	Home	31.5.93	1 Hour	Refused taping	Fieldwork notes completed
Ward D	D22	Patient	72 years	M	Home	5.6.93	1 Hour	Refused taping	Fieldwork notes completed
Ward D	D23	Patient	70 years	M	Home	21.6.93	1 Hour	Refused taping	Fieldwork notes completed And refused taping
Ward D	D24	Patient	72 years	M	Home	21.6.93	1 Hour	No	Fieldwork notes completed and taping

Ward D	D25	Patient	80 years	F	Home	23.6.93	1 Hour	No	Fieldwork notes completed and taped
Ward D	D26	Patient	73 years	F	Home	25.6.93	1 Hour	No	Fieldwork notes completed and taped
Ward D	D27	Patient	71 years	M	Home	30.6.93	1 Hour	No	Fieldwork notes completed and taped
Ward E Interviews									
Ward E	E13	Patient	69 years	F	Home	10.5.93	1.5 Hours	No	Fieldwork notes completed and taped
Ward E	E14	Patient	70 years	M	Home	11.5.93	1 Hour	No	Fieldwork notes completed and taped
Ward E	E15	Patient	71 years	M	Home	14.5.93	1 Hour	No	Fieldwork notes completed and taped
Ward E	E16	Patient	68 years	M	Home	14.5.93	1 Hour	No	Fieldwork notes completed and taped

Ward E	E17	Patient	72 years	F	Home	25.6.93	1 Hour	No	Fieldwork notes completed and taped
Ward E	E18	Patient	71 years	F	Home	29.6.93	1 Hour	Yes	Fieldwork notes completed and taped
Ward E	E19	Patient and carer	70 years	M	Home	1.7.93	2 Hours	Yes	Fieldwork notes completed Tape poor quality
Ward E	E20	Patient	66 years	M	Home	2.7.93	1 Hour	No	Fieldwork notes completed and taped

